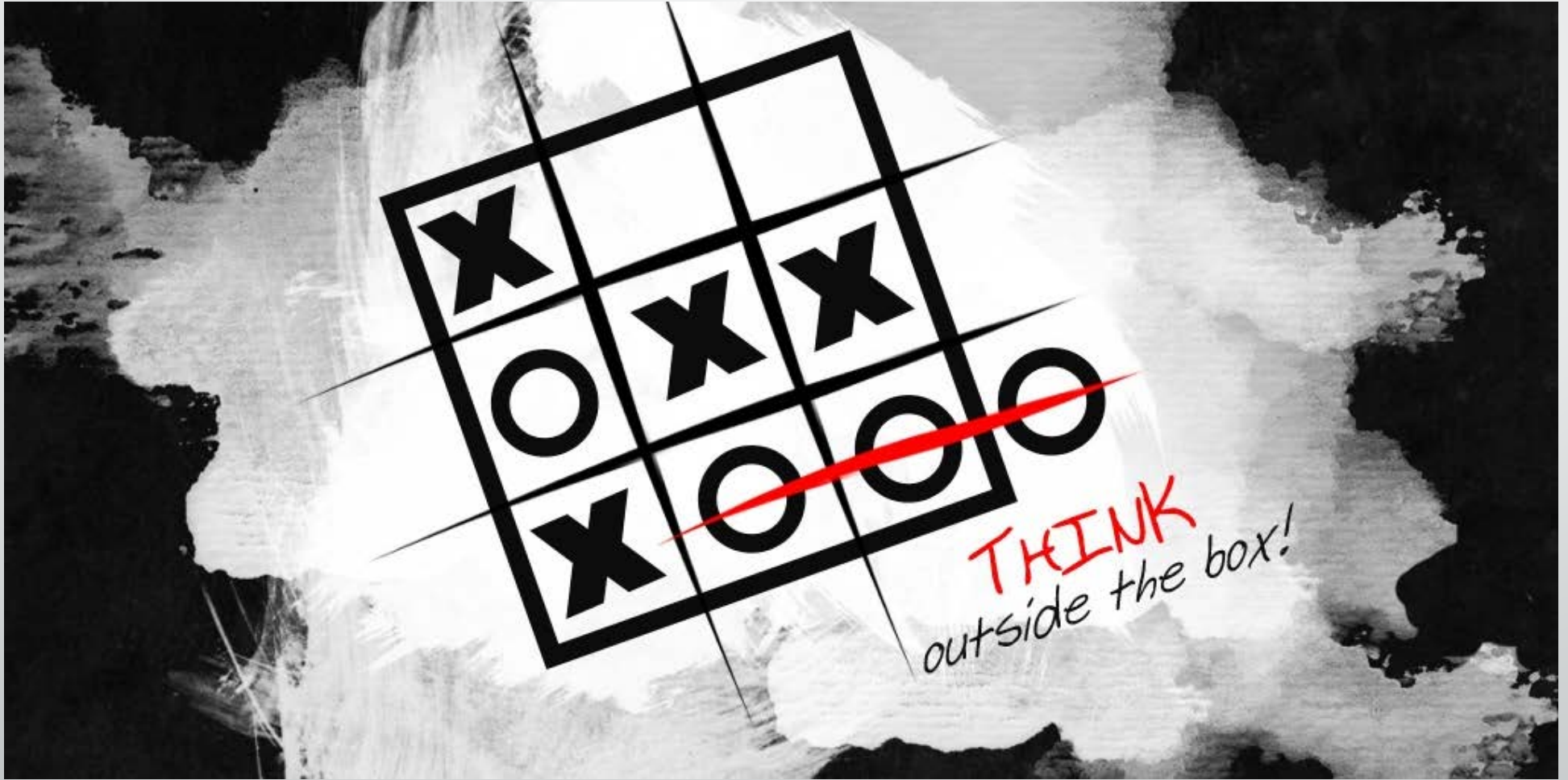# Managing Sex Offenders with Mental/Intellectual Disabilities

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Definition of Terms

- We will be discussing three separate, but overlapping populations:

  - Serious Mental Illness (SMI)

  - Intellectual Disability (ID)

  - Personality Disorders (PD)

SMI Defined

- National Institute of Health (NIH) defines SMI as "a mental, behavioral, or emotional disorder (excluding developmental and substance use disorders)…resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities."

ID Defined

- The Diagnostic and Statistical Manual, 5th Edition (DSM-5) defines Intellectual Disability as:

  - "a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains."

PD Defined

- The Diagnostic and Statistical Manual, 5th Edition (DSM-5) defines a personality disorder as:
  - "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment."

Sex Offending in the Context of SMI

- Sometimes, sex offending occurs within the context of SMI, meaning that an individual's symptoms played a direct role in the offending.

- If this is the case, the individual was likely experiencing psychotic symptoms at the time of the offense.

    - **Example #1**

    - **Example #2**

SMI: Treatment Considerations

- In these cases, helping clients successfully manage their psychiatric symptoms is key (Berlin, et al., 2009).
  - Pharmacotherapy
  - Increasing social support
    - Goal for support people to recognize signs of psychosis and intervene early on, to help prevent offending
  - Individual and group therapy aimed at managing symptoms
    - Importance of medication compliance
    - Working through denial about having a mental illness

SMI: Treatment Considerations

- Discussing hallucinations/delusions

  - It is generally contraindicated to "argue" with or try to speak rationally regarding psychotic thought processes.

  - Instead, it is important to understand how the client makes sense of the hallucinations/delusions

    - Are they helpful or harmful to the client?

    - Are there pros and cons to acting on delusions/hallucinations?

    - Can the client choose not to act on delusions/hallucinations?

ID: Differences between Populations

- Different contributing factors/intent
  - Environment (e.g., insufficient sexual education or social skills training)

- Counterfeit Deviance (Hingsburge, et al., 1991)
  - Offensive versus Offending

- Superficial Compliance

ID: Differences in Treatment Models

- Therapeutic Engagement
  - Humanistic approach
  - Catchy phrases
    - Dirty window, stinkin' thinkin', danger zone, on the boat or in the water, etc.
  - Visual aids
  - Concrete examples
    - "Old Me" versus "New Me" model, Good or Better game, Distance
  - Sexual Education

Sex Offenders with Prominent Personality Disorders

- Cluster B Personality Disorders:
  - Have the strongest correlation with early institutional care and criminality (Coid et al., 2006) and include the following disorders:
    - Antisocial PD
    - Borderline PD
    - Histrionic PD
    - Narcissistic PD

Antisocial Personality Disorder

- *A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:*

    1. *Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.*

    2. *Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.*

    3. *Impulsivity or failure to plan ahead.*

    4. *Irritability and aggressiveness, as indicated by repeated physical fights or assaults.*

    5. *Reckless disregard for safety of self or others.*

    6. *Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.*

    7. *Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.*

Borderline Personality Disorder

- *A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:*

  1. *Frantic efforts to avoid real or imagined abandonment. (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)*

  2. *A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.*

  3. *Identity Disturbance: markedly and persistently unstable self-image or sense of self.*

  4. *Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)*

  5. *Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.*

  6. *Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).*

  7. *Chronic feelings of emptiness.*

  8. *Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).*

  9. *Transient, stress-related paranoid ideation or severe dissociative symptoms.*

Histrionic Personality Disorder

- *A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:*

    1. *Is uncomfortable in situations in which he or she is not the center of attention.*

    2. *Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior.*

    3. *Displays rapidly shifting and shallow expression of emotions.*

    4. *Consistently uses physical appearance to draw attention to self.*

    5. *Shows self-dramatization, theatricality, and exaggerated expression of emotion.*

    6. *Is suggestible (i.e., easily influenced by others or circumstances).*

    7. *Considers relationships to be more intimate than they actually are.*

Narcissistic Personality Disorder

- *A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:*

    1. *Is uncomfortable in situations in which he or she is not the center of attention.*

    2. *Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior.*

    3. *Displays rapidly shifting and shallow expression of emotions.*

    4. *Consistently uses physical appearance to draw attention to self.*

    5. *Shows self-dramatization, theatricality, and exaggerated expression of emotion.*

    6. *Is suggestible (i.e., easily influenced by others or circumstances).*

    7. *Considers relationships to be more intimate than they actually are.*

PD: Treatment Outcomes

- By definition, personality disorders are pervasive and, thus, generally difficult to treat (Egan, 2013).

  - **Example #4**

- Outcome research shows that treatment targeting Cluster B personality disorders has a wide variety of outcomes.

  - For example, in a study in which individuals with BPD were followed up with for 10-15 years, 50-60% showed decreased symptomatology; however, 3-9% committed suicide (either intentionally or as a result of self-mutilating behavior; Mehlum *et al.*, 1994).

  - In addition, many individuals with ASPD no longer meet criteria when they are older (referred to as "antisocial burnout);" however, this burnout does not occur in individuals with ASPD who have co-occurring psychopathy (Huchzermeier *et al*., 2008).

PD: Treatment Outcomes

- **Given the variable outcomes, working with individuals with these disorders can be exhausting, as some individuals will not make improvements (or at noticeable improvements) despite a treatment provider providing the best care possible.**

- Instead of thinking "nothing works," attempt to think, "something works (Martinson, 1974, 1979).

PD: Targeting Specific Behaviors

- Research suggests that it is "clinically prudent" to focus on dynamic or changeable factors with these individuals (Egan, 2013).

- Factors that can be helpful to focus on are:

  - Dynamic Risk Factors (Stable 2007)

  - Substance use/abuse

  - Triggers to offending

  - Motivations to change

  - Criminalistic cognitions (can be classified into "thoughtless" and "callous" types).

  - May be helpful to consider "offense paralleling behaviors."

PD: Essential Treatment Elements

- Maintenance of the **therapeutic relationship** is key.
    - "All personality-disordered persons (and maybe all patients) require a therapist who provides 'a secure base' to manage attachment problems" (Agrawal et al., 2004; Romano et al., 2008).
- Focus must be on **how and why the individual needs to change** (Grencavage & Norcross, 1990).
    - This is a great place for <u>motivational interviewing</u>. Remember to focus on the offender's reasons for change, even if these reasons seem selfish or callous to you.
- Helping the offender **believe that change is possible** is also important.
    - This very likely will begin with YOUR belief that this individual can change.
    - When you find it difficult to believe that a client can change, a good starting point is to consider something that you admire about the offender.

PD: Essential Treatment Elements

- Teaching skills outlined by Dialectical Behavior Therapy is helpful (Linehan, 2015).
  - Mindfulness
  - Interpersonal Effectiveness
  - Emotion Regulation
  - Distress Tolerance
    - <u>Don't Sweat the Small Stuff, and It's All Small Stuff</u>, by Richard Carlson, Ph.D.

PD: Collusion vs. Support

- Although a warm and supportive therapeutic environment is essential, it is **important to avoid colluding** with a client (Fernandez, 2006).

- Examples of collusion involve the following:
  - Viewing your client as a victim, or spending most of the time discussing your client's victimization, rather than the harm he has caused others.
  - Not requiring your client to take responsibility for his crimes/actions.
  - Choosing not to engage in ***supportive challenging*** of the client.
  - Wanting to be liked by clients or being worried about the client being mad at you.
  - Taking responsibility for your client's change.
  - Attempting to solve clients' problems.

- Engaging in these last two "may inadvertently encourage clients to believe that their behavior is out of their control" (Fernandez, 2006).

PD: Controlling Anger and Hostility

- Due to the ways in which individuals with personality disorders present, therapists often have difficulty controlling their emotional reactions, and displays of anger and/or hostility, in the therapy room (Fernandez, 2006).
  - Although this is normal, it is imperative that therapists avoid expressing anger and hostility toward their clients.
    - Expressing such emotions is related in the research to:
      - Client negativity
      - Disrupted therapeutic relationship
      - Decreased progression in treatment
  - There may be a few times throughout therapy that it may be appropriate to express anger toward a client, but these things should be few and far between.
  - It is suggested that when therapists become angry or hostile, they take responsibility for that behavior and discuss the inappropriateness of their actions with the client. The therapist can then use the situation to discuss with the client that their actions have an effect on others.

Struggles?

- Co-facilitation for PD offenders

- Smaller and shorter groups

- LOTS of positive reinforcement

- Thinking outside the box

- Managing your own expectations

- Self-Care

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