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Wise mind—risky mind: A reconceptualisation of dialectical behaviour therapy concepts and its application to sexual offender treatment

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Abstract *This paper aims to introduce a reconceptualisation of dialectic behaviour therapy (DBT), "wise mind–risky mind", and its application to sexual offender treatment. This reconceptualisation holds some promise in addressing issues around general, affective, cognitive and sexual dysregulation, and may provide an alternative way of thinking about sexual offender treatment. The wise mind–risky mind dialectical construct helps clients and therapists utilise a common language that captures and validates the experiential difficulties that clients go through in effectively managing their risk for sexual offending. The incorporation of DBT principles in standard sexual offender treatment programmes can assist clients in effectively managing problems with dysregulation in various domains. It can also afford a more integrated treatment framework when working with sexual offending dynamics. The authors discuss this new construct and its possible applications within the broader forensic mental health field.*

Keywords *DBT skills training; dialectical behaviour therapy; emotional dysregulation; intellectual disability; sexual dysregulation; sexual offender treatment*

Introduction

A systematic review of the effectiveness of various psychological interventions for sexual offenders has shown that cognitive behaviour therapy (CBT) is the most effective treatment model (Brooks-Gordon et al., 2006; Hanson et al., 2002; Marshall et al., 1999). The standard CBT group treatment programmes for sexual offenders focus broadly on correcting cognitive distortions, changing attitudes towards sexual offending and relapse prevention training. As an exclusive focus this may become problematic, given that a predicted change in cognition does not, in itself, necessarily equip clients with the core self-regulatory base that can help them manage their risks effectively and create personally meaningful lives. Larger problems with self-regulation within the domains of general/affective (e.g. impulsivity, poor problem-solving, negative emotionality), interpersonal (e.g. intimacy deficits, general social rejection, lack of concern for others) and sexual dysregulation (e.g. sexual preoccupation, sex as coping) appear

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to form a core group of deficits associated with risk of sexual offending. Hanson (2006) considered these as critical risk factors for sexual recidivism. The STABLE-2007 (Hanson et al., 2007), a widely used dynamic sexual offender risk assessment instrument, identifies several psychological (stable dynamic) risk factors associated with risk of sexual recidivism. Given that, theoretically, these dynamic risk factors are amenable to change, expectably targeting these factors in treatment should result in a decreased risk for sexual recidivism.

In addition, the importance of addressing affect regulation, which appears to be impaired in sexual offending clients (Ward & Hudson, 2007), has gathered some momentum, with research findings indicating that these clients tend to choose ineffective strategies to manage painful affect states (Serran & Marshall, 2006). Addressing affect regulation in treatment thus becomes critical in helping clients learn to manage their psychological distress effectively. Intense negative affect states may interfere with clients' abilities to utilise learnt cognitive skills and result in a loss of internal controls when faced with future stressors as they attempt to reintegrate into society and life. Frustrations and challenges that accompany re-engaging with tasks of daily living, sometimes under strict supervisory conditions and societal sanctions, can rapidly erode the cognitive learning in treatment. Thus, a focus on self-regulatory and affective domains could help clients begin to make shifts in the core ways in which they come to organise their self-experience in response to the outside world.

Dialectic behaviour therapy (DBT) and sexual offender treatment

DBT, a CBT-based treatment integrated with principles from eastern philosophies, was designed originally by Marsha Linehan (1993) as a treatment for individuals diagnosed with borderline personality disorder (BPD). DBT is based on a biosocial theory of personality functioning. The DBT approach balances therapeutic validation and acceptance of the person along with cognitive and behavioural change strategies. The standard DBT programme involves four components—group treatment, individual therapy, telephone coaching and the consultation group (Linehan, 1993). Each component is designed to support the client (and therapist) to develop and practice skills systematically in the domains of mindfulness, distress tolerance, emotional regulation and interpersonal effectiveness.

The use of DBT has been expanded to clinical populations with diagnoses such as substance misuse (McMain, Sayrs, Dimeff, & Linehan, 2007), eating disorders (Wisniewski, Safer, & Chen, 2007) and depression with comorbid personality disorders (Lynch & Cheavens, 2007). DBT has also been used in forensic and correctional services, and both mental health inpatient and outpatient facilities. It has been found to be highly compatible with best-practice principles for effective treatment in forensic settings. The DBT biosocial theory has proved to be relevant in explaining the genesis of other personality disorders; in particular, antisocial personality and psychopathy, which are found frequently among correctional populations (McCann et al., 2007). Thus, there is growing evidence that DBT can be effective with personality and mentally disordered offenders. In this connection, the pertinent question would be whether DBT could have some utility in sexual offending treatment. Currently, there is a paucity of research on the use of DBT with sexual offenders.

As a client population, sexual offenders can be considered a heterogeneous group. Substantial efforts have gone into researching and understanding their psychopathologies, risks and ways to reduce the likelihood of further offending. Thornton (2002) grouped the stable dynamic factors implicated in sexual offender recidivism studies into four domains, namely: (1) socio-affective functioning; (2) self-management; (3) problematic/deviant sexual interests; and (4) distorted attitudes. There is some overlap between the *Diagnostic and*

Statistical Manual IV borderline personality disorder (DSM-IV BPD) diagnostic description and the literature on stable dynamic risk factors. DBT would be particularly well suited to working with Thornton's first two domains, mentioned above.

Shingler (2004) identified key clinical similarities between sexual offenders and borderline personality clients and how DBT principles could be appropriate in working therapeutically with sexual offenders. These include high levels of potential risk of harm (to self/others), dysfunctional thinking patterns, responsivity issues and a tendency for both groups to engender anger, helplessness and even hopelessness on the part of their therapists. Both sexual offenders and BPD clients experience dysregulation across different domains (i.e. cognitive, emotional, interpersonal and behavioural). In terms of treatment utility, Adams (2010) argued that DBT might prove to be useful with sexual offending clients with histories of difficulties with impulse control. Training in DBT with these clients might be a useful way to begin treatment as Adams recommends, thus providing them with skills to manage themselves more effectively in treatment (Linehan, 1993). Affective dysregulation can otherwise become a significant barrier during treatment.

Treatment hierarchies

DBT is organised into stages with clearly structured hierarchies of targets in each stage (Koerner & Dimeff, 2007) (see Figure 1). An adapted hierarchy of treatment targets potentially affords a particularly useful frame to structure treatment and case management in working with sexual offenders. Therapists working with sexual offending clients could aim to prioritise treatment targets, based on the literature on stable dynamic risk factors for sexual offending. Proposed below is one possible frame for ordering these hierarchies (see Figure 2):

1. Addressing sexual dysregulation and implementation of risk management strategies to minimise threat to self and others (e.g. sexual preoccupation, sexual preference, access to victims);

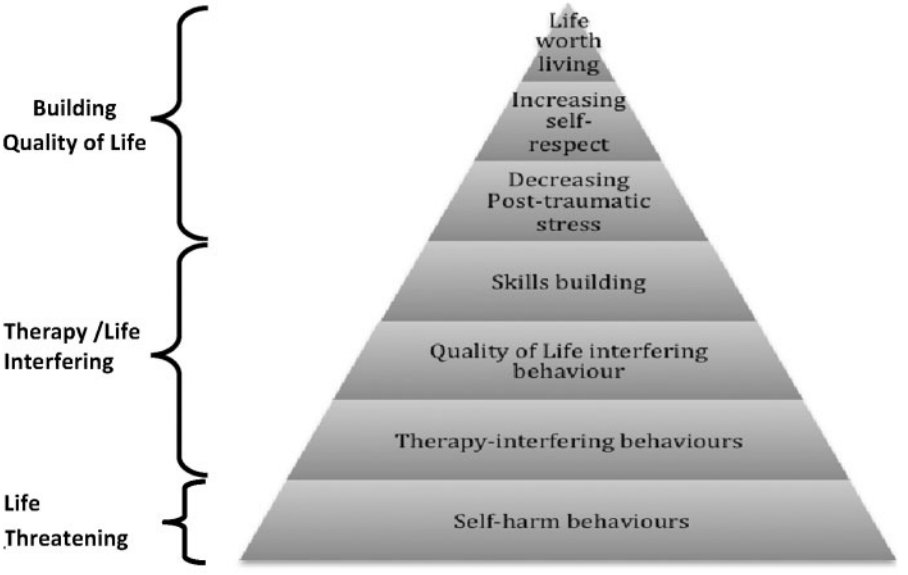

FIGURE 1. *DBT structured hierarchy of targets.*

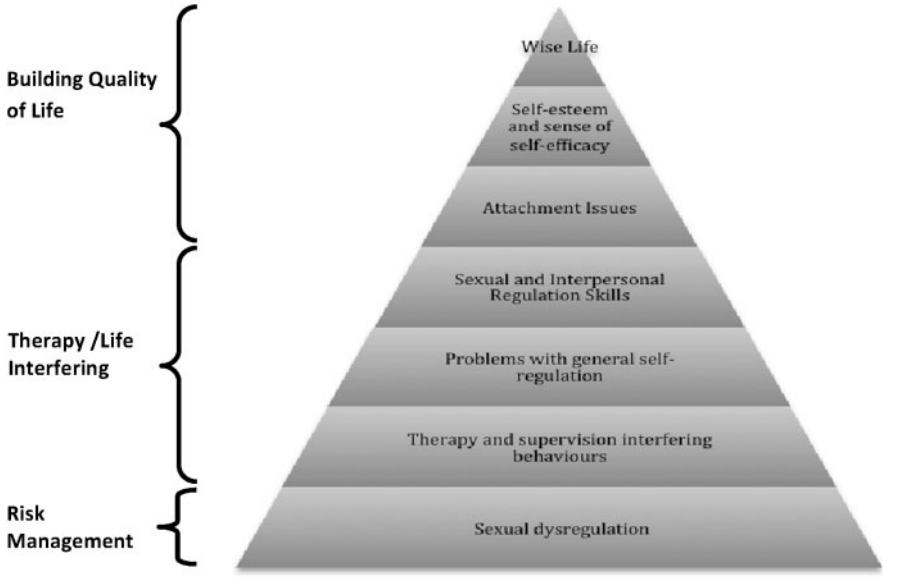

FIGURE 2. *Sexual offender treatment structured hierarchy of targets.*

2. Addressing therapy and supervision interfering behaviours (e.g. hostility, rejection of supervision, etc.);
3. Addressing issues around general self-regulation including affect regulation (e.g. negative emotionality, substance use, impulsivity, poor problem-solving);
4. Addressing sexual and interpersonal regulation skills (e.g. capacity for relationship stability, hostility towards women);
5. Addressing behaviours that are related to historical trauma/stress (e.g. attachment issues, social rejection);
6. Improving general self-esteem and sense of self-efficacy; and
7. Addressing particular treatment goals/needs/values that are important for the individual client in terms of supporting their vision of their "Wise Life Journey" or "Wise Mind Walk" [authors' terms].

The designing and following of an explicit set of treatment rules/hierarchies would facilitate greater consistency and cross-learning between therapists working in a team. It also allows for therapists within a team to begin to engage in a process of peer consultation with each other as a group. The team can begin to reflect on the consistency of treatment principles/protocols, practice/rehearse DBT skills, support and give assistance as necessary, while honouring limits and finding ways to validate each other in work that has potential to sometimes become demoralising and feel unrewarding.

Therapeutic stance

As a therapeutic modality, DBT focuses specifically on the stance the therapist holds in relation to the client. Validation, one of the central tenets of DBT, can revise ways in which therapists work with their sexual offending clients. Existing programmes appear to rely heavily on a more traditional CBT and relapse prevention approach. Inevitably, therapists feel pressured to correct/challenge cognitive distortions to effect change. This is not always

helpful. Clients bring with them to treatment their attachment and life histories, and within those contexts, experience their perspectives as valid (even though they may be 'distortions' from a therapist's perspective). The use of languaging by therapists can inadvertently become antithetical to the client's self-experience—problematic, given that the goal of treatment is to help clients develop more integrated self-regulatory mechanisms. Clients can experience negative judgement, rejection and denigration coming from their own therapists, proving in the long term to be counterproductive to successful rehabilitation (Fernandez, 2006). Negative transference results in increased resistance, denial, non-compliance, reduced self-esteem and superficial/adapted cooperation with treatment or rejection of treatment.

Shingler (2004) reflects on some of the uses of validation in working with sexual offenders. Counterintuitively, validation can actually further the acceptance of responsibility for one's offending. Most sexual offender treatment programmes require clients to accept 'full' responsibility for their sexual offending. Taking responsibility is more than an admission of guilt or a full disclosure of the details of the offending—in the authors' view, it involves an internal process by which intellectual and emotional insight is achieved into the dynamics of one's offending and a commitment made to manage one's vulnerabilities. While not condoning sexual offending as an acceptable or long-term effective problem-solving strategy, validating the clients' sexually abusive behaviours as understandable within the context of their life histories/challenges may open avenues to identify other aspects or facets of their sexual offending that need to be addressed. Validation does not necessarily equate to collusion—it is a recognition or 'getting' of how it feels from inside another's subjective standpoint; conversely, collusion is 'believing' that this subjective view is objectively true (Shingler, 2004).

The use of validation is not limited to exploring offence accounts. It is a core therapeutic stance the therapist utilises to reach the client, to communicate in some essential sense that the therapist understands that the client's perspective feels true to him at this point in this process. At later stages of the therapeutic encounter or meeting, deeper levels of validation (Linehan, 1997)—radical genuineness, alongside irreverent and reciprocal communication (strategies)—become important in engaging clients in working with the therapist in managing their individual combination of risk factors. For instance, in one of the authors' group sessions, a disconcerting discussion among our sexually preoccupied group members about how often they masturbated changed rather suddenly when one of the therapists, in keeping with radical genuineness, irreverently remarked "It's not a . . . . . competition". Another time, in a moment of reciprocal communication, a therapist shared how he had managed to work through some difficult life experiences. It was a critical moment that distilled hope for the clients that they might come to learn ways with which to overcome their vulnerabilities. Validation may not appear to be singular to DBT; in its explicitness, however, DBT is unique. It gives permission to the therapist to meet the client fully in his experience while staying authentic to his experience and reality. In this approach, the therapist's stance would be a significant departure from the more traditional ways in which therapists relate to this client group.

Wise mind and risky mind: A new dialectic

In DBT, clients are presented with the concept of three primary states of mind: "reasonable mind", "emotional mind" and "wise mind" (Linehan, 1993). "Wise mind" is considered the integration of the "emotional mind" and the "reasonable mind". It is considered as an incorporation of all ways of knowing and is by definition a "state where one is able to make the

wisest decision possible, knowing just what is needed in any given moment" (McMain et al., 2007, p. 158).

The term emotional mind, developed within the context of a specific client group, i.e. BPD clients, is useful in helping these clients to understand their issues with affective dysregulation. Clearly, this term was not designed while holding clients with sexual offending behaviours in mind. A different construct seemed necessary for this client group, one that could allow for a metaphorically rich and meaningful engagement with them. This construct would need to relate to this client group's identified psychological needs which are captured in their dysregulation across the different domains—sexual, interpersonal, general, affective and cognitive. Accordingly, the authors postulated a theoretical fourth state of mind, the "risky mind".

Theoretically, risky mind was posited to be in direct dialectical relationship to wise mind; in that wise mind represents an integration of ways of knowing, in dialectical relationship to this integration, risky mind was conceptualised as a state of non-integration or unintegration of ways of knowing. This state of non-integration was close to the experience of clients and the descriptions used by them when talking about their state of mind leading up to their offending. For example, commonly clients referred to or made statements such as "I don't know what got into me . . .", "I know what I did, but it makes no sense . . .", in an attempt to communicate their internal sense that there was something deeply not-integrated within at times when they chose to sexually offend. As a construct, risky mind allowed for work with a wider client group than the group for whom the three primary states of mind in DBT were first introduced.

This reconceptualisation has widened the applicability of DBT to working with sexual offending dynamics. For example, a commonly encountered issue in treatment, such as cognitive distortions, becomes in this model a subset of risky mind as a specific form of dysregulation. This recasting could permit a certain shift in the way therapists hold and work with clients' cognitive distortions when they present or are elicited during treatment—the frame or task then becomes not so much the correcting or challenging of these distortions, but assisting clients to shift from a place of cognitive dysregulation to cognitive regulation. Cognitive regulation would mean helping clients to integrate aspects of knowing which, for a number of reasons (early social learning experiences, poor role modelling, etc.), were previously not available to the client. Thus, a client might move from a place where he is blaming of the victim for demonstrating sexual interest in him (a common 'distortion') to acknowledging and integrating the disavowed 'knowing', i.e. "I wanted so much to believe that she was attracted to me . . . so that I did not have to think about the loneliness that I have felt in my [adult] relationships".

Figure 3 depicts the states of mind as proposed by Linehan (1993). The proposed construct of risky mind is added to this frame. Risky mind is conceptualised as overlapping/intersecting partially with the reasonable mind and emotional mind, but it does not have any overlap with the wise mind. Wise mind and risky mind coexist in direct dialectical relationship to each other. Practically, this would mean that risky mind incorporates elements of reasonable mind and emotional mind operating in isolation or unintegration from each other. For example, this unintegration/isolation can be seen when an offender actively plans and organises his offending or when an offender chooses to offend in response to overwhelming negative feelings.

This reconceptualised DBT frame allows for the acknowledgement of the tension that we might expect the client/offender to experience at various points, the pull between regulated and dysregulated ways of functioning. The dialectic of wise mind–risky mind validates this phenomenological tension. If one has been successful in reaching the client in therapy by

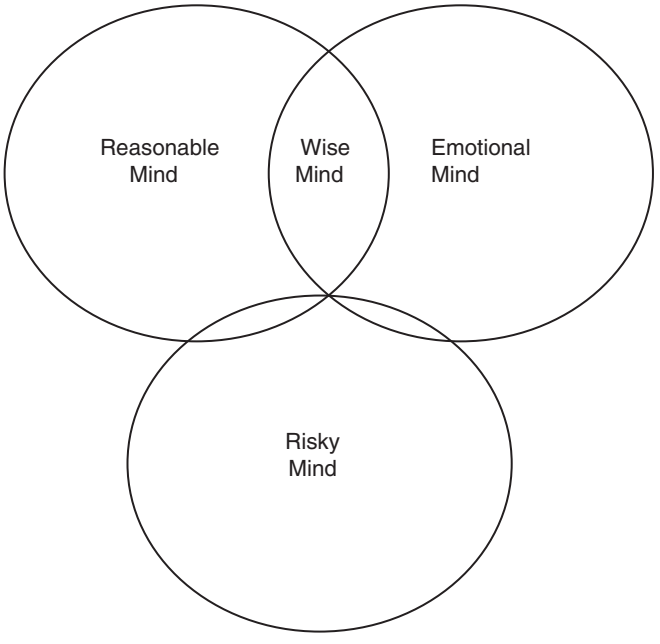

FIGURE 3. *Dialectic of the wise mind–risky mind.*

validating this tension, it is anticipated that the client will recognise his risky mind and attempt to shift himself out of this mental state and move towards its dialectical wise mind state. The dialectic of wise mind–risky mind simplifies therapeutic concepts, supporting clients to identify their different states of mind and to use skills they have learnt in treatment to build "a life worth living" (Linehan, 1993). In addition to the standard DBT skills modules, the work with sexual offenders includes adapted modules on sexual and cognitive regulation and intimacy deficits.

Comparison with other conceptual frameworks

Prevailing conceptual frameworks that are used in sexual offender treatment may have underpinnings similar to the proposed wise mind–risky mind construct. It is perhaps inevitable that this proposed construct may have aspects in common with other frameworks; however, it can be considered distinct in its assumptions—the issue of dysregulation across different domains/levels, its underlying specific therapeutic philosophy and skills-building and consultancy to the client frame. Notwithstanding, it is important to try to make some limited distinctions/demarcation from other models, such as the pre-eminent self-regulation model of relapse prevention (Ward & Hudson, 2007) and Good Lives model (Ward & Gannon, 2006).

Risky mind is envisioned as a construct that captures the phenomenological difficulties that clients have in negotiating domains, as shown in Figure 4. Sexual offending can occur when the client is in a state of acute dysregulation in response to a series/combination of life stressors. These stressors, which occur close to the time of the offending, interact with biological sensitivities and background, invalidating psychosocial experiences that have created a core set of vulnerabilities. These vulnerabilities exist in a latent or chronic state of

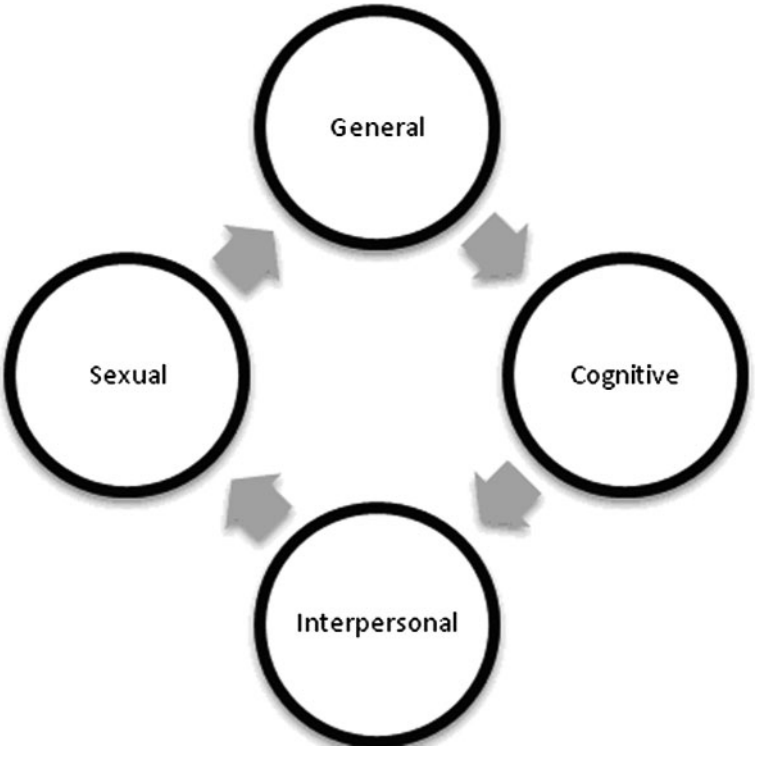

FIGURE 4. *Risky mind and dysregulated states.*

dysregulation within the particular domain/s and when activated in the client's life may lead to a 'decision' to offend. It is these dysregulated states that collectively comprise the risky mind.

Risky mind precedes the actual offending and the events that precipitate the acute state/form of dysregulation and will continue in its chronic/latent form after the offending. The client will need to develop skills to help him move to a place of integration in relation to those domains relevant for him, in other words to his wise mind. The client will have to discover ways of accessing his wise mind when varying dysregulated processes are triggered for him—thus, the importance of gaining insight into the workings of his risky mind.

A model like "old me/new me", which uses a dipartite construct with clients with intellectual disabilities (Haaven et al., 1990), at first appears similar to wise mind–risky mind. In the proposed model, however, a client needs to understand the links between past and present experiences and ongoing areas of dysregulation that contribute to his risks of sexual offending. Conversely, the use of the old me/new me model might potentially reinforce cognitive distortions, specifically the leaning to believe that "the past is the past" and that the "new me" is someone who does not and should not experience any "old" cognitive, emotional and sexual/interpersonal dysregulation which could place him at risk of sexual offending. The concept of old me/new me appears more dichotomous as a construct, with a clear split between the two formed identity states, than as a dialectic between two existing mental states as proposed in wise mind–risky mind.

A similar conundrum exists with the "good way" model (Ayland & West, 2006), developed for working with youth and adults with intellectual disabilities. Using a narrative therapy and strengths-based approach, the first stream to the model (good way/bad way) focuses on encouraging clients to identify and develop a positive lifestyle by employing

externalising conversations that allow for a separation between positive (good side) and negative (bad side) impulses, cognitions and behaviours. The wise mind–risky mind dialectic, on the other hand, focuses on helping clients identify their internal mental states or states of mind and the ever-present relationship between these states. Both states of mind coexist at any point in time; clients will need to recognise this so that they can actively manage the same. Change does not equate to choosing one side or way over the other; rather, it is learning to live with/accept and manage the dynamic tension between regulation–dysregulation, wise mind–risky mind.

DBT and wise mind–risky mind dialectics in sexual offender treatment

The operationalisation of wise mind–risky mind as a construct was first piloted in a sexual offender treatment programme for forensic mental health and intellectual disability (ID) clients. The programme included adapted DBT coping skills training modules (i.e. mindfulness skills, distress tolerance skills, emotional regulation and interpersonal effectiveness) (Sakdalan, Shaw & Collier, 2010). The relapse prevention portion of the programme was significantly reconceptualised within the context of DBT terminology (e.g. vulnerability factors, triggers, problem behaviours, consequences, etc.). Wise mind–risky mind dialectics were incorporated into the group activities and as an underlying theme throughout the programme.

Vignette

Jack (not his real name) is a European male in his mid-20s, diagnosed with mild intellectual disability. He has an extensive forensic history that includes general, violent and sexual offending behaviours since early adolescence. His index offence, an indecent assault against prepubescent girls, involved a high degree of aggressive control, impulsivity and some explicit planning on Jack's part.

At the beginning of the programme, Jack indicated severe sexual dysregulation (masturbating up to 12 times a day). Jack's sexual arousal and thinking appeared to have strong associations with affectively dysregulated states, particularly angry and hostile feelings with deeper underlying feelings around abandonment. In the group, Jack was helped to begin to discriminate between his wise mind and risky mind in their various daily expressions. For example, a disparaging comment about a female staff member which Jack would have initially considered 'appropriate' or behaviours involving sexual scanning slowly came to be recognised by Jack as part of his risky mind. He began to develop some early insights into other expressions of his risky mind, in particular the association of diffuse unmet needs around connection and belonging in his sexual attraction towards children. Jack gradually began to recognise old vulnerabilities around abandonment stemming from invalidating experiences and how his attempts at interpersonal control and aggression were designed to ward off the same. At the end of the pilot group, Jack had also started to indicate to staff where he saw himself at any point in time in terms of the wise mind–risky mind continuum, so that potential safety issues could be discussed and negotiated. The dialectic of wise mind–risky mind and the meaning it held for Jack is best communicated in his own words: "One half of my head is wise and the other half is risky".

The authors hypothesise that the construct of wise mind–risky mind matched Jack's internal experience closely, helping him to organise and contain dysregulated states that previously had felt untameable, like a "monster locked in a cage, fighting to get out" (Jack's description). Jack feels more in control of his risky mind now that he can acknowledge its

existence. He has also come to know his wise mind and has learnt skills to cope with the particular pulls of his risky mind.

Current status and future directions

This paper introduces a reconceptualisation of DBT in terms of sexual offending treatment and the potential use of a new dialectic, wise mind–risky mind, in working collaboratively in treatment. The development of this conceptual framework is at an early stage and further work will need to be carried out to elaborate the framework and to test its utility in treatment. The incorporation of DBT philosophy and skills in standard sexual offending treatment can not only assist clients in managing problems effectively with self-regulation, but can also provide a more integrated treatment framework.

The proposed dialectic of wise mind–risky mind may help clients and the therapists to utilise a common languaging that captures and validates the experiential difficulties that clients encounter in effectively managing their risks for sexual offending. The authors consider that the primary scope of the proposed concept lies in its simplicity and its attunement to the clients' experience. Clients related easily to the construct and they used it to understand and communicate their risks. The authors have trialled the method with clients who have limited cognitive abilities and, as might be clear from the brief vignette, they appear to find it useful in helping them to map their internal states. It is designed explicitly to be non-judgemental and non-pejorative, a stance in keeping with the larger spirit of DBT. This appears to have played an important function in the clients' eagerness to 'pick up the ball', so to speak, and 'run' with it.

Finally, it is envisaged that this construct may have application to the broader forensic field, in working with clients with other violent and non-sexual offending histories. For these offenders, where impulsivity and general and emotional dysregulation are critical factors, risky mind might help them begin to understand and manage some of what they have habitually thought, felt and done. It may hold some promise in the treatment of sexual offenders with severe personality disorders, affording them a frame that allows them to make sense of their vulnerabilities and ways of relating to/with the world. A non-standard DBT-informed programme which incorporates the wise mind–risky mind construct has begun to be implemented with the forensic mental health client groups within the Auckland Regional Forensic Psychiatry Service.

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