

FORENSIC MENTAL HEALTH

Association of California

Newsletter

Dear FMHAC Members,

I'm happy to present to you our 2009 Newsletter. Inside, you'll find articles on trends in forensic mental health, a teaser for our 2010 conference, a call for student conference attendance, guidance on forensic mental health legal research, a discussion of a recent webinar, *The Mentally Ill in Jail*, and an article from one of our regular presenters on expanding sex offender treatment.

What We've Been Doing The Board of Directors and I have worked this summer, as always, to develop a great conference for next March. We've also implemented a student chapter program and worked on keeping you, our members, up to date on events and happenings in forensic mental health via twitter, email announcements and website updates.

Save the Date! Our 2010 conference will be held at the Embassy Suites, Seaside, March 24th - 26th. The theme is *Integrating Disciplines: Affirming Our Core Values* to emphasize the need to work together and to support core activities as budgets are cut. Please visit our website in the coming months for more information.

We hope you find the articles here interesting, informative and helpful.

Sincerely,

Molly Willenbring
Executive Director

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Trends in Health and Human Services

Nothing is as constant as change. That's certainly apparent to us as Californians while our state undergoes a radical restructuring of its spending. As government continues to cope with a dramatic drop in revenue, officials will continue to try to find ways to cut spending. Researchers and provider organizations will innovate new delivery methods seeking efficiency and effectiveness. The private sector will continue to invent and market new and creative solutions. The budget is not the only driver in these changes; mental health parity and health care reform will also drive major change in the future as delivery systems evolve to meet the standards and values contained in these initiatives.

I was recently able to listen to a lecture by Monica Oss of Open Minds, a market research firm specializing in mental health, addictions and social services, as she outlined the major forces shaping policy and practice in mental health and addictive disorders. A few more of them are summarized here.

New Science Rules

Treatment will be increasingly driven by biochemistry and neuroscience discoveries and keeping up with these advancements will be more critical to provider organizations. Psychiatrist roles will likely evolve as we move further beyond medication into new treatments. Our organizations will require the ability to review and evaluate new technologies that emerge. For instance, new brain scanning technologies provide 'demonstrable' evidence of brain changes. This could be useful in diagnosis, early detection, and affect our treatment interventions as we begin to look for signs of progress in brain scans, rather than just symptom manifestations. There is also a pipeline of new pharmaceutical agents for approval, including 22 medications targeting addiction treatment. Other inventions include an implanted ECT device, as well as an implanted brain stimulator that reportedly helps OCD.

Interestingly, there is also a new field of cosmetic neurology treatment emerging. So called "Brain Fitness Programs," marketed not for those who have disorders but for those who are healthy but looking for enhanced cognition. It sounds an awful lot like Starbucks to me.

Bioconnectivity

The good old computer chip and connectivity technology will continue to merge technology and people. EMRs (electronic medical records) are increasingly being implemented in anticipation of upcoming trigger dates. The Mayo Clinic already provides downloadable medical records. The implications of EMRs on psychotherapy are yet to be fully determined. These new digital records will now be able to interact more easily with medical devices directly and be accessible via the web. As their use

continues with more acceptance, more innovations, convenience, and enhanced treatment, the costs will continue to fall. However, they also bring the need for redefining privacy and questions surrounding the use of data in health care rationing and risk management. Professional liability will be impacted since, with more access to health information, the expectations that medical history is known and accounted for will increase. Currently, there is a lack of national standards which continues to limit the use of the data within 'proprietary' systems. Regulations in this area will have a huge impact in how fast and far the advancement of EMRs impacts the field.

Place Matters Less

Technology has allowed so called virtual interaction between people. This includes telehealth where the provider and patient "meet" by broadcast pictures of each other and telephone rather than in person. This has been used to provide specialized treatment in rural areas that do not have enough qualified professionals or to avoid time consuming and expensive travel to see institutionalized individuals. Services such as GPS and electronic monitoring are also increasingly used to enable remote monitoring and many more products are in place that monitor anything from drug use to medication compliance to vital signs and other health data. There are even virtual surgeries (are you ready to receive your surgery here, while your surgeon is in India?). These will ultimately decrease the need for facility based services – both residential and outpatient – and allow more home based care. The roles of hospitals and nursing homes will be reconsidered for trauma and acute end-of-life care – certainly a topic near and dear to our heart with rising costs of an aging population in our institutions. While this will

provide cost savings from standard facility based treatment in the community, it may cause conflict in patient and family preferences. It also brings with it issues of a mobile and remote workforce and how to ensure competencies, training, productivity and quality when employees are working in remote locations with less personal contact with supervisors and administration.

Other Factors

Other significant forces that will influence our field include the demographic time bomb coming. Not only will the baby boomers be passing through their older years, but everyone's life expectancy has been increasing over the past decade and will likely continue to increase. There is also the institutionalization of clinical decision making (i.e., limiting funding to "approved effective" treatments only) and the professional education needs secondary to the rapid advancements in diagnosis and treatment. This last one will be a specific concern of FMHAC in our charge to provide ongoing continuing education in the face of these rapid new advancements.

All of these emerging factors will provide both challenges and opportunities as we continue to work to provide the highest quality services to our target populations. At the end of the day, our field will remain focused on the care and treatment of human beings - but technology will advance our abilities. At this point, it is not a matter of if we will have to delve into these factors, but when. Forethought and planning will prepare us to utilize these advancements with a mind to the well being of individuals and families. ❏

Integrating Disciplines: Affirming Our Core Values 2010 FMHAC Conference

Munir Sewani, PhD, FMHAC Director of Conference



I would like to thank everyone who attended our last conference. Last year was difficult with the early stages of deep budget cuts and reorganization in many of our state's agencies and institutions and we at FMHAC are humbled by your commitment to the Association and to your patients and colleagues. Furthermore, the success of the conference would not be possible without excellent courses presented by volunteers who work hard to prepare for the conference months in advance as well as the support of your organizations who donate staff hours.

In keeping with our promise and tradition of presenting a valuable learning experience each year, the FMHAC Conference Planning Committee and the Board of Directors have selected a collection of high quality presentations for the 2010 conference addressing some of the current issues and challenges faced by the varied stakeholders in California's forensic mental health system.

The months since the last conference have been equally tough, if not tougher, than the year before for many of our members' organizations. The resonating sounds we hear are, "crowded prisons, crowded state hospitals, crowded jails, too many incarcerated mentally ill in the state, no money, no money." Followed by "empty the prisons, release inmates from local jails, develop community programs to rehabilitate prisoners and integrate mentally ill in the community, no money for community programs, what happened to Prop 63 money, no mentally ill and sex offenders in our backyard." The beat goes on; memories of deinstitutionalization haunt the mentally ill who were ostracized and stigmatized, their families and local community administrators and officials.

Hearing the voices of our membership (as

opposed to hearing voices), the board and planning committee have developed a program for the upcoming conference that addresses many of the questions raised in the forensic mental health community in California and across the nation. This year's theme, *Integrating Disciplines: Affirming Our Core Values*, emphasizes the need to work together and to support core activities as budgets are cut across California's programs, institutions, and agencies.

General Sessions

We are lucky to host three excellent presenters on timely issues for our general sessions. Dr. Stephen Behnke will present a 3 hour session on Wednesday afternoon addressing Tarasoff and evolving concepts in mental health law and Honorable Steven Manley will give our keynote presentation that evening. To wrap up the conference, Dr. Steven Miles from the University of Minnesota will address the medical and mental health clinician complicity found in his research of the torture at Abu Graib Prison and implications of these findings in relation to California's forensic mental health clinicians.

***Integrating Disciplines:
Affirming Our Core Values***

March 24-26, 2009

Embassy Suites, Seaside

Registration to open at the end of the year

Legal Track

During the past few years, there has been much debate between the courts, the judiciary, state hospitals, sheriff's departments and local law enforcement about over crowding and the backlog of individuals found incompetent to stand trial, not guilty by reason of insanity, sexually violent predators and the mentally disordered.

An Administrative Office of the Courts task force has been meeting

to develop recommendations to improve the evaluation process, treatment, and expediency of the legal route. To assist in this process, FMHAC developed a legal track focusing on court evaluations. We have invited some members of the AOC task force to present at the conference including Judge Steven Manley as a keynote speaker and David Meyer moderating a panel discussion of the issues. In addition, presentations in this track include one on the clinical and legal knowledge necessary for completing court evaluations and Dr. Craig Lareau addressing malingering, which is often raised in forensic assessments. Dr. Karen Franklin will address diagnostic controversies that may arise for forensic evaluators and Dr. Robert Gaines with colleagues from Atascadero State Hospital will present a study on decreasing the length of hospital stay for individuals adjudicated as incompetent to stand trial.

Mental Health Court Track

The needs of the forensic mental health population are being addressed by many individual and agencies working together across disciplines. This is better represented in no other delivery service than the Mental Health Court. This year, Judge Roper and the Tulare County Mental Health Court Team will present the gains made in addressing issues of mentally ill individuals in their widely spread out and sparsely populated area. From the more mature San Francisco Behavioral Health Court, Public Defender Jennifer Johnson will discuss how the natural evolution of their Court into a recovery-based program mirrors the approach set forth in National Leadership Forum's Essential System of Care.

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PRESENTER SPOTLIGHT

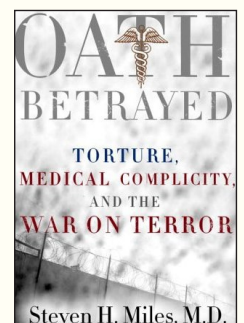


Dr. Miles will present our Wrap-up session on Friday, March 26th.

Steven H. Miles, MD

Center for Bioethics, University of Minnesota

Steven H. Miles, MD, University of Minnesota Professor of Medicine and Bioethicist, is an expert on the use of torture in war and conflicts. He examines the history of torture in the War on Terror and the role that medical and mental health professionals have played in carrying out torture. His presentation will address how this can instruct clinicians in forensic mental health in California.



Clinical and Research Tracks

The rest of our conference line-up includes some excellent presenters we asked back such as Dr. Steven Berman on paradoxical interventions, Dr. Tim Brennan on women's pathways to prison and Dr. Hy Malinek on SVP risk assessment. We will also host presenters on topics of interest to a variety of forensic mental health professionals such as experiential learning, cyber-stalking and a case study of an 18th century serial killer. Completing our conference program are sessions on stabilization of developmentally disabled individuals,

discussions of local programs - STRP at Anka Behavioral Health and the Integrated New Family Opportunities Program in San Bernardino - and suicide risk assessment of high-risk correctional patients.

Save the date for this excellent conference and watch for the conference announcement and the opening of online registration at the end of the year! ❏

ANNOUNCEMENTS

California Crisis Intervention Team Association

The 2010 California CIT Association Training will be held in San Diego next October. Watch our website for more information!

Student Scholarships

[Apply for the FMHAC Working or Financial Scholarships](#)

Send your Letter of Interest, resume, and Sponsorship Letter (from a faculty member or supervisor) to the Director of Education, David Polak, LCSW, by February 15th. You must be a full-time student to apply. We accept applications by mail or email. Visit www.fmhac.net for more information.

Board Nominations

Submit your Letter of Interest and resume for any of the following open Board positions:

- Director of Conference
- Director of Education
- Secretary

Award Nominations

[Submit your nomination for the Rossiter and West Awards](#)

The Rossiter Award honors an individual who has made an exceptional global contribution to the field of forensic mental health over a period of time.

The West Award recognizes a person, collaboration, department, or agency for significant individual contributions in areas such as forensic mental health education, clinical treatment, research or program development. Visit www.fmhac.net for more information.



I am sure that everyone has heard about the current recession/depression; it has adversely affected the world in general, the United States worst than most and California perhaps most of all. Even so, I humbly submit that we, the membership of

FMHAC, refuse to participate.

Personal income is down and, with it, both our charitable giving and our discretionary funds for training opportunities. Even so, the board steadfastly believes - I steadfastly believe - that our annual conference is an unmatched opportunity for professionals in forensic mental health and allied fields to meet, to learn, and to grow. Moreover, even with our state's budget shrinking faster than a snowman in a Santa Ana windstorm your board has decided to refuse to participate in these hard times. We continue to compensate our speakers as best we can and continue to offer financial scholarships to students. We have begun expanding presentation and networking opportunities for the membership by opening the annual meeting up to poster sessions. We are growing the Forensic Mental Health Association of California at a time when membership in most professional associations is shrinking by broadening our tent and reaching out to allied professions and specialties.

You can refuse to take this economy's shrinkage lying down as well. We have committed to bringing fifty new student members to our annual meeting this year. If we can get them hooked on FMHAC early, like I suspect you were, we will have new, loyal members for life. And here is where you, dear reader, come in. I personally believe that with the educational, social networking and

training/career opportunities available to students at Seaside, that there is no good reason why we cannot have ONE HUNDRED NEW STUDENT MEMBERS join this coming year. I believe that each of us knows two or three students who would benefit from attending the annual meeting, two or three students waiting for a kind mentor to take them under the wing and introduce them around, two or three students just waiting to be asked. So, what are you waiting for? Ask them, recruit them, bring them into our order.

If you have a connection with a graduate school program whose students may have an interest in forensic mental health, you should know that this year we are launching a student chapter program. In addition to the traditionally modest dues for student membership, student chapter members will enjoy the following year-round benefits: discounts on annual FMHAC conference tuition and membership to the International Association for Correctional and Forensic Psychology; an annual presentation by an FMHAC member at a meeting of their chapter on a current issue in forensic mental health; one guaranteed poster acceptance per chapter at the annual FMHAC conference (all other student poster presentations may of course submit their presentation directly to the FMHAC conference planning committee.) Detailed information is available on our website: <http://www.fmhac.net/membstudchapter.html>. Please use your connections to get institutions of higher learning teamed up with FMHAC. The students will thank you, the school will thank you and, of course, you will receive the customary warm handshake by the Treasurer awarded to all those who help the FMHAC to grow and prosper.

In closing, allow me to express my sincere wish to see you at Seaside this March, preferably with two or more students in tow. 🚩



Welcome to Briefly Speaking, FMHAC's up-to-the-issue column on developments in forensic mental health law and public policy. With each Newsletter issue, this column will alert you to legal developments that affect your practice, in whatever discipline it might be. We will also keep you on top of public policy issues to inform your decision-making on matters of interest to FMHAC members. This is an ever-evolving process, so our slogan for Briefly Speaking is: Stay tuned!

As you read it, remember that Briefly Speaking is not a form of legal advice or an FMHAC position on public policy. For the former, you will need to contact your lawyer and for the latter, you will have to decide for yourself. Briefly Speaking's purpose is to keep you, our members, informed about issues and developments. And yes, we will take general questions about laws or public policy matters emailed to us at fmhac@fmhac.net. BUT, we will not answer questions seeking legal advice about your particular case or situation!

This column and the next provide some basic instruction on using free tools to expand your own legal research ability. Using these tools, you will be able to access both statutes and cases in their original form and without the inevitable subjectiveness of anyone else's interpretation or "spin."

Constitutions, statutes, regulations and written appellate decisions make up the law. Virtually anything related to law can be found on the internet and any of the broad-based search engines will provide a gateway to whatever there is. The problem is that Googling virtually always returns an unmanageable number of responses. A better approach is to use the website <http://lp.findlaw.com>, a free and huge legal database maintained by the publishing giant Thomson Reuters West.

Once at <http://lp.findlaw.com>, narrow your search by using the "Browse Research Materials" selections to target the Type of Law (for us, usually Caselaw or Codes), Jurisdiction (the particular state or the federal law), or Practice Area (for us, usually Criminal or Health Law). From there, make selections from the checklists provided. With each selection you make, a

subsequent web page will lead you to your ultimate destination. It takes some practice to master Findlaw, but persistence and experience will reward you with almost all of what the high-priced legal research services provide to lawyers.

Here's an example. Let's say you treat forensic outpatients in California. You are confused to the point of exasperation about what so-called Tarasoff warning obligations exist when a family member relates your patient's threat of harm to another. Every conference you go to seems to have a different tack on the subject and your lawyers won't clearly answer your questions without specific real facts. So, you decide to find out for yourself. From <http://lp.findlaw.com>, go to Jurisdiction: California. Then explore what the appellate courts have said about the issue by choosing California Supreme Court

and Courts of Appeals Opinions. From the resulting page, you have a choice of entering a specific case's publication citation (e.g. *Tarasoff vs. the Regents...* (1976) 17 Cal.3d 425) or selecting an advanced search option. Choose the latter and go to Full-Text Search. Following the Findlaw search tips (called options), enter "family member and threats and harm." What comes back is a list of cases covering the search terms, the first two of which (*Calderon vs. Glick* (2005) 131 Cal.App.4th 224 and *Ewing vs. Goldstein* (2004) 120 Cal.App.4th 807) state the most recent interpretations of Civil Code §43.92. Click on the links to the cases. Between the written holdings of the two Court of Appeals panels and the statutory language, you will have your answer—and nobody has to do it for you.

To close this edition of Briefly Speaking, here are two legal "briefs."

Incompetency in SVPA Proceedings

The purpose of criminal litigation is to hold individuals accountable for their willful anti-social behavior. Consequently, when a person's mental condition is such that he or she cannot meaningfully participate, criminal litigation is suspended. The purposes of civil litigation are to resolve private disputes or to support or facilitate private behavior (for example, the transfer in probate of personal property after a person dies). Whether or not someone is "present" during civil litigation generally is inconsequential. The legislature and the appellate courts have said that judicial commitments like Mentally Disordered Offender or Sexually Violent Predator Act proceedings are civil litigation.

So, what happens when a candidate for life-long commitment under the SVPA is so mentally ill as to be incapable of understanding what is going on in the litigation or incapable of assisting an attorney? In *People v. Allen* (2008) 44 Cal.4th 843, the California

Supreme Court held that because of the potential for significant deprivation of liberty, certain constitutional due process considerations apply in civil SVPA cases. Recently, in *Moore v. Superior Court* (2009) 174 Cal. App. 4th 856, a panel of the intermediate California Court of Appeal held that a defendant in an SVPA proceeding has a constitutional due process right to a competency determination before an SVPA trial (174 Cal. App. 4th at pg. 879). That is, an SVPA candidate must be competent to stand trial.

Why do we care? Well, there is a little problem because by their own terms the Penal Code incompetency statutes don't apply to civil cases. Relying on the Juvenile Law, the *Moore* case says that the courts can, essentially, make up their own SVPA competency procedures. But, the case doesn't get specific about those procedures. For example, we don't know who initiates the

COUNCIL ON MENTALLY ILL OFFENDERS



The Council on Mentally Ill Offenders (COMIO) is soliciting projects for the third annual Best Practices Awards. Applicant projects

should have exhibited success in addressing mentally ill offenders at the local and state levels. Eligible agencies are courts, mental health departments, probation, law enforcement agencies, and community organizations.

Applications are due January 29, 2010, and awards will be given at the FMHAC conference in March 2010. See the COMIO website for more information.

www.cdcr.ca.gov/comio

proceedings, what standard for competency is used, which forensic experts, if any, are involved, whether there is a right to a jury trial, where is the defendant treated, or how long the treatment can last. We'll just have to wait for the legislature or more appellate cases to tell us. Stay tuned...

Professional Discipline and Off-Job Alcohol Use

Every clinical professional is subject to oversight and potential discipline by their respective licensing authorities. That oversight is quite similar when it comes to the unprofessional use and abuse of intoxicants. Physicians are accountable for their professional conduct to the Medical Board of California. Specifically, California Business and Professions Code section 2239, subdivision (a) identifies as a form of unprofessional conduct the use of alcoholic beverages "to the extent, or in such a manner as to be dangerous or injurious to the

licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely...."

In *W. v. Superior Court* [3rd Appellate District case #C059957 8/25/09], a panel of the California Court of Appeal upheld the imposition of professional discipline. The facts were that Dr. W. was placed on professional probation by the Board after several incidents of alleged criminal behavior, including four DUI arrests over a five year period. However, none of the incidents resulted in a criminal conviction of record for Dr. W. and the Board found that at no time had alcoholism impaired Dr. W's professional competency. Dr. W. sued to reverse the Medical Board decision arguing that the Board lacked authority to impose professional license discipline for after-hours conduct that (a) does not result in conviction for any criminal offense, and (b) fails to demonstrate a nexus to professional competence or ability to practice with safety to the public. Relying on the arrest reports in the four DUI arrests, the Superior Court upheld the Medical Board and Dr. W. appealed.

The Court of Appeal upheld the trial court finding that criminal convictions were not required for the imposition of discipline and that a sufficient "nexus" to professional practice had been established by the potential for such adverse impact in the future. Hence, a pattern of substance abuse outside of the workplace or professional practice was upheld as a basis for disciplining this physician.

Why do we care? Licensed professionals in every discipline are rightfully concerned about their employers' or a licensing authority's examination of off-work behavior that does not amount to criminal conduct. The Dr. W. case is not an outlier and relies heavily on statutory language and two previous Court of Appeal holdings. But, does the case apply to other forms of licensure and other kinds of non-criminal misbehavior? I dunno. Stay tuned... ❏

2009 SUSTAINING MEMBERS

- | | |
|-------------------------|------------------------|
| Gil Abdalian, MFT | Barclay Kenyon, MFT |
| Pat Butler, RN | Robert Leark, PhD |
| Kenneth Carabello, LCSW | Alice Lebron, LCSW |
| Mark Duarte, LCSW | Joseph Lockhart, PhD |
| David Ezra, MFT | Gilbert McFarlane, PhD |
| Joel Fay, PsyD | David Polak, LCSW |
| Harry Goldberg, PhD | Neil Ross, MA |
| Mark Grabau, PhD | Jennifer Rossi, MFT |
| Thomas Granucci, LCSW | John Schipper, PhD |
| Carrie Gustafson | Munir Sewani, PhD |
| Greg Horn, MSW | Angela Shannon, MD |
| Peter Kalmar, MFT | |

SUPPORTING FMHAC

The Mentally Ill in Jail: A Webcast

David M. Polak, LCSW,
FMHAC Director of Education



The Mentally Ill in Jail

This was the title of a live internet broadcast hosted by the National Institute of Corrections on July 15th

this year. The goal was to provide an overview of opportunities to help organizations prepare to work with persons suffering from mental illnesses in the criminal justice system. During the three hour broadcast, corrections stakeholders, government officials and corrections personnel from all parts of the country were interviewed to investigate the scope of the problem and to propose creative solutions from model programs across the nation. The FMHAC's own Jo Robinson from San Francisco Jail Psychiatric Services was one of the many individuals interviewed, referring to the MIOCR programs that had been created in California as successful programs.

The webcast was well done but, for those of us who have worked in the field for many years, it offered little new information; giving the alarming rate at which, nationwide, people with mental illnesses are landing in the criminal justice system, the current state of the mental health system, which is too overwhelmed or too frustrated to help some of the individuals who often have a history of being denied treatment or refusing it altogether, and that the absence of affordable housing public housing exacerbates the problem. The overarching theme can be instructive, however, especially for those of us who have been in forensic mental health for awhile and are used to things working a certain way - this is the time for all the stakeholders involved in forensic mental health to start cultivating higher degrees of collaboration.

Here in Santa Cruz County, Superior Court Judge Heather Morse recruited a working group to watch the webcast, consisting of the District Attorney, the

Public Defender, Mental Health providers, Probation Officers, a member of the Board of Supervisors and representatives of the Sheriff's Department. The goal of the workgroup was to identify ways in which we can work in a collaborative way with the limited resources we have. Following the webcast, this was certainly the momentum - how can we work smarter and do a better job with the resources we can pull together? We were in complete agreement that something needs to be done and now is the time to come together to begin working on creative changes for this population. The FMHAC would like to be a catalyst for counties to exchange ideas along these lines. We encourage members to send us ideas, letters or articles for future newsletters about creative solutions that may be occurring in other counties across California. 📧

At the end of the web cast, those in attendance were referred to the Criminal Justice/Mental Health Consensus Project.

The Consensus Project bases its work on their outline of policy statements and issues, which are key to increasing the effectiveness of treatment for this population. The Consensus Project is involved on a national level lobbying for the value of substantive bi-partisan cross-system dialog regarding mental health issues as they relate to the criminal justice system. The Project encourages communities to begin having discussions to capitalize on windows of opportunity that may currently exist or may be created.

Currently, federal legislation has been proposed to commit between \$10 and \$15 million for MIOCR grants to be implemented through SAMHSA.

For more information about the project visit www.consensusproject.org.

About the Author

Dr. Jay Adams holds a Ph.D. in clinical psychology from the University of Washington and a Master's degree in criminology from the University of California, Berkeley. She taught for 2 years in the Psy.D. program at Baylor University before beginning a career in forensics that spans more than 25 years. She worked for 9 years in an intensive treatment program for sex offenders at Patton State Hospital under the old MDSO law and has been a long-time advocate for sex offender treatment. While in private practice in San Bernardino for 5 years, she treated adolescent sex offenders, adult sex offenders on parole, women in abusive relationships and adult survivors of child abuse. Since 1986, her interest has focused on the relationship between early childhood abuse and later violence, including sexual offending.

In 1991, Jay moved to the San Luis Obispo area and worked for 10 years at the California Men's Colony, a medium-security state prison, where she specialized in the treatment of sex offenders

Abstract

A growing consensus has been developing over the past 10 years that relapse prevention may be "necessary but not sufficient" to successfully treat some sex offenders. This has led to the realization that many of the established principles of psychotherapy apply to sex offenders as much as to other client populations, and to renewed interest in the therapist-client relationship. Part of this interest stems from the increasing influence of attachment theory and research. "Intimacy deficits" are a major factor in sex offender recidivism, but attachment is a complex issue and we should be wary of taking short cuts, for example, using self-report, in our research. Given that negative mood has frequently been found to be associated with sex offender "lapses," the author suggests that more attention needs to be given to the causes and treatment of affect dysregulation, and in particular, to the role of shame in sexual offending. Concerns regarding the diagnosis of antisocial personality disorder and the use of the PCL-R are also discussed.

Sex Offender Treatment Re-discovers Psychotherapy Research

I've spent almost 30 years treating sex offenders, trying to understand why they do what they do, how they differ among themselves, and how they can be helped to stop. It is gratifying to see a rising current in the literature which is finally questioning the long-standing and widespread assumption that our sex offender clients are totally different from every other client population. This assumption has allowed us to violate a number of our own ethical standards (Glasser, 2003) and to disregard many of the established principles of psychotherapy. One of the unfortunate consequences of the widespread acceptance of Relapse Prevention is that it has fostered a "cook book" approach to sex offender treatment, which may have attracted individuals to the field who lack the qualities necessary for effective clinical practice. There has been no more consistent finding in psychotherapy research than that the quality of the therapeutic relationship accounts in large part for improvement, regardless of the therapeutic paradigm or technique used. This is acknowledged by some cognitive behavior therapists,

such as Linehan (1993), who expresses it in reinforcement terms: “The relationship with the therapist is the primary reinforcer.” This obvious fact has been largely ignored in sex offender treatment for the past 20 years, perhaps because some in the field feared being accused of “coddling” sex offenders or being “soft on crime.”

Now some sex offender therapists are calling attention to the importance of the therapeutic alliance. In a recent article, Fernandez (2006) questions the value of confrontation in sex offender treatment, which has gone largely unchallenged until recently. She cites research from both the general psychotherapy literature and from sex offender treatment which found that confrontation was related to later non-compliance, lack of generalization beyond the therapy situation, lower self-esteem, increased levels of resistance, and deterring clients from making a commitment to treatment. Fernandez also notes the importance of instilling hope. “The failure of therapists to instill hope in treatment participants appears to result in clients believing that they do not have the ability to change and is related to a lack of motivation by clients to make the necessary changes in their lives” (p.192). The instillation of hope is a factor cited by Yalom in what is widely regarded as the best book ever written on group psychotherapy. First published in 1970, Yalom’s book delineated 11 therapeutic factors that he believed were what caused group therapy to be effective. Despite the fact that this book was written many years before the women’s movement forced rape and child sexual abuse out of the closet, the factors Yalom thought were important have turned out to be very closely related to the long-term sequelae of childhood abuse, as delineated in the more recent literature.

Fernandez (2006) expresses concern that sex offender therapists should avoid a collusive approach, noting that “Collusive therapists tend to construe their clients as victims and, as a result, do not require offenders to take responsibility for their own behaviors” (p.190). This seems to me a completely artificial dichotomy, a straw man. While the victim-to-victimizer path is complex, it is closer to the rule than the exception. For example, Hanson (1999) reports that “in file reviews of 409 sexual offenders, we found that 75% had been victims of some form of child abuse—physical, sexual, or neglect” (pp.85-86). Validating a client’s feelings about his own abuse does not mean not requiring him to take responsibility for his victimization of others. Such validation does not constitute an “excuse.” It is in fact one of the most important things we can do to encourage him to take responsibility. It doesn’t make much sense to be continually telling our clients how much their behavior harmed their victims while at the same time implying that whatever happened to them in childhood is of no consequence.

and adult survivors of childhood abuse. She served for three years as Director of Training and Education for the Forensic Mental Health Association of California, was Conference Chair in 1986, and was awarded the Christine M. West Award for Outstanding Service in the Field of Forensics at the 2000 Asilomar Conference. She has given numerous presentations on sex offenders, domestic violence, and the long-term effects of child abuse to both professional and non-professional audiences, and has published half a dozen articles in professional journals. Since retiring from the Department of Corrections and Rehabilitation in 2000, she has devoted time to writing, giving training presentations and serving as an expert witness in SVP and death penalty cases.

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Therapists who establish appropriate group norms and a strong sense of group cohesion will find that group members will not allow each other to make excuses. When a client makes what could be construed as an excuse (“I molested that kid because I was molested”), this is a great therapeutic opportunity to ask an open-ended question such as, “How do you see those things as being connected?”

In 2000, the Canadian National Sex Offender Treatment Program moved away from reliance on Relapse Prevention as its primary treatment modality to what they call “the self-regulation model” or “self-management.” The Director of the Canadian program noted that the new model is less punitive, focuses more on the development of a strong therapeutic alliance, and is geared toward reducing resistance and client drop-out (Yates, December 19, 2003, personal communication). This appears to be one of many indications that we are moving away from the notion that treatment is something we impose on sex offenders and more toward an appreciation that sexual offending is an interpersonal problem. Some writers have even suggested that collaboration with our clients is an approach that could improve both treatment and risk assessment (Shingler & Mann, 2006). The view that therapy is a collaborative endeavor is quite consistent with the “phenomenological approach” used by many who work in the field of trauma treatment (see Briere, 2002; Courtois, 1999). There are a number of areas where what we have learned from trauma research could greatly enhance our work with sex offenders.

The re-focusing of attention on the importance of the therapeutic relationship is an encouraging development which is long over-due. There are other issues in sex offender research and treatment

where we seem to be making little headway. This lack of progress is in many instances due to a failure to understand the findings of trauma research and how they apply to sex offenders. Several areas where trauma research could be more effectively applied to sex offenders are: the application of attachment theory to sex offenders based on self-report; the failure to understand the causes of affect dysregulation and the role that it plays in many sex offenses; the role of shame as a precipitant in many sex offenses, rather than a consequence; the use of the PCL-R and the diagnosis of antisocial personality disorder with little or no reference to the offender’s own abuse history; and the general failure of sex offender treatment to provide avenues for decreasing intimacy deficits.

Sex Offenders and Attachment Theory

The recent attention to the field of attachment theory is encouraging but the method of studying this rather complex subject is a source of concern. The literature on attachment clearly suggests that, in terms of potential dangerousness, we should be most concerned about the roughly 13% of individuals who have what is called “disorganized” attachment. The human infant explores its environment but returns to the “safe base” of the attachment figure when the novelty of the environment is too frightening. What happens when the primary attachment figure is herself the source of the fear? In order to get a true feeling for the bizarre behaviors of some parents of children who show disorganized attachment, one must read some of the observations made in the “Strange Situation” experiments by Ainsworth, Main, and others. “They [parents of disorganized offspring] are disruptive to an organized strategy because the infant cannot make sense of the internally generated and confusing parental responses. Furthermore, the

child cannot use the parent to become soothed or oriented, because the parent is in fact the source of the fear or disorientation" (Siegal, 1999, p.108). "We suggest that disorganized/disoriented behavior is expectable whenever an infant is markedly frightened by its primary haven(s) of safety, i.e., the attachment figure(s)...then disorganized behavior should of course occur when an infant is maltreated by the parent" (Hesse & Main, 2004, p.1102). Indeed a number of studies have found that almost 80% of infants known to have been maltreated by their parents show disorganized attachment (Carlson et al, 1989; Lyons-Ruth, 1996). They account for a high percentage of those who commit violent crimes and/or are later diagnosed as having major mental illnesses. "Children with disorganized/disoriented attachment have been found to have the most difficulty later in life with emotional, social, and cognitive impairments...Studies have found that these children may become hostile and aggressive with their peers. They tend to develop a controlling style of interaction that makes social relationships difficult" (Siegal, 1999, p.109).

The descriptions of disorganized attachment in the literature are highly reminiscent of many of our sex offender clients, as will be seen below in the discussion of affect dysregulation. Thus it is of vital importance that we be able to identify individuals with disorganized attachment. Attachment is not something that anyone has conscious awareness of because it occurs so early in human development. The process of attachment is thought to begin as soon as the infant is able to differentiate one human face from another, and continue until about age 24 months. Yet much of the sex offender research which has focused on attachment is based on self-report. Experimental observations of mother-child interactions in the "Strange Situation" have been conducted over more than 4 decades and in

numerous cultures. Main (2002) reports that this research involved 66 hours of observation per dyad. This is a large body of painstaking research which has to be respected for its thoroughness. I do not believe that it can be ignored and replaced by self-report instruments. Rather, in order to obtain valid and reliable information about attachment status, research should use the instrument developed and validated specifically for this purpose, the Adult Attachment Interview (George, Kaplan & Main, 1984,1986, 1996). Main cautions, "Self-reported relations to mother or parents show little or no relation to the Adult Attachment Interview" (2000, p.24). Unfortunately this instrument requires specialized training to use. The sex offender literature often makes general reference to Bowlby (1969) but fails to cite the wealth of research that has grown out of his ideas. A notable exception to this is the work of Gail Ryan and her colleagues at the Kempe Center in Denver (Ryan et al., 1999). The importance of getting accurate information about the attachment status of sex offenders cannot be overestimated. In a recent article Laws and Ward note that the early uncritical acceptance of relapse prevention "resulted in the widespread implementation of a largely unproven treatment approach" (Laws & Ward, 2006, p.242). I fear that the failure of sex offender researchers to draw on the extensive and well-documented findings of developmental research may lead us down a similar erroneous path and result in wrong conclusions.

Affect Dysregulation

There has been a fair amount of interest in the relationship between negative mood and sexual offending. Many sex offenders report stress and negative affect immediately prior to offending (Serran & Marshall, 2006) and Ward and Hudson

(2000) found that the regulation of affect appears to be impaired in sex offenders. Serran & Marshall (2006) also concluded that “research examining the coping strategies of sexual offenders suggests that these offenders tend to choose ineffective strategies...” (p.112). They delineate coping strategies as generally falling within one of three categories. The most effective are described as task-focused, which occur when the individual has a sense of efficacy and believes that he can change the situation. The other two are described as either emotion-focused or avoidance-focused. The first involve ineffectively venting emotions, fantasizing, or self-preoccupation in the form of ruminating, becoming depressed, or wallowing in self-pity. The second are techniques to avoid the problem, such as substance abuse, watching T.V., eating or engaging in sex. All of these maladaptive “strategies” are also among the long-term effects of abuse.

I have argued elsewhere that the findings of Hanson and Harris (2000) regarding the stable dynamic factors related to recidivism support the contention that it is the offender’s own untreated history of childhood abuse that makes him vulnerable to re-offend (Adams, 2003). In a more recent article, Hanson notes that “problems with sexual self-regulation form a core deficit associated with sexual offending” and goes on to suggest that “problems with sexual self-regulation can be understood within the larger context of general self-regulation problems and antisocial orientation” (Hanson,2006, p.24). Not coincidentally, “general self-regulation problems” are also a primary long-term consequence of early childhood abuse. “In fact, it has been suggested that affect dysregulation may be the core dysfunction that results from psychological trauma...Such individuals tend to overreact to

minor stresses, become easily overwhelmed, appear to have extreme reactions to neutral or mild stimuli, have trouble calming themselves...They also typically have a great deal of trouble either expressing or modulating their anger...Further such individuals frequently exhibit suicidal preoccupation, either sexual preoccupation or difficulty modulating sexual impulses, and heightened risk-taking behavior” (Luxenberg et al., 2001, p.377).

An understanding of how the infant brain develops reveals how affect dysregulation comes about. One of the first functions to come “on line” after an infant is born is the “startle reaction.” When an intrusive event occurs in the infant’s immediate environment, such as parental yelling or fighting, breaking dishes or furniture, or even loud noises on a nearby T.V, the startle response is triggered. The infant begins to cry and must rely on its caregiver to respond with comfort and protection. The brain develops in a “use-dependent” fashion (see Siegel, 1999; Perry, 1997). Each time the startle response is triggered, the connections in the brain which cause it are strengthened, increasing the likelihood that it will occur again. A “kindling effect” is established, so that as the brain connections are strengthened, it takes less and less to trigger the response. The result is a child who reacts strongly to even minor stress, becomes easily overwhelmed, and experiences his emotions more intensely than other children. Such children have trouble calming themselves once emotionally aroused. Prolonged hyperarousal while the brain is developing causes difficulties in affect regulation. This means that the individual becomes emotionally vulnerable.

A second major causal factor in affect dysregulation is how the mother or primary caregiver responds to the infant’s emotional arousal. Research on attachment theory has established that a secure

bond requires the mother to be acutely responsive to the emotional states of the infant. It is from the mother's attunement with the child and her appropriate response to his distress that the child learns how to self-soothe and how to be empathic. The ability to self-soothe is related to the child's later capacity to develop coping skills rather than becoming overwhelmed. A primary caregiver who has her own history of trauma can establish a secure attachment bond with her infant IF AND ONLY IF she can discuss her own trauma in a logical, coherent and emotionally connected way (Main, 2000). A mother is unlikely to be able to establish a secure attachment bond with her infant if she is being abused by her partner, if she is overwhelmed by the demands of numerous other very young children, if she is abusing drugs or alcohol, or if she has her own unresolved trauma issues. Thus events in the surrounding environment and the primary caregiver's own trauma history and ability to be acutely "tuned in" to the infant can interact in a variety of ways to lay the ground work for later difficulties in modulating emotions. In addition, the strength of early attachments plays a crucial role in how an individual copes with later trauma, such as being sexually abused.

Treatment outcomes with our most at-risk clients will not improve without an understanding of the etiologic role of attachment failure and abuse. Teaching such clients effective coping strategies and/or trying to increase their motivation are of little benefit, because many of our clients do not "choose ineffective [coping] strategies" (Serran & Marshall, 2006). Rather, they rely on the only coping skills that they have, which are the products of their early developmental deficits. It is essential to assess clients with respect to their impulsivity and difficulty modulating affect. Clients who are experiencing painful emotions and feel overwhelmed are likely to

flee from treatment, to call upon familiar defenses that have worked in the past, or act out in a variety of ways as a distraction. Distraction behavior may include substance abuse, self-injury, and/or deviant sexual fantasy or behavior. Therefore it is important to provide such clients with treatment that can help them learn how to tolerate strong affect and modulate it BEFORE we expect them to approach areas that are scary and painful. Marsha Linehan's dialectical behavior therapy (DBT) has proven successful with severe borderlines, and her techniques should be equally applicable with many sex offender clients (Linehan, 1993). DBT should be the starting point in treatment for sex offenders whose history includes difficulty with impulse control. Linehan's extremely structured approach can give sex offenders the skills they need in order to deal effectively with the emotional arousal that is likely to occur when engaging in treatment assignments such as Behavior Chains and Autobiographies. Providing offenders with the skills to manage the arousal of painful affect would go a long way in reducing "resistance" and treatment dropout.

The Role of Shame in Sex Offenses

Shame has recently become a focus of interest among researchers and clinicians seeking to understand sex offenses. Allen Schore, one of the most well respected and prolific attachment theorists, regards shame as the emotion evoked when a child's aroused state is not attuned to by the caregiver (Schore, 1994). Moreover, shame is one of the emotions most commonly experienced by children when they are abused, especially when the abuse is sexual (Briere, 1992). Shame is an excruciatingly painful emotion which strikes at the very core of the self. It is not something we did which is bad or worthless, but our very being. There are

numerous practices which we routinely employ in sex offender treatment which are likely to elicit shame. Some examples are the preparation of a detailed autobiography, the processing of crimes in detail through the constructions of Behavior Chains, and phallometric assessment.

One of the most important developments in this area are the findings that shame interferes with empathy and is likely to increase the externalization of blame (Hanson, 1997; Bumby, 2000; Proeve & Howells, 1993). This consideration of shame in the literature has created awareness that the usual ways in which sex offender therapists attempt to induce victim empathy in clients may often be counterproductive. However, the emphasis continues to be on the offender's experience of shame after an offense or a lapse. In a recent article, Proeve and Howells (2006) discuss shame in terms of its possible evolutionary role in promoting conformity and prosocial behavior. This formulation fails to consider that humans are capable of experiencing shame long before they become capable of complicated reasoning. If Schore's ideas regarding the origins of shame are correct, it is likely that many sex offenders avoid treatment, flee from treatment, blame the victim, and in some cases commit their offenses because they are already overwhelmed with shame. In this formulation, shame is the cause rather than the effect of many sex offenses. In light of what is known about the effects of shame and the childhood abuse in the histories of many sex offenders, it seems logical that the most effective way to encourage victim empathy is to model it in relation to the client's own abuse. This means creating a therapy situation that is a safe place where the offender can feel comfortable to explore the relationship between his offenses and his own history. "It could be argued that unless

the offender is heard as a victim in his own right, his capacity to develop victim empathy will be impaired" (Craissati et al., 2000, p.236).

ASPD/Psychopathy

Hanson (2006, p.24) lists general self-regulation problems as a factor under "Antisocial orientation." It seems somewhat contradictory that an antisocial orientation implies volitional control, yet some of the indications of such an orientation, such as problems with self-regulation, impulsivity, and irritability, clearly imply a lack of volitional control. On the one hand, we see such people as impulsive and unable to delay gratification, but at the same time, as crafty and manipulative. This seeming contradiction may stem from our failure to heed the following caveat from Hare: "The neglect and abuse of children can cause horrendous psychological damage. Children damaged in this way often have lower I.Q.s, and an increased risk of depression, suicide, acting out, and drug problems. They are more likely than others to be violent and to be arrested as juveniles. Among preschool children, the abused and neglected are more likely than other children to get angry, refuse to follow directions and show a lack of enthusiasm. By the time they enter school they tend to be hyperactive, easily distracted, lacking in self-control, and not well liked by their peers. But these factors do not make them into psychopaths" (Hare, 1993, p.170).

Hare's early research on psychopathy was based on the theory that psychopaths are chronically under-aroused and that they engage in dangerous and risky behavior in an effort to bring their arousal level up to normal. This hypoarousal was theorized to be innate, or genetic. Psychopaths are also generally seen as engaging in instrumental aggression, i.e., aggression with a specific purpose,

used to obtain a desired result. However, much of the violence seen in prison populations, including sex offenders, appears to be impulsive, and those who engage in it appear to be hyperaroused. The criteria for antisocial personality disorder are largely behavioral, and overlap substantially with Factor 2 of the PCL-R. Many of the symptoms in both the ASPD diagnosis and the PCL-R could be easily confused with the long-term sequelae of early childhood abuse. A few examples are: "impulsivity," "promiscuous sexual behavior," and "poor behavioral controls" may be caused by affect dysregulation as described above; "shallow affect," "lack of remorse," and "lack of empathy" could be due to the presence of dissociation, which is also a long-term effect of childhood abuse.

"Evidence of conduct disorder with onset before age 15" is another of the required criteria for diagnosing ASPD. In the discussion of the diagnostic features of conduct disorder, the text states, "Running away episodes that occur as a direct consequence of physical or sexual abuse do not typically qualify for this criterion...the Conduct Disorder diagnosis should be applied only when the behavior in question is symptomatic of an underlying dysfunction within the individual and not simply a reaction to the immediate social context" (DSM-IV-TR, p.94, p.96). The authors suggest that it would be helpful to consider the social and economic context of the behavior in making this diagnosis but this is rarely taken into account in forensic assessments. These are a few of the issues which may have led to a confounding of grown up abused children with true psychopaths. In light of the emphasis now placed on the PCL-R and the ASPD diagnosis in predicting risk, assessing motivation, and selecting treatment approaches with sex offender clients, the deleterious consequences of such confusion can be profound. It is essential, both clinically and ethically, that we exercise care in

assigning these labels and that we know as much as we can about our clients' histories before we do so.

Intimacy Deficits

Research by Hanson and Harris (2000) identified intimacy deficits as one of the major variables that predict recidivism. However the Relapse Prevention paradigm, with its emphasis on cognitive factors and identifying offense triggers, provides no avenue for working on intimacy. How does an offender work on his intimacy deficits in treatment? Main (2002) noted that intimacy deficits are not as immutable as might be thought. One of her most important research findings has been that a relationship with a secure partner can transform insecure partners to secure partners in approximately 5 years. This is consistent with other brain research which has found that the prefrontal cortex retains some degree of plasticity through-out life and that the primitive portions of the right hemisphere will continue to re-organize IF the individual is exposed to a close relationship (Siegel, 1999).

Unfortunately many individuals who have a history of childhood abuse select partners who have also been abused, and therefore also have attachment deficits. For many of our clients, the only context in which they are likely to experience a relationship with a securely attached person is psychotherapy. Thus we have come full circle from the opening discussion of the importance of the therapeutic alliance. The exciting developments in neurobiology and attachment theory in the past 20 years have shed light on how crucial the therapeutic relationship is in effecting lasting change.

Now we have re-discovered what we already knew but with the important addition that we have a much better basis for understanding why and how

psychotherapy works. We can also see more clearly why there are no “quick fixes.” If we want our clients to undergo lasting change, we must be willing to accompany them on a journey which is likely to be painful and dark. We must provide a safe place for this journey to take place and allow them to explore how their history has affected them. This must be followed by the learning of new skills and repeated opportunities to practice them. Deeper understanding can help us to deal more therapeutically with the frustration and counter-transference which our sex offender clients often engender. Nicholas Groth, a pioneer in sex offender treatment, used to say that if you want sex offenders to come to treatment, you have to offer them something that feels like help. Our colleagues in neurobiology, developmental psychology and trauma treatment have provided us with valuable information. All we have to do is be willing to use it.

Implications for Policy and Practice

In the United States, public policy with respect to sex offenders has been headed in the wrong direction for almost 20 years. If the issues discussed in this article have any merit, it must be clear why isolation, punishment, and stigmatization are precisely the wrong way to deal with sex offenders. Many jurisdictions are increasingly experiencing problems caused by Draconian legal measures adopted in response to public hysteria. Some law enforcement officers and district attorneys are beginning to see that these measures don't work. In many cases, they actually make the problem worse by forcing sex offenders to live far away from jobs, therapy services, and family support, thereby increasing their likelihood of re-offense. We know from victim research that sex offenses are alarmingly common. Yet, as a society, we appear to be approaching a point where the public

believes that all sex offenders should be locked up “for good,” or have someone hired to watch them 24 hours a day. But neither of these “solutions” is affordable or legal.

Public policy decisions must be based more on science and focus more on the intelligent allocation of resources. Research has established that those who benefit most from intensive treatment are the most serious offenders. Such treatment is long-term and expensive, and should be reserved for those who most need it. Since such treatment is painful and stressful, it should be undertaken when offenders are in secure settings. It makes little sense to keep serious sex offenders in prison for many years, providing them with no treatment and exposing them to violence which makes them more dangerous, and then spend million of dollars evaluating and “treating” them as sexually violent predators. Many sex offenders can be safely treated in the community but recent laws have made this extremely difficult. At this point, it is virtually impossible to find residential substance abuse treatment for a registered sex offender anywhere in the United States, due to residency restrictions. This is another problem which puts many of them at greater risk for re-offense.

Treating any forensic population, including sex offenders, is not something that is valued or considered worthy of equal remuneration within the field of forensic psychology/psychiatry. Few forensic professionals want to be bothered with treating this difficult group when assessment offers so much more financial reward. There has been a tendency to blame offenders and label them as “untreatable” rather than take responsibility for our own failures. The media and the passage of SVP laws have only exacerbated this situation.

We must make a concerted effort to correct the constant media refrain that “sex offenders are not

treatable and they all re-offend.” Those of us who support treatment must move beyond the superficial notion that sex offenders can be treated by anyone with a “work book” who gives assignments in a rote fashion and expects the offender to virtually treat himself. We must also move away from the lopsided emphasis on cognition, and appreciate the central role of affect in sexual offending. Emotions are messy, but no meaningful work with any client population is possible without them. This also means that the therapist’s rapport with the client is a critical element in recovery. Finally, successful treatment of sex offenders requires training in the effects of early trauma and how to treat it. We must actively oppose the prevalent “abuse excuse” rhetoric and move to an understanding that, for the majority of sex offenders, abuse is the central problem, not an excuse. ❏

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