New directions in research on well-being: psychological process in everyday contexts

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Core cognitive distortions:

1. **Self** – egocentric vision
2. **Victim** – dehumanised
3. **Sex** – as a tool to manage emotions

*(Hanson et al., 2002)*
Established Predictors of Sexual Recidivism

• Sexual Deviancy
  – Deviant sexual interests (pedophilia)
  – Sexual preoccupations
• Antisocial Lifestyle
  – History of rule violation
  – Lifestyle instability
Are treated sexual offenders less likely to reoffend than untreated offenders?
Reviews finding lower recidivism rates among treated sexual offenders than untreated sexual offenders

• Gallagher et al. (1999) – 22 studies
• Hanson et al. (2002) – 43 studies
• Lösel & Schmucker (2004) – 69 studies
Reductions in both sexual recidivism (17% to 10%) and general recidivism (51% to 32%) found when current treatments are evaluated with credible designs.
Conclusions

• Most sexual offenders are never reconvicted for a new sexual offense
• Not all sexual offenders are equally likely to reoffend
• A number of risk assessment tools are available that have demonstrated moderate to large accuracy
• Offenders who attend treatment are less likely to reoffend than offenders who do not attend treatment
• Psychoanalysis (Balier, 1995a,b)

• Relapse prevention (Marlatt, 1982, 1989; Dèttore & Fuligni, 1999)

• Efficacy of the impact of couple therapy & group therapy on recidivism (Crowell & Burgess, 1999; Paymar, 2000)
Offence’s Chain

Abstinence

Background intrusive elements

Need to fostering his own desires (cognitive semplification)

Positive opinions related to the offence

High risk behaviour related to the offence

Cognitive distortions

Contact with the victim & cognitive semplification

Sexual offence

Rationalizations following the offence

(Marshall et al., 1999)
Relapse Prevention Model - 1

(Pithers, 1990, 2003)

In North America UK
Model of the abuse chain - 2

(Pithers, 1990, 2003)

• Apparently Unimportant Decisions -> increase the probability of being exposed to high risk situations
• Dealing with the situation using coping strategies can restore abstinence
• AVE (abstinence violation effect): important element of the chain
• PIG (problem of immediate gratification)
• Coping failure -> relapse
• Focused on high risk factors, their precursors, warning signs...
• Each patient has to develop adaptability to address any risk factors typical of his aggression chain (*relapse prevention plan*: avoid high risk situations & manage unavoidable high risk situations)
• Group support & supervision settings (family, friends, counsellors, offenders...)
Relapse prevention - model

(Marlatt, 2005)
Model of the abuse chain

(Ward and Huston, 2000)

Study on 26 child molesters not in treatment -> describe their most recent offence (significant units: every event, thought, feeling & categories) -> 9 stages:

1. Background (unresolved childhood conflicts, current affective states, self-esteem’s lack or excess, etc.)
2. Offence’s remote planning (disclose or hidden)
3. Non sexual contact with the victim
4. New evaluation of the victim to allow further contact
5. Offence’s planning (cognitive distortion: the victim likes/wants it)
6. Aggression
7. Evaluation of the offence (positive or negative)
8. Relapse
9. Try to stop
1. Educational and cognitive restructuring interventions

First goals:

- Traumas resolution
- Emotional Training (emotional literacy)
- Work on cognitive distortions related to the abuse
- Changing of deviant activation modules
- Training on interpersonal skills
- Training on the lack of empathy

2. Interventions of Changing deviant sexual activation

3. Strategies to identify lapse antecedents
4. Strategies to cope with lapse:
• Stimuli control strategies
• Escape strategies
• Decision-making matrix
• Problem solving process

5. Empowerment skill strategies:
• Anxiety management Training
• Social skills Training
• Problem solving and self-control Training
• Anger and aggressive behaviour management Training
• Treatment of any eventual sexual disease

6. Team Supervision strategies focused on prevention
In Canada all the institutions available for SOs treatment offer a full range of programs, each patient follows the treatment program useful for his functioning.

Setting: Group therapy (less efficacy of individual therapy), male + female therapists, 10 participants; 2-3 sessions a week (2.5 hours per session); therapists are informed about victims’ testimony and offenders’ personal history. Creating an appropriate therapeutic alliance and a cohesive group atmosphere. Integrating into treatment approaches what is currently known about the influence of process variables will vastly improve the outcome and quality of treatment with SOs.

- Self-esteem
- Changing cognitive distortions
- Empathy’s empowerment
- Social functioning & Modelling appropriate behaviours
- “Real-life” issues and problems
- Focused on client strengths
- Responsibility
- Changing deviant sexual preferences
- Relapse prevention
The self-regulation model of relapse prevention

(Ward & Hudson, 2000)

9 phases & 4 pathways organised around the nature of sexual offence goals (approach versus avoidant) and the types of strategies used to achieve those goals.

Phase 1: Life event
Phase 2: Desire for deviant sex or activity
Phase 3: Offence related goals established
Phase 4: Strategy Selected
Phase 5: High-risk situation
Phase 6: Lapse
Phase 7: Sexual Offence
Phase 8: Post offence evaluations
Phase 9: Attitude towards future offending
Murphy and McGrath (2008):

All the programs should in SO treatment have a clear, evidenced-based model of change; adhere to the risk, need, and responsivity (RNR) principles:

• intensity of services is matched to risk (the risk principles);
• treatment targets are chosen that are clearly linked to reoffending (need principle);
• use effective methods, primarily, cognitive behavioral and skills based, and ensure treatment is adjusted to the learning style of the individual and methods are designed to engage and motivate (responsivity principle);
• ensure continuity of care;
• provide staff appropriate training and supervision;
• conduct ongoing program monitoring and evaluation.
SOs’ Treatment programs: empathy training component as part of a comprehensive intervention package, because social disconnection and relationship ruptures related to empathy failures often trigger offending, and also because it is hard for people to grasp how individuals can inflict severe harm on others without lacking empathic capacities. Concept of psychological altruism and altruism failure and consider its conceptual relationship to empathy and morality. Multidimensional concept of altruism can provide a useful ethical resource through which to approach the various tasks of practice.

They describe recent innovations in SO psychological treatment that integrates into a strength-based approach the following programs:

• Andrews and Bonta’s Principles of Effective Offender Treatment
• Ward’s “Good Lives Model” (GLM)
• Miller and Rollnick’s Motivational Interviewing.

An example of a strength-based program is described, which the evidence suggests is effective in reducing sexual reoffending.

The authors recommend that therapists providing treatment for SOs incorporate these recent developments in psychological treatment into their programs.
Schmucker and Lösel (2015):

• The study contains a meta-analysis (3000 published and unpublished documents: 29 eligible comparisons containing a total of 4,939 treated and 5,448 untreated sexual offenders).

• Cognitive-behavioral and multi-systemic treatment as well as studies with small samples, medium- to high-risk offenders, more individualized treatment, and good descriptive validity revealed better effects.

• In contrast to treatment in the community, treatment in prisons did not reveal a significant mean effect, but there were some prison studies with rather positive outcomes.
Safe Offender Strategies (SOS)

• is a manualized SO treatment program that emphasizes the role of self-regulation and self-regulatory skills development in SO treatment, particularly for offenders with serious mental illness and intellectual/developmental disabilities
• 156 adult male SOs in an inpatient psychiatric setting who received SOS treatment (6 months-1 year).
• Dependent variables included monthly count rates of verbal and physical aggression and contact and noncontact sexual offending, as well as sexual deviancy attitudes, self-regulatory ability, and cooperation with treatment and supervision, as measured by the Sex Offender Treatment Intervention and Progress Scale (SOTIPS).
• Significant treatment dose effects were identified for improvements in aggression, sexual offending, and indicators of treatment compliance and change.
• Skills-based, self-regulation approach utilized in SOS may be effective in improving clients’ aggressive and sexual behaviors, attitudes toward their offenses and treatment, and self-regulatory ability over time.

(Stinson, Becker, McVay, 2015)
Kim, Benekos, Merlo (2015):

Review and synthesize meta-analyses of SO treatments designed to reduce recidivism

Findings:

• Every meta-analysis found significant recidivism reduction outcomes.
• SO treatments can be considered as “proven” or at least “promising,” while age of participants and intervention type may influence the success of treatment.
• The most recent five meta-analyses (Hanson et al., 2009; Lo¨sel & Schmucker, 2005; Pray, 2002; Reitzel & Carbonell, 2006; Walker et al., 2004) did find significant effects, suggesting a 22% reduction in recidivism.
Blagden, Winder & Hames (2016):

• Research evidence that SO treatment programs (SOTPs) can reduce the number of SOs who are reconvicted.

• The study of the prison environment was conducive to rehabilitation. The quantitative strand of the research sampled prisoners (n = 112) and staff (n = 48) from a therapeutically orientated SOs prison.

• This strand highlighted that both prisoners and staff had positive attitudes toward offenders and high beliefs that offenders could change. Importantly, the climate was rated positively and in particular, had very high ratings of “experienced safety.”

• The qualitative strand of the research consisted of semistructured interviews with prisoners (n = 15) and a range of prison staff (n = 16).

• The qualitative analysis revealed positive prisoner views towards staff relationships, with the greatest contribution to positive change in prisoners
Table 2
Differences between the RNR and the GLM.
Adapted from Wormith (2015, November). RNR and GLM: Shall (or should) ever the twain meet?, The 2nd Annual IACFP Edwin I. Megargee Lecture presentation at the International Community Corrections Association (ICCA) Conference, Boston, Massachusetts.

<table>
<thead>
<tr>
<th>RNR</th>
<th>GLM</th>
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<tbody>
<tr>
<td>Neutral perspective of humankind – learning and social learning theory</td>
<td>Positive perspective of humankind – comparable to strain and frustration-aggression theory</td>
</tr>
<tr>
<td>Negative orientation to offender client and task</td>
<td>Positive orientation to offender client and task</td>
</tr>
<tr>
<td>Risk based – suppress</td>
<td>Strengths based – build</td>
</tr>
<tr>
<td>Criminogenic needs targeted</td>
<td>Primary needs targeted</td>
</tr>
<tr>
<td>Objective: management of risk</td>
<td>Objective: life enhancement</td>
</tr>
<tr>
<td>Well-being is ‘discretionary’</td>
<td>Well-being is essential</td>
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<tr>
<td>Criminals are different from non-criminals in many ways (e.g., cognitions, personality)</td>
<td>Criminals are fundamentally the same as non-criminals; universal underlying values</td>
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</tbody>
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Video:

• https://www.youtube.com/watch?v=9TtY6WyJNZM&t=773s
Grady et al. (2017):

- Examined recidivism outcomes for a sample of formerly incarcerated SOs who participated in a state prison-based cognitive-behavioral-skills-based treatment program, comparing treatment participants with a matched sample of non-participants.
- N= 512 ss observed for a minimum of 4 years and a maximum of 14 years.
- Findings indicate that there were no differences in recidivism rates between treatment participants and non-participants in sexual or violent crimes.
- However, participants demonstrated significantly lower rates of recidivism for non-violent crimes.
It is proposed that the standard cognitive-behavioural programs could be improved by providing extensive opportunities for offenders to practise disengaging deviant sexual schema.

**Foundamental active ingredients of effective treatment:**

1. creating a context in which change is possible,
2. teaching mechanisms for disengaging schema,
3. using mechanisms for invoking schema, and,
4. repeated practice invoking, then disengaging schema.
Some possible methods for invoking deviant schema would be to:

• have the offender remember all the times that he has been used, humiliated, or rejected by women.

• repeat key phrases that have been particularly hurtful ‘I’m such a loser’.

• create ideal sexual fantasies tailored to the offenders’ offence history.

• read material containing attitudes tolerant of sexual assault, such as North American Man Boy Love Association (a paedophile group) newsletters.

• view pornography.
1. Obtain an account of the sexual offense(s) moving from parents, to siblings, to offender, to victim
2. Ask each family member why it was wrong beginning with the offender
3. Therapist adds that it was also wrong because it caused the victim spiritual pain or “pain in the heart”
4. Therapist adds that it also causes a spiritual pain in the victimizer
5. Discuss other sexual victimization that has gone on in the family
6. Therapist adds that these behaviors also cause a spiritual pain in the family
7. The Apology – offender gets on knees in front of the victim and repents
8. The Apology II – other family members get down on their knees and repent for not having protected the victim
9. Discussing the consequences of any future abuse
10. Find a protector for the victim (e.g. responsible uncle, two grandmothers, etc.)
11. Individually with victim – work to place the abuse in context and orient victim to positive things in his/her life
12. Reparation – an act of long-term sacrifice for the offender that is beneficial to the victim
13. Reconnecting the offender to peers and appropriate social and sexual activities
14. Restoration of the parent’s love for the offender
15. Restoration of the offender’s role as protective of younger sibling
16. Help offender to forgive him/herself

Strategic model
(Madanes, 1990, 1995)