



## Proven Strategies for Engagement, Effective Change and Enduring Risk Reduction with Offenders

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### Abstract

Research indicates that at least 70% of offenders reach criteria for personality disorder other than antisocial and, due to the closure of mental health hospitals world-wide; there are an increasing number of offenders with mental illness located in prisons. To fully assess and reduce the risk an offender poses and to try to remediate that risk, the underlying drives to offend must be understood and addressed. To do this an offender must be genuinely engaged. It is suggested that this is in part due to having poor attachment histories and no internal model of a healthy attachment. This paper is written by a consultant clinical and forensic psychologist with a long standing proven record of establishing and running services for and working therapeutically with men with mental health issues with outstanding results in risk reduction alongside and by an expert by experience who has in-depth personal insights into the both the processes needed for effective engagement and change. It describes useable strategies as to how to successfully engage offenders and how to develop a healthy and reparative therapeutic relationship. It describes the importance of a collaborative clinical formulation to aid the development of a coherent narrative and of an emotionally present and engaged therapist. The need to work on both victim and offender issues to bring about real change and risk reduction is elucidated throughout.

**Keywords:** Clinical psychiatry, Forensic psychiatry, Mental illness and Mental health.

### Introduction

Forensic patients, whether in hospital or prison settings, are notoriously difficult to engage and maintain in treatment at the level necessary to bring about effective enduring change. While the extended stay and revolving door syndrome in patient in forensic psychiatric hospitals and high levels of recidivism for those in the criminal justice system are well known phenomena, few studies reporting therapeutic failure are ever published. Even in non-forensic populations, studies only report on those that are successful in therapy [1] and failure rate across all areas of psychological therapies are greatly under-reported.

The exception to this has been the extensive study looking at recidivism rates of men who have followed the UK Sex Offender Treatment programme. Whilst acknowledging the confounding factors and the complexities of carrying out this form of research, the research found that those who completed the standard treatment programme were more likely than a comparison/control group to reoffend [2].

Nevertheless, there is successful work carried out those who offend and in order to ensure genuine rehabilitation the key issues common to these interventions need to be identified and utilized. This paper considers those key issues and proposes a need to focus on the relational process during the therapeutic interventions rather than on the content which has previously been the case. Using case studies, this paper will discuss the factors which lead to genuine engagement, effective change and enduring risk reduction in offenders.

### Strategies for engagement

Engagement requires the development of a genuine therapeutic relationship [3,4]. Ironically those people most in need of therapy are often those who struggle most to develop that therapeutic relationship. This is primarily because therapeutic relationships are based on early attachment relationships and almost all offenders have had significant disruptions in those early attachment relationships [5]. Good attachments are essential in developing the neural connections between the cortex, the right occipital lobe and the limbic region.

Failure to develop these connections leads to an inability to modulate emotional state, impaired ability to develop reciprocal social relationships and a disturbed sense of self [6]. Early experience does not cause later pathology in a linear way but plays an aetiological role in the complex, transactional nature of development [7]. For example, due to not having a secure base through attachment, they will not believe that they can rely on others; therefore they will not do so.

This then reinforces the belief that others are not supportive and the only person that can truly be relied on is oneself. Not feeling attached to any one, much of the drive for their behaviors is survival and they will interpret any situation in relation to potential or perceptible threat. Factors that constitute threat may not however be perceptible to other people, as they often carry distorted beliefs and act on those beliefs. Thus, a therapist showing warmth and genuineness before the development of a therapeutic alliance may be regarded as threatening and manipulative and immediately rejected by the patient.



Offenders are unlikely to have good access to their thoughts and feelings and will frequently act impulsively, or in what is perceived to be a planned manner, without any awareness of the underlying issues driving their behavior. They experience numerous negative automatic thoughts and have a lack awareness of their emotional states. They have learnt to block out emotions from conscious awareness and can state they 'feel nothing' or tend to rely on one predominant emotional state, usually anger. They are rarely able to discern the underlying emotion or the triggers that led to the emotion and drive the subsequent behavior.

Thus, as the harmful behaviors of offenders are primarily emotionally driven, a failure to access those emotions during treatment will leave the offender untreated and with a high likelihood of the continuation of that harmful behavior. The way individuals learn to identify and regulate their emotions and understand the experiences that trigger those emotions is through a secure attachment relationship [8]. Secure relationships are also known to promote socially adaptive and morally responsible behaviors through the impact of interpersonal relationships on the brain's neural structures [9,10].

Adverse experiences in a child's early life negatively shape the development of the complex brain circuitry, thus impact negatively on the ability to develop healthy social and moral behaviors. Research now shows that contrary to previous views the brain is plastic and able to develop throughout the lifespan [11]. Thus, the aim of the therapy being proposed in this paper is that the individual therapeutic relationship needs to mirror a secure attachment relationship. That secure attachment relationship has been shown to actually change brain structure [12]. There are certain strategies that are needed to facilitate such a relationship to develop (Table 1).

Collaboration-Secure relationships are based on collaborative, contingent communication.	The therapist will always try to collaborative with the offender rather than authoritarian. The response will always be appropriately responsive to that of offender in both content and underlying message being communicated by offender.
Reflective Dialogue-Secure relationships involve verbal sharing of a focus on the internal experience of each member of the dyad.	The therapist will enable the offender to focus on the emotional experience in the emotion behind their communication and also aid that process by focusing on and communicating their own emotional experience.
Repair-When communication is disrupted, as it inevitably will be repair of the rupture is important. Repair is healing.	It is important that the offender learns the relationships can withstand differences and ruptures and still be maintained. It is always the responsibility of the therapist to ensure that the relationship with the offender is repaired.
Coherent Narratives-The connection of the past, present and future is one of the central processes of the mind in the creation of the autobiographical form of self-awareness.	The therapist will try to help the offender make connection between their past and present experience and how this impacts on their future choices.
Emotional Communication-Share in both the negative and positive experience living and ability to remain connected during moments of uncomfortable emotion. Thus, negative emotional states can be shared and distress soothed.	The therapist will aim to connect emotionally with the offender at the level of attunement. This means that the therapist will emotionally connect with the offender and manage their own emotional state thus modeling for that offender appropriate emotional modulation.

**Table 1:** Strategies needed to form an attachment relationship.

The structure of the therapy must be regular and consistent and the strategies used should follow those known to enable the development of secure attachment relationships. These strategies are collaboration, reflective dialogue, repair, coherent narratives and emotional

communications [13]. At the start of the therapeutic relationship, the therapist needs to be explicit is telling the patient that the aim is for them to try to develop is to try and develop a healthy attachment bond. The reasons why this is important also need to be made explicit to the patient. Indeed, due to the likely perceived vigilance for threat in forensic patients, every aspect of the relationship and the processes being followed needs to be made explicit.

The content of the work needs to begin with the start of a collaborative clinical formulation. This enables the patient to be the expert on his or her own experience with the therapist providing the psychological framework for, and underpinning of, the patient's experience. This clinical formulation is written up as a joint report and is a dynamic document that will be developed further over the course of therapy as new information is revealed. Self-understanding is a key to the therapeutic process. The genuine curiosity and the emotional empathy that a therapist has for the patient creates a safe space for that patient to explore their own story and start to make sense of it.

### Case Material

Man in his late 30's who was undertaking therapy in a specialist service for offenders with a diagnosis of severe personality disorder. He had little emotional support in early life due to both mother and grandmother having mental illness. He experienced physical torture by another family member from a young age He spent time being looked after in care system and once able to fend for himself, he had to be the best at everything and have the best things materially. As a child, he took on an adult role in caring for others, even parental figures. He was a 'man' while he was still a 'child'.

By 12 years of age he owned a new BMW and by the age of 14 he was a father. The only person trusted was himself and he always had to be the one in control. He engaged in various criminal activities threatened, and engaged in, extreme violence, to protect self from any potential abuse by others. In relationships, slightest chance of abandonment would leave the person first to protect him-self. In prison, he was highly refractory. He was referred to a therapeutic unit in a high secure prison; he was diagnosed with antisocial personality disorder and bipolar disorder.

He writes: At the start of therapy, I began to work with a psychologist. I initially thought she was a man-hater who was on a crusade to crush all men but in the space of months, I realized she was actually genuinely caring and not trying to manipulate me. Although I did not consciously realize it, I had already begun to emotionally trust her. Cognitively, however I didn't trust her for at least the first year of therapy. This was played out in the fact that I would not look directly at her for that first year. My relationship with her changed when I began to realize that my therapist was connecting with me on an emotional level.

She was able to pick up the emotion in my responses and feed that back to me; even changes in my tone of voice, or the way I looked or how I sat. As she became emotionally attuned with me and my experience and was able to hold my emotions, I began to be able to feel those emotions. Through this relationship, I began to be able to connect to my experiences as a child and most importantly, to connect to, and have empathy for, the part of me that was hurt as a child that I had repressed for many, many years.

The relationship my therapist developed with me enabled me to feel safe enough to connect to my sadness and fear as there was someone who was genuinely caring and protective of my experiences as a child. I learnt that it was not only okay but that it was normal to express and not repress such emotions. The importance of being therapeutically connected to an emotionally available therapist who is self-reflective enough to engage in emotionally explicit communication cannot be overestimated.



## Strategies for effective change

### The birth of the offender working at a therapeutic level with the trauma

During the initial phases of therapy, the clinical formulation is begun and developed. This is a dynamic document and changes as more information is gathered in the process of the therapy. The clinical formulation will describe offender's presenting problems and use psychological theory to explain the causes and maintaining factors of those problems.

Thus, it not only describes the offender's behavior but how and why that offender was 'born'. The clinical formulation will describe:

- The presenting issues;
- The offender's life history
- Within a psychological framework indicate the factors that act to create the vulnerability or precipitate the problems developing
- The factors that are helping to maintain the problems
- The positive characteristics and resilience factors of the offender
- The interventions that will most support that offender to change

Most people have a narrative of their lives which has been constructed through a combination of experience and the interpretation and recollection of others, particularly parents and siblings. Most forensic patients have distorted narratives of their lives and the links between their experiences, thoughts, emotions and behavior. Thus, the clinical formulation becomes a vehicle through which a collaborative coherent narrative of the patient's life can be developed. The emphasis within individual therapy is upon developing an emotionally intimate attachment relationship in which the aetiological factors of the dysfunctional behavior can be explored and addressed by working therapeutically at an emotional level.

This allows the offender to experience empathy at the level of affective attunement (that is, feeling with the person) rather than solely at intellectually understanding how difficulties have arisen. Almost all offenders in addition to experiencing attachment difficulties have experienced childhood trauma. Trauma is a key factor in the aetiology of disturbed and disturbing behaviors [14-15] describes children abused within their families who experience a "familial climate of pervasive terror". Terror can also be the experience of children abused outside the family who have no physical or emotional refuge.

Such terror inhibits a children's normal development as they make adaptations to their ways of thinking, managing emotions, development of identity, managing interpersonal relationships and behaving, whilst maintaining the optimum proximity to their care givers to ensure survival. These 'adaptations' which are described by [15] as Complex Posttraumatic Stress Disorder. Chronic trauma impacts on neurobiological development, inhibiting the integration of sensory, emotional and cognitive information [16].

Whilst these adaptations are functional within abusive environments, they become dysfunctional and maladaptive when utilized within other environments. Not everyone that experiences trauma develops behavioral difficulties. Vulnerability to doing so could be genetic, or due to poor attachment relationships, other dysfunctional family constellations and/or social and cultural environments.

Extreme neglect is a trauma often overlooked. Such neglect means that the infant/child experiences terror of annihilation; a defining characteristic of traumatic experiences. That terror needs to be repressed to survive without an adult on whom to depend. Children that have experienced extreme early neglect and show minimal overt fear reactions as they have learnt to suppress these in order to survive. Many offenders who are described as being highly psychopathic have experienced profound early neglect [17]. Therapy therefore needs to involve working through the trauma.

Through this process, the individual needs to see him, or her, self as a victim and be enabled to develop true emotional empathy and compassion for the child within the individual that experienced that trauma. Without being able to develop that empathy for the victim within the individual, he or she will not be able to develop emotional empathy for any victim. Therefore, change at a cognitive level may bring about initial change in behavior but will not bring about enduring risk reduction as, whenever the trauma is triggered, the individual will again become vulnerable to offend.

### Case material

Therapy enabled me to develop a great emotional, as well as cognitive awareness of others and, importantly, over time, of myself. This journey was not however without pain. I was unlocking trauma in my therapy sessions and having my emotional reactions to those experiences validated. After sessions, in my cell I was processing and making sense of it.

I was suffering bad nightmares and at times, the feelings of fear shame and sadness associated with the abuse I was unlocking often left me feeling suicidal. This process, whilst highly distressing, I now know that that pain I was experiencing to which my therapist was connecting with me with true emotional empathy and giving me care was actually repairing my damaged brain.

## Strategies for enduring risk reduction

### Taking responsibility for offending - the death of the offender

Often when people undertake therapy on their own victim experience, they can become enmeshed in that experience and find it difficult to move on and take responsibility for their offending. Whilst working on the victim issues is essential to develop empathy and compassion for self as a victim, it is also essential to take full responsibility for offending and the damage done to others by that offending? Offenders can be reluctant to move to this stage as it involves the most painful emotions of shame, guilt and remorse.

Offenders often actively get stuck in the victim stage as they find it so emotionally aversive to move through to taking more than verbal responsibility for their offending behavior. Therapists can also be reluctant to move onto this phase of therapy as they have developed such strong attachment to the child victim within the offender. Having developed a collaborative understanding of the birth of the offender, to then see the person that they have developed this close attachment with as an offender, can be distressing for the therapist. They may try to protect the offender from experiencing the shame and guilt of the offences that have been committed.

Nonetheless, it would be unethical of the therapist not to enable the individual to take the level of responsibility needed for the offences they have committed and the victims that they have created. To do so require the offender to explore their offending in depth. A useful strategy to ensure that they develop emotional empathy and compassion is to use 'transformational chair work' [18]. Transformational Chairwork is based on the belief that there is a healing and transformative power in giving voice to one's inner parts, modes, and selves and in enacting or re-enacting scenes from the past, the present, or the future.

To tell the offender the impact on the victim will have little impact, as the offender will defend him or herself from that knowledge at an emotional level [19]. Stated, "Nobody can stand truth if it is told to him. Truth can be tolerated only if you discover it yourself because then, the pride of discovery makes the truth palatable". Transformational Chair work is a highly powerful technique and enables the individual the access the more unconscious aspects of



beliefs about, aspects of self, beliefs about others and perception of relationships. Importantly, it enables the offender to truly discover the true emotional impact on his or her victim/s. The offender describes the offence he or she committed from the perspective of an outside observer. The offender and the therapist then discuss the scene to clarify the details. An empty chair is then brought in for the victim and the offender and the victim have a two-chair dialogue about the experience with the offender taking both roles.

Supported and deepened as appropriate by the therapist. The victim confronts the offender and tells the offender how he/she feels about the offence. The offender may need support to recognize and accept the feelings of the victim. This form of therapy can bring about great insight and associated emotional distress and this in turn brings about integration and healing [20-21] stated development of true empathy for a victim is the greatest inhibitor of offending.

## Case material

For me it was important to understand the meaning of the words that relate to offending at an emotional level. On courses people use the words guilt and shame and remorse and expect you to understand them but they need to be felt, truly felt and only then can they really be understood. For myself, shame is internal, it is what I feel about myself, my behaviors, and shame focuses on the part of me that have hurt others. It is a deeply painful feeling that makes me want to curl up within myself. Guilt is more external. I feel it internally but it is about others, about the damage that I now understand that I have done to others.

Remorse is both internal and external, I feel remorse that part of myself is capable of damaging others and remorse for having hurt others. Guilt and remorse can only come when a person is able to develop compassion and empathy. Shame is carried within the self and is associated with an internal sense of defectiveness, incompetence or inadequacy. The more self-knowledge that is developed through therapy, the more a person is able to understand and develop effective emotional regulation, the more the person can take responsibility for the self and their own choices and actions, the more effective the change.

## Evidence of enduring change-internal rather than external risk factors

Often when risk management plans are carried out offenders are often asked to identify high risk situations; that is situations that mean that they are more likely to be triggered into offending. This is a focus on external risk factors rather than what is needed for enduring change, a focus on the internal risk factors. If treatment has been effective no situation (external risk factor) will be at any higher risk than others, it will be about the individual's ability to regulate the emotional states (internal risk factors) in ways that will not lead to offending.

For enduring risk reduction, the internal risk factors must be addressed and then the external risk factors will be far less relevant. When through a collaborative clinical formulation, through individual therapy and the development of a secure attachment relationship and through working therapeutically on trauma and the impact of trauma on the individual's development and the birth of the offender, the individual develops true self-knowledge and self-compassion and empathy, there will be no high-risk situations.

This is because the individual will be able to appropriately express and modulate emotion. If triggered the person will also and know them well enough to be able to work out what has triggered them and act appropriately. This means that in developing empathy and compassion and taking responsibility for self, the risk of that individual offending directly against another person is highly unlikely.

This does not mean that the individual will not be able to offend again, in any way; indeed, anyone of us could offend if we chose to do so. It means that the person now has the ability not to offend as he or she has self-knowledge and alternative strategies.

## Case material

My primary hope is that I will never offend again. Through therapy, I have come to know my triggers and, having worked on my trauma; those same triggers have not led to the offending behaviors or parallel offending processes that they would have in the past. I now want to experience living in society as a pro-social member of the community.

## Conclusions

Every person engages in interpersonal relationships. Within those relationships, the interpersonal dynamic will be a product of the accumulated interpersonal experiences of each of the participants in that interaction. For a therapist to bring about effective long lasting change with forensic patients, it is proposed that that change needs to be brought about within a therapeutic relationship that replicates an attachment bond.

Such a relationship is needed to make the fundamental changes in brain structure that will enable lasting change. In order to do so effectively, the therapist needs to be able to develop an authentic emotional connection to the client and be genuinely empathetic at the level of affect. Such a therapeutic relationship will require that the therapist is acutely self-aware so that a real differentiation can be made between what emotion genuinely belongs to the client and what emotions are being triggered that belongs to the therapist.

It is also important that the therapist is aware of their own distorted beliefs so that these beliefs do not become incorporated into the client's formulation. This focus on the interpersonal interaction requires that therapists have had some level of personal therapy so that they are at least aware of their own issues so as not to impose these into the relationship with the client. Therapy enables therapists to examine their 'blind spots' and work through their own issues so as not to act them out with the client [22].

Whilst it is part of the qualification that psychotherapists and counselors have therapy, personal therapy is not part of the qualification criteria for psychologists. As it is most frequently a psychologist that work therapeutically with forensic clients, in the community, in prisons and in hospitals, it is often those who have had the least personal therapy that are working with the most complex, damaged and damaging clients and those clients who are most likely to trigger issues in anyone with whom they are in any form of relationship.

Thus, unless those therapists undertaking this kind of therapy have had their own therapy, they are likely to instinctively engage in safety behaviors in the therapy. These safety behaviors that are self-protective strategies which will inhibit the development of the kind of relationship through which they can genuinely facilitate change. Having personal therapy and good supervision will enable the therapist to be able to be truly self-aware and engage at the emotional level required to form the attachment bond needed for the therapy to be able to bring about effective and enduring change.

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