Illinois ATSA Newsletter

JUNE 2017

Mark your calendars for March 15 & 16, 2018. We will be back in Sugar Grove at Waubonsee College with a conference that promises to be even bigger and better.

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Welcome to our New Board Member!
Chris Blakley

President's Message

Hello fellow Illinois ATSA members and colleagues:

I hope everyone is shaking off the winter and starting to enjoy the spring, wet as it is. The board of directors was thrilled to be able to present the first ILATSA conference in several years this past March. As much as I would like to take credit for the success of the conference, the truth is, I walked in as president after all of the hard work had been done. The success of the conference depended almost exclusively on the efforts of the conference planning committee. Michelle Evans, Guy Groot, Rhonda Meacham, and Tracy Tholin are the board members responsible for all of the planning and hard work that went into getting this event ready to go. We also had a great group of volunteers who were with us during the conference and helped ensure things ran smoothly. For nothing more than a great big thank you and an extra ribbon for their name badges, Jamie Oliphant, Glen Ensinger, Chris Blakley and Shannon Chrismore arrived at the conference site early and stayed late both days. Special thanks go out to these folks for all of their hard work.

Of course the event would not have been nearly as successful as it was without the incredible presentations that were given by several dedicated individuals in the field. Dr. Michael Caldwell and Dr. Robin Wilson lead the conference off with their key note presentations. The rest of the field had a tough act to follow, and they did not disappoint. With presentations ranging from the effective use of the polygraph, to motivational interviewing, to treating the victimized sexual offender, the presentations were all outstanding and very well received. If you go to the ILATSA website (www.ilatsa.org) you will find links to the presentations' printed material or the emails of presenters who would be happy to send you their information.

We have gone through all of the evaluations for the conference and the presenters, and the responses have been overwhelmingly positive. There were also a few much appreciated suggestions as to what we might do better next time. We hope to incorporate these suggestions into next year's conference. Speaking of next year's conference, we ask that everyone mark their calendars for March 15 & 16, 2018. We will be back in Sugar Grove at Waubonsee College with a conference that promises to be even bigger and better! Watch the newsletter and other announcements concerning a "call for presentations" late this summer or early fall. We hope that we can encourage some attendees of this year's conference to be presenters at next year's event.

We are always looking for ILATSA members who are interested in serving on the board, or if you think you'd like to present or volunteer at next year's conference, please contact me at jreynolds@4crcc.org. Thanks and enjoy the spring!

Illinois ATSA Conference Review

Looking After Ourselves and Each Other

Robin J. Wilson. Ph.D., ABPP
McMaster University, Hamilton, ON
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Why do we do this work?

A long time ago, most of us who work in sexual violence prevention made a few critical decisions. We were bright-eyed, bushy-tailed teenagers who had no idea what we wanted to do when we "grew up." In high school we talked with our friends and family about the sorts of things we'd like to study in college or university. I initially thought I would go to medical school and become a surgeon, but shaky hands put the boots to that idea. That's how I found psychology. I suspect many of you also had academic dilemmas with which to contend, but you ultimately found yourself in the humanities or studying something that would eventually lead to work in social services.

In our work with offenders, we try to help them become desisters, instead of persisters.

Interestingly, I didn't pick sexual violence prevention as a career; it sort of chose me. After my third year of full-time study in psychology at the University of Toronto, I needed a break and went looking for a job. I managed to secure a position at the university's psychiatric teaching hospital, working for a Czech psychiatrist named Kurt Freund who, it turned out, was the pioneer of the phallometric test (or penile plethysmograph as it's known more broadly in the USA). Working for Dr. Freund was the single greatest influence on my future and after having had the opportunity to conduct research, study human sexuality, and to rub shoulders with other great practitioners in Canada, my career path was set. I've never looked back and I can honestly say that I've never had a boring day at work. However, that's not to say that I haven't also had some very upsetting days at work.

We work in a field that brings us in contact with people who have been harmed in a particularly intimate way, as well as with the people who have harmed them. We're in the public safety business. We work with victims of sexual offenses to help them survive their experiences, knowing that some of them – particularly young persons – may find themselves engaging in abusive behaviors in the future. These abusive behaviors are not necessarily always sexual in nature, nor are they always directed at others; they may be more inwardly destructive. In our work with offenders, we try to help them become desisters, instead of persisters.

So, why do we do this work? Because we want to make a difference. We care about our families, friends, and communities and through our interventions we strive to achieve the ATSA goal of making society safer. But, this potentially comes at a cost to each and every one of us. We know that the work we do can be hugely exhilarating when we see the successes of our clients, but we

shouldn't kid ourselves that there aren't darker things of which we need to be mindful.

Why do we keep doing this work?

There is no denying that working with persons with sexual behavior problems and antisocial orientations is challenging. Some of our clients are really good at "pushing our buttons." How do we offset our natural tendencies to be empathic and helpful with our natural tendencies to be angry and upset at what our clients have done (or continue to do)? Because we know the consequences of such strong emotional responses in clinical environments. We also know that it is unconscionable to do nothing. So, we work to reduce the number of potential victims, knowing that poorly managed clients have the capacity – already demonstrated – to do tremendous harm. We work to ensure that clients receive appropriate treatment and care according to evidence-based practices, like the Risk-Need-Responsivity framework with which we're all so familiar. We work to ensure that our clients are able to approximate a quality of life as close as possible to that of others without sexual behavior problems – that's the essence of the Good Lives Model.

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One of my absolutely most favorite concepts I learned in school is that of the "balanced, self-determined lifestyle." I try to include this phrase in almost everything I write (as I just did here) and I try to follow it myself and to instill it in others around me. I co-opted this concept from the YWCA's Life Skills Coach Training program in Canada, as they did from Saskatchewan NewStart. NewStart was a basic job readiness training program for Aboriginal Canadians in the mid-60s. Search it out on Google, if you like; it bears a striking resemblance to many aspects of the GLM, but some 30 years earlier. At its heart, a balanced, self-determined lifestyle means making time for all the important elements of life – self, others, community, job, leisure. And, it also encourages people to think about the range of opportunities they have in life and to make good choices while learning from mistakes. Clearly, our clients have not always done both of these things, and that is perhaps why they land themselves in trouble.

Vicarious Trauma

Job stress is the result of a complex interaction between the individual and the challenges of the job. Burnout involves physical, mental and emotional exhaustion that is attributable to work-related stress. It is a uniquely human phenomenon that if a person holds the capacity for empathy, he or she will experience distress when hearing about terrible things that have happened to others. Have any of you ever experienced anything like that – during an assessment, when reading police reports or victim impact statements, or during a group or individual treatment session?

Even though we weren't there when our clients committed their offenses, we are privy to intimate details of what happened. This can lead to what is known as vicarious trauma. Because we are caring people and because we express empathy and feel compassion, we often experience characteristics of victimization just by hearing about what happened to others. This emotional contagion can sometimes lead to compassion fatigue – a key component in burnout. Ultimately, this is the cost of caring, but there are things we can do about it.

High Risk Professionals

The first thing we need to acknowledge is that we are members of a select group of persons who are at higher risk for vicarious trauma and compassion fatigue. These workers include, but are not restricted to:

- Counselors, Psychologists, Social Workers
- Health/Hospital Staff
- Emergency Workers
- Child Protection Workers
- Corrections Staff
- Law Enforcement Officials
- Court Officials
- Volunteers

The effects of vicarious trauma and compassion fatigue can be particularly pertinent to people who interview and counsel trauma victims, those who working with victims and their families and, notably for us, people who work with clients who have abused others.

Predictors and Mediators of Secondary Traumatic Stress Effects

It's important to recognize that not everyone will be affected by troubling information or traumatic stress in the same way. Some of us are really resilient and it doesn't seem to matter much what we see or hear – we get past it. Others, however, may find certain situations or scenarios much more difficult to manage. The research on self-care and burnout tells us that there are individual factors to consider, as well as situational and environmental factors at play. This shouldn't surprise us, as this is pretty much the case with virtually everything in social services – it's a mix of internal and external variables.

Individual Factors

A good bit of how we respond to traumatic stress has to do with our personal history; that is, our personal experiences of trauma, loss, and victimization and how we've managed to cope (or not) with situations throughout our lives. Our personality style (and ego defenses) will influence our coping style and the mechanisms we use to deal with difficult situations – either at work or in other environments (e.g., have you ever found yourself bringing work crap home with you?).

Another important consideration is current life context. What's happening for you outside of the work environment? Is your teenage daughter or son having difficulties, are you having problems in important relationships, has someone in your family or friendly circle just experienced a situation of abuse? All of these private life situations can affect our ability to cope with difficult situations at work.

Here are some individual risk factors to consider:

- Lifestyle balance
- Sense of control
- Perceptions of organizational intentions/commitment
- Perceptions of fairness
- Fit between values of self and organization
- Coping skills and strategies

What can we do to protect ourselves? I won't get too far into that right now, but some obvious recommendations are to take opportunities to increase our training base and to take the time to debrief situations we experience at work with our colleagues and trusted confidantes. And, keep in mind that we may need to practice what we preach: If you have problems you can't manage, maybe think about seeking professional help.

Situational Factors

As much as there are factors we bring to the table in terms of our own personal makeup and experience bases, there are factors over which we have a lot less control. In the beginning part of this article, I suggested that we all made a choice to work in the field of sexual violence prevention. I guess that means that we probably can't, at this point, change the nature of the work we do. Nor are we able to change the nature of our clientele; at least, not without leaving the field.

At many of the workshops I do, I often ask participants whether or not they work for an agency that has too much money or too many staff. I'm never surprised by their answers. I also typically ask them whether or not they feel like they have enough time in a day to do all the things expected of them – either by superiors or their own work ethic. Workload is a big factor. The more we do in a compacted workweek, the less time we have to step back and insulate ourselves from the cumulative exposure to trauma material. This can affect our relationships with co-workers, which can sometimes lead to "cubicle-effect" in which people keep their heads down, working away in isolation and ultimately losing important social and cultural contexts and opportunities present in the work environment.

Here are some workplace risk factors to consider:

- Role ambiguity
- Role conflict
- Availability of tangible and intrinsic rewards
- Workload
- Recognition that work is valuable
- Social support

Over the years, I'm moved away from direct service provision and more into administration and consultation. As a worker, I knew all too well that there were expectations on me and that there were minimum production quotas (e.g., three psychotherapy clients a day, two groups a week, two assessments, etc.). I, too, worked in relative isolation with little opportunity to debrief my work experiences with others. As an administrator, I became keenly aware of the need for "real" supervision – not the annual performance appraisal, but REAL supervision. Frankly, the last performance appraisal I got was emailed to me by a supervisor who cared very little for my experience of my job.

Supervision is the opportunity to share what you're proud of, as well as what causes you to quietly freak out.

As a word, "supervision" connotes a certain cringe-worthy experience. None of us like being informed of our faults, nor do we like being told what to do. As such, it's something of an unfortunate choice of word and many of us may have experienced supervision as a chore. However, when I say supervision

here, I mean something wonderful – the opportunity to sit down with someone who cares about you and the work you do enough to listen like David Prescott, consider the information provided like Karl Hanson, and give advice like Robin McGinnis. Supervision is the opportunity to share what you're proud of, as well as what causes you to quietly freak out. Regularly sharing your work experiences with concerned peers or supervisors – either individually or as a group – can have profound effects on quality of life, both professionally and personally. And, we don't do it often enough. Period.

Mitigation Factors

Maintaining a balanced, self-determined lifestyle is central to effective self-care. How well are you taking care of yourself? Of course, self-care needs to be practiced in the workplace as much as in your personal life. We've seen the effects of the holistic revolution in our treatment approaches with clients, why shouldn't that also apply these ideas to aspects of our lives? The more balanced we are across the full range of personal care, the more we are able to cope with the stresses and demands that we will face in our admittedly very challenging professional experiences.

People are at less risk for burnout if they feel they have some degree of control or influence over their work situation, believe that they are important enough to be treated fairly, and value the work they do and are committed to it. We need to create opportunities for renewal, but this is a shared responsibility. We need to get out of our cubicles and talk to one another! We need to recognize that when someone is cooped-up in their cubicle that that's a cause for concern and requires a check-in.

"How are you doing?"

"Is everything OK?"

"Do you want to come out for lunch with us?"

These are the sorts of questions we owe it to ourselves and others to ask. It's often been said that there is safety in numbers, and there is a lot of truth to this when we think about how we can lessen the negative effects of trauma we may experience as sexual violence preventers.

We need a strong, interactive, and reciprocal social support network to keep us on the right track, too. So, look out for yourselves and your colleagues as you continue to make society safer.

If you've been reading through the lines in this article, you may have noticed that a lot of the concepts we apply to our clients who have sexually offended may also hold some worth for us. Many of you will know that I have spent a lot of time in my career working in a framework known as Circles of Support & Accountability. One key idea behind CoSA is that "nobody does this alone" – meaning that reintegration to the community after incarceration should not be a solitary endeavor. I would extend the CoSA idea to other domains, including high-risk professionals as noted above – that means us. We need a strong, interactive, and reciprocal social support network to keep us on the right track, too. So, look out for yourselves and your colleagues as you continue to make society safer.

Dr. Robin Wilson was a keynote speaker at the 2017 Illinois ATSA Conference.

A New Group Treatment Approach towards Sex Offenders on the Autism Spectrum

Harmony Goorley, MA, LCPC, Jennifer Block, Psy.D., & Marissa Quinones, Psy.D.

During the 2017 IL ATSA Conference, M. Quinones, J. Block, and H. Goorley described the pioneering autism-specific programming offered at the Illinois Detention and Treatment Facility. This presentation described the rationale for the distinct treatment program, including the specific needs of residents on the autism spectrum, along with commonly-faced challenges when such individuals are streamlined with neuro-typical peers. Synopses on the psychoeducational groups targeting information processing, self-regulation, and social skill peculiarities indicative of the autistic condition were explored. Case examples illustrated the historical struggles and recent treatment accelerations of participants of this unique program. Tips on how providers can foster more successful treatment engagement with individuals on the spectrum, as well as anticipated future developments (exploring the distinction between autistic traits and personality disorders, community reintegration, and vocational development) were also introduced.

Utilizing Hypnotic Interventions With Clients Who Sexually Abuse: Clinical Options

Mark S. Carich, Ph.D.

Hypnotic interventions are commonly used throughout psychotherapy and with most client problems. Interestingly, hypnotic interventions are acceptable when working with survivors and other clients; however, they have not received widespread acceptance when working with clients who abuse.

Interestingly, many commonly used tactics with the above clients involve hypnotic elements &/or maybe considered the same, including: imagery, relaxation, deep breathing and mindfulness (Carich, Maus & Brandon, 2016).

This author has been studying hypnotic intervention since 1979/1980. Many years ago, the author had opportunities to learn from the best. The author used hypnotic interventions with a client who sexually exposed himself in 1984, and with more clients in the 90's onward.

Hypnotic intervention may be broadly defined as a set of related tactics using hypnotic phenomena or behavior in the form of techniques. The key is implementing hypnotic interventions within contemporary treatment framework, and targeting contemporary dynamic risk factors (DRFS) (Carich & Calder, 2011; Carich & Mussack, 2014; Marshall, Marshall, Serran, & O'Brien, 2011).

Hypnotic states are an everyday occurrence or phenomena involving the absorption or focused attention to some degree (Carich, 1990a,b, 1991; Erickson, Rossi & Rossi, 1976; Edgette & Edgette, 1991; Haley, 1967; Hammond, 1990; O'Hanlon, 1987; Kroger, 1977; Yapko, 1984, 1995). This means the individual or client is concentrating on a selected stimulus in which the client becomes oblivious to their immediate surroundings, creating a dissociative state or context. There is a sense of detachment at one level.

There are different hypnotic expressions including basic relaxation or calming mind frame strategies, daydreaming (in which one's attention begins to drift into the "zone"), and the ultradian cycle. The ultradian rest cycle is where the mind-body wants to shut down every 90-120 minutes for 20 minutes in order to rejuvenate. It is a non-sleep night dream state.

Hypnotic states are contextualized states based upon dissociation. Accessing or reflecting on memories creates hypnotic experiences because one is absorbed and focused on those particular memories, automatically creating a dissociative state. Time doesn't have meaning when in trance states (technically called pseudo time distortion), in which one's sense of time is distorted. Sometimes a behavioral suspension of limbs or body occurs, called cataleptic response, (catatonic or the immobility or rigidity of limbs) expressed in the form of hypnotic hand or arm levitation. In summary key elements include:

- Totally absorbed (focused attention)
- Totally focused attention with a high level of concentration
- Oblivious to current surroundings (given the intensity of focusing)
- Catalepsy or rigidity/immobility of limbs
- Non-sleep dream state (not including daydreaming)
- Dissociative state

There a number of hypnotic techniques, scripts and protocols in the literature (Carich, 1990a,b, 1991; Erickson, Rossi & Rossi, 1976; Edgette & Edgette, 1991; Haley, 1967, 1973; Hammond, 1990; O'Hanlon, 1987; Yapko, 1984, 1995). The typical interventions include: deep breathing, relaxation protocols, imagery, age regression and progression, direct/indirect suggestion, metaphors or symbolic communication, etc.

The basic relaxation protocols involve any form of relaxing the mind &/or body, including progressive relaxation (Carich, 1990a,b, 1994). These tactics help self-regulation and bypass client defense structures. Age regression is helping helps the client go back into time or accessing memories formally or informally. Anytime the client, or anyone for that matter, reflects on, or accesses memories, it is a processes and a form of hypnotic age regression. For example, when clients recall offenses or developmental experiences they are often in a trance state at some level. Age progression helps the client to project him or herself into their future. The client experiences their future without literally experiencing it. With direct/indirect suggestion most any other non-hypnotic intervention can be employed. For example, imagery and metaphors are used frequently throughout therapy and most definitely have hypnotic qualities, rather used directly or indirectly in or out of trance work. The bottom line is, whether formally used in trance states, many interventions commonly used have hypnotic qualities and/or elements.

Hypnotic interventions has been successfully used with a variety client issues (i.e., client responsibility, cognitive restructuring, motivation, victim empathy, sexual regulation or arousal control, emotional regulation, self-management in terms of RP skills or now referred to as change maintenance, self-esteem, trauma related core issues,…). It is a matter of applying specific tactics with

the established goals (Carich, 1990a, b, c, d, 1994a & b, 1999; Carich & Metzger, 1999a, 1999b & 1999c; Carich & Patrick, 1994; Carich, Metzger, Baig, Harper, 2003; Carich, Cameron, & Raimandi, 2012).

Conclusion

Historically, there are a number of reasons why hypnotic interventions are not used in this field, including: responsibility & choice issues; the experts in clinical hypnosis and working with clients who sexually abuse are typically unaware of each other's work; some therapists view it as a mystery and scary process, etc. People experience trance states or behaviors throughout the day in various forms, including intensely focusing on a book, TV, or simply daydreaming (Havens, 1985, Rossi, 1993; Kroger, 1977, Yapko, 1984, 1995). Hypnosis is not a mystery or mystic experience. It stems from the mind-body connection (Rossi, 1993). Utilizing hypnotic techniques or interventions elevates the skill level of the clinician. Hypnotic techniques are used with most client problems and issues (ASCH, 1973, Hammond, 1990; Havens, 1985; Kroger, 1977 and Yapko, 1984 & 1995). Hypnotic techniques can be in individual and group work, targeting the contemporary dynamic risk factors. Hypnotic interventions are not the entire treatment, however, but adjunctive techniques that serve to enhance treatment.

Interestingly, many commonly used tactics with the above clients involve hypnotic elements &/or maybe considered the same, including: imagery, relaxation, deep breathing and mindfulness (Carich, Maus & Brandon, 2016). It is suggested that the therapist employing hypnotic tactics be trained by ASCH or the Ericksonian foundation or other reputable trainers.

Citations and references may be obtained by emailing illinois-atsa@mediacom.bb.net.

Meta- Change Maintenance: Applying It Effectively

Mark S. Carich,Ph.D.

The Meta Change Maintenance Model was developed to help clients maintain treatment gains, thus avoiding relapse by maintaining a coherent life plan and enhancing coping responses.

Over the last few years, emphasis has been placed on the integration of positive psychology via Good Lives Model (GLM) with CBT, thus creating a more dynamic humanistic CBT approach. Likewise, emphasis is placed on implementing the self-regulations model (SRM) with GLM, and dropping Relapse Prevention (RP) (Laws, 2003; Yates & Ward, 2009). This has effectively created a gap in treatment in terms of change maintenance, especially for clients in the moderate and high risk categories.

Change maintenance has taken several different forms in this field. Prior to RP and CBT, booster sessions of aversive conditioning were used as change maintenance. The classical RP models were originally established to help clients maintain change. Even though RP was adopted and/or adapted from the substance abuse field to help clients prevent relapse, it eventually became much if not most of the treatment. The RP models were criticized for a number of reasons including rigidity and a lack of empirical support (Laws, 2003; Yates & Ward, 2009). Yates & Ward (2009) were in favor of replacing it with SRM/GLM. Yet, proponents of the SRM/GLM models emphasized the need for some type of change maintenance. Carich, Dobkowski and Delehanty (2009); Carich, Colwick, Cameron & Moore (2016) emphasized utilizing the spirit of RP and useful elements of the outdated models, along with elements of SRM/GLM.

Don't forget to mark your calendars for Illinois ATSA Free Webinar Series 2017

Sponsored by Global Institute of Forensic Research

Webinars held from 2–3:30pm CST; go to http://www.ilatsa.org/webinars/ for registration information.

June 21, 2017
Human Trafficking: Hidden in Plain Sight
Presented by Joy Kelleher, LCSW

August 8, 2017
Using REBT for Sexual Behavior Problems
Presented by Glen Ensinger, LCPC, LSOE, LSOTP

December 20, 2017
Effective Use of the Polygraph
Presented by Rhonda Meacham, LCSW

The meta change maintenance (MCM) model consists of integrating the best of RP/SRM & GLM based on a holistic view, and was developed to fill the gap Carich, Colwick, Cameron & Moore (2016). By helping clients maintaining meeting their needs appropriately, they preserve a pro-social life plan/style. This can be done by helping clients identify and differentiate between functional (what works) vs. dysfunctional (what doesn't work) patterns, with a deviant sexual subset referred to as the Meta Pathways Model. Key risk factors and triggers, along with cues, are identified with interventions. Clients develop effective coping responses for key risk factors. Client strengths are mobilized to help clients meet needs or goods appropriately and intervening triggers as necessary. The MCMM can be implemented into any program as a component of treatment or faded into groups for smaller programs.

Most programs can be generically mapped out in terms of the following sequence:
Pre-Tx &/or orientation → Mainline Tx. Addressing DRFS related to client's needs often associated with sexual offending (consisting of both process & psycho ed groups) → Change maintenance.

The Meta-Change Maintenance Program objectives include:

- Identifying and differentiating functional vs. dysfunctional states/patterns with a sexual subset
- Helping clients meet & maintain meeting needs or primary goods appropriately
- Help clients identify key triggers/risk factors, cues along with useful interventions
- Help clients transfer learning across contexts or apply learning (changes) outside of the treatment program
- Provide the essential elements of the meta-change maintenance program utilizing elements of RP/GLM/SRM.
- Program implementation of the model involves the timing of utilizing the change maintenance program component within the program sequence and an accumulation of learning.

Conclusion
The Meta Change Maintenance Model was developed to help clients maintain treatment gains, thus avoiding relapse by maintaining a coherent life plan and enhancing coping responses. The best of GLM/SRM/RP combined to help client maintain change. This model is based on a holistic perspective. The key theme is helping clients maintains a coherent life plan by meeting their needs appropriately and coping with high risk factors/triggers.