Psychiatr. Pol. 2022; 56(6): 1253–1267
PL ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
www.psychiatriapolska.pl
DOI: https://doi.org/10.12740/PP/143847

Prospect of using schema therapy in working with sex offenders

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Summary

The search for effective methods of treating sex offenders is essential in order to reduce the risk of their subsequent sexual offences. This article presents Jeffrey Young's concept of schema therapy with a discussion on the appropriateness of its use in the treatment of those who engage in problematic sexual behavior directed against sexual freedom. Such behaviors are prohibited by law and involve the commission of crimes set out in Chapter XXV of the Penal Code (including rape, exploitation of helplessness, abuse of dependence relation, sexual act with a minor under 15 years of age).

The article presents the main assumptions of schema therapy. Then, with reference to the main assumptions of this therapeutic approach, a theoretical model of schema therapy in the context of violent sexual behavior is proposed and discussed. The authors also attempted to analyze the mechanism of formation and perpetuation of deviant criminal behaviors in the context of key constructs of this approach, such as: early maladaptive schemas and schema modes. As schema therapy has proven to be effective in treating chronic personality aspects of disorders, this approach seems to be a promising trend for such a difficult population of people.

Key words: schema therapy, early maladaptive schemas, schema modes, sexual violence, sexual crimes

Introduction

Sexual violence, especially in the era of technological and Internet development, is a serious social problem. Through new technologies and opportunities that they create (amongst others, easier access to and knowledge of the victim), committing a crime or paving the way for committing a crime seems to be easier, whereas detecting criminal behaviors is much more difficult. Counteracting sexual violence seems to be a major challenge today, and understanding the nature of sexual violence and the mechanisms

of its occurrence is essential in the context of diagnostics, effective prevention and especially clinical and judicial procedures. Effective treatment of offenders plays a special role in preventing recidivism.

The therapeutic treatment of perpetrators should depend on the risk of recidivism. According to the Polish Sexological Society, treatment should be provided not only to perpetrators suffering from sexual preference disorders, but to all sex offenders presenting a high or moderate[1] risk of recidivism. However, the legal system in Poland requires that treatment is provided to persons who have been convicted of a sexual offence committed in connection with a sexual preference disorder[2] and to persons convicted of a deliberate sexual offence committed in connection with a personality disorder of such a nature or severity that there is at least a high probability of a criminal act being committed with the use of violence or threat of violence[3]. Interventions directed at such perpetrators include, among others, pharmacological therapy to weaken sexual drive, psychotherapy or psychoeducation aimed at improving their functioning in society[4].

Currently, the preferred treatment for sex offenders globally is based on the principles of risk-need-responsivity (RNR)[5], cognitive-behavioral therapy (CBT); supplemented with a relapse prevention model (RP) [2, 3]. According to the assumptions of this therapy, "cognitive processes, emotions and behavior are independent subsystems that play equally important roles, mediating the development of mental disorders and influencing their persistence" [4, p. IX].

According to these assumptions, deviant sexual behavior is a manifestation of emotional difficulties and/or mental disorders experienced by the individual, and is associated with giving specific meanings to environmental stimuli.

The popularity of CBT in the treatment of offenders involves, among others:

- a structured nature of the therapy, which enables implementation of programs in institutionalized facilities as well as facilitates measurement of its effectiveness,
- an educational character of the intervention, through which the patient is taught how to deal with problems on their own, and:
- a particular emphasis placed by CBT on strengthening the ability to prevent relapses – which in the case of SO seems to be particularly important in reducing the risk of recidivism, which, in addition to protecting society from violence and criminal behavior, is the main objective of treatment of sex offenders [5].

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1 Resolution of the Board of the Polish Sexological Society of 03.03.2017 on the treatment of sex offenders.

2 Art. 93c item 3 of the Criminal Code Act of 6 June 1997 (Journal of Laws 1997 No. 88 item 553 as amended)

3 Art. 93c item 4 of the Criminal Code Act of 6 June 1997 (Journal of Laws 1997 No. 88 item 553 as amended)

4 Art. 93f § 1 of the Criminal Code Act of 6 June 1997 (Journal of Laws 1997 No. 88 item 553 as amended)

5 The recidivism assessment model developed in 1990 by D.A. Andrews, J. Bont and R. D. Hoge is based on the assumption that the intensity of treatment should be proportional to the level of risk posed by the offender (risk principle), treatment should focus on features related to the risk of recidivism, i.e., criminogenic needs (need principle) and be adapted to the learning style and capabilities of the offenders (responsivity principle) [1].

In the context of such a treatment goal, the therapy should be aimed at creating an effective means of controlling the sexual drive of the offender, so that they can refrain from criminal behavior. Therapeutic programs place particular emphasis on the development of social and interpersonal skills (including the development of empathy towards the victim, anger management, assertiveness training), as well as learning about the deviant cycle, changing deviant patterns of sexual stimulation and prevention of relapses [6, 7].

However, basing therapy solely on change of behavior and views does not ensure its effectiveness. It is necessary to supplement cognitive-behavioral interventions aimed at deepening such changes with elements derived from dynamic and humanistic psychotherapy [8]. It is particularly important for the offenders to understand the mechanism of the formation and persistence of deviant sexual behaviors against the background of individual life stories, which results in the need for so-called matching, i.e., adjusting psychotherapy to the problems of the specific patient [9]. There is no universal form of treatment for all offenders. A fuller understanding of the mechanism leading to a crime in a specific offender increases the chances for applying the right therapeutic tools and reduces the risk for potential victims [10].

A trend that integrates the findings from different schools of psychotherapy is Jeffery Young's schema therapy (ST). This therapeutic approach seems to be aimed at working with the patient on a deeper level, as it has been enriched, in comparison to traditional therapeutic cognitive-behavioral programs, with working on childhood trauma. In ST, greater emphasis is placed on the therapeutic relationship: on the patient's emotions, affect and moods (so-called modes), as well as on developmental processes and a search for the sources of current problems in the early stages of life. The aim of the therapy is to help the patient meet key emotional needs in an adaptive way by treating non-adaptive patterns, coping styles and modes.

Schema therapy

Schema therapy is an integrative, unifying theory and a treatment method. It derives from the cognitive-behavioral model and combines elements of various paradigms and theories (e.g., psychodynamic, emotion-focused, attachment theory), skillfully using cognitive, psychodynamic and experimental techniques. This type of therapy was created to treat patients with chronic personality problems and difficult-to-treat emotional disorders, who could not be sufficiently helped with the use of traditional cognitive-behavioral therapy [11]. Due to the confirmed effectiveness of ST in the treatment of many disorders and health problems of axes I and II[6], schema therapy is

[6] The American Psychiatric Association's Classification of Mental Disorders (DSM-IV) groups disorders into 5 dimensions (known as clusters), where axis I includes clinical disorders, axis II includes personality disorders and developmental disorders; axis III includes general medical conditions; axis IV includes psychosocial and environmental problems; and axis V represents the level of adjustment.

gaining increasing interest from researchers and clinicians. In recent years, this interest has been expanding into the judicial area, exploring the effectiveness of treatment in difficult-to-treat patients (i.e., forensic patients, persons obliged to undertake treatment with low or external motivation to engage in therapy) [12–14] or even ones considered incurable (including psychopaths) [15]. The association of early maladaptive schemas with features of psychopathy was investigated [16] and the prevalence of schemas in populations of different types of offenders was studied [17–19], associations between schemas and different types of criminal behavior [20] as well as between schema modes and crime patterns [21] were also investigated.

Theoretical model of schema therapy in the context of violent sexual behavior

The model of schema therapy is not a comprehensive theory of the formation of psychopathologies, but a working theory aimed at integrating and conducting clinical interventions with patients with severe character disorders [22]. The essence of this model consists of four concepts: (1) early maladaptive schemas, (2) schema domains, (3) schema modes, and (4) coping styles.

Early maladaptive schemas and schema domains

Early maladaptive schemas are the central concept of schema therapy. They are defined as emotional and cognitive patterns, harmful to the individual, consisting of memories, emotions, bodily sensations, and perceptions concentrated around childhood problems [23]. The patterns arise as a result of the failure to meet basic emotional needs in childhood and tend to develop throughout life. In addition to unfavorable environmental factors (toxic environment, attachment disorders, early childhood trauma – abandonment, maltreatment, neglect, rejection), they are also influenced by biological factors, especially temperamental conditions. Young et al. [23] singled out 18 early maladaptive schemas and grouped them into 5 so-called domains (Table) based on 6 general categories of emotional needs of people, which they considered universal[7].

These schemas influence the functioning of every human being, determining his or her behavior, way of life, the way they feel, and the way they enter into relationships with others.

[7] According to Young, people's universal emotional needs are secure attachment, including: safety, care, attention, and acceptance; autonomy, competence and awareness of one's own identity; freedom to express important needs and emotions; spontaneity and fun, and self-control and awareness of existing boundaries [23].

Table. **Domains of early maladaptive schemas [23]**

DISCONNECTION AND REJECTION	Abandonment/instability Mistrust/abuse Emotional deprivation Defectiveness/shame Social isolation/alienation
IMPAIRED AUTONOMY	Dependence/incompetence Vulnerability to harm or illness Enmeshment/undeveloped self Failure
IMPAIRED LIMITS	Entitlement/grandiosity Insufficient self-control/self-discipline
OTHER-DIRECTEDNESS	Subjugation Self-sacrifice Approval-seeking/recognition-seeking
OVERVIGILANCE AND INHIBITION	Negativity/pessimism Emotional inhibition Unrelenting standards/hypercriticalness Punitiveness

Schema modes

Schema Modes are specific patterns of behavior and emotional experience of an individual; they are emotional states changing from one moment to the next and reactions of coping with painful emotions that control the individual's behavior [23]. Young et al. [23] identified 10 schema modes and grouped them into four general categories: (1) maladaptive child modes, (2) maladaptive parent modes, (3) healthy adult mode, and (4) maladaptive coping modes. Child modes have been recognized as innate and universal. They are the child's way of experiencing difficult situations and relate to such emotions as loneliness, anger and a sense of abandonment. Parent modes are secondary because they are the internalized, moralizing voice of the guardian. The manifestations of these modes are self-criticism and self-punishment (punitive parent mode) as well as demands and requirements (demanding parent mode). These modes carry strong pressures, self-hatred and self-blame. Finally, healthy modes include healthy self-reflection (healthy adult mode) and experiencing joyful, fun emotions (happy child mode). Strengthening the healthy adult mode is crucial in schema therapy. This mode is a rational, responsible and sustainable alternative to dysfunctional modes and enables the proper perception of the surrounding reality, healthier functioning and coping

with crises. This state enables the individual to properly perform roles, develop and fulfill important needs and developmental tasks (i.e., education, work, raising children, harmonious relationships with others, sport, intrests, and health).

Maladaptive coping modes

Maladaptive coping modes include dysfunctional attempts to deal with painful feelings. In relation to the three basic responses to a threat (i.e., Fight, Flight, Freeze), Young et al. [23] identified three leading strategies: avoidance, surrender or overcompensation.

Early maladaptive schemas as a source of problems with emotional regulation and sexual self-control

The cognitive-emotional structures and processes described above, which are the main assumptions of ST, as well as the core of Young's concept, can be applied to the issue of sex offenders. Research shows that the temperament of offenders is affected by disorders in the operation of neurotransmitters, specifically a dysfunction of the dopamine system, which is responsible for the tendency to actively respond to stimuli [8]. Most likely the malfunctioning of this system, combined with early childhood deprivation of basic emotional[8] needs, leads to the development of early maladaptive schemas (EMS). This is supported by previously cited studies (e.g., [17–20]) indicating that sex offenders differ in terms of "consistent cognitive patterns". For example, the perpetrators of sexual abuse of children compared to a group of non-sexual violent criminals show a greater intensity of schemas related to the domain of abandonment (social isolation and defectiveness/shame) and the domain of other-directedness (self-sacrifice, subjugation) [18]. Having schemes in these domains suggests an unsafe environment while growing up. In the domain of disconnection and rejection, it is a climate of emotional coldness, indifference, rejection, secrecy, and loneliness, occurring in unpredictable, violent conditions leading to the conviction that needs will not be fulfilled in the expected way. In the domain of the other-directedness, it is a climate of conditional acceptance, in which children suppress important elements of their personality in order to gain love, attention or support from their guardian, leading to excessive concentration on other people's desires, feelings and reactions at the expense of their own needs, in order to gain love, support, maintain a sense of closeness to others or to avoid revenge. This results in suppression and lack of awareness of one's own anger and tendencies.

[8] Research shows that sex offenders have mostly experienced bad relationships with their parents or have been abused by them [24, 25].

The formation of early maladaptive schemas is usually associated with the development of self-defeating life patterns (e.g. relationship disorders). Marshall and Barbaree [24] emphasized that an "insecure" style of attachment is an influential factor in the etiology of sexual crimes. Non-development of safe attachment in childhood for sex offenders may result in an inability to acquire interpersonal skills and self-confidence, factors which are crucial for achieving intimacy with other adults [25].

Self-defeating life patterns are again reinforced by ineffective coping strategies[9] and lead to intensifying of many deficits in offenders which are described in literature as static and dynamic risk[10] factors.

Mechanism of formation and reinforcement of deviant criminal behaviors based on the schema therapy model

According to the schema therapy model, neurophysiologically-conditioned cognitive processes (memory, attention, thinking), feelings, life experiences of an individual, as well as environmental conditions play a key role in the mechanism of perpetuation of deviant behaviors. These factors may amplify or weaken the dominant maladaptive schemas that are the cause of the disorder as well as the basis of personality pathologies. Young et.al [23] identify three mechanisms that play a special role in this process: (1) cognitive distortions, (2) self-defeating life patterns and (3) schema coping styles. Among them, cognitive distortions are the mechanism best studied in the population of sex offenders and described extensively in literature; they are based on the perpetrator's misperception of the situation. The reinforcement of the schema through cognitive distortions takes place by accentuating information that confirms the schema and by diminishing or completely rejecting information that contradicts it. For example, a pedophile may believe that by engaging in sexual contact with a child they actually educate the child and act in the best interests of the child, or they may blame the victim and believe that the child was being seductive [30], therefore they regulate the schema of their defect. Distortions may appear at various stages of the perpetration: before the motivation for the act arises – becoming its source, or after it is committed – as a result of the reaction of the perpetrator and their environment – in order to justify their own motives [31]. Distortions affect both the manner of committing an act and the degree of its brutalization [32], and thus have an impact, among

[9] Research has shown that sex offenders do not have sufficient skills to deal effectively with problems, adopt the wrong attitude or choose the wrong way (style) to solve problems and respond to life's problems by falling into extreme moods (e.g., anger, depression or despair) [26]. Moreover, they also lack the skills necessary to deal with specific problems [27, 28].

[10] Static risk factors include: intimacy deficits, faulty sexual self-regulation, attitudes/convictions which support sexual assault, general self-regulation, quality of interpersonal cooperation, e.g., with the therapeutic team; dynamic risk factors are indirect deficits, e.g., level of social isolation dependent on social skills, level of psychological functioning of the offender (psychopathology, abuse of psychoactive substances), as well as the level of anger and the offender's preoccupation with sex [29].

others, on the perpetuation of self-defeating behavior patterns described in literature as the deviant cycle. This cycle is a special sequence of actions of the perpetrator and of the accompanying conscious and unconscious reactions [33], and includes behaviors preceding and following an assault [34].

Another mechanism that reinforces the schema and thus influences the perpetuation of deviant criminal behavior are coping styles. Research cited by Beisert [35] shows that sex offenders tend either to use ineffective remedial styles (i.e., avoiding or focusing on emotions) or to replace an appropriate strategy with sexual behaviors [27]. Out of the 3 maladaptive coping strategies identified by Young, avoiding the schema involves making efforts to protect oneself from its activation, because it is a source of painful experiences for the individual. In such a case, the perpetrator may remove themselves from social situations and/or emotions through dissociation, fantasy, denial; withdraw from contact with people through social isolation; engage in lonely, reassuring activities through alcohol abuse or excessive masturbation; or, on the contrary, to divert attention away from the active schema, they may compulsively seek stimulation by engaging in risky behavior. In the causal mechanism, overcompensation is an alternative to the pain accompanying the schema as it allows the perpetrator to escape the sense of helplessness and excessive sensitivity [36]. In this strategy, the perpetrator is capable of doing the opposite of what the schema imposes on them, treating the truth about themselves as the opposite of the schema. When they feel defective, weak, unimportant, worthless, they seem confident, strong; when they feel hurt, they start attacking and harming others.

Whereas subjugation to the schema means that the perpetrator accepts the schema as the truth about themselves ("I am defective so no adult woman takes me seriously") and submits the patterns of their own behavior to the schema (choosing critical, demanding, rejecting or abandoning partners). These patterns may confirm the perpetrator in the belief that they are not capable of creating and maintaining close emotional relations with adult partners and lead to criminal behavior (seeking understanding and closeness in safer relationships, e.g., with a child).

The key role of the modes in the mechanism of criminal behavior was highlighted by Bernstein's team [37]. In their therapeutic work with forensic patients, they observed similar patterns of behavior and described them in the categories of "criminal modes". Thus, they supplemented the list of basic modes of schemas created by Young with modes involving breaking the law, aggressive behavior or cunning actions aimed at deceiving or intimidating others [37]. For example, in the abuse and attack mode – the perpetrator uses threats, intimidation, aggression or extortion to get what they want, retaliates against others or confirms their own dominant position; they feel a specific sadistic pleasure resulting from attacking others. In the control and manipulation mode, the perpetrator deceives, lies or manipulates in such a way as to achieve the intended purpose, to achieve what they want, sacrificing others or avoiding punishment.

Whereas in the predator mode they focus on eliminating a threat, rival, obstacle or enemy in a cold, ruthless and calculated way.

Delinquent modes increase the likelihood of delinquent and aggressive behaviors because they often represent maladaptive attempts to cope with painful or unpleasant feelings [37].

Schema therapy for sex offenders

As offenders generally exhibit severe personality disorders (mainly cluster B), their behavioral patterns are often associated with violations of boundaries and even of the law and (or) the freedom of others, while their critical evaluation of their own actions is compromised. This makes it necessary to modify classical schema therapy, from a schema-oriented therapy to a therapy oriented towards criminal schema modes [36, 38].

Course of therapy

At the initial stage, we analyze the patient's life (with emphasis on information about the main symptoms and the dynamics of their occurrence over their lifetime) as well as information about the patient's various problem areas and functioning in important aspects of life (including relational, intimate and occupational aspects). We assess the patient's temperamental traits and the degree to which they have completed various developmental tasks (especially in the population of offenders with a diagnosis of psychosexual immaturity).

Information gained at this stage will be necessary to create an initial conceptualization with the patient, during which we educate the patient about schema therapy and mode concepts. The aim of this conceptualization is to create an effective model of the offender's psychological functioning, with particular emphasis on the problematic sexual behaviors he or she manifests. The conceptualization includes, in addition to early maladaptive schemes and modes, self-destructive patterns of functioning, early developmental processes and coping styles of the offender [23]. The conceptualization created is the culmination of the process of diagnosis, which, as Young et al. [23] note, is not an easy process for both the therapist and the patient who, while identifying their patterns on a rational level, simultaneously experiences them on an emotional level.

The next stage is the process of introducing new, healthier coping styles and changing behaviors that cause the patient to confirm, avoid or overcompensate for their patterns [23]. Research suggests that schema modes are responsible for maladaptive behavior, as they keep offenders in a deviant life pattern. Moreover, events leading up to and culminating in criminal and violent acts can often be explained by the unfolding sequence of schema modes [37]. It is useful to create with the patient a list of specific criminal behaviors and/or patterns of functioning that could become subjected to such

change. Working with modes is also crucial for other reasons. First, because "most forensic patients are unable or unwilling to expose their emotional vulnerability, it is often difficult, particularly early in the therapy, to discuss early maladaptive schemas with the patients" [38, p. 660]. Second, because the patient's naming of modes (e.g.: distrustful John; angry part of John) is emotionally and morally neutral for the patient and therapist. Personalizing the modes helps the patient place the mode outside the Self and make it more egodystonic. As a result, the patient does not feel that their maladaptive behaviors are the result of moral flaws critically evaluated by the therapist, but are the consequence of ineffective patterns that can be modified in the course of therapy.

Empowering the patient and showing them the possibilities of influencing their own reality is necessary for the patient to make subsequent changes, although for the therapist it involves placing special emphasis on the therapeutic relationship. Given the sources of early maladaptive patterns in offenders resulting in bonding disorders discussed in this article, the process of building a relationship based on a sense of security and trust, especially in forensic psychotherapy contexts, is not an easy task. Insecure attachment patterns in offenders can hinder the therapeutic cooperation or result in premature breaking of the therapeutic bond [38]. Building a good, soothing relationship means showing the patient warmth and care [36], and it also means accepting the patient as a person (but not the behaviors they engage in) and their emotional needs. Such therapeutic relationship in schema therapy consists in limited re-parenting, in which the therapist, as the caring parental figure, gives the patient what the patient needed as a child but did not receive from his or her parents – nurturing and developing aspects of life that have been neglected in the past. The therapist gives advice when the patient is unable to cope, and when necessary, maintaining an attitude of empathic confrontation, sets limits to reduce dysfunctional behavior. As a consequence, the patient learns and internalizes the therapist's roles, producing healthier patterns and modes of functioning [11] reinforcing the healthy adult mode crucial in schema therapy characterized by mental health, maturity and balanced judgment [39].

When working on changing behavior patterns, teaching strategies of stopping/controlling violent behaviors and making the offender take responsibility for the harm done, the techniques used in schema therapy, widely described in the literature, are useful. Among them are cognitive techniques (cognitive restructuring), behavioral techniques (breaking the vicious circle/deviant cycle), techniques based on experience and emotions (e.g., role playing, imagination work), and experimental techniques (e.g., hot chair technique, dialogues between the pattern mode and healthy adult mode).

Recapitulation

Analysis of the structures described in the article indicates that the pathology of the personality of sex offenders may involve certain combinations of early maladaptive schemas and maladaptive patterns. In the context of the mechanism of perpetuation of

deviant criminal behaviors presented in the article, sexual behavior of the perpetrators should be understood as a response to the activation of early schemes, formed already in childhood and perpetuated during the offender's life. An accurate analysis of these structures seems to be necessary to understand the mechanism of the formation and persistence of deviant sexual behavior against the background of the individual life stories of these offenders. Reliable measurement of schemas is a prerequisite for a proper understanding of chronic and dominant problems faced by such perpetrators. It also helps organize the problems experienced by offenders in an understandable manner. A tool that can be helpful in estimating the dominant schemes in offenders is *the Young Schema Questionnaire – YSQ-S3*, created by J. Young and adapted to Polish conditions by Oettingen et al. [40]. There is also a questionnaire for the measurement of schema modes (SMI – *Schema Mode Inventory*) and its Polish version has been created (translated by: J. Oettingen) but has not yet been validated.

Conclusions

Schema therapy is a trend that focuses on pathological features of an individual's personality. An understanding of the formation of symptoms displayed by a patient is associated with the development of maladaptive schemas which were influenced by various environmental factors such as early childhood environment (i.e., abuse, trauma, neglect) and biological factors that affect the emotional temperament of the individual.

The concept of schema therapy with its key elements: early maladaptive schemas and schema modes seems to be a rich source of clinical information about offenders and the motives of their actions. As the schemas directly relate to the early experiences of the offender, their reconstruction by reinforcing maladaptive schemas may be crucial in understanding the nature of perpetration and thus important in the course of therapy and prevention of recidivism.

However, although the prospect of using schema therapy in working with sex offenders as described in this article seems promising, reports on its application in the sex offender population are still scarce. The fact that Young's concept is used to understand deviant beliefs and attitudes of sex offenders and for their treatment in various institutions around the world is known mainly from conference reports [41–47].

There has also been little literature describing the course and effectiveness of this type of intervention with the group of individuals in question. In these studies, sex offenders were not the target group, they were merely a subgroup among other violent non-sexual offenders [14]. Importantly, preferential sex offenders were excluded from the sex offender group. Results of a randomized controlled clinical trial presented at a conference in Austria [48] showed that ST patients had significantly superior outcomes compared to those receiving TAU on a broad range of variables, including lowering risks for recidivism and improving strengths and protective factors, improving PD symptoms, reducing early maladaptive schemas, and facilitating the

process of reintegrating patients into the community. The effectiveness of long-term schema psychotherapy in the rehabilitation of forensic patients is supported by recent reports [14]. Patients undergoing ST underwent faster rehabilitation and showed faster improvement on personality disorder symptom scales.

The authors' analysis of subject literature shows that in Poland, the subject of empirical verification of J. Young's concept has not been taken up in studies published so far. The need for such studies in order to verify the knowledge on the possibility of its application in the group of sex offenders and to verify the knowledge on the outcomes is unquestionable.

References

1. Bonta J, Andrews DA. *Risk-need-responsivity model for offender assessment and rehabilitation*. Corrections Research User Report Nr. 2007-06. Ottawa: Public Safety Canada; 2007.
2. Association for the Treatment of Sexual Abusers (ATSA) Professional Issues Committee. *Practice standards and guidelines for members of the Association for the Treatment of Sexual Abusers*. Beaverton, OR: ATSA; 2001.
3. Yates PM. *Treatment of sexual offenders: Research, best practices, and emerging models*. Int. J. Behav. Consult. Ther. 2013; 8(3–4): 89–95.
4. Popiel A, Pragłowska W. *Psychoterapia poznawczo-behawioralna – teoria i praktyka*. Warsaw: Paradygmat; 2008.
5. Association for the Treatment of Sexual Abusers (ATSA). *Practice guidelines for the assessment, treatment, and management of male adult sexual abusers*. 2014.
6. Center for Sex Offender Management. *Community Supervision of the Sex Offender: An overview of current and promising practices*. Washington, D.C.: U.S. Department of Justice; 2000.
7. Lew-Starowicz Z. *Program leczenia w warunkach ambulatoryjnych sprawców przestępstw przeciw wolności seksualnej z rozpoznaniem zaburzeń preferencji seksualnych. Zalecenia Konsultanta Krajowego w dziedzinie seksuologii*. Seksuologia Polska 2015; 13(2): 43–44.
8. Beisert M. *Komunikacja ze sprawcami przemocy seksualnej w przebiegu psychoterapii*. In: Cierpiałkowska L, Wolska A, editors. *Komunikowanie się w psychoterapii: wybrane zagadnienia*. Szczecin: AMP Studio Paweł Majewski, 2003.
9. Czabała JC. *Czynniki leczące w psychoterapii*. Warsaw: Polish Scientific Publishers PWN; 1997.
10. Stusiński J, Lew-Starowicz Z. *Leczenie przestępców seksualnych. W poszukiwaniu optymalnego modelu*. Przegląd Więziennictwa Polskiego 2014: 82: 47–68.
11. Arntz A, Genderen van H. *Terapia schematów w zaburzeniu osobowości typu borderline*. Gdansk: Gdansk Psychological Publishing House; 2015.
12. Keulen-de Vos ME, Bernstein DP, Arntz A. *Schema therapy for offenders with aggressive personality disorders*. In: Tafrate RC, Mitchell D, editors. *Forensic CBT: A practioner's guide*. Chichester, UK: Wiley Blackwell; 2014. P. 66–83.
13. Bernstein DP, Nijman HLI, Karos K, Keulen-de Vos M, Vogel de V, Lucker TP. *Schema therapy for forensic patients with personality disorders: Design and preliminary findings of a multicenter randomized clinical trial in the Netherlands*. Int. J. Forensic Ment. Health 2012; 11(4): 312–324.

14. Bernstein DP, Keulen-de Vos M, Clercx M, Vogel de V, Kersten G, Lancel M et al. *Schema therapy for violent PD offenders: A randomized clinical trial*. Psychol. Med. 2021: 1–15.
15. Ruiter de C, Chakhssi F, Bernstein D. *Treating the untreatable psychopath*. In: Gacono C, editor. *The clinical and forensic assessment of psychopathy: A practitioner's guide*, 2nd ed. New York: Routledge/Taylor, Francis Group; 2016. P. 388–402.
16. Chakhssi F, Bernstein D, Ruiter C. *Early maladaptive schemas in relation to facets of psychopathy and institutional violence in offenders with personality disorders*. Leg. Criminol. Psychol. 2012; 19(2): 356–372.
17. Haghighat Manesh E, Agha Mohammadian Shaer Baf HR, Ghanbari Hashem Abadi BA, Mahram B. *Early maladaptive schemas and schema domains in rapists*. Iran. J. Psychiatry Clin. Psychol. 2010; 16(2): 145–153.
18. Chakhssi F, Ruiter de C, Bernstein DP. *Early maladaptive cognitive schemas in child sexual offenders compared with sexual offenders against adults and nonsexual violent offenders: An exploratory study*. J. Sex. Med. 2013; 10(9): 2201–2210.
19. Carvalho J, Nobre PJ. *Early maladaptive schemas in convicted sexual offenders: Preliminary findings*. Int. J. Law Psychiatry 2014; 37(2): 210–216.
20. Sigre-Leirós V, Carvalho J, Nobre PJ. *Rape-related cognitive distortions: Preliminary findings on the role of early maladaptive schemas*. Int. J. Law Psychiatry 2015; 41: 26–30.
21. Keulen-de Vos ME, Bernstein DP, Vanstipelen S, Vogel de V, Lucker TPC, Slaats M et al. *Schema modes in criminal and violent behaviour of forensic cluster B PD patients: A retrospective and prospective study*. Leg. Criminol. Psychol. 2016; 21(1): 56–76.
22. McGinn LK, Young J. *Schema-focused therapy*. In: Salkovskis PM, editor. *Frontiers of cognitive therapy*. New York: Guilford Press; 1996.
23. Young J, Klosko J, Weishaar M. *Schema therapy: A practitioner's guide*. New York: Guilford Press; 2003 [Young J, Klosko J, Weishaar M. *Terapia schematów. Przewodnik praktyka*. Gdansk: Gdansk Psychological Publishing House; 2014].
24. Marshall WL, Barbaree HE. *An integrated theory of the etiology of sexual offending*. In: Marshall WL, Laws DR, Barbaree HE, editors. *Applied clinical psychology. Handbook of sexual assault: Issues, theories, and treatment of the offender*. New York: Plenum Press; 1990. P. 257–275.
25. Marshall WL, Hudson SM, Hodkinson S. *The importance of attachment bonds in the development of juvenile sex offending*. In: Barbaree HE, Marshall WL, Hudson SM, editors. *The juvenile sex offender*. New York: Guilford Press; 1993. P. 164–181.
26. Marshall WL. *Treatment of sexual offenders and its effects*. National Institute of Corrections; 2006. https://nicic.gov/treatment-sexual-offenders-and-its-effects-2006 (retrieved: 1.10.2022).
27. Cortoni F, Marshall WL. *Sex as a coping strategy and its relationship to juvenile sexual history and intimacy in sexual offenders*. Sex. Abuse: J. Res. Treat. 2001; 13(1): 27–43.
28. Miner MH, Day DM, Nafpaktitis MK. *Assessment of coping skills: Development of a situational competency test*. In: Laws DR, editor. *Relapse prevention with sex offenders*. New York: Guilford Press; 1989. P. 127–136.
29. Marcinek P, Peda A. *Leczenie sprawców przestępstw seksualnych – kompleksowy program terapii*. Psychoterapia 2010; 3: 154.
30. Moster A, Wnuk DW, Jeglic EL. *Cognitive behavioral therapy interventions with sex offenders*. J. Correct. Health Care 2008; 14(2): 109–121.

31. Szumski F. *Zniekształcenia poznawcze u sprawców wykorzystania seksualnego dziecka*. Doctoral thesis written under the supervision of prof. dr hab. Maria Beisert, Department of Social and Clinical Sexology, Institute of Psychology, Adam Mickiewicz University. Poznann; 2013.
32. Oettingen J, Brataniec J. *Forms of sexual abuse and the degree of their brutalization, and the perpetrators' attitude to committed acts*. 15th Conference of the International Association for the Treatment of Sexual Offenders (IATSO): "Successfully Implementing Sexual Offender Treatment and Management: What is Helping and what is Hindering?". August 28–31, 2018; Vilnius, Lithuania.
33. Rutkowski R, Sroka W. *Projekt systemu oddziaływań terapeutycznych na tle seksualnym*. Seksuologia Polska 2007; 5(1): 1–8.
34. Gierowski JK, Paprzycki L. *Niepoczytalność i psychiatryczne środki zabezpieczające. Zagadnienia prawno-materialne, procesowe, psychiatryczne i psychologiczne*. Warsaw: C.H. Beck; 2013
35. Beisert M. *Pedofilia. Geneza i mechanizm zaburzenia*. Gdansk: Gdansk Psychological Publishing House; 2011.
36. Arntz A, Jacob G. *Terapia schematów w praktyce. Praca z trybami schematów*. Gdansk: Gdańsk Psychological Publishing House; 2019.
37. Bernstein DP, Arntz A, Vos de M. *Schema focused therapy in forensic settings: Theoretical model and recommendations for best clinical practice*. Int. J. Forensic Ment. Health 2007; 6(2): 169–183.
38. Bernstein DP, Clercx M, Keulen-De Vos M. *Schema therapy in forensic settings*. In: Polaschek D, Hollin CR, Day A, editors. *The Wiley international handbook of correctional psychology*. Hoboken, NJ: John Wiley & Sons, Inc., 2019. P. 654–668.
39. Roediger E, Stevens BA, Brockman R. *Kontekstualna terapia schematów. Integracyjne podejście do zaburzeń osobowości, dysregulacji emocjonalnej i funkcjonowania w relacjach*. Gdansk: Gdańsk Psychological Publishing House; 2021.
40. Oettingen J, Chodkiewicz J, Mącik G, Gruszczyńska E. *Polish adaptation of the Young Schema Questionnaire 3 Short Form (YSQ-S3-PL)*. Psychiatr. Pol. 2018; 52(4): 707–718.
41. Oettingen J. *Zastosowanie Terapii Schematu w leczeniu preferencyjnych sprawców przestępstw seksualnych*. Polish Sexological Society scientific and training conference entitled "Preferential sex offenders. Clinic. Issuing opinions" [Preferencyjni sprawcy przestępstw seksualnych. Klinika. Opiniowanie]. Ustka, 10–12 May 2013.
42. Oettingen J. *Schema therapy and its application in the sex offenders treatment*. 13th Conference of the International Association for the Treatment and Sexual Offenders (IATSO). September 3–6, 2014, Porto, Portugal.
43. Oettingen J. *Terapia schematu w leczeniu sprawców przestępstw seksualnych – rozważania teoretyczne i praktyczne implikacje*. International Conference of the Polish Sexological Society entitled "Challenges and reality of contemporary sexology" [Wyzwania i codzienność współczesnej seksuologii". Poznan, 21–23 November 2014.
44. Wright L. *Using schema therapy formulation in group sex offender treatment*. International Society for Schema Therapy annual conference. Vienna, 2 July 2016.
45. Oettingen J. *Zastosowanie terapii schematów w pracy ze sprawcami przestępstw seksualnych*. Clinical sexology conference "Sexuality in psychotherapy" [Seksualność w psychoterapii]. Krakow, 3–4 October 2020.

46. Chakhssi F, Kersten T, Ruiter de C, Bernstein DP. *Treating the untreatable: A single case study of a psychopathic inpatient treated with schema therapy*. Psychotherapy (Chic) 2014; 51(3): 447–461.

47. Oettingen J, Łasak-Ponikło P. *Przemoc seksualna względem kobiet w oparciu o typologie gwałcicieli – stadium przypadków*. In: Stojer-Polańska J, editor. *Przypadki kryminalne. Ciemna liczba przestępstw przeciwko kobietom*. Silva Rerum; 2019.

48. Bernstein DP. *The effectiveness of schema therapy in forensic practice*. International Society for Schema Therapy annual conference. Vienna, 1 July 2016.

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