A Group For Integrating Treatment Lessons Into Daily Life

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Introduction

This article describes an approach to working with people who have sexually abused and who have completed some aspects of treatment but may not be ready to progress to another stage of treatment. For example, many programs offer some type of preparatory work for sexual abuse-specific treatment through one or more cognitive skills curricula. However, simply completing one workbook or curriculum does not mean that the client is successfully applying the skills and insights gained in treatment to their daily life. This can particularly be the case in civil commitment settings, where clients sometimes experience fluctuating levels of motivation.

The process described below, developed by the clinical team at Sand Ridge Secure Treatment Center (Wisconsin's civil commitment program), is one means by which clinicians can ensure that patients meaningfully complete one phase of treatment before moving on to another. It builds upon a process described elsewhere (Prescott, 2007) for helping patients having difficulty in treatment get themselves back on track for change. Although this article describes a process that typically takes place in an early stage of treatment, there is no reason that facilitators could not apply many of its principles to other situations.

Phase One of the Conventional track at Sand Ridge offers an Applications Group to help patients address issues that may prevent them from a successful transition to Phase Two. It is oriented toward work with individuals who are of normal intelligence and who do not possess high levels of psychopathic traits, although with some accommodation, professionals could use elements of this method with these populations. Upon entering a Phase One Applications group, patients should have completed the Smarter Thinking and Thinking Errors curricula. In fact, facilitators in Smarter Thinking and Thinking Errors are expected to prepare patients that they will likely enter an Applications Group. Completion of the curricula does not mean an automatic advancement to Dual Placement or Phase Two of the program.

Treatment Context and Rationale

Therapist style is among the most fundamental elements of the treatment program. Studies (e.g., Marshall, 2005; Marshall, Fernandez, Serran, Mulloy, Thornton, Mann, & Anderson, 2003) have shown that treatment providers with a warm and empathic style whose actions are directive yet rewarding produce the best outcomes with respect to dynamic factors associated with sexual recidivism risk. Sand Ridge trains treatment providers to work in this fashion and to model the changes they expect patients to make. Given the preparatory nature of the early stages of treatment, facilitators should prepare themselves to encourage and mentor their patients, demonstrating a concern for their welfare while remaining firm around the values underlying sexual offender treatment. Facilitators

have received training in many of the techniques and spirit of motivational interviewing (Miller & Rollnick, 2002).

Group treatment is at the center of the program. While there is little research into the efficacy of group versus individual treatment, the literature on treatment sex offenders describes numerous advantages of group treatment (e.g., Marshall, Anderson, & Fernandez, 1999; Marshall, Marshall, Serran, & Fernandez, 2006; Frost, 2004; Jennings & Sawyer, 2003). A recent survey by the Safer Society Foundation (McGrath, Cumming, & Burchard, 2003) found that 98.9% of residential treatment programs and 89.9% of community programs for adults use group treatment, most often with adjunctive individual treatment. The authors note, "Sole reliance on individual treatment is often contraindicated. Individual treatment is more expensive and does not provide the same opportunities for peer support and social skill practice as group treatment" (p. 48).

To this end, the early stages involve group treatment to prepare patients for the more stringent demands that come later, when self-disclosure and the supportive challenges of teamwork become increasingly important. Treatment groups at Sand Ridge also use homework assignments and role plays. Unit staff and their supervisors are available to help with assignments for patients in earlier phases of treatment. Unit staff members also attend formal and informal case planning meetings, and contribute to the development of individualized treatment plans and goals. In many instances, individual therapy is used to address specific patient concerns. However, the primary emphasis is on group treatment wherever possible.

Beyond the advantages of group treatment, several other aspects are important to the long-term success of Sand Ridge patients. As noted above, an often unstated but significant challenge in treating high-risk offenders is that much of the work involves fostering success in those who have all too often been poor candidates for treatment.

Ultimately, to achieve the final goals of treatment, the early phases should help patients move closer to a lifestyle conducive to supervision in the community. Hanson and Harris (2001) noted that higher risk offenders were often less cooperative with supervision requirements (including treatment) while Hanson and Bussiere (1998) speculated, "High risk offenders may be those most likely to quit, or be terminated, from treatment" (p. 358).

In summary, the early stages of the Sand Ridge treatment program invite patients whose offending has persisted, often despite detection, sanction, and prior treatment experience, to engage meaningfully in group treatment that will address their history of offending and the psychological factors that contributed to their offending. Very often, these patients enter treatment demonstrating impulsivity, irritability, and unwillingness to accept responsibility for their actions. The majority of patients have diagnosed sexual and personality disorders that require considerable personal effort (and external support) in order to change.

It would therefore be unfair to expect that these patients could immediately meet the challenges of entering treatment and quickly begin examining their histories. 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. This takes place via cognitive skills curricula and special attention to demonstrating change in their daily lives. Patients do not progress to the next phase of treatment until they have demonstrated an ability to integrate lesson material into their daily lives. Prior to completing this early phase of treatment, facilitators assess each patient's progress in 10 key areas:

1) *Acceptable group behavior*
2) *Managing criminal thinking errors*

3) *Use of pro-social problem-solving skills*
4) *Emotional regulation*
5) *Interpersonal skills*
6) *Productive and responsible use of time*
7) *Positive attitude towards change*
8) *Self-monitoring* (essentially, this means monitoring and discussing specific goals)
9) *Sexual functioning*
10) *Compliance with rules and supervision*

After completing the cognitive skills-based curricula, many patients still have challenges that they are working on in order to meaningfully complete the goals of Phase One. For this reason, the treatment team established the Applications Group (AG), where patients directly address these aspects within a group setting. This group provides the benefits of feedback, questions, and discussion from other patients, and provides patients the opportunity to practice having challenging discussions within a group context before delving into deeper issues.

For many patients, the issues they have yet to resolve are contained within the phase goals themselves (e.g., compliance with rules). For others they may include goals found within their treatment plans (e.g., relationship issues not captured directly in the interpersonal skills phase goal). Some examples include (but are not limited to):

- Persistent grievance thinking despite work completed in earlier curricula
- Mistrust of staff
- Adequate self-monitoring of specific issues that the treatment team has identified
- Negotiating relationship boundaries
- Maintaining motivation to change
- Factors related to repeated polygraph examination failures
- Remaining active in the program (e.g., maintaining a productive use of time, refraining from isolating oneself from others)
- Accepting and acting upon feedback from others
- Fully applying problem-solving skills in daily life
- Fully recognizing and managing thinking errors in day-to-day life, in the here and now
- Ongoing deception with staff and peers

Putting the Group Together

The therapist's style is critical. Warmth, empathy, and acceptance, combined with a directive approach are optimal for these individuals, who all too often have failed in confrontational settings. A key task for group members is to determine for themselves whether they are at a point where they can meaningfully commit themselves to personal change in a given area. To this end, the task of the facilitator is not to advocate the merits of participation in treatment, but to remain open to ambivalence and supportive of any emerging commitment to change. Along the way, the patient can analyze the costs and benefits of the focus issue. There is no shortage of research demonstrating that people are more convinced by what they hear themselves say than what others say to them (Miller & Rollnick, 2002; Ryan & Deci, 2000) particularly when they experience having some choice in the matter (Bem, 1972).

Guiding elements of the AG come from the spirit and techniques of motivational interviewing (Miller & Rollnick, 2002). Berg-Smith (2006) defines motivational interviewing as a "client-centered, directive counseling style for enhancing intrinsic motivation for change by exploring and resolving ambivalence" (p. 11). Miller and Rollnick describe four general principles (p. 36):

1. Express empathy
2. Develop discrepancy
3. Roll with resistance
4. Support self-efficacy

The authors provide a full discussion of these principles that needs no further elaboration here, except as they relate to the AG. Facilitators enter groups prepared to express empathy and support self-efficacy, although these areas can potentially take a lifetime to master. They use open-ended (or "Socratic") questions that elicit information rather than provide instruction. This contributes to an empathic environment that supports self-efficacy. The principles of rolling with resistance and developing discrepancy are of critical importance to the AG.

Resistance has been the source of much discussion among sex offender treatment providers. Authors such as Blanchard (1995) and Jenkins (2006) have explored the therapeutic relationship within sex offender treatment. Discussing research showing that client behavior can provoke clinician confrontation and vice versa, Miller (2006) observes, "Client resistance and clinician confrontation are complementary behaviors that elicit and reinforce each other, much like the cycle of aggression and retaliation between nations" (p. 16). For purposes of the AG, facilitators recognize that resistance enters the process naturally and inevitably. Facilitators are at their best when they welcome resistance, as it very often accompanies ambivalent statements that contain the first indicators of a willingness to change.

For purposes of the AG, developing discrepancy is the difference between where the patient is and where they want to be with respect to the focus topic. This simple difference is often how facilitators approach the challenges that patients face. By asking questions using this language ("Where would you like to be with this? How does this issue fit into your future"), they can prevent debate and maintain focus. Facilitators can reframe resistance such as blaming others for their actions (e.g., "I can't participate when all these other guys' crimes have been different from mine") with statements such as, "This really shows how important their support and understanding is to you." Likewise, facilitators can reframe patients' complaints about the perceived arbitrariness of rules as a strong desire to understand the reasons that those rules exist. Discussions can then include the discrepancy between the patient's current functioning and the requirements for re-entry to the main stream of their treatment track, with an emphasis on how decisions about their participation are between themselves and their future.
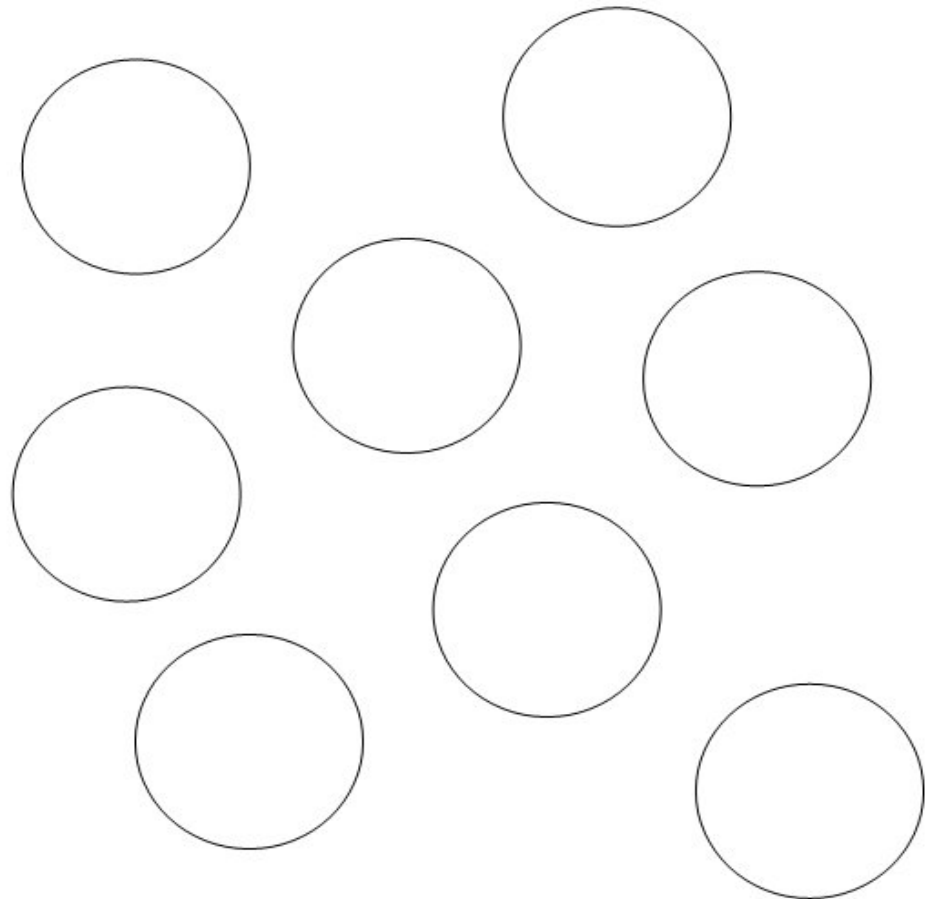
Getting Ready

Throughout the treatment experience at Sand Ridge, patients and facilitators meet to discuss progress and the expectations of the program. Placement in an AG follows a process in which the patient meets with staff members involved in his treatment. This can include a treatment team consisting of facilitators and unit staff, and can occur as an informal staffing. The team asks permission to discuss the individual's status in treatment and seeks his perspective on his progress in treatment. Adherence to the principles of warmth, empathy, acceptance of ambivalence, and rolling with resistance are critical during this discussion. Facilitators often find that patients are reliable at assessing their progress in specific goals while their desire to advance quickly through treatment can result in an overly optimistic global assessment of their readiness for advancement. A facilitator then discusses factors that the team feels the patient still needs to work on in order to prevent difficulties later on. The patient and others in the treatment team can then work together to establish areas that the patient can work on. Although it is helpful for the patient to enter the AG with a menu of issues he can work on, it is not uncommon that when he shares these issues in group, other members may have ideas or feedback that results in their refinement or the creation of new issues.

It is most helpful when the team can focus on a small number of core elements of the treatment-interfering factors rather than a comprehensive laundry list. Ideally, one to four goals for the AG is optimal in order to maximize the patient's ability to stay focused on them. This may require team members to conceptualize single behaviors as part of larger areas of need. Often team members establishing these goals rely on the 10 key areas of progress for the early phase of treatment.

Once the team determines these areas of need, they can be written into an options tool" (see figure 1). By writing the issues into the circles, the patient then has:

- a hand-crafted document different in appearance from the usual formatting of clinical paperwork, including treatment plans
- a tangible, visual roadmap whose structure does not necessarily imply a specific sequence of tasks
- a menu from which the patient can choose for himself the areas he will address first… this emphasis on choice is fundamental to the patient's ability to make change for himself as well as to advance in treatment
- additional circles to which the patient can add goals of his own
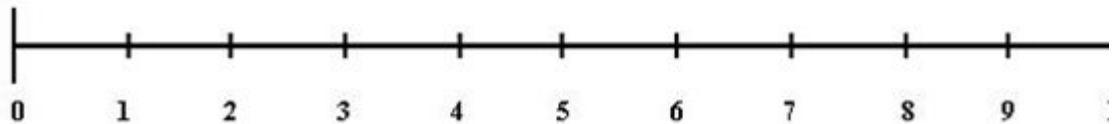
Figure 1: Options Tool

Facilitators should anticipate that the patient might not agree with some or all of the goals. This is to be expected; the team can note that the patient does not agree with all of the treatment team's

concerns and recommendations. Likewise, the facilitators encourage the patient to add concerns of his own. Ultimately, the process is collaborative and includes the treatment team's concerns. After all, left alone these elements could prevent progress in areas key to meaningful personal change.

Upon establishing the goals for patient progress in the AG, facilitators can next use a "readiness ruler" (Miller & Rollnick, 2002, p. 183; Berg-Smith, 2006) to explore the patient's motivation further.

Figure 2: Readiness ruler

Using this deceptively simple ruler can produce fruitful discussion as well as another tangible visual aid. Facilitators can also easily use it as a written assignment as well. The facilitator asks, "On a scale of one to ten, how ready are you to consider addressing these areas?" When the patient offers only a "four," the facilitators can then ask why he didn't choose a one or a two. Whatever the patient's response, it will almost invariably involve some sort of strength, positive attribute, or belief in his ability to address the issue (known in motivational interviewing as "change talk"). The facilitators can then affirm and explore these areas before asking, "What would need to happen for you to move up one half-step to a four-and-a-half? The patient's answer will likely involve some sort of action that he and/or others can take as well as including change talk. This can provide considerable insight and direction for patient and team members alike.

Facilitators at Sand Ridge have found that asking directly about motivation does not always make sense to patients. Rather, it can be more productive to break this down into:

- On a scale of zero to ten, how ready are you to consider a change in this area?
- On a scale of zero to ten, how confident are you that you can make a change in this area?

Alternatively:

- On a scale of zero to ten, how possible do you think a change in this area is?
- On a scale of zero to ten, how clearly can you picture making a change in this area?

The answers to these two questions can vary dramatically from one patient to the next. As many authors consider motivation and hope to be made up of a number of components (e.g., motivation as readiness and confidence, and hope as knowing that change is possible and having ideas on how to make it happen), it may be most productive to use the ruler with these individual facets of motivation and hope.

The Group Process

As opposed to many curriculum-based group situations, the AG is open-ended, providing the opportunity for patients to receive feedback from one another. Once involved, the patients present and review each of the issues outlined in their option tools, discussing them with the group. The facilitator can simply ask, "Which of these areas would you like to discuss today?" The readiness ruler can be useful for exploring each area. In addition to eliciting discussion around change and commitment, the process provides a forum for other patients to ask open, thought-provoking questions and to provide support.

Once the group begins exploring a relevant area, they next examine the costs and benefits of each

issue. For a patient addressing problem behavior, this involves discussing what he gets from the behavior along with the costs (e.g., continued failure to progress). This discussion can be as simple as asking what are the "good things" about change and what are the "not-so-good things" about change. Some further questions for this discussion include:

- How has this issue played a role in your past behavior?
- How does this issue play a role in your current behavior?
- What kinds of payoffs do you get from this?
- And, on the other hand, what kinds of difficulties is it bringing you?

Depending on circumstances, supplementary questions can include:

- What is happening when you decide to engage in this behavior?
- Have there been times when this was not an issue for you? What were they like and what was going on for you?
- What do you want to happen and what do you get?
- How might this issue affect others?
- How might one approach situations where this issue might arise and get what you need without this issue happening?
- What concerns do you have about this issue?
- How has this issue been a problem for you in other times of your life, either here or in the community?
- What are some obstacles you might find if you do make a change in this?
- Who is their in your group and on your unit that can help you with this?
- If you were in my (or someone else's) shoes, what might you think about this issue? (other patients often have a number of contributions to add to this question)

By exploring the benefits as well as the costs, the patient can decide for himself how committed he is to making change in this area. It is important that he make these decisions free of coercion or the sales pitches of well-intentioned professionals. The patient will have only his own commitment to rely on in later stages of treatment.

A further area for exploration involves a "cognitive check-in" (Thornton, 2005). This assignment tasks patients with monitoring how their thoughts influence their behavior. As applied in the AG, patients describe:

1. a situation in which they experienced strong emotions
2. what went through their mind (patients often find it helpful to include what their goals were in the moment)
3. what they did/what skills they used
4. what they could have done/what skills they could have used

The group will then work with the patient to help them identify the beliefs that underlie their thoughts. This sequence stays simple in order to maximize the patients' use of it. They can then apply this series of questions to any area of focus.

Patients a typically have at least one cognitive check-in ready to present in each group. During the subsequent feedback and discussion, the patient can also discuss how this situation relates to his AG goals.

Action Planning, Quests, and Completing the Group

Facilitators and patients monitor the options menu issues both on the unit and within the group. Patients bring their options tool to each group and be prepared to discuss the various issues they

include. The patient and facilitators work to explore these issues and develop action plan plans for what meaningful change in this area looks like. The patient then self-monitors progress and reports to these in the group. This can take place via regular discussions or cognitive check-ins. Facilitators and patients should meet with unit staff in informal staffings to review progress. In addition, the team can use rapid reviews to discuss interim progress.

Some of the AG options tool goals are substantive issues, while others may be minor or easily accomplished in the short term. The more substantive issues are often referred to as *quests.* These goals require diligent self-monitoring by the patient. This involves explicit action planning, and facilitators should ensure that that the schedule informal staffings so that patients can receive feedback from unit staff. Here is an example of one such quest:

> *Patient X had made considerable progress in the Phase One curricula. He had not received any behavioral sanctions for over a year and had little difficulty discussing his application of problem-solving skills, managing thinking errors, or giving and receiving feedback in his treatment groups. However, the unit staff noticed that he didn't interact with his peers as much as he might. Further, they noted that increased peer interaction is an expectation of later phases of treatment, while social isolation is a known risk factor for sexual recidivism. X's facilitators and unit staff held an informal staffing to share this feedback, elicit X's response, and work together to build an action plan. Mr. X committed himself to contributing more in his treatment group, and worked out a plan with the unit staff that he would organize unit meetings, help cook for unit gatherings, and check in with a unit PCS twice a week to discuss h is progress. Mr. X agreed to adjust his sleeping schedule in order to be out of his room at times when other patients were more likely to be available for socializing. Three months later, the treatment team convened. The unit staff noted that Mr. X had made good on his action plan, and that this was particularly apparent in the fact that attendance at unit meetings had doubled since he took it upon himself to invite most members of his unit to attend.*

Potential Traps

Providing treatment in civil commitment settings provides no shortage of challenges. The following are some, but not all, potential difficulties that facilitators might experience:

- *Discrepancy hurdles.* Patients are sometimes ambivalent about discussing the discrepancies between their current and desired statuses. Under these conditions, facilitators are at risk to argue for change, often in the form of offering suggestions as to the advantages of change. Under these conditions, possible solutions include focusing on other patients and convening staffings to discuss alternatives.
- *The negative spotlight trap.* Professionals with experience in diverse inpatient settings can understand how problems command attention far more readily than successes do. In some cases, simply getting out of bed or maintaining a schedule represents success. Facilitators should remain active in their attempts to highlight even small successes while maintaining respect for the challenges that patients have yet to address. With no spotlight on success, patients have fewer avenues for exploring what has worked in their attempts to get back on track.
- *The expert trap.* Described by Miller & Rollnick (2002), this is a familiar problem in which patients defer responsibility, asking (and in some bases, baiting) the facilitator with questions such as "you're the expert; you tell me what to do," or "What would you do in my shoes?" Very often, when facilitators enter the expert trap, patients will quickly write off their suggestions as meaningless or impossible, further strengthening their commitment not to change.

- *The urge to fix problems.* Berg-Smith (2006) also refers to this as "the righting reflex" – a tendency among professionals to try to fix the problem instead of patiently allowing patients to arrive at solutions. This can combine with the expert trap to leave professionals with a crippling sense that although they desire to motivate group members, they must do so quickly in order to maintain a posture of authority. Very often, the best solution to the urge to fix is to maintain an active focus on remaining warm, empathic, rewarding, and directive.
- *The etiology trap.* Group members sometimes engage in lengthy discussions and other periods of reflection in which they explore how various issues in their lives came to be. Although there can be great merit in exploring one's life history and assembling an autobiography of one's life is an expectation within subsequent treatment phases, understanding the roots of a treatment need is not the same as making change. It can be very easy for group members to substitute eloquent life narrative for acceptance of responsibility and demonstrated change. To prevent the etiology trap from taking time away from change, facilitators can remind patients that there will be more time to search out the causes of their behavior in other treatment venues.

Summary

Not all patients progress through treatment at the same pace. The Applications group can help better prepare patients for later stages of treatment by attending to those goals where the patient has had trouble. In this way, patients and facilitators needn't repeat lesson material from curricula, but can instead talk about the issues as they occur in real life. The treatment team should select goals carefully based upon the needs of each individual patient. Further, the Applications group can refine patients' understanding and capabilities in these areas, and providing them the opportunity to demonstrate meaningful change.

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