



Forensicare

Schema Therapy in Sexual Offender Treatment

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Overview

- Therapeutic Models and Sexual Offender Treatment
- Gaps and Limitations
- Trauma, ACE, Personality Disorder and Sexual Offenders
- Use of Schema Therapy in Sexual Offender Treatment
- Case Vignette
- Future Directions

Cognitive Behavioural Therapy and Sexual Offender Treatment

- **Several meta-analytic studies revealed the effectiveness of Cognitive Behavioural Therapy (CBT) based interventions in the treatment of sexual offenders.**
 - A meta-analysis encompassing more than 9,000 subjects reported lower rates for treated offenders of 12.3% recidivism compared to 16.8% for the comparison groups who received either no treatment or a form of therapy judged to be inadequate or inappropriate (Hanson et al., 2002).
 - Schmucker & Losel (2015) compared 4,939 sexual offenders with 5,448 untreated sexual offenders. The results yielded recidivism rates of 10% versus 13.7 %, respectively.
 - Harrison and colleagues (2024) conducted a meta-analysis of 19 studies, which showed that CBT programs are effective in reducing sexual and violent/combination recidivism behaviours post-treatment.

RNR and Sexual Offender Treatment

- Hanson, Bourgon, Helmus and Hodgson (2009) conducted a study examining the reported treatment effects that adhered to Risk-Need-Responsivity (RNR) principles examining 23 studies ($n=6746$).
- Hanson et al. (2009) found that the sexual recidivism rate in untreated samples was 19%, compared to 11% in treated samples.
- **Studies that adhered to all three RNR principles produced recidivism rates that were less than half of those of comparison groups.**
- On the other hand, studies that did not follow the RNR principles had little effect in reducing recidivism levels.

Relapse Prevention

- The Relapse Prevention (RP) model used in sexual offender treatment is primarily based on the relapse prevention model used for substance use.
- The RP model is embedded within the CBT framework and utilises cognitive and behavioural interventions interrelated with lifestyle changes to promote and maintain abstinence from aberrant behaviours (George & Marlatt, 1989).
- The primary goals are to help sexual offenders:
 - Identify risk factors that precipitated relapse to offending
 - Teach them self-management strategies using behavioural, cognitive, educational and social skills

Best practice in Sexual Offender Treatment

- The hybrid CBT-RP can be considered as best practice in sexual offender treatment.
- However, researchers and sexual offender treatment specialists acknowledge the serious gaps in the knowledge base and that there is an ongoing need for further study about what, when, and how the treatment of sexual offenders works.

Gaps and Limitations

- SOTPs have been primarily developed in correctional and other community-based criminal justice settings.
- Most SOTPs do not generally address issues around offenders' traumatic histories and attachment problems, which are relevant to sexual offenders, especially those with mental health issues. Furthermore, these programs generally do not provide trauma-informed treatment.
- Mainstream SOTPs do not address personality issues that are prevalent in sexual offenders.
- Standard SOTPs do not generally address early maladaptive schemas.

Trauma & Sexual Offenders

- **High prevalence of trauma in sexual offender populations**
 - Adult SOs are three times more likely to have experienced sexual abuse than non-SOs
 - Those offending against adults (vs children) had a lower prevalence of sex abuse histories but a higher prevalence of physical abuse histories (Jespersen et al. 2009)
 - ACE studies with male SOs: **84% experienced ACE** (45.7% experienced 4+ ACEs)
 - 3x odds of CSA, and nearly 2x odds of physical abuse compared to the general population (Levenson et al. 2016)
 - ACE score associated with higher arrests, persistence, and versatility – adult rapists scored higher than child sex offenders across each of these issues (Levenson & Socia, 2016)
 - ACE study with female SOs: **80% experienced ACE** (41% endorsed 4+ ACEs)
 - Greater odds for CSA, verbal abuse, emotional abuse, incarcerated family member
 - 50% had experienced CSA (Levenson et al. 2015)
- **Prevalence of trauma also in clinicians working with offenders/FMH contexts**

Sexual Offenders and ACE

- Sexual offenders have higher levels of adverse childhood experiences (ACE) than the general population or other criminal populations.
- It can be argued that the evidence of trauma in high numbers of sexual offenders that it would be reasonable to consider a more trauma-informed approach to treatment.
- Trauma sequelae may include disengagement, dissociation, criminal involvement, mistrust, decreased self-esteem, depression, decreased sense of self-control, and identification with the aggressor.
- Sexual trauma often leads to confusion about sexual norms, confusion of sex with love and caregiving, sexual preoccupation, fetishism of sexual parts, bonding of sexual activity with negative emotions and memories, and sexual dysfunction (Finkelhor, 1986).

Sexual Offenders and Personality Disorders

- Many sexual offenders have personality disorders (Fazel et al., 2007), with research estimates varying from 30-60%, and many more have dysfunctional personality traits.
- Sexual offenders have a higher prevalence of personality disorders compared to non-sexual offenders. There is a higher prevalence of antisocial personality disorder among adult vs child sexual offenders (Arbanas, 2022).
- Sexual offenders with BPD are more likely to offend against both adults and children (Sigler, 2017).
- Staff working with sexual offenders should be aware of PD and its presence so that appropriate specialist assessment and advice can be obtained (Darjee & Russell, undated).

The Use of Schema Therapy in Sexual Offender Treatment



Schema Therapy

- Schema therapy is an integrative therapy derived from CBT that combines elements of various paradigms and theories (e.g., psychodynamic, emotion-focused, attachment theory, Gestalt), utilising cognitive, psychodynamic, and experiential techniques.
- ST was developed to treat patients with chronic personality problems and difficult-to-treat emotional/psychological disorders that do not respond well to the use of traditional CBT.
- A large-scale randomised trial has revealed that ST is significantly more effective than traditional treatments such as CBT in the treatment of a broad range of personality disorders and other chronic mental health issues, which resulted in higher rates of recovery, not just symptom reduction and is more cost-effective (Lotte et al., 2013).

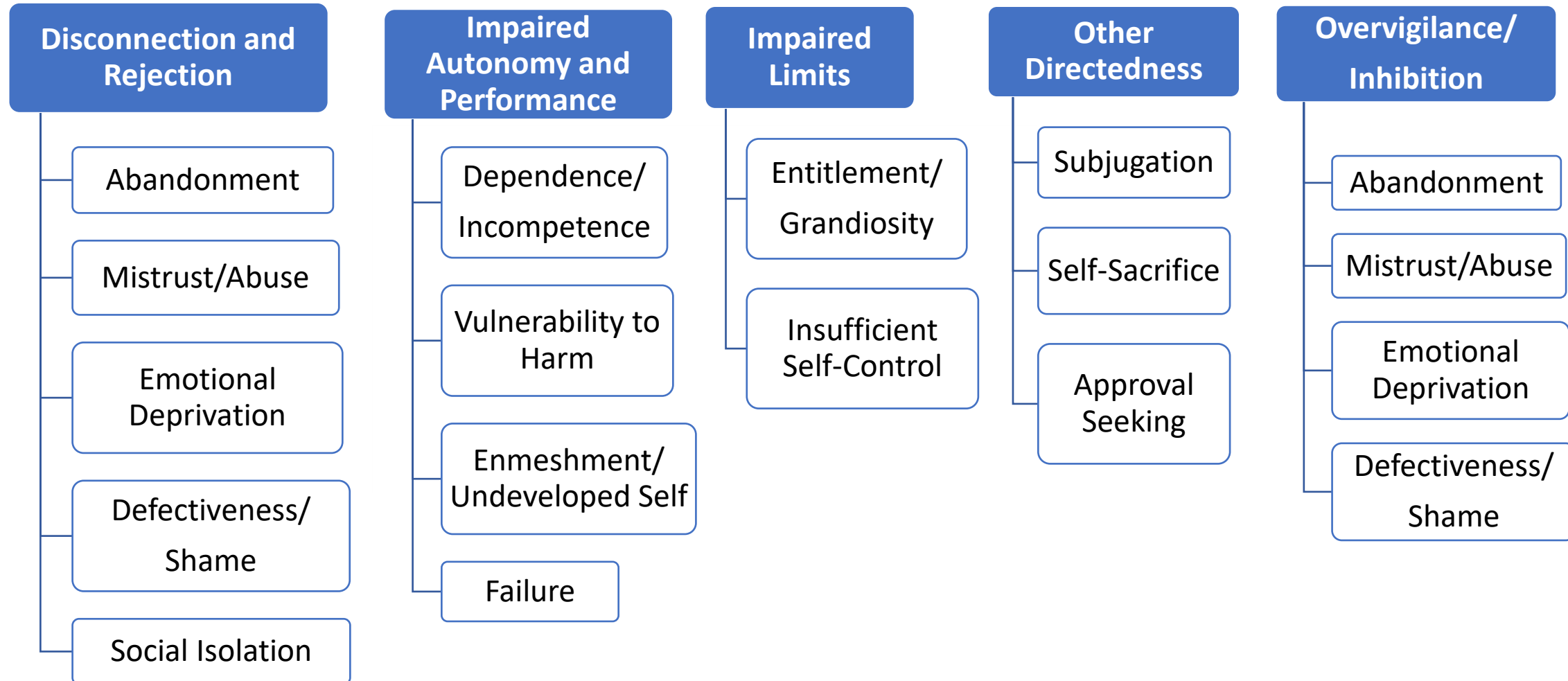
Schema Therapy

- The use of schema therapy has expanded to forensics, particularly in treating difficult-to-treat forensic clients with personality, trauma, and mental health issues or those considered to be 'incurable' (e.g., forensic clients with psychopathic traits).
- ST has a greater emphasis on emotional change, experiential techniques, and the therapy relationship (in addition to cognitive behavioural techniques)
 - Developed in recognition of the lack of response to CBT/TAU protocols
 - BPD, other personality disorder presentations, complex trauma and attachment disruption
 - Evidence emerging for chronic mood disorders, eating disorders

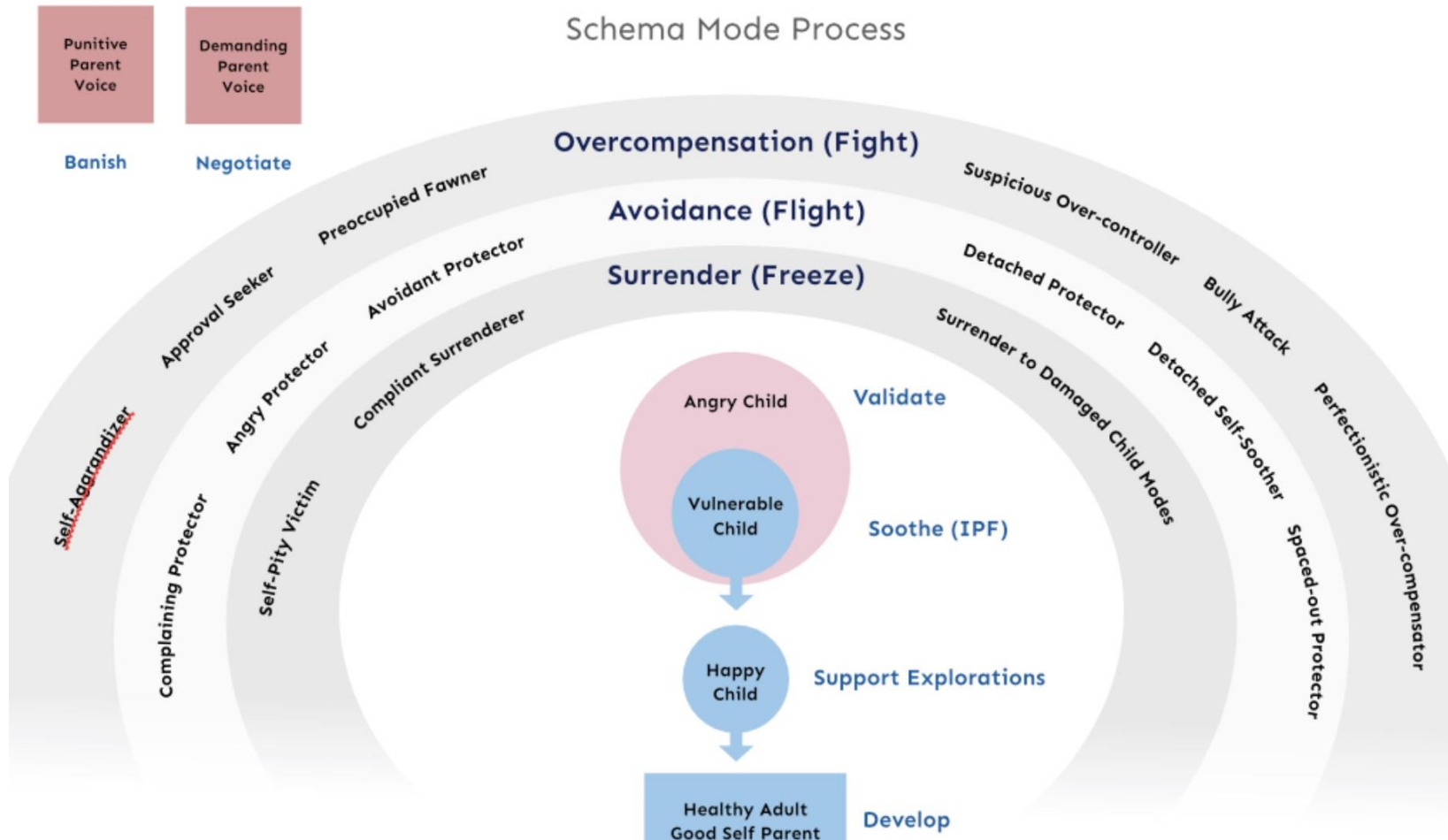
Core Concepts of Schema Therapy

- Early Maladaptive Schemas (EMS) – stable and enduring maladaptive emotional and cognitive patterns of beliefs associated with memories, emotions, body sensations, and perceptions around childhood problems.
- Core emotional needs – unmet during the child’s developmental years
 - Secure attachment, autonomy, competence, sense of identity, freedom to express needs/emotions, spontaneity and play, realistic limits & self-control
 - To be *safe, secure, seen, and soothed*
 - It may be due to Big T trauma (physical abuse, early loss, neglect), or little t trauma (lack of emotional attunement, favouritism of other children)

Schemas and Associated Core Emotional Needs



Schema Modes



<https://attachmentrepair.com/articles/schema-mode-diagrams-coping-styles/>

Goal of Schema Therapy

- Schema therapy aims to help patients meet their core emotional needs.
- Critical steps in accomplishing this involve learning how to:
 - Stop using maladaptive coping styles and modes that block contact with feelings
 - Experience growth as you heal schemas and vulnerable modes through getting needs met in and outside of the therapeutic relationship
 - Incorporate reasonable limits for angry, impulsive or overcompensating schemas and modes.
 - Fight punitive, overly critical or demanding schemas and modes
 - Build healthy schemas and modes

Schema Therapy in Forensic Populations

- **Forensic-specific modes & guidelines (Bernstein & Arntz 2007)**
- **Increasingly seeing associative, predictive and explanatory power of modes over EMSs**
 - Child (vulnerable, anger) and disinhibition (DSS) modes in the lead-up to crimes, with over-compensatory modes (bully and attack, predator) more pertinent during the actual crimes/institutional violence
 - Anger, rage (EC, IC), and disinhibition modes are positively associated with an aggression history
- **Promising outcomes for ST over TAU – in RCT, single case studies**
 - Reduced HCR ratings, more/quicker progression to leaves
 - Forensic inpatient settings, predominantly in the Netherlands
 - Experiential strategies promising to evoke emotional states
 - Lack of empathy, psychopathy not an exclusionary condition – can benefit

Schema Therapy & Sexual Offending

Self-aggrandiser
Bully and attack
Conning/
manipulator
Predator
Overcontroller

Detached protector
Detached soother
Angry Protector

Punitive parent

Vulnerable Child
Impulsive Child
Angry Child
Vulnerable Child

- EMS – greater presence across all domains compared to non-offenders, with some differences between sex offence types (sometimes)
- Greater mean scores across EMS domains compared to nonsexual violent offenders
 - Particularly child sex offenders (Chakhssi et al., 2013)
- Greater endorsement of EMS associated with compulsive sexual behaviour (Efrati et al. 2019, 2021)
- Generally, see a cycle involving child mode activation, movement into coping and/or overcompensatory modes during the crime itself, and a return of child modes following the crime
 - Importance of individualised mode formulation (Keulen-de Vos et al 2016)

Barry

- 42-year-old male
- Referred following a custodial sentence
- Convicted of two counts of Indecent assault of a minor (<16yrs)
- Known victim, 9-year-old female friend of daughter
- First sexual offence, although disclosed accessing child abuse materials (CAM) in a police interview
- History of dishonesty, driving offences, minor violence history
- Removed from a group SOTP due to poor engagement, denial of offending, argumentative themes include the victim being comfortable about having sex with him

Barry cont.

Personal History

- Middle of three siblings
- *Alcoholic and violent father and witnessed domestic violence*
- *Mother emotionally and psychologically abusive, emotionally unavailable*
- He goes out of his way to please his parents and emotionally overinvolved

Educational and Occupational History

- *Bullied in school and was a loner*
- Worked in IT and has a stable employment history. *He feels disappointed when he does not meet unusually high standards and thinks he is better than his colleagues.*

Psychiatric, Medical and Substance Use History

- Social drinking and relaxation; however, he has reported aggression when drunk, including family violence.
- Denied history of substance use
- No history of involvement with mental health services, although complains of chronic depression

Barry cont.

Psychosexual History

- Matured sexually quite early, masturbating to father's skin magazines
- Sexual touching with same-aged neighbour <10yo
- *CSA by football coach – confusion about this. Dismissed by mother.*
- Penetrative sex at 14 (same-aged partner)
- Subsequent casual, one-night-stands, often at parties involving alcohol
- Accessed pornography but preferred partnered experience
- *Sex: wanted, connection, gratification*
- *Sex: primary way to connect, struggles to convey himself, feels lonely*

Barry cont.

Relationship and Social History

- 10-year marriage, 7yo daughter & 9yo son
- Increased fights, emotionally distant, feeling unappreciated
- Infidelity nearly ended marriage – increasingly turned to pornography
- *Broader pornography exploration in recent years, including CEM*
 - *Found arousing, gratifying*
- *No social network*
- *Copes via shutting down and drinking alcohol*

Barry's 4 Ps

Predisposing	Precipitating	Perpetuating	Protective
CSA – gratifying, normalizing, implicit beliefs	Sexual frustration, invalidation and loneliness in marriage, feeling unimportant	Underlying attitudes, implicit beliefs around sexuality of children etc	Compliance
Early sexual scripts around child sexuality	Recent sexual attraction and arousal to the victim	Cognitive distortions about victim's experience	Relatively prosocial
Sensitivity to rejection, acceptance	Recent CEM use/gratification	Self-regulatory difficulties	
Regulatory issues, excessive masturbation	Drinking	Poor coping resources	
Sex to cope, some entitlement	Opportunity, alone from other adults	Sex is associated with connection, acceptance, and being wanted	
Difficulty expressing himself, communicating with women		Relationship breakdown, loneliness	
High sexual drive			
Practice of accessing CEM for gratification			

Barry & Sexual Offending?

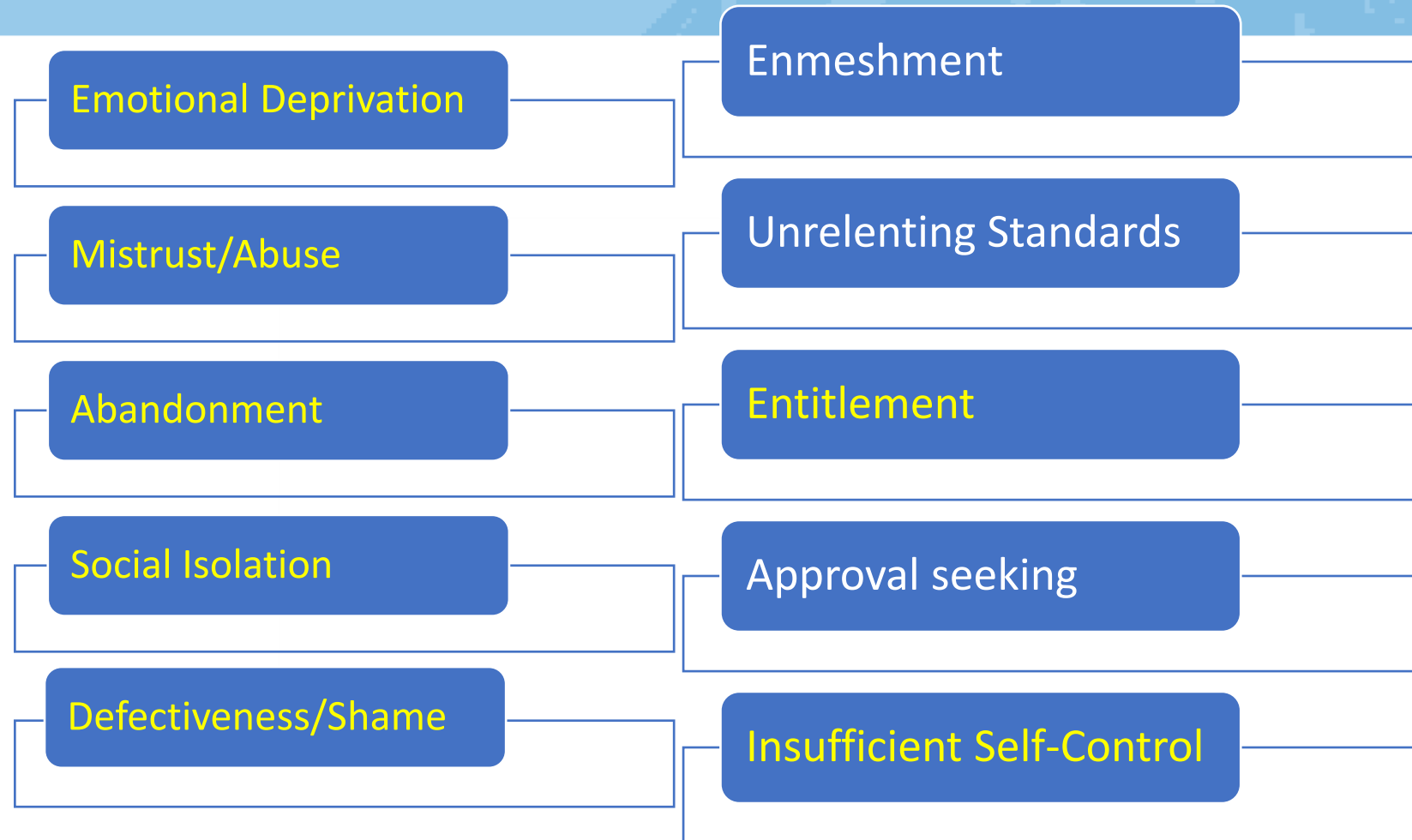
Schemas?

Modes?

Intervention options/treatment plan?

Risk relevant elements?

Early Maladaptive Schemas



EMS and Schema Modes

Punitive Parent

Demanding Parent

Predator

FORENSIC SCHEMA MODES

Conning manipulator

Self-Aggrandiser

OVERCOMPENSATION

Detached Self-Soother

AVOIDANCE

Angry Protector

Detached Protector

SURRENDER

Compliant Surrenderer

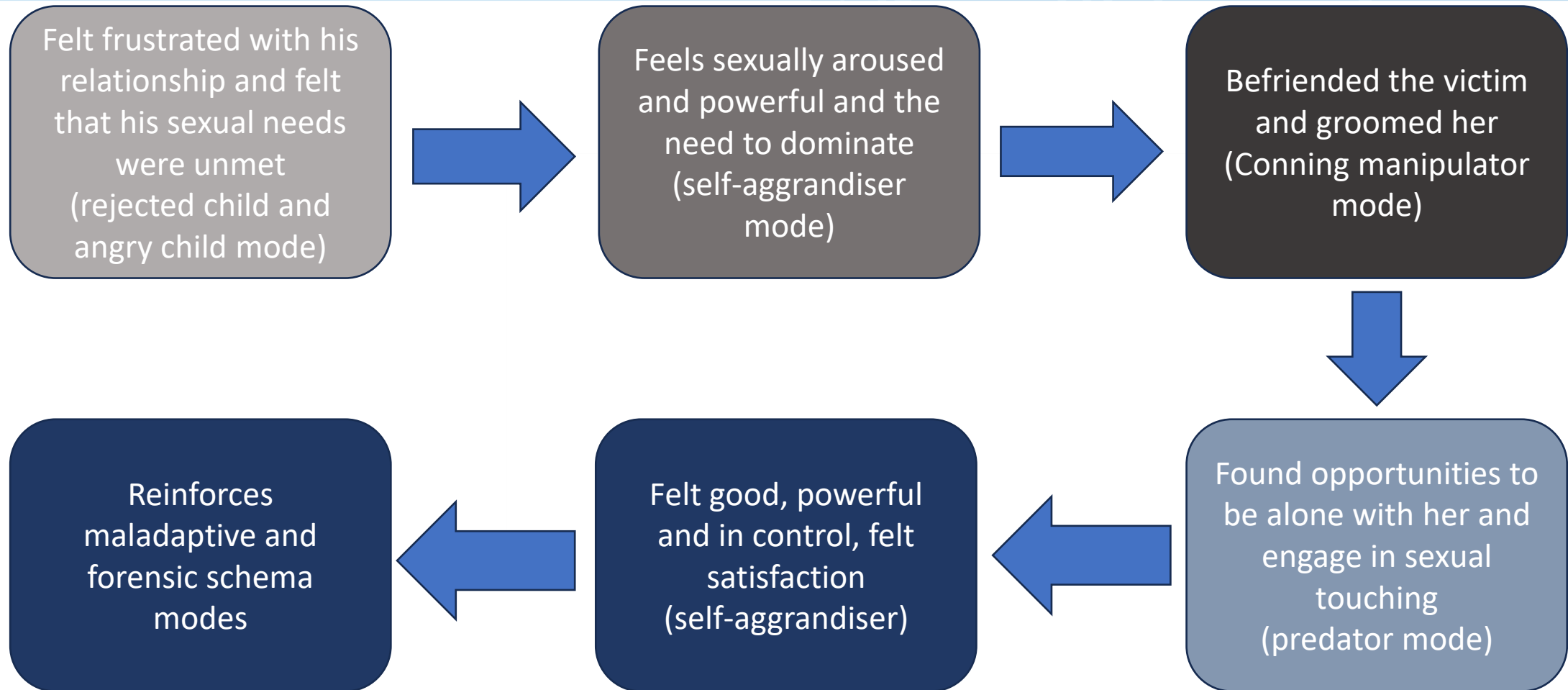
Abandoned Child

Abuse Child

Angry Child

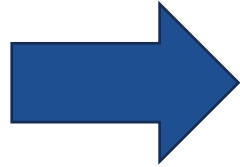
Impulsive Child

Index Offending



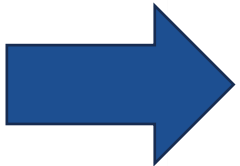
Schema Therapy Intervention

Cognitive



Challenging harmful/risky thoughts and offence-supportive cognitions
Use of Flash Cards – summarise healthy responses to triggers

Experiential

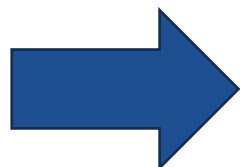


Chair Work – access and work with the schema modes; understand the function of the modes

Imagery Rescripting - process traumatic childhood memories and rescripted to meet the needs of the child;

Limited reparenting – attune to the needs of the vulnerable/abandoned/abused child such as encouragement, support, validation; empathic confrontation

Behavioural



Homework
Rehearsal
Rewarding Adaptive Behaviour

RSVP-2 Risk Factors

Problems with Self-Awareness

Improved self-awareness, particularly of his schemas and modes and situations where they are activated

Problems with Stress or Coping

Develop more adaptive coping skills rather than relying on his detached protector, compliant surrenderer, detached soother, etc.

Problems from Child Abuse

Process and rescript traumatic childhood memories and meet emotional needs

Problems with Intimate and Non-intimate Relationships

Address underlying disconnection-rejection schemas and accompanying modes and develop more adaptive modes

**Attitude to Condone Sexual Violence
Sexual Deviance**

Address forensic schema modes that contribute to cognitive distortions and offending issues
Urge management and meeting sexual needs in more adaptive ways

Future Directions

There is a good rationale for utilising schema therapy given the high prevalence of personality disorder and ACE, especially with difficult-to-treat sexual offenders.

Schema therapy addresses EMSs assumed to be responsible for the onset and maintenance of offending behaviour.

A systematic review of 15 studies revealed that schema therapy has beneficial effects on EMSs, schema modes, personality symptoms, and risk factors for committing crimes (Sousa et al., 2024).

There is a need to conduct research evaluating the effectiveness of ST, particularly for sexual offenders being provided treatment in an outpatient setting.

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Questions?

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Thank you!



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