RNR and the Power of Preparation and Motivation for Engagement in Group-Based Treatment

1

Continuing Excellence – November 12, 2021

Jerry L. Jennings, Ph.D.
Vice President of Clinical Services
Liberty Healthcare Corporation
Bala Cynwyd, PA
jerry.jennings@libertyhealth.com

Steven Sawyer, MSSW
President
Sawyer Solutions, LLC
White Bear Lake, MN
ssawyer@sawyersolutions.org

1

Agenda

2

11:00–11:15 Introduction and key points of training focus
11:15–11:30 The current state of contemporary treatment
11:30–12:00 Review empirical/clinical studies of group tx specific to SOST
12:00–12:30 Common barriers to entering and engaging in treatment/denial
12:30–12:45 Break
12:45-1:30 Strategies for increasing engagement in treatment
1:30–2:00 Research pertaining to pre-treatment preparatory programs
2:00–2:15 Break
2:15–2:30 Risk Needs Responsivity principles – more than dosage?!
2:30–2:45 Examples of "prep treatment" from the research literature
2:45–3:25 Incorporating a client workbook with chapter by chapter examples
3:25–3:30 Conclusion

2

Workshop Goals

3

1) Learn methods for pre-treatment orientation and preparation for group-based treatment.
2) Learn of research related to pre-treatment and motivational approaches in sex abuse-specific group-based treatment.
3) Learn how a client workbook can be incorporated into pre-treatment preparation and can invite self-discovery of personal character strengths, "toxic" masculinity and gender stereotypes, cooperation, and receiving and giving help, and can enhance motivation and openness to treatment engagement.
4) Learn techniques for facilitating interpersonal interaction in the group for enhanced cohesion and treatment effectiveness
5) Learn group-based techniques for reducing defensiveness and facilitating social engagement.

3

Topics to Cover

4

1) RNR principles as related to the value of pre-treatment preparation and individual motivation for group-based treatment
2) Integration of strengths-based client workbook approach to enhance engagement in group-based offender treatment
3) Group techniques for facilitating interaction and group cohesion
4) Explain how the exercises of each chapter address common barriers to engagement in treatment and can help overcome them, such as
   - Strengths-based self-evaluation
   - Fears about entering group
   - Giving and receiving help/feedback
   - Toxic masculinity/gender role training

4

Mission: Getting a good start to group-based treatment

5

Ways to facilitate meaningful client engagement in treatment as early as possible and maintaining it.

Conversely, understanding ways we hinder and delay engagement by (inadvertently) increasing defensiveness, denial, program drop-out, resistance, poor participation, etc.

5

Contemporary Sexual Offense Specific Treatment (SOST)

6

1) SOST is typically **group-based**, with psychoeducational modules, and primarily cognitive behavioral treatment (CBT) with other theoretical models (self-regulation, Good Lives model, relapse prevention).

   But much SOST neglects, ignores, or fails to take advantage of the therapeutic power of **the group modality** itself.

   For more than 20 years, Sawyer/Jennings have promoted improved effectiveness of SOST by making better use of the group modality, especially cohesion and interpersonal relating.

2) SOST is **guided by principles of RNR** (Risk Needs Responsivity).

   But much SOST neglects the importance of **responsivity**.

6

So… our two-fold focus today is to:

1) Talk about the vital ways that entering/starting SOST is especially and specifically about **entering group treatment** and taking advantage of the unique therapeutic power of the group modality.

   AND

2) Talk about how to genuinely incorporate the **responsivity principle** in **group-based** treatment by attending to the individual's needs, barriers, and readiness to enter group-based treatment.

Both are built into a new client workbook for preparation and motivation for "*Getting the Most from Group*" – to be described.

7

Barriers to entering and engaging in treatment

More often than not, individuals are "thrown" into a one-size-fits-all structured group program with little or no preparation or orientation and… at a time when they are most overwhelmed and in their most acute emotional states of vulnerability and grief.

Worse yet, their lack of preparation and lack of motivational readiness is too often negatively perceived by the treatment provider as denial, evasion, avoidance of responsibility, and resistance to treatment.

8

Common barriers to entering/engaging in treatment (1)

- Clients are most often mandated into SOST, or feel adverse pressure to enter treatment (external pressure vs internal motivation to change) = no freedom of choice.
- Tremendous social stigma of being labelled a sexual offender.
- Fear of public humiliation and social condemnation.
- Overwhelmed by emotional trauma of arrest/incarceration (depression, suicidality, anxiety, terror, etc.).
- Overwhelmed by grief of the losses of loved ones, job, reputation, home, freedom, etc.

9

Common barriers to entering/engaging in treatment (2)

10

- Anger at the criminal justice system and injustice.
- Perception of therapist as agent of criminal justice and therefore cannot be trusted.
- Legal advice to withhold incriminating information vs. disclosure
- Concerns about violation of privacy/confidentiality in a group.
- Loss of dignity, self-loathing, self-condemnation.
- Hopelessness, helplessness, loss of control.

10

Revisiting RNR in terms of barriers and readiness for treatment

11

Given the prevalence of these barriers and lack of internal motivation challenges, what can we do better?

RNR "responsivity" principle is about maximizing the individual's ability to benefit from the rehabilitative intervention by providing CBT and tailoring the (CBT) intervention to the learning style, motivation, abilities and strengths of the individual offender.

11

What does research say about SOST group treatment?

12

Therapeutic qualities of group therapist (warmth, empathy, encouragement, and guidance) can strongly affect outcomes (Marshall & Burton, 2010; Marshall et al 2013)

Quality of group cohesion and therapeutic climate can profoundly affect treatment effectiveness (Jennings & Deming, 2016)

Overwhelming evidence that confrontation is ineffective, if not counter-therapeutic

Evidence that SOST clients generally prefer group over individual.

★ Also, the general group therapy literature emphasizes the importance of **pre-group preparation**

12

Empirically Guided Principles for Group Therapy

(Burlingame, Fuhriman & Johnson 2002)

13

1. Pre-group preparation… ★
2. Clarity…in early sessions…
3. Composition…
4. Real time observation…
5. Timing and delivery of feedback…
6. Emotional presence of therapist…

13

1. Pre-group Preparation

14

- ❑ Inform client about group process, structure, expectations
- ❑ Acknowledge and help to reduce anxiety
- ❑ Answer questions/address barriers
- ❑ Elicit engagement
- ❑ This is a pre-treatment focus until the client voices a stronger degree of engagement.

14

Sample Group Guidelines/Expectations

15

- Come prepared and on time to group.
- Remain in the group for the duration of the session.
- Maintain confidentiality; what is said in group stays in group.
- Be respectful.
- Assist the group by actively participating.
- Role model accountability.
- Support other group members to be accountable.
- Show respect for the group physical space.

15

Educate about preferred group member behavior

16

- ***Challenge.*** Client appropriately (in a supportive and non-abusive manner) challenges other group members.
- ***Support.*** Client offers comments that are encouraging toward another group member.
- ***Relate to Offense.*** The client may reference his or her sexual offense or offending behavior as part of a treatment assignment, or may refer to thoughts, triggers or behavior consistent with criminal behavior.
- ***Personal Reference.*** Client references his or her own experience, thoughts, or feelings; "I can relate…", "That makes me feel", "I had a similar experience…"

16

Do you provide pre group preparation?

17

- Is it about the rules?
- Is it about how to participate?
- Is it about how to benefit from the group experience?

"Every rock has it's soft spot".

Client in group reflecting on how he failed by committing his offense.

17

Importance of how group treatment is delivered - or can be delivered

18

Psychoeducational group (without interaction)	Group-centered group (emphasis on interaction)
Group leader always leads – more like teacher in classroom	Group leader facilitates interaction among members
Tendency to focus on one member at a time to review his individual homework/assignment ("individual therapy-in-a-group")	Focus on group as a whole, facilitating discussion and sharing of common fears, experiences, problems among members.
Problem-solving is focused on identifying and correcting each individual's thinking errors and behaviors	Encouraging group members to give help and support to peers (altruism) and facilitating ability to accept/receive help and helpful criticism – using group feedback and engaging all group members in problem-solving process.
Content over cohesion – primary emphasis on covering the educational material in today's group topic (per curriculum)	Cohesion over content – primary emphasis on maintaining a safe and accepting group climate where members can build bonds and trust

18

Importance of how group treatment is delivered

19

Group therapeutic climate promotes treatment change: Successful groups were cohesive, effective leadership, sense of group responsibility, encouraged expression of feelings, and instilled hope in members (Beech and Fordham (1997)

Groups with strongest cohesion showed superior outcomes on measures of dynamic risk, cognitive distortions, denial & admission of offense behaviors. Low cohesion showed worst outcomes (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005).

Cohesion (over content): Group cohesion fosters a learning environment in which clients can be more receptive to SOST CBT interventions.

Cohesion is therapeutic factor considered most important and foundational in group therapy and is the therapeutic factor most often studied in group therapy research (Burlingame, McClendon & Alonso, 2011).

19

Importance of how group treatment is delivered

20

Engaged group members make better progress: Strong relationship between engagement and treatment progress. Clients who actively contribute are more connected to other members and therapist. Clients engaged and invested in treatment more likely to progress in treatment than those who are not (Levinson, Macgowan, Morin & Cotter, 2009).

Positive (no confrontation): Using positive, empathic approach encourages client ownership of change, which may decrease need for self-protective strategies such as denial (Kear, Colwell & Pollock,1997; Jenkins,1990).

Group therapist qualities: Empirical studies show therapists' qualities of warmth, empathy, encouragement, and guidance can decisively impact engagement and outcomes (e.g., several Marshall studies).

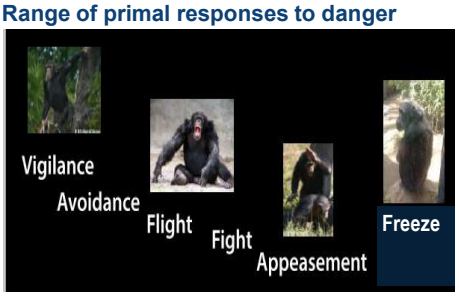
Importance of group process & facilitation techniques (Sawyer & Jennings (2003, 2014, 2016)

20

Understanding group at the biological level:

21

Range of primal responses to danger



21

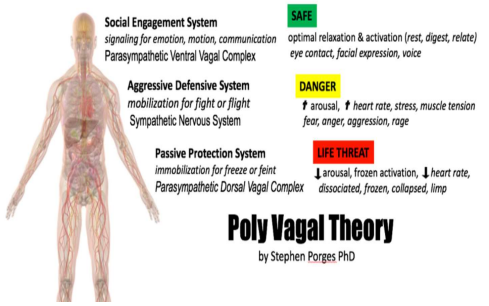
Mechanisms of polyvagal theory/neuroception

22

Humans are pre-wired in two fundamental ways:

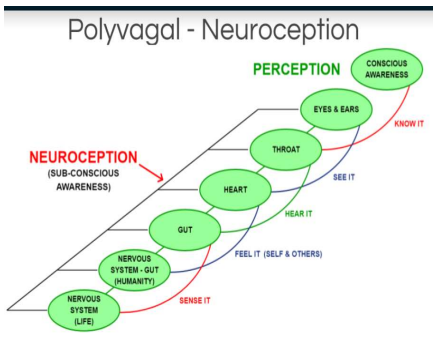
- #1—our bodies are pre-wired to be defensive and vigilant to danger and to react quickly (fight, flight, freeze). And even more so for this client population with trauma, ACEs, attachment deficits, etc.
- #2—we are social animals pre-wired to need and seek interpersonal connection (highly rewarding when experienced!)

22



23

23



24

24

Group therapy is a process of…

25

#1—establishing a safe climate in which members can lower defensiveness and better attend/learn…

in order to activate

#2—innate social engagement (group cohesion) for emotional and interpersonal learning

25

Strategies for increasing engagement – Do's

26

- Reducing and allaying fears/anger/defensiveness thru preparation & education/orientation re: treatment in general & group in specific.
- Showing sensitivity to the client's level of distress and vulnerability.
- Starting with identification (self-discovery) of personal individual strengths/virtues.
- Preparing group to receive new member.
- Using group's capacity for "installation of hope" for new members.
- Appealing to and inviting curiosity, self-discovery,
- Motivational interviewing techniques.

26

Strategies for increasing engagement – Dont's

27

- Avoid confrontation.
- Avoid programmatic requirements for premature disclosure of offenses/shameful behavior.
- Avoid premature and intensive focus on offenses, criminogenic factors, negative self-labeling.

27

Research about pre-treatment prep programs

28

Pre-treatment approaches have been tried, but our guiding question is the nature of that pre-treatment:

Quantity (dosage) vs **Quality** (different treatment).

Clients who get pre-treatment prep are simply getting more hours of the same main CBT treatment?

Or

Is pre-treatment providing a **qualitatively** different treatment that promotes engagement in standard CBT?

28

RNR – Risk principle

29

RNR "risk" principle says that intensity/dosage of treatment should be proportional to individuals' level of risk (low risk do better with less intensive Tx, high risk do better with more Tx).

- Little research on impact of dosage for those who complete SOST
- Dosage in programs differs in terms of:
  - Extending the length of Tx over longer period of time, or
  - Including more hours in Tx in more concentrated time frame.

29

Risk principle

30

"Treatment is driven by level of risk."

How high is the individual's risk for reoffending? (presumes that risk can be predicted from low to high)

Treatment should be preserved for medium and high risk (and not "wasted" on low risk)

But dosage concept impacts here, too: give more treatment to medium risk and most treatment to high risk

Restated: "dosage of treatment is driven by level of risk."

30

RNR – Need principle

"Need" principle says to assess and target criminogenic needs –

but what if other (non-criminogenic) needs (especially the client's initial emotional/defensive state) is functioning as a barrier to both accurate assessment and engaging in treatment?

Can non-criminogenic needs (such as low perceived self-efficacy and inadequate adult attachment styles) impede treatment of underlying criminogenic needs?

31

Needs principle

Needs: Criminogenic needs are unique to each individual.

Common categories/types are the "Big Four" or "Big Eight":

BIG 8	**BIG 4**	❖ Anti-social behavior (early & continuing involvement) ❖ Anti-social personality pattern (poor self-control, restlessly aggressive, thrill seeking) ❖ Anti-social thinking/attitudes ❖ Anti-social associates
		❖ Family/intimate partner problems ❖ Work/school problems ❖ Substance abuse ❖ Lack of leisure/ recreation

32

RNR – Responsivity principle

"Responsivity" principle is maximize the client's ability to benefit from the (CBT) treatment by tailoring interventions to the learning style, motivation, abilities and strengths of the client.

- This is NOT just giving **more** CBT treatment and more exposure to the core content, and is NOT just targeting criminogenic needs.
- Preparatory treatment can be used to promote individual motivation and strengths that increase ability to engage in treatment.

33

Responsivity Principle

34

Research on Responsivity principle is still **scarce** (Bonta & Andrews, 2017)

Limitation of research on responsivity principle is HOW it is conceived and investigated:

- Most research focuses on the **characteristics** of the individual,
- Rather than **how** interventions should be **tailored** for individual

Treatment effectiveness increases when it addresses **all three** RNR principles

The more responsivity issues clients show, the **less** likely they are to benefit from treatment (Hubbard & Pealer, 2009; O'Brien & Daffern, 2016).

34

Six examples of preparatory SOST treatment:

35

(1) "Non-disclosure" treatment for deniers (Ware 2017)

(2) Pre-SOAR program (Renn, et al, 2020):

(3) Rockwood Preparatory Program (Marshall, et al 2008, Marshall & Moulden, 2009).

(4) "Barriers to Change" Motivational Program (Jennings, Jumper & Baglio, 2021)

(5) Brief offending-focused motivational interviewing (Anstiss et al, 2011)

(6) "Applications" motivational group (Prescott, 2008, 2007).

35

(1) "Non-disclosure treatment" for deniers – first generation of "motivational" pre-treatment?

36

Problem of treating "deniers" has been discussed & researched since 1980s.

Denial was seen as both important **risk factor** and primary **treatment target.**

Presumption was that deniers lack motivation to change because they won't take responsibility and therefore are at increased risk of reoffending.

Ultimately, large scale meta-analyses show **no consistent relationship between denial and sexual recidivism**! (Hanson et al, 1998; Hanson & Morton-Bourgon, 2005; Mann, Hanson, & Thornton, 2010)

Before knowing this, however, denial (accepting responsibility) was typically one of the very first treatment targets in traditional CBT/RP.

In turn, CBT SOST treatment was more **confrontational** in style – largely elicited by and centered upon attacking denial to reduce risk.

36

Treatment for those in Denial

37

- Presumption was that deniers would be disruptive and undermine the group treatment for non-deniers. So many programs would withhold treatment for offenders "in denial."
- In clinical practice, vigorous efforts to overcome denial early in treatment would cause both the therapist (& group peers) to become more confrontational or hostile.
- Increasing recognition that confrontation was ineffective, if not counter-therapeutic, by actually increasing defensiveness and "denial."
- Nonetheless, denial still seen as problematic – as a barrier to engagement or as a lack of motivation. So what to do?

37

Three approaches to treating deniers

38

(1) Separate for pre-treatment of denial: Deniers were separated from non-deniers for an intervention that **explicitly targeted denial** using either one-to-one or group format (Brake & Shannon, 1997; Murphy & Barry, 1995; Schlank & Shaw, 1996). But poor results (<50% took responsibility) (Ware, Marshall & Marshall, 2015)

(2) Separate, but don't require disclosure of primary offense: This approach separated deniers, but **explicitly avoided** attempts to confront denial of primary offense, but instead focused on reducing the likelihood of further *allegations"* and continued addressing other criminogenic issues (Marshall, Thornton, Marshall, Fernandez and Mann, 2001; Ware, 2018)

(3) Treat together and address denial indirectly: This approach treats deniers together with admitters, but attempt to **overcome denial indirectly** within the broader context of treatment addressing criminogenic issues (very common approach, but no research)

38

Do "deniers" harm group therapeutic climate?

39

Ware (2018) measured therapeutic alliance and group climate early and late in treatment for 77 sex offenders (categorical deniers and admitters in separate groups, same tx except no challenging of denial).

Therapeutic alliance: no differences except that…

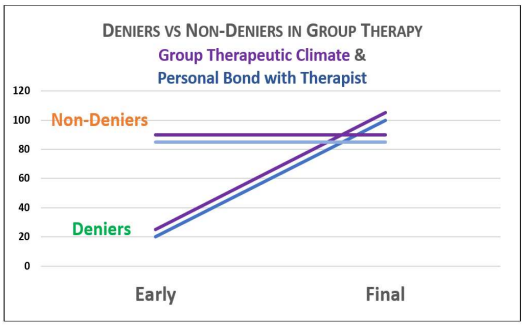
Early in treatment, deniers struggled more with forming personal **Bond** aspect of TA (but fine with **Task Agree** and **Goal Agree**), but equal to admitters by the end of treatment.

Group therapeutic climate: no differences except that…

Deniers perceived significantly lower levels of anger and disagreement within the group (i.e., deniers perceived group as more "safe" than admitters).

Deniers made significant improvements in group climate over time, while admitters were unchanged.

39



40

40

Conclusions about denial and treatment?

- Pre-treatment that separates deniers and explicitly targets denial appears ineffective and may increase denial.
- Not necessary to separate deniers from non-deniers in group treatment.
- Categorical deniers are significantly more shame-prone, and likely to use externalization as a method of impression-mgmt (Ware, Blagden & Harper, 2018) .
- Denial often due to shame or fears of losing family support (Ware & Harkins, 2015).
- Deniers are **not** different from admitters either in terms of risk or **amenability** to treatment (!!!). So "deniers" are no less "ready" for treatment, but appear more sensitive about public shaming.
- Purpose of denial has important implications for risk assessment & treatment.
- But research limited by small sample sizes and lack of consistent definition of "denial."

41

41

(1) Pre-treatment for deniers -- Conclusions

►Separating deniers from admitters and putting them into special **pre-treatment to explicitly address denial** = **poor results**

►Separating deniers from admitters and giving them standard treatment **without requiring disclosure** of offense = **effective**

Results: Although deniers may struggle more with bonding with group therapist and group therapeutic climate at the START of treatment, they can respond to and benefit from group treatment just as well.
ESPECIALLY if treatment is modified so that deniers are NOT pressured to disclose and admit to their sex offenses at the START of treatment.

- Deniers appear to be more shame-prone and thus more defensive to confrontative approaches (Ware & Harkins, 2015).
- Deniers use denial because of fear of losing family/support and to reduce feelings of shame or low self-worth (Ware, Marshall, Marshall, 2015)

42

42

(2) Pre-SOAR program

Role of preparatory programming in increasing effectiveness of SOST
(Renn, Veeh, Grady, Edwards, Pettus-Davis & Kelton, 2020)

Sexual Offender Accountablity & Responsibility (SOAR) -- NC DOC

20-week CBT residential group treatment: 5 days a wk/6 hrs day = 600 hrs total

Compared Pre-SOAR pre-preparatory program with full SOAR program for 343 SOs: 103 completed pre-SOAR, 147 completed SOAR, 93 completed both.

Pre-SOAR addresses same core topics as SOAR, but is less intensive with fewer group interactions, more condensed lessons, and less program time (8 weeks for 1.5 hours per week).

- Found that combination of Pre-SOAR preparation and full SOAR program did better than SOAR alone (8% less reincarceration).
- Pre-SOAR-alone did poorly, returning to prison one year earlier.

43

(2) Pre-SOAR program -- Conclusions

Critique:

- The study only shows the effect of **dosage** because pre-prep was the same (not different) than full SOAR program. Participants received more of the same treatment program.
- Huge difference between just 12 hours (pre-SOAR) vs 600 hours (SOAR) vs 612 hours (both)
- Program is admittedly described as “confrontational” by the authors.

44

(3) Rockwood Preparatory Program

Corrections-based, designed to reduce resistance to main SOST tx program
(Marshall, et al 2008, Marshall & Moulden, 2009).

- Enter assessment facility to determine prison placement based on Risk & Need.
- Invited to volunteer and given a **group-based intro session**, covering:
  - -- Group rules, i.e., confidentiality, appropriate participation, attendance;
  - -- Orientation to risk and prison-placement (based on Risk and Needs);
  - -- Orientation to treatment content and outcome; and
  - -- Group members introducing themselves and **sharing nonthreatening information**, such as what they did for work prior to coming to jail.

Trained to use empirically-supported group processes: therapist features (warmth/empathy/supportive guidance), clients’ perceptions of therapist, therapeutic alliance, and group climate (Marshall & Burton, 2010)

45

(3) Rockwood Preparatory Program

46

Preparatory program components:

- Open-ended groups - members roll in and out as placed in their prisons.
- Attend two 2.5 hour group sessions per week.
- Average 6 to 8 weeks to complete (32 to 42 hours total).
- 2 sessions to "**get adjusted** to group before starting first in-group exercise."

After single introductory group session, sessions involve in-group exercises on:

- ✓ Disclosure.
- ✓ Autobiography.
- ✓ Victim empathy.

Note: The group exercises are same as the subsequent full treatment program, but aim is to "motivate participation" (later on…)

46

(3) Rockwood Preparatory Program

47

Study #1: 26 SOs completed pre- and post-treatment measures of motivational effects – conceptualized as hope, self-efficacy, stages of change, and readiness for treatment. Found significant improvements in:

Optimism
Hope for future
Agentic thinking, and
Readiness to change.

Study #2: focused on long-term recidivism: Compared 94 prep program completers with 94 non-completers and found **no** differences in sexual recidivism, but completers had lower non-sexual recidivism

47

(3) Rockwood Preparatory Program - Summary

48

Results: Increasing motivation and hope prior to treatment enabled individuals to fare better both during course of incarceration and on release.

"Hope theory as a theory of motivation" – role of hope in behavioral change (Marshall & Moulden 2009)

Critique:

- Provides pre-group orientation, but too much information to cover in a single introductory group session?
- Given two sessions to "adjust" to group format before start exercises.
- No confrontation; attention to therapeutic alliance qualities.
- But treatment content (i.e., "exercises") are the same as subsequent full treatment program

48

(4) "Barriers to Change" Motivational Program

49

50 civilly committed SVPs resistant to and/or failing to engage/make progress in main CBT SOST program. (Jennings, Jumper & Baglio, 2021)

- Started five simultaneous groups of 10 SVPs with explicit intention to NOT target criminogenic issues and offense behavior
- Instead provide an opportunity to experience positive interpersonal relations.
- Attended twice weekly relationship-focused group therapy sessions.
- Measured attachment style/deficits pre- and post-treatment of 7 months duration.
- Measured group therapeutic climate once per month.

49

(4) "Barriers to Change" – Conclusions

50

Results:

- Found improvements in secure subscale items for reduced loneliness, reduced fear of acceptance, & increased comfort in depending on others.
- Groups with better overall ratings of therapeutic climate showed more movement toward secure attachment.
- Improvements in attitude and motivation so dramatic and consistent that ***open-ended motivational groups continue today as a program staple 3 years after the pilot***.

Critique: An excessive focus on offense behavior emphasizes personal weaknesses and generates resistance. Distinctly different treatment that appealed to individual strengths and relatedness.

50

(5) Brief offending-focused motivational interviewing

51

58 prisoners with mixed offenses (some SOs) offered brief MI – consisting of an offending-focused intervention manual and 1-hour individual sessions. typically completed in 3 to 5 sessions. Entirely voluntary. (Anstiss et al, 2011)

- There was NO "traditional" criminogenic rehabilitation program. So this was **not used to prepare or motivate** participation **in main treatment program**. MI completers increased readiness to change by an average of one stage, while no-MI men showed no change.
- MI completers were significantly less likely to be reconvicted than no-MI.
- Whether undertook MI or not, a positive change in state of readiness to change predicted less reconviction.

See also case study of Motivational Interviewing for "deniers" by Ware & Hawkins (2015).

51

(5) Brief offending-focused MI – Conclusions

52

Critique:

- Raises question as to RNR "risk" principle that treatment program must directly target change in dynamic criminogenic risk factors to reduce reconviction risk.
- Perhaps there is MORE than one mechanism involved in desistance.

52

(6) "Applications" motivational group

53

Group-based program for civilly committed SVPs at Wisconsin secure treatment facility to facilitate early phase of SOST program and enable progress to next level (Prescott, 2008, 2007).

Designed to avoid problems of confrontation, coercion & "resistance"

Heavy use of Motivational Interviewing principles and techniques:

- Do not expect that all clients can immediately meet the challenges of entering treatment and start examining their offense histories.
- Facilitator's job is NOT to advocate value of treatment, but remain open to client ambivalence & supportive of any emerging commitment to change
- Focus on **just one to four goals** rather than a comprehensive laundry list of treatment-interfering factors so client can stay focused on goals.
- No curriculum – open-ended: "What areas would **you** like to discuss today?

53

(6) "Applications" motivational group – Summary

54

Results: By addressing attitudes, thoughts, and behaviors that interfere with treatment, the early phase of the program can better prepare patients for the later phases of treatment.

- Group provides the benefits of feedback, questions, & discussion from peers and is opportunity to practice having challenging discussions within a group context before delving into deeper issues.
- Uses a cognitive skills curricula.
- Special attention to demonstrating change in their daily lives.

Critique:

- Explicit attention to promoting motivation first; highly individualized.
- But does requirement of cognitive skills curricula itself retain "coercive" approach and conflict with MI principles of promoting individual choice?

54

Types of Pre-Treatment	Always focus on criminogenic	Strict avoidance of confront	Qualitatively different than standard treatment?	Hours/ Weeks
Deniers treatment (Ware 2018)	Yes	Yes	Same CBT, but allow non-disclosure at start	(45 hrs?) 20 wks
Pre-Soar (Renn et al, 2020)	Yes	No	No	12 hrs 8 wks
Rockwood Prep (Marshall et al, 2001, 2009)	Yes	Yes	Yes, focus on hope, allow non-disclosure, 2 sess to "adjust"	32-42 hrs 6-8 wks
Barriers to Change (Jennings, Jumper, B, 2021)	No	Yes	Yes, focus on self-esteem and interpersonal relating	60 hrs 30 wks
Brief Motivational Interv. (Anstiss, et al 2011)	No	Yes	Yes, focus on motivation	3-5 hrs
Applications (Prescott 2007, 2008)	Yes	Yes	Yes, focus on motivation	flexible (months?)
Client Motivational Workbook (Jennings & Sawyer, 2021)	No	Yes	Yes, focus on strengths, invite self-discovery, and openness for motivation	flex 7-8 hrs 1-2 wks

55

Incorporating a client workbook approach

56

Getting the Most From Group workbook designed to complement and augment overall treatment and group work by:

- *Preparing* clients to enter group therapy with hope rather than apprehension
- *Motivating* them to engage early and more meaningfully in treatment,
- *Engaging* their own process of self assessment and self reflection, encouraging more internal focus and internal locus of control

Fits any therapeutic framework (CBT, psychodynamic, Good Lives, interpersonal)

Fits any setting: outpatient, residential, inpatient, correctional, forensic

Fits multiple treatment types (substance abuse, DV, SOS, MH, Anger)

56

Key elements – Chap. 1. Starting with Strengths

57

To facilitate positive attitude toward treatment, workbook begins with orienting description that:

(1) treatment will be both a personal and **social** experience (the group and relationships) and

(2) Treatment is about building on strengths.

The latter becomes an invitation to **self-assessment** and recognition of personal strengths:

Thus far, client's experience with criminal justice and SOS assessments have been drilling down on offense details, sexual history, deviance, risk, faults, etc. In sharp contrast, client is invited to **self-identify positive character traits**.

57

Key elements – Chap. 1. - Strengths

58

- Self-discovery and recognition of positive strengths helps to counteract the tendency toward self-reproach and dwelling upon all the wrongs, mistakes, and failures.
- Beneficial for motivating clients who are angry or in despair over losses, mistakes, or offenses that led to being recommended or mandated for treatment.
- Facilitates positive mindset of curiosity, discovery, and learning.
- Helps with barriers

58

Key elements – Chap. 1. Strengths

59

Self-assessment of character strengths is cast in **interpersonal** context, not a self-focus.

Examples:

Self-focus	vs.	Interpersonal (Group) Focus
"I am brave."		"I stick up for others when it's right and fair…"
"I am enthusiastic."		"Others like my energy and readiness to participate and try new things."
"I am sensitive."		"When I see others in pain or sadness, I feel their unhappiness and want to help them."

The self-assessment begins creating mindset toward relatedness – how one's strengths are socially impactful – and **will be valued in the group**.

59

Key elements – Chap. 1. Strengths

60

Self-assessment of strengths helps with barriers such as:

Barriers	Corrective/Counterbalance
Mandated treatment, no freedom of choice	Exercise gives freedom of choice. Treatment so far is pleasant, not aversive.
Stigma/humiliation of being nothing but a sex offender –	I am much more than a SO and have many other positive features.
Loss of dignity, self-loathing, self-contempt.	I have features that I am proud of.
Distrust therapist as agent of criminal justice	For first time, I'm not being hounded about my crimes and failures.

60

How Chap. 1 can compliment standard SOST

61

- ❑ Positive and strength-based approach vs pathology/offense focus which increases defensiveness.
- ❑ Client can focus on strengths vs feeling hopeless.
- ❑ Facilitates awareness of social relatedness, need for connection.
- ❑ Applicable to Dynamic Risk Factors such as General Social Rejection/Loneliness, Lack of Concern for Others, Self Regulation, Relationship Stability, as well as Good Lives concepts.
- ❑ Engages client in self-reflection early in the treatment experience.

61

Key elements – Chap. 2. Hopes and Fears of Group

62

***Group Research: Principle One*:** Conduct pre-group preparation that sets treatment expectations, defines group rules, and instructs members in appropriate roles and skills needed for effective group participation and group cohesion.

This chapter facilitates positive orientation and preparation:

- ❖ Describes common myths/fears about starting a group treatment program.
- ❖ Invites client to express biggest fears.
- ❖ But also invites the client to consider positive **hopes** for group. This counterbalances the negative mindset and cultivates a more hopeful attitude.

62

Key elements – Chap. 2. Hopes and Fears

63

Managing fears of group helps with barriers such as:

Barriers	Corrective/Counterbalance
Expecting public humiliation.	I'm not alone; others share similar problems.
Fear of being forced to reveal worst and ugliest behavior.	Reassurance that disclosure will not be required at the start (and is voluntary).
Fear of being judged by others	Reassurance that others will be curious, not judgmental, share the same fear.
Hopeless, helpless.	Invited to imagine and entertain positive hopes of what can come from group.

63

How Chap. 2 can compliment standard SOST

64

- ❑ Helps reduce natural anxiety about groups, social stigma, privacy, negative judgement, etc.
- ❑ Compliments empirically driven guidelines for pre-group preparation (e.g., sets treatment expectations, expectations about group, education about group rules, instructs members in appropriate roles and skills, etc.).
- ❑ Gives client a chance to articulate fears, expose myths.
- ❑ Applicable to Dynamic Risk Factors such as Social Rejection/ Loneliness, Lack of Positive Social Supports, Negative Emotionality/Hostility.

64

Key elements – Chap. 3. Giving & Receiving Help

65

Brief orientation to relationships and ability to give or receive help.

Common fears about asking for or needing help from others (e.g. appearing weak, needy, unmanly, not being worthy of care and attention)

Common fears about giving help to others (e.g. risk getting too close, revealing one's affection or caring, not smart or worthy enough to give help to others, help may be rejected)

Open-ended thoughts about these fears.

Managing such fears helps with barriers such as:

Barriers	Corrective/Counterbalance from Group
Fears of appearing weak, incompetent, stupid, needy	Experience of being cared about. Experience of helping others bolsters self-image and self-esteem.

65

How Chap. 3 can compliment standard SOST

66

- ❑ Consistent with empirically-driven pre-group preparation by reinforcing treatment agreement about the expectation of participation,
- ❑ Reduces resistance to feedback, entitlement, getting help for losses
- ❑ Applicable to Dynamic Risk Factors such as Social Rejection/Loneliness, Lack of Positive Social Supports, Negative Emotionality/Hostility.
- ❑ Engages client in relational thinking, the importance of give and take (implied vulnerability).
- ❑ Sets a tone of relational engagement, opportunity for altruism.

66

Key elements – Chap. 4. Cooperation

67

Orientation: Six of the seven fundamental principles of human societies entail **cooperation.**

Cooperation is all about interpersonal relationships and the societal groups we belong to:

1. Help your family.
2. Help your group.
3. Return favors.
4. Defer to superiors.
5. Divide resources fairly.
6. Respect others' property.
7. Be brave.

Through open-ended queries and self-exploration, helping client to expand awareness of how everything is related to others and many ways we are connected.

67

How Chap. 4 can compliment standard SOST

68

- Sexual abuse, sexual preoccupation and compulsive sexual behavior are precipitated and maintained by social isolation, withdrawal from relationships and meaningful interactions with others
- Group is ideal lab for seeing and practicing relatedness via cooperation:

7 principles of cooperation		**As applied in group _____.**
"Dividing resources fairly"	=	sharing time in group, respecting each other's time to talk, problems of group domination or excessive silence
"Deferring to superiors"	=	deferring to group therapist or more experienced members
"Respecting others' property"	=	both perpetrating acts of sexual abuse and having one's own body stolen thru sexual / physical abuse
"Helping your group"	=	Group therapeutic factors of Cohesion, Altruism, and Imitative Behavior

68

How Chap. 4 can compliment standard SOST

69

- Self assessment of relationships and values sets the stage for looking at how client relates to and values others/groups.
- Applicable to Dynamic Risk Factors such as Cooperation with Supervision, General Social Rejection/Loneliness, Capacity for Relationship Stability, Sexual Preoccupation, Lack of Concern for Others, Negative Emotionality/Hostility, and the need for positive social supports.
- Consistent with Good Lives, healthy balanced lifestyle vs social isolation
- Sets a tone of relational engagement, opportunity for altruism.

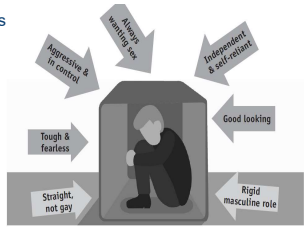
69

Key elements – Chap. 5. Masculinity

Introduction to **the Man Box**

Toxic masculinity and seven elements

- ►Tough and fearless
- ► Aggressive and in control
- ► Independent and self-reliant
- ► Always wanting sex
- ► Straight, not "gay"
- ► Good-looking
- ► Rigid male sex role stereotype



70

Exploring masculinity

Escaping "the Man Box" and building a self-concept of healthy masculinity

Exploring what it means to be a male.

Instead of asking about the beliefs the client holds about masculinity, he is invited to explore masculinity in a **more personal, concrete and emotional fashion** by using an actual man he admires and man he dislikes.

- Is it true about the man you admire?
- Is it true about the man you don't like or respect?
- Is it true about yourself?

71

Masculinity

	True about man I like	True about man I dislike	True about myself
A man can cry in front of other men.	*always*	*never*	*sometimes*
A man can get respect without threatening or using violence.	*always*	*never*	*sometimes*
A man can show simple affection for other men.	*always*	*never*	*never*
A man can listen and give in to his wife or girlfriend.	*always*	*never*	*always*

72

By comparing personal models of masculinity…

73

- Can discover that, independent of what he has been taught to believe, he is naturally drawn to and emulates the healthy masculinity of the good model and is repulsed by the hypermasculinity of the bad model.
- Can discover (and take hope and pride in seeing) that he already shares many of the desired characteristics of his admired model of masculinity (identifying and affirming strengths).
- Alternatively, can gain a clearer picture of undesired characteristics he may share -- which he will be motivated to change.

73

How Chap. 5 can compliment standard SOST

74

- Most men, even in the 2000's, are exposed to traditional masculine role models or even pressured into adopting hyper-masculine attitudes via peer pressure, bullying, or abusive environments.
- Counter the myth that "Real Men" do not need help, fear of vulnerability.
- Able to use the exclusively male group to safely explore and experience healthy closeness to other males, experience male acceptance.
- Applicable to Dynamic Risk Factors such as Hostility Toward Women, Negative Emotionality/Hostility, Social Rejection/Loneliness, as well as underlying negative attitudes/schemas, and Lack of Positive **male** Social Supports.

74

Key elements – Chap. 6. Setting Goals

75

- Client invited to think about and develop personalized goals of his own design and stated in his own words.
- And how those goals can be achieved through **the group experience.**

Personal goal:	Goal for group:
Greater self-confidence	Use group to try taking the risk of being more open and honest about self and feelings.
Not overreact when upset	Use group to try being honest about why my feelings were hurt" instead of attacking.

- Opportunity for self-efficacy and promotes awareness of primary importance of social relatedness and connection – as experienced in the therapy group.

75

How Chap. 6 can compliment standard SOST

76

- ❑ The material promotes hope, self-efficacy,
- ❑ Promotes awareness of social relatedness and connection – as experienced in the therapy group.
- ❑ Applicable to Dynamic Risk Factors such as Self Regulation/lifestyle, Sex as Coping, Poor Cognitive Problem Solving, as well as some elements of Good Lives Model

76

Key elements – Chap. 7. Joining the Group

77

- ❑ Simple tips for introducing oneself to the group.
- ❑ Instead of focusing on one's problem, offense, or weaknesses, or labeling oneself as a "child molester" or "sex offender", client can introduce self by describing his positive character traits
- ❑ Can use positives from Chap 1 self-assessment of **social** strengths which will be relevant **to the group**:
  - "I'm a great team player because I like to help my teammates do their best."
  - "I'm a trustworthy person. If you share a secret with me, I'll keep it."
- ❑ Invited to reflect on experience in the group:
  - "Did members reach out to you in a way that felt supportive?"
  - "Did other members express feelings and problems like your own?"
  - "In what ways can you benefit more from group next time?"

77

How Chap. 7 can compliment standard SOST

78

- ❑ Anxiety and apprehension (resistance) is highest just before entering group for the first time. Reassurance that won't begin with telling one's worst and most shameful behavior.
- ❑ Counters negative self-labeling as "just a sex offender".
- ❑ Starting with strengths increases likelihood of a "good start" experience.
- ❑ Other group members can introduce themselves in positive terms.
- ❑ Applicable to Dynamic Risk Factors such as: Capacity for Stable Relationships, General Self Regulation/lifestyle, Poor Cognitive Problem Solving, Sex as Coping (with anxiety), as well as Good Lives Model.

78

Key elements – Chap. 8. Journaling

79

Consistent with the workbook's focus on "social self", the journaling form is oriented toward the positive ("best moment") and interpersonal experience.

The form asks the client to self-assess:

- ❑ Anxiety level at the start and end of the group session
- ❑ How much he felt accepted and "belongs" in the group.
- ❑ Items specific to group issues of giving help & receiving help.
- ❑ Items specific to social self: how others see me, how I see myself, and self-knowledge.

79

How Chap. 8 can compliment standard SOST

80

- ❑ Journaling is a form of self reflection that is beneficial in calming anxiety, improving self awareness, reducing distorted thinking, shifting to an internal vs external focus.
- ❑ The practice of self reflection and self awareness is generally complimentary with all treatment approaches or methodologies.
- ❑ Applicable to Dynamic Risk Factors such as: Self Regulation, Negative Emotionality, Sex as Coping, as well as self-awareness, self-efficacy.

80

References

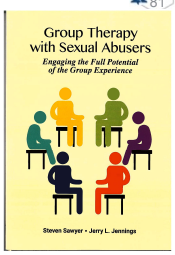
81

Sawyer, S. and Jennings, J. (2016). *Group Therapy with Sexual Abusers: Engaging the Full Potential of the Group Experience*. Brandon, VT: Safer Society Press.

Jennings, J. & Sawyer, S. (2021). *Getting the Most from Group: A Motivational Client Workbook to Support Group-Based Treatment Programs*. Brandon, VT: Safer Society Press.

Jennings, J. and Sawyer, S. (2003). Principles and techniques for maximizing the effectiveness of group therapy with sex offenders. *Sexual Abuse*, *15*(4), 251-267.

Jennings, J. and Deming, A. (2017). Review of the empirical and clinical support for group therapy specific to sexual abusers. *Sexual Abuse*, *29*(8), 731-764.



81

References

Burlingame, G., McClendon, D. & Yang, C. (2018). Cohesion in group therapy: A meta-analysis. *Psychotherapy, 55*(4), 384–398.

Curry, O., Mullins, D. & Whitehouse, H. (2019). Is it good to cooperate? Testing the theory of morality-as-cooperation in 60 societies. *Current Anthropology*, *60*(1), 47-69.

Marshall, W. & Burton, S. (2010). The importance of group processes in offender treatment. *Aggression and Violent Behavior, 15*(2),141-149.

Marshall, L., Marshall, W., Fernandez, Y., Malcolm, P. & Moulden, H. (2008). The Rockwood Preparatory Program for sexual offenders: Description and preliminary appraisal. *Sexual Abuse*, *20*(1), 25-42.

Prescott, D. (2008). A group for integrating treatment lessons into daily life. *ATSA Forum*, *20*, 1-9.