

# IJBCT

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*Joe Cautilli and BAO Journals*

## Introduction to the Special Issue

Phil Rich

This special themed issue of IJBCT, *Current Approaches and Perspectives in the Treatment of Adult and Juvenile Sexual Offending*, offers a bit of a “dream team” lineup of articles, written by some of the most relevant, forward thinking, and well-respected thinkers, researchers, and practitioners in the field. These papers not only give us a sense of the present, and a sense of where we are headed in the management and rehabilitation of both adult sexual offenders and sexually abusive youth, but also where we have come from. In this issue, we see the history of our field, which we must first understand in order to better understand and plot our journey ahead, and we see many common themes, running throughout virtually every article, that highlight our current thinking and practice and point toward the immediate future of the field. Together they add to broad changes and, perhaps of greater relevance, how we see, visualize, and approach treatment, reflecting changes in our sensibilities about treatment. Indeed, this special issue represents the state of our thinking about assessment, treatment, and support for sexual offenders, both adult and juvenile, half way through this second decade of the 21<sup>st</sup> century.

There are many common themes that run through each of these articles, but the core is that treatment is comprehensive and multi-dimensional. It operates on more than a single principle, and on more than one simple perspective, recognizing the comprehensive nature of treatment and the holistic, multi-faceted nature of the people we treat. A related theme, also common to many of these essays, captures and embraces the environmental and contextual aspects of treatment, recognizing the inseparable relationship between the client and his or her environment, and the importance of understanding that environment in our approach to the assessment and treatment of sexually troubled behavior. Yet another thread tying many of these

articles together is the fact that treatment itself operates within an environment that consists of client and practitioner, highlighting the power and importance of what the practitioner brings into the treatment equation. Here we see the collaborative nature of treatment, as a partnership and alliance between client and treatment provider, and the importance of the practitioner’s view of what treatment requires in order to yield success.

This issue of the journal not only reflects current thinking and trends, but challenges our thinking as well. It asks us to consider important questions about what counts in treatment, what we need to do in treatment, and what should be thinking about in the development and application of our treatment models. Some authors challenge the current and changing status quo, some offer new ways to think about *how* to approach treatment and what is important, and others point to enhancements that they believe are necessary for effective treatment and lasting personal change in our clients. In this special edition of IJBCT, you will find discussions about important issues and models in our current practice and, in every case, articles that push us to think more critically, more globally, and further than our current horizons. Some essays discuss treatment for adults and others adolescent treatment; in other cases, articles present a more global and generic view that reflect and shape our thinking about practice for both populations. Of special note, in discussing this special issue with Joan Tabachnick, she urged me to ensure a focus on not just the treatment of sexually abusive behavior, but also its *prevention*. Joan, in fact, was just the person to write that article and, like every author in this issue, graciously and generously accepted my invitation to contribute.

Frankly, I had no idea how to sequence these articles. Every article deserves first spot. Instead, I

decided to most simply order the articles by the last name of the primary author - with one exception. Although every article in this special edition is excellent, and each with a point (or two or three) to make, I chose to feature Deirdre D’Orazio’s essay as the opening article. Deirdre’s beautifully written essay in many ways embodies the focus of this issue, in which she describes the history and development of treatment for sexual offenders, and her parallel journey as a psychologist in the field. In so doing, Deirdre describes and narrates the journey of sexual offender treatment, its evolution, and its changing, and in some ways, unchanging, face. As she puts it, “as is often the case in the evolution of ideas, it became clear these necessary new developments are not new at all.” Deirdre puts us in touch with the totality of the treatment experience, leading directly to what she has experienced in her career as a practitioner and scholar. This serves as a road map to a treatment that takes on board what we have learned and is individualized to each client we serve, and in so doing also address an ethics of care and the nature and quality of the therapeutic relationship in contemporary treatment.

Finally, I am privileged to serve as guest editor for this special issue of the *International Journal of Behavioral Consultation and Therapy*, and very much appreciate the opportunity to present these invited essays and articles. Together, they give us a picture of treatment unconstrained by received wisdom and conventional thinking, a treatment focused on the individuality of each client in the context of his or her environment, and a treatment in which the power of the treatment environment and the therapeutic alliance is evident. I’m glad we’ve arrived at this place in our thinking about practice, although at the same, in many ways, I wonder why it’s taken us so long to get here.

## Lessons Learned from History and Experience: Five Simple Ways to Improve the Efficacy of Sexual Offender Treatment

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### Abstract

This article chronicles the development of the field of Sexual Offender Treatment in the United States since the 1980's. It offers an analysis of the Relapse Prevention model, a case study, and a summary description of contemporary field advancements. Through historical and personal reflection, the author summarizes lessons learned as five simple strategies to enhance the efficacy of Sexual Offender Treatment: (1) Focus first on the client's self, assessing and treating old wounds, (2) highlight affective factors, (3) cultivate empathy for the abuser and a landscape for change, (4) embrace the mystery of wholeness, and (5) care for the therapist.

This article emphasizes and urges a re-focusing in the field of sexual offender treatment in order to both recognize the importance of and prioritize participant response to treatment delivery, the impact of the therapist upon treatment outcome, and a return to the basic principles of general psychotherapy.

### Keywords

sexual offender, sexual offender treatment, relapse prevention treatment, sexual offender treatment efficacy

When I was asked to write an article in response to the questions, "Where has the field of Adult Sexual Offender Treatment come from?" "What have you learned through your experience in this field?" and "Where do you think the field is headed?" I was pleased because these questions reflect the historical and personal contemplative approach that guides my own professional development. Indeed, among the principal lessons of our collective journey toward reducing the prevalence of sexual abuse is the indispensable value of a long-lensed perspective that takes in both the history of events and ideas, as well as the experience of those who have walked before and alongside. Absent a commitment to self-reflection as individual professionals and as a field, our solutions will merely be unhelpful reactions and re-enactments to the powerful phenomenon of abuse to which we delve. Embedded in the questions Phil Rich poses to our field in organizing this special journal issue is the valuable reminder that even as healers we can get lured into the cycle of abuse and unintentionally promote solutions that beget further problems.

### ■ The History of Sexual Offender Treatment in the United States

In the United States, Sexual Offense Specific Treatment emerged as a unique branch of psychotherapy in the 1980s alongside the momentum of the Women's Movement (D'Orazio, Arkowitz, Adams, & Maram, 2009). For the first time in national history, societal attention focused on the problem of abuse against women and children perpetrated by men. Rising from the knowledge that the extant sociopolitical culture had been suppressing the reporting, arrest, and conviction of crimes of abuse upon women and children, there was a spring-like blossom of criminal justice sanctions for sexual offending. Penal codes criminalizing sexual abuse expanded exponentially, rates of detected sexual

offending skyrocketed, and the sexual offender inmate population soared.

Psychiatric facilities that had theretofore primarily treated the psychotically mentally ill found themselves accommodating burgeoning rates of paraphilic and personality disordered patients. The "newly discovered" social malady triggered a pressing demand within criminal and civil justice systems for large-scale treatment programs. Born out of a too long ignored social problem, Sexual Offender Treatment represented a component of justice for a victimized class.

Relapse Prevention (RP) treatment was developed in the 1980s in the substance abuse field by Marlatt and Gordon (1985) who promoted the idea of addiction as a byproduct of social learning as opposed to being a type of biological disease. The RP approach sought to address the problem of maintaining abstinence after treatment; despite initial success in overcoming substance abuse, 80% of substance abusers seemingly fell prey to beliefs they were afflicted and powerless by addiction, and relapsed within just 12-months of treatment (Hunt, Barnett, & Branch, 1971). Central to RP is the theory of a Relapse Cycle where relapse is the result of small knowable events that occur over time rather than in an all or nothing and uncontrollable manner. RP's premise is that abstinence is empowered by the identification of risk factors that drive the abuser toward re-lapse and self-management strategies to avoid or cope with these risks.

As the pendulum of psychotherapeutic popularity swung from psychoanalysis to behaviorism, landing in the 1980s on Cognitive Behavioral Therapy (CBT), pioneers like Gene Abel and Judith Becker popularized CBT as the method of choice for everyone who was anyone in the field of sexual abuse treatment. In an effort to resolve the problem of an exploding sexual offender population at California's Atascadero State Hospital (ASH), an emerging psy-

chologist, Janice Marques, attempted to crossbreed the two applications of abuse treatment – the RP approach of the substance abuse field and CBT. She convened at ASH with Bill George, Richard Laws, Bill Pithers, and others to discuss how the innovative RP model might apply to the problem of sexual offense recidivism. The Relapse Prevention Model of Sexual Offender Treatment was born (Marques, 1982)! Since its timely birth in the 1980s, RP has gained enormous popularity and has been applied to many disorders of impulse control; for example, sexual behavior, gambling, spending, shoplifting, and domestic violence.

Almost twenty years later, as a psychologist myself at ASH, I sat at the same tables Dr. Marques and her colleagues sat. I contemplated the same problem, "How can programming be improved to reduce the rate of sexual offense relapse among repeat sexual abusers?" I had experienced the staff at ASH become overwhelmed with the increasing population of sexual offenders, desperately longing for the days when the place they worked was filled with "simpler offenders, more acutely mentally ill but less emotionally draining." On the contrary, I had sought work there for the very opportunity to work with sexual offenders. My eventual promotion to the post of directing the sexual offender treatment and evaluation program at the newly built Coalinga State Hospital, designated to serve only the sexual offender population, may have been more the result of lack of other candidates than my unique merits.

In the early years of the 21st century, societal disdain and rejection of sexual offenders reached an unprecedented peak, reciprocally pervading news media and political platforms. This pandemic of sensationalized emotional responding to sexual offending resulted in reactive, disorganized and severe criminal justice responses. Irrefutably, sexual offenders have become the pariahs of American society, viewed as more like monsters than fellow human beings. The Governor of California, the body builder, action film actor Arnold Schwarzenegger-turned "Governator," boasted his goal of making California have the toughest laws on sexual offending (Schwarzenegger, 8/16/05). Civil commitment laws for sexual offenders, commonly called "Sexual Predator Laws," reached an all time high in twenty states plus the District of Columbia (Thornton & D'Orazio, 2013). Arguably due to this era of impossibly stringent, financially irresponsible criminal justice responses to the problem of sexual offending, current programs are undergoing significant cut backs, some operating with scarce resources available for critical operations. Meanwhile and sadly, entertainment media continues to flood our children with provocative sexual and violent messaging. When a society's message systems both condemn a class of people whose sexual behavior is considered to be abusive and also promotes early and prevalent sexualization, it both begets further problematic sexual behavior among its members and undermines the kind of self-repair necessary for offenders to rise out of that class.

## ■ Challenges of the Relapse Prevention Model

Sexual Offender Treatment continued to evolve during the first decade of the 21<sup>st</sup> century as substantial data came to indicate Relapse Prevention's lack of robust effectiveness in reducing sexual offense recidivism, including that from the gold standard Sexual Offender Treatment and Evaluation Project research study by Dr. Marques at ASH (Marques et. al, 2000). This came as a deep disappointment to sexual offender treatment programs across the U.S. who uniformly endorsed the use of RP in program surveys (Freeman-Longo, Bird, Stevenson & Fiske, 1994). In contemplating the results of the SOTEP study of RP, which found a lack of treatment efficacy, alongside the everyday demands of implementing the sexual offender treatment program at Coalinga State Hospital the wisdom of history and those who've walked before me seemed to echo clearly in the direction the field needs to take to set us on a new path toward improved treatment outcome. As is often the case in the evolution of ideas, it became clear these necessary new developments are not new at all.

In endeavoring to conduct an analysis of the Relapse Prevention Model for Sexual Offender Treatment that was pre-eminently popular by the 1990s, I quickly learned that essentially all programs called themselves Relapse Prevention-based regardless of the degree of fidelity to the original model developed by Marques and colleagues. Relapse Prevention became the catchphrase that described all sexual offender treatment that had the prevention of sexual offense relapse as its goal. Therefore, any critical analysis of studies examining RP is in part an analysis of the broad state of the art of sexual offender treatment up to about the year 2000, and in part an analysis of the RP conceptual model. While a complete analysis of the shortcomings of RP may be useful for some purposes (e.g., Laws, Hudson & Ward, 2000), the lessons that most illuminate our path toward maximizing treatment outcome are described as follows.

Primarily, RP over-looked the heterogeneity and totality of sexual offenders. Its focus was almost entirely on the sexually deviant aspects of functioning and it assumed that the features of offense cycles were similar, inevitably involving a failure of self-restraint over deviant impulses. The RP model was initially developed to address the problem of substance abuse, a form of self-abuse, and did not map adequately onto the problem of sexual abuse, a form of other-abuse. As such, it did not value as worthy treatment objectives the interpersonal attachments, betrayals, and needs embedded in the decision to offend against another.

Similarly, there was a lack of good fit between features of the Relapse Cycle concept borrowed from substance abuse in its application to the cycle of sexual abuse. For example, the definition of a "Lapse" as a minor return to substance use really did not have a correlate in sexual offender treat-

ment as a "minor return" to sexual offending, and was not as forgiving. In the treatment of sexual offenders, even a minor lapse in behavior potentially represents treatment failure. For example, masturbation to a deviant fantasy was viewed as a lapse and therefore undesirable, despite the reality that it may have diverted the creation of an actual victim. Success in sexual-offense-specific treatment was therefore defined as the *elimination* of harm, rather than just harm management or harm reduction, which were equated to treatment failure. This way of labeling transgressions tended to over-pathologize and under-reward sexual offenders in treatment.

A critical shortcoming, also evident in the SOTEP results, is that RP assumed that offenders in treatment possess a high and stable level of motivation to refrain from sexual offending. It did not account for the fact that offenders start treatment at varying stages of change. The kind of motivation that RP assumes is typically present only long after the change process has begun. Facilitating the motivation of offenders who are consciously or unconsciously ambivalent or resistant about giving up sexual offending is a foremost challenge for Sexual Offender Treatment that was entirely ignored by RP. Relapse Prevention neglected to address the most important requisite for successful treatment - willingness to change.

The concept of Cognitive Distortions, the tendency to distort information in a way that serves underlying beliefs, was first applied to Sexual Offender Treatment in the 1980's by Abel and Becker (e.g., Abel, Becker, & Cunningham-Rathner, 1984). In RP treatment programs, lists of cognitive distortions that sexual offenders commonly, and more or less unconsciously, employ to serve offending interests facilitated the identification of these problematic thinking errors of treatment participants. The difficulty for many offenders in treatment is that the standard method of having one's cognitive distortions challenged by group members and therapists is often insufficient to extinguish them from operating in the future. Accurate assessment does not insure successful treatment. These early programs did not include components that address offenders' emotional bonding such that would allow the kind of trust and readiness to receive corrective feedback in a way that facilitates deep cognitive restructuring.

To generalize from the previously detailed shortcomings of RP, early programs did not allow sufficient focus on the internal change process of individuals. In a sense they did not work deep enough. There was also a concomitant over-emphasis on factors external to the offender. While fear-based motivation is in part an inevitable consequence of any treatment mandated as part of a criminal justice system response, it is incumbent upon the program to mitigate feelings of coercion among offenders in treatment. Effortful interventions are required to facilitate a sense of autonomy among even mandated treatment participants. Fear of

further impingements of freedom, harsher institutional conditions, and aversive consequences for unfavorable treatment behavior is often effective at motivating superficial treatment compliance, although undermines long lasting treatment efficacy. It is worthwhile to observe the parallel processes at work in these kinds of circumstances, where the treatment system demonstrates characteristics similar to those it wishes to extinguish in participants. When systems coerce offender clients with high levels of external control, they are in a sense creating an internal experience in offenders that simulates that which offenders instill in their victims. Many sexual offenders have themselves been the victims of neglect or abuse. This means that offenders in treatment already have schema, deep underlying beliefs of both the victim and the powerful abuser, in their psyches. It is not surprising that coercive treatment of offender populations leads to increased abuse supportive attitudes among offenders. Pairing treatment participants' fear with the message from society that they are more like monsters than fellow humans, it is not surprising that our attempts to remedy their behavior are not wholly efficacious. Any treatment, such as RP, that focuses on failures over successes and external motivation over internal motivation for change is sacrificing long lasting change for short-term obedience.

While RP's initial success was in carving the identity of the sub-niche of Sexual Offender Treatment, its long-term gifts are derived from its shortcomings. Of most significance, we learned that a one-size-fits-all approach to Sexual Offender Treatment clearly misses the mark. Treatment style and methods must be broad enough to fit the various psychological sizes and shapes of sexual offenders.

During the reign of RP, Sexual Offender Treatment programs increasingly diverged from the field of General Psychotherapy, abandoning principles of the therapeutic alliance, trust, rapport, and flexibility. While manualized programming does have the benefit of ensuring structure, consistency of program delivery and targeting relevant treatment objectives, treatment that is applied in a step-wise boilerplate fashion akin to following the steps in a recipe entirely overlooks the essential internal ingredients for change. While it may be easier for providers, simply teaching offenders to memorize lists of risk factors and new coping strategies does nothing to ensure that offenders will deploy those new coping strategies when the future need arises. At least in part this problem of oversimplification seems to reflect that RP was insufficiently theoretically informed. While it was promoted to be a treatment application of Cognitive Behavioral Theory (CBT), its implementations did not reflect a sophisticated understanding of the nuances and complexities of CBT.

An additional concern is that RP tends to over-rely on cognitive factors - the "thinking function" of both treatment participants and providers. The Relapse Cycle is espoused to occur in a gradual,

logical manner with offense being the predictable end of this linear chain of events. Properly trained offenders mentally travel back in time, accurately deduce critical events in the chain then mentally proceed forward in time and forecast future events along with successful new responses, which they promise to deploy when exactly those forecasted situations occur in the future. The problem is that the future does not typically happen as forecasted and a variety of contextual and situational factors impact behavioral decision-making. The kind of executive functioning needed to access pre-established RP plans is undermined by strong affective and physiological arousal.

There is also a dynamic element absent from RP. The RP model seems to focus excessively on the past and future, altogether neglecting the here and now present. The cognitive exercises of RP and disallowing the present experience of offenders in treatment is convenient to therapists who are anxious about diving into an unknown and likely pathological psychological space. Clearly a place in treatment is needed to practice new coping skills in reality rather than the cognitive hypothetical. Additionally, RP prioritizes restraint and avoidance of risk factors, which imbues these things external to the offender with a tremendous amount of power, as if to say, "it is so powerful over you that you must avoid it altogether." Many offenders are by disposition influenced by beliefs that they are controlled by external factors. They would benefit more so from opportunities to promote their sense of self-efficacy.

### ■ A Case Example of RP's Shortcomings

The case of Mr. Brown, whom I treated for five years, exemplifies several of the deficiencies of Relapse Prevention (name, case facts, and other identifying information from this case have been altered to protect client identity). As a young adult he sexually molested his step-son, was convicted, and participated in the SOTEP RP treatment program, which offered him the opportunity to serve part of his sentence at the state hospital instead of prison. Through the SOTEP treatment program, he learned the cycle of his abuse of his step-son and never offended against his step-son again. However, Mr. Brown did go on to sexually molest two-dozen other male and female children even while maintaining his employment as a law enforcement officer. This led to his return to the secure facility through civil commitment. The treatment program there had begun to change aspects of its treatment program given the results from the SOTEP research study which provided some valuable insights about parts of the program that required changing to improve outcome.

Throughout his treatment, Mr. Brown's account of his sexual offending remained consistent. It was lacking in any indication he experienced the Abstinence Violation Effect, which RP teaches is negative affect due to failure to maintain a self-imposed

rule to not re-offend. In fact, Mr. Brown had never tried to "quit" sexual offending altogether; he used words like "eager anticipation" to describe the immediate emotional precursors to his offending. He proudly averred that he "only" molested children who were willing and that he would never proceed if the child said "no" or appeared frightened. He described his periods of sexual offending as the only times in his life he was really happy. At the outset of our treatment he demonstrated no awareness of the harm he created for the victims and their families.

Through our therapeutic relationship we learned that his prior treatment was overly specified to his victimization of his step-son. It had neglected to attempt to motivate him to want to never create another victim. He also had difficulty mapping his offending onto the components of the Relapse Cycle. He struggled to identify the pervasive self-control problems the model told him he had. He did not lack the ability for self-control but rather the desire to restrain one aspect of his functioning - his behavior toward children.

Mr. Brown was very intentional and methodical in his planning to sexually target children. In examining the immediate antecedents to his sexual offending, he could not identify what was going wrong as everything was working well with his plans to offend. RP over-focused on proximal factors and insufficiently on etiological factors. As with Approach Type offenders, he did not lack adequate skills to resist deviant interests; instead, he lacked the motivation to access skills (Hudson, Ward & McCormack, 1999). Importantly, there had been no place in the prior treatment program for him to process his own childhood experiences involving his retreating to sexual activities with other children while his home life rejected him. The treatment program did not strive to instill in him a sense of self-efficacy that he "could make it in the adult world." It did not encourage him to expect value and trust in adult relationships.

The RP based treatment program also did not value therapy process variables, such as Mr. Brown's relational style with therapists and other group members. As a female therapist, at times Mr. Brown projected on to me his feelings toward his ex-wife, which allowed him to process his protective defense of withholding of intimacy and mistrust. At other times he experienced me as his grown adult daughter, and both rejected me and desired to show me an apologetic and protective side of himself. At other times, he showed me an immature flirtatious side as if I were a child female he desired. By my continually and reliably showing up physically and psychologically and by my unwavering professional boundaries, Mr. Brown came to trust me enough to work through the underlying vulnerabilities that fueled his "risk factors." Within a therapeutic landscape of safety, he was able to experience his vulnerabilities in the here and now. In processing these vulnerabilities emotionally, verbally and cognitively, we seemed to create real changes in his

information processing template and motivational system.

After being detained for over a decade, it was legally determined that Mr. Brown demonstrated sufficient reduction in his risk for sexual re-offense and he was released. Throughout the subsequent years to date he continued to maintain his therapeutic gains. While he at times struggled to manage urges to sexualize children he never created another victim and he was able to develop some meaning out of his life. Years after his release he contacted me and shared that the most meaningful aspect of his inpatient treatment experience were the empathy components and the therapeutic relationship. He opened himself to experience the pain of others as he came to feel his own wounds resolve. When exposed to the long-term negative effects of abuse he grieved deeply, and experienced regret and insight. His respect and trust of myself and group members facilitated his amenability to explore and be challenged about his beliefs involving sex with children.

### ■ Contemporary Advancements: Lessons Learned from Early Sexual Offender Treatment

The rise and fall of Relapse Prevention has paved the way for numerous advancements in the field of Sexual Offender Treatment. Notable advancements to theory and application include the Self-Regulation Model and its pathways to offending (Ward & Hudson, 2000), strengths based approaches such as the Good Lives Model (e.g., Ward, 2002), attachment informed approaches (e.g., Rich, 2005), motivational interviewing and the stages of change (e.g., Prescott, 2009), and integrated theories of sexual offending and advancements in our understanding and emphasis on the neurobiological factors (e.g. Ward & Hudson, 2005).

Perhaps the most encouraging finding to come about from the research on the efficacy of sexual offender treatment to date is that the Risk, Need, Responsivity (RNR) principles of effective general correctional programming also apply to sexual offender treatment (Hanson, Bourgon, Helmus & Hodgson, 2009). There is finally substantial conclusive data indicating that sexual offender treatment programs are effective at reducing sexual recidivism. The degree of success is proportional to the degree of adherence to the three guiding principles.

1. Risk Principle: The comprehensiveness, intensity, and duration of treatment provided to individual offenders should be proportionate to the degree of risk they present.
2. Need Principle: Treatment should be appropriately targeted at participant characteristics that contribute to their risk.
3. Responsivity Principle: Treatment should be delivered in a manner that strives to engage participants meaningfully and facilitate their learning.

## ■ Five Simple Ways to Improve the Efficacy of Sexual Offender Treatment

Having contemplated the general psychology, general criminality and sexual offense specific literature base, as well my personal experience having worked in the field of sexual abuse, especially during the post SOTEP years at Atascadero State Hospital, then at Coalinga State Hospital, the institution that replaced ASH as the catchment for California's civilly committed sexual offenders, it appeared to me that there are five important ways we can enhance the efficacy of sexual offender treatment. Essential to these lessons was my direct experience with the individuals who have ventured to the dark side of our shared humanity, the perpetrators of sexually abusive behavior, and also sometimes the victims as well, both of whom have become ensnared in our collective problem of abuse.

The five "ways" are more akin to guiding principles that require flexible individualized application, rather than a step-by-step method. Though convenient and comforting in their standardized approach to anxiety producing ailments, cook book like mechanistic techniques often do not generalize to out-of-treatment settings because "subjects" fail to derive meaning from them. In order to reliably encode and store information for use at a later time (such as a way to prevent abusive relating to children or women), memory requires the individual to ascribe meaning to events. Meaning requires full, willing, awareness. Much to the chagrin of researchers, meaning is not always linear, logical or language based.

Unlike standard RP techniques, the "Five Simple Ways" call for treatment that fits the individual rather than fitting the individual into pre-existing categories valued as having supreme knowledge. They are constructive, whole person focused suggestions that strive to overcome "the perception of offenders as bundles of risk factors rather than integrated, complex beings who are seeking to give value and meaning to their lives (Ward & Marshall 2004)." They attempt to bring balance to a field of treatment that has become dominated by problem-focused, deficit-based programming. The "five ways" underlie long-lasting change based on collaborative relating with others and are useful in working with abusive individuals regardless of setting or context.

The necessity of deriving meaning from treatment through collaborative relationships underlies what is talked about as The Responsibility Principle. Among the most salient lessons of contemporary research and surely an impending area for further study and development is the Responsibility Principle (Andrews & Bonta, 2006). Adherence to the Responsibility Principle means that treatment methods and delivery are adapted to meet the unique learning style of individual participants. In a sense, the Five Ways are an amplification of this principle.

### 1. Focus on the Client's Self First: Assess and Treat "Old Wounds"

It comes as no surprise that the prevalence of childhood trauma among adult offender populations is significantly higher than in the general population, with rates ranging from 30% to 70% in offender samples. Motivated by the awareness of harm offenders have proximally caused, programs are reluctant to address the distal wounds of these abusive individuals. While acknowledging the suffering of offenders has been interpreted by many as coddling that facilitates their abusive attitudes, a central idea of this principle is that treatment will not be effective if it does not address the wounds of offenders.

Unmet needs caused by trauma such as physical or psychological abuse, neglect, and accidents cause disruptions in development. These "wounds" are stored in various body systems and cause excessive self-focus and dysregulation, greatly impacting the structure and function of the brain (Siegel, 1999). Herein the seeds for a variety of mental illnesses involving impaired affective bonding and dysregulation of internal states are implanted. The unmet needs of childhood, including the fear, shame, confusion, and need for soothing of trauma, are fertile breeding grounds for problems of sexual abuse.

As often is the case, many years later the wounded self continues to behave as if the ongoing victim of early violations. The victim who could not contain, manage and integrate the abuse transforms it into aggression; the recipient becomes the abuser. The intolerable receptive state of fear is transformed to the reactive solution of aggression. This is the cycle of abuse in action. Early trauma that has not been adequately integrated manifests as excessive self-focus and deep-seated victim stancing that are typically labeled as a form of treatment resistance and aggressively challenged or otherwise not tolerated by treatment providers.

This principle calls upon treatment providers to initiate treatment at the place of the offender's wounds. We start with the offender's worldview, and assess for and empathically validate his woundedness. We receive rather than react. This fundamental acceptance of the offender as an ailing fellow human facilitates trust and reduces psychological defensiveness such as externalizing, avoidance, and denial.

As the offender begins to integrate the trauma at a neurobiological level, the embedded self-protections against being overwhelmed by it are no longer necessary. It is through the validating relationship with the therapist that the offender learns it is no longer necessary to avoid or fear his internal experience. With the self's wounds adequately tended to the offender can fearlessly set aside the self and attend to and receive the other. Often a wellspring of empathy for others occurs when this happens. With this new place for others to exist in the lives of offenders, internal motivation for non-abusiveness begins. The abuse he perpetrated is viewed through

this new other-oriented lens; real accountability occurs. To my supervisees I have called this strategy for preventing the abuse of others by focusing on the self-first, the "back door approach" to offender treatment.

### 2. Highlight Affective Factors

The second principle underlying long lasting change involves the significant contribution of affective factors upon human behavior. The emotion system plays an organizing role in human functioning. Strategies to prevent future abusiveness solely through cognitive processes, such as challenging the logic of distorted beliefs, identifying components of relapse cycles, and memorizing lists of risk factors and new coping strategies often fail to "sink in" to the deep preconscious memory systems that are accessed automatically in the context of high affective and physiological arousal. When the opportunity for future offending occurs, as it often does, in the context of high levels of arousal, rational decision-making is bypassed for responding that is evoked by subcortical levels of the brain – meaning, without thinking.

Several valuable treatment strategies emerge from this knowledge that explicit memory is typically bypassed in the context of high arousal. Do not yield to the convenient temptation to treat abusiveness solely through cognitive methods. Allow a place in treatment for participants to experience, identify, and process affect. Practice strategies to facilitate improved tolerance and modulation of affect. Value the "here and now" of therapy as opposed to using available treatment time to focus entirely on discussing what happened in the past and what will happen in the future. Underscore the value of non-verbal experience and assign emotionally rich "homework assignments," such as video and bibliotherapy. Prioritize creating a therapeutic landscape that is safe, supportive, reliable, and nurturing. Process offenders' affective reactions to other group members, family members, and therapists; rather than reactively punish, receptively explore offender client's attempts to ingratiate, devalue, bully, and/or seduce the treatment provider. Model strategies to avoid miscommunication such as direct, clear conversing with good eye contact and congruence between emotions and body language; ask for attention before making important statements and provide appropriate statements of your own feelings and beliefs.

### 3. Cultivate Empathy for the Abuser and a Landscape for Change

A fundamental challenge to treatment providers of abusive individuals is to do good work while being exposed to unpleasant, tragic, and harmful aspects of those in our care. Metaphorically, we are paid to psychologically swim in a dark, unpredictable pool of human behavior, where there are things no one wants to claim floating on the surface and who knows what dangerous things lie underneath. What is the best way to resolve this dilemma? One approach is to avoid jumping in altogether, to treat

from the outside looking down. Another approach is to close one's eyes, plug one's nose, dive in, and get the job done as quickly as possible and get out of there.

A third option is to invest in preparations and protective wear before immersing oneself in the job. While this option is more resource intensive than the previous options, it yields better results. The immersion into the dark pool is necessary. It can be frightening but with proper precautions the therapist's innermost self remains protected. Therapists that have proper training, a viable professional network, and ongoing supervision or professional consultation tend to derive more job satisfaction and less burnout than unprepared clinicians. Importantly, effective treatment requires meaningful engagement by the therapist. It is not only necessary to dive into the dark pool but to explore its murky contents with a sense that there is something rare and valuable to be found.

The central premise of this principle is that the therapist and the therapeutic landscape are essential features of effective treatment (Marshall, 2005). This means that "how" treatment is delivered is at least as important as "what" is delivered.

The relatively recent research finding that outcome in sexual offender treatment is strongly influenced by process is a welcome invitation to our field to put the "psychology" back into forensic psychology. Indeed, just as sexual offender treatment separated itself firmly from the field of general psychotherapy in carving out its identity, training programs in forensic psychology have become increasingly differentiated from their clinical psychology predecessor. It was not until the 1990's that psychology training programs began offering masters and doctoral degrees in forensic psychology. Some such programs have often sacrificed intensive clinical training for classes on legal knowledge and forensic application, such as evaluation and court testimony. The call to focus on therapy process with sexual offenders is also a call for our therapist training programs to better prepare forensic psychologists with solid psychotherapy skills.

Strategies to maximize participant response to treatment involve attending to the following: therapist attributes, style and behaviors, the nature and quality of the interactional processes among treatment participants and providers, the therapeutic climate and the degree of group cohesion, and indices of participant satisfaction. Therapist behaviors that encourage change are genuineness, respect, support, warmth, directiveness, flexibility, rewarding-ness, being encouraging emotional expression and active participation, moderate humor, imbuing confidence and hope, and foremost, empathy (Marshall, 2005).

Over fifty years ago, Carl Roger's identified the participant's experience of therapist empathy as the most essential ingredient for effective therapy.

*To sense the client's private world as if it were your own, but without ever losing the "as if" quality —*

*this is empathy, and this seems essential to therapy. To sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it (is empathy). When the client's world is this clear to the therapist, and he moves about in it freely, then he can both communicate his understanding of what is clearly known to the client and can also voice meanings in the client's experience of which the client is scarcely aware (Rogers, 1957, p.99).*

Offenders will not see themselves differently until we do. Ensnared in a criminal justice system with competing punitive and rehabilitative goals, sexual offender treatment all too often seems to get lured into the cycle of abuse. This is evident in deviancy and deficit focused treatment, inadequate focus on strengths and resiliencies, and aggressively confrontational, authoritative, punishing, rejecting, and disinterested behaviors toward offender participants by staff.

Good healers utilize a fine tuned empathic system. This means we can weave a rational thread through the confusion and discomfort that accompanies abuse. We strive to see the world from the offender's emotional and cognitive perspective. This empathy for the offender participant helps him feel understood, cared about and amenable to do the real work of therapy. It cultivates the development of the offender's empathy, internally motivating the attachment system, pro-social behavior and the inhibition of abusive impulses.

#### 4. Embrace the Mystery of Wholeness

Like any effective change intervention, sexual offender treatment requires involvement from the past, present, and future totality of the offender client, in all senses of body, mind, emotion, and spirit. It seems a merciless case of the "izes" has unfortunately befallen contemporary sexual offender treatment - "standardize programming, manualize the treatment, categorize the offenders, analyze the data, sterilize the subject matter, etc." There is a strong pull to create cookbook approaches to offender treatment that are inflexible to individual characteristics. This certainly simplifies clinician training and program evaluation, but it also devalues the dynamic individuality of participants and the unique psychological atmosphere that emerges when therapy happens. Relevant criminogenic needs can be targeted in a way that is responsive to the unique learning style of individual participants. The reminder to embrace the mystery of wholeness in sexual offender interventions does not mean to discard psychological science in favor of unguided clinical judgment. It means to consider the cost when we remove consideration of the individual offender client from the treatment process.

We all have moments when we experience a sense of integration or wholeness within ourselves; the difficulty is that this state is not typically accompanied by logical comprehension. An essential distinguishing feature of humans compared to mammals earlier on the evolutionary chain is our

capacity for meta-cognition, to think about thinking. A unique human urge is to know, most often through logic and language, but there are other ways to experience something as true. Embracing the aspects of the human condition that are not scientifically proven, or perhaps even rationally known, is challenging but valuable.

Embracing that which is not known means to acknowledge the operation of intrapsychic motivations beyond conscious awareness. States of disease often occur when there is an incompatibility between conscious rational desire and outward behavior. This suggests the behavior may be motivated unconscious irrational processes. An example of this is an offender who feels, thinks, and articulates that he does not want to create another victim, yet for reasons not known to him he continually places himself in situations that increase the likelihood for re-offense. Some would conceptualize this as a type of dissonance or disagreement between two competing beliefs. This principle suggests that competing drives, desires, fantasies, etc. are not ignored or chastised but identified and processed in an effort to continually strive to know and integrate. It means striving to make conscious the strong forces that lie beneath awareness.

This principle acknowledges the power of those aspects of life and living we have not figured out yet. It acknowledges the influence of the preconscious, the unconscious, the unknown, and the irrational. It calls us to value the experiential, the affective, the non-linear, and the non-verbal dimensions wherein clients can derive that essential sense of meaning necessary for internal change. This holistic approach is multimodal and values creative pursuits, work, play, somatic methods, spiritual, and meditative efforts, and the cathartic experience of art, storytelling, music, and drama as ripe opportunities for offender clients to transform destabilizing internal states and shore up resiliencies. These experiences are reminders of a universal connection with all of humanity.

Embracing the Mystery of Wholeness involves valuing that activity of willing awareness of whatever emerges in offender clients' inner and external world. Prioritizing the goal of being fully present and attentive to experience the full scope of activities of living facilitates mindful behavioral choices that can counteract affective and behavioral dysregulation and impulsivity. As an antidote to program features involving heavy emphasis on deviancy, self-control, and self-restraint, this principle calls upon the need for constructive approaches that build up resiliencies, replace deficits with strengths, and facilitate offender clients' connection to the universal commonalities of humanity.

#### 5. Care for the Therapist

For many treatment providers, a tendency to empathize with the pain of others was part of a professional calling to the field of forensic mental health. Unfortunately, the empathy that brought us to this work and which is necessary to do the work well

can also be a genuine job hazard that contributes to dissatisfaction, burn-out, vicarious traumatization (Pearlman & Saakvitne, 1995), and impaired work performance. We immerse ourselves into the dark aspects of humanity, where real pain predominates. We contain distress. We continually intervene against abusiveness. We foster health. These efforts have positive and negative impact upon us as therapists.

Appropriate care for the therapists who, on a daily basis, vicariously experience traumatic events through empathic engagement with offender clients is a necessary component of effective Sexual Offender Treatment. Absent such care, therapists are vulnerable to personal distress and other trauma symptoms that tempt participation in the cycle of abuse. There are numerous ways that program administrators, supervisors and therapists can achieve adequate care for therapists.

At the administrative level, clinical staff should be selected in part on the skills and traits that are responsive to participants' unique learning styles and abilities; for example, genuineness, warmth, empathy, and directiveness. Such traits and skills often reflect a personal commitment to self-awareness, personal growth, compassion, and a desire to ally with others to evoke change. Staff that can communicate effectively, are open to feedback and can think and act flexibly tend to demonstrate resiliency to the difficult nature of the work. Respect for the professional boundary between staff and offender clients is essential.

Administrative strategies that promote the well-being of staff include allowing flexible work schedules (e.g., a 4 day, 10 hour work week), on grounds staff exercise facility and break areas, in-service trainings involving staff care, and staff celebratory events. Staff retention, work satisfaction, and work quality are enhanced by providing ample time for professional development, allowing staff time to pursue and develop areas of expertise, and creating opportunities for position advancements and shifting duties. It is essential that programs ensure appropriate resources for supervisory staff and procedures and communicate to treatment staff that their contributions make a difference.

Given the unusual, taxing and high stakes nature of the work, it is not surprising there is a good deal of therapist turnover in the field of Sexual Offender Treatment. The goal of staff-retention is served by promoting awareness of counter-therapeutic pulls and its effects. Staff are educated about the signs and symptoms of burn-out, vicarious traumatization, and boundary violation. Some treatment providers may ultimately find working with abusive individuals too difficult or the emotional and psychological toll too great; for these staff a job change

may be in the best interest of both the treatment consumers and the treatment provider.

Therapists can engage in a number of strategies to avoid negative impact. Expect counter-transference and negative reactions to the work. Continually assess personal signs of burnout. Practice the kind of therapy that we espouse to offender clients on one's own self. Utilize mindfulness techniques. Strive to incorporate your best qualities in your work. Promote a well-rounded lifestyle but prioritize your personal life above work. Develop a passion in your professional life. Allow ourselves some kind of personal therapy. Utilize debriefing, supervision, and consultation, and foster connections with other professionals in the field.

### ■ Final Word/Conclusion

The field of Sexual Offender Treatment has developed markedly since its initial establishment in the 1980's and the days of Relapse Prevention. Through a historical and personal reflection, five simple strategies have emerged as ways to enhance the efficacy of Sexual Offender Treatment: Focus on the Client's Self-First: Assess and Treat Old Wounds. Highlight Affective Factors. Cultivate Empathy for the Abuser and a Landscape for Change. Embrace the Mystery of Wholeness. Care for the Therapist.

Commonalities that underlie these strategies include a focus on participant response to treatment delivery, the impact of the therapist upon outcome, and an encouragement to return basic principles of general psychotherapy to the application of Sexual Offender Treatment. It is hoped these strategies will take on meaning to individual therapists and program developers and assist the forward progress of the field of Sexual Offender Treatment.

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## Some Essential Environmental Ingredients for Sex Offender Reintegration

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### Abstract

Until the systematic work on the Good Lives Model (GLM) produced by Tony Ward, not a great deal of conceptual structure existed to provide sex offender treatment specialists with a theoretical underpinning for their work in helping offenders develop a better life as a way to prevent reoffending. However, the work of Ward and colleagues initially focussed more attention to making treatment more effective, with less attention devoted to applications of the GLM to the reintegration of sexual offenders into the community.

It is the contention of this article that expanding the focus of reintegration planning so that it includes the recognition of ingredients in the offender's environment that support reintegration will make that process more effective and hopefully thus help to reduce reoffending.

The basic environmental ingredients essential to effective community reintegration discussed in this article fit well with the general GLM model and apply to all sex offenders, including both adults and juveniles, and include the elements of support, occupation, accommodation, programs, and plans (SOAPP). It is acknowledged that these are but a subset of the protective factors relevant to effective community reintegration, but these are nevertheless some of the essential ingredients, in the author's view, for helping to ensure a "Good Life."

The sex offender literature is heavily focused on assessment and treatment. Until the systematic work on the Good Lives Model (GLM) developed by Tony Ward and colleagues, not a great deal of conceptual structure existed by which to provide sex offender treatment specialists with a theoretical underpinning for the work of helping offenders develop a better life as a way to prevent reoffending. Nevertheless, in my opinion, Ward and colleagues initially devoted less attention to applications of the GLM with respect to offender reintegration into community than they did to making treatment more effective in general.

That said, there have been some recent applications of the GLM with respect to issues related to reintegration, such as case management and community planning. However, it is my contention that expanding the focus of reintegration planning so that it includes the recognition of ingredients in the offender's environment that support reintegration will make that process more effective and hopefully thus help to reduce reoffending.

The basic ingredients essential to effective community reintegration discussed in this article fit well with the general GLM model and can be applied to all sex offenders, including both adults and juveniles.

### ■ The Guiding Framework of the Good Lives Model

The Good Lives Model (GLM) has been elucidated in a number of publications since it was originally proposed by Ward and Stewart in 2003. Numerous papers have since been published that explain the conceptual framework of the GLM (e.g., Ward & Stewart, 2003) and its application to sex offenders, the majority of which have focused on the rehabilitation of sexual offenders (e.g., Ward & Brown, 2004; Ward, Mann, & Gannon, 2007). Ward and

his colleagues have provided a number of excellent papers to inform those who treat sex offenders in terms of how to incorporate the GLM into sex offender programs (e.g., Ward & Gannon, 2006) and this focus remains a priority in even the most recent publications regarding the GLM (e.g., Willis, Yates, Gannon, & Ward, 2013). That said, the GLM has also been applied to case management (e.g., Purvis, Ward, & Willis, 2011) and goal planning (e.g., Ward & Fortune, 2013).

The present paper will not review the theoretical underpinnings of the GLM as that has been done well elsewhere by Ward and his colleagues (e.g., Ward & Fortune, 2013). Rather, this paper will focus on the last stage of intervention guided by the GLM as summarized by Ward (2010), namely the development of a "good lives plan" (GLP). A comprehensive GLP should take the information from the treatment program and formulate a plan that covers how the offender can best attain the various relevant primary and secondary "goods" central to the model. The reader is referred to any of the above publications by Ward and his colleagues for a detailed elucidation of what is meant by these terms. Basically, however, primary goods are basic human needs (e.g., life friendship, spirituality, pleasure, inner peace) that human beings try to attain via secondary goods which are essentially the practical means by which the primary goods are sought (e.g., attending a church to obtain the primary goods of friendship, inner peace, and presumably, spirituality). Of course, the great theoretical structure of the GLM has been simplified by the above analysis, and the reader is again referred to the above articles by Ward and his colleagues to become better informed. Ward (2010) noted that the development of a comprehensive GLP requires an evaluation of the environmental circumstances of each individual, as well as an analysis of their main primary goods. To make this theoretical structure work in practice, a case manager or sex offender treatment specialist will

have to contextualize these issues for the individual offender who may be living in the community (e.g., on probation or parole) or being considered for release. For example, if a sex offender is preparing for release from prison, the construction of an effective GLP will entail looking at probable environments for release in which the offender can safely pursue his (most sex offenders are male, so only male pronouns are used in this article, but all points are equally relevant to female sex offenders) goals. The initial steps in an environmental analysis require an overview of the resources and supports in the community that will help the offender attain his goals in a safe manner, in which the GLP basically contextualizes the offender's goals in a holistic fashion.

Of course, the GLM itself cannot account for all environmental variables, as the variables themselves will be as unique as each individual sex offender. However, there are two main areas of related offender literature that appear of relevance in providing additional guiding principles in the formation of the GLP – namely, that pointing to the contextual nature of risk and the literature describing protective factors.

### ■ The Contextual Nature of Risk

A number of theoretical papers over the years have noted that the environment around the sex offender is relevant to the risk that the offender poses to reoffend (e.g., Ward & Beech, 2006), and that any release planning exercise should examine the nature of the release environment when formulating release or treatment plans (e.g., Ward & Gannon, 2006). Indeed, there is no doubt from a theoretical point of view that risk is context-dependent. Nevertheless, the research literature has been less forthcoming in providing evidence that this common-sense claim is valid as most risk assessment strategies eschew any reference to the offender's environment and focus on client risk issues only (e.g., Static-99; Hanson & Thornton 1999), or those that are contained within the client himself.

However, it is a central position of this paper that the risk *context* is as important as the risks inherent to the offender when an overall risk level is being assessed, or when a risk management plan is being formulated. In my view, the "risk context" is composed of the environmental variables that are "risk relevant," or those variables that affect and influence the offender's risk in some manner. For example, Boer, McVilly, and Lambrick (2007) discussed the importance of analyzing environmental factors when assessing the risk of sex offenders with an intellectual disability, and although that paper was a theoretical exercise there is support for the importance of environmental analysis of risk. For example, Lofthouse and colleagues (2013) examined the predictive validity of the *Assessment of Risk and Manageability for Individuals with Developmental and Intellectual Limitations who Offend Sexually* (ARMIDILLO-S; Boer et al., 2012). These authors found that the environmental items of the instrument had almost the same level of predictive validity

Author Note: The author would like to acknowledge feedback from Dr Phil Rich on previous versions of this article.

ty as the offender items (AUCs of 0.79,  $p=0.003$  and 0.85,  $p<0.001$  respectively)<sup>1</sup>.

While the offender variables in the ARMIDILO-S are well-known (e.g., supervision compliance, sexual deviance, impulsivity, substance abuse), the environmental items were relatively new to offender risk evaluation (e.g., attitude of staff towards the client, communication among support persons, client knowledge by support persons, consistency of supervision and intervention, changes in social relationships, situational/accommodation changes, changes in victim access, and unique considerations that could include access to drugs or alcohol). While Boer and colleagues (2012) limited the literature review supporting the use of the ARMIDILO-S for offenders with developmental and intellectual limitations, and the Lofthouse et al. (2013) study was conducted only with sex offenders with intellectual disabilities, it is arguable that all of the environmental issues in the ARMIDILO-S are also relevant to risk for all sex offenders (and probably other client groups as well, with the usual empirical questions being applied and satisfied).

The implications of the Lofthouse study (2013) are clear for sex offenders with intellectual limitations, if not, by extrapolation, to all offenders and other groups with problematic or challenging behavior; the risk-relevant environmental variables, such as those found in the ARMIDILO-S, are evidence that the risk context is critical in ascertaining the risk for reoffending by the client.

### ■ A Brief Discussion of Protective Factors

The SAPROF (*Structured Assessment of Protective Factors for Violence Risk*; de Vogel, de Ruiter, Bouman, & de Vries Robbé, 2009), the ARMIDILO-S (Boer et al., 2012), and other publications (mostly regarding juvenile offenders; e.g., Bremer, 1998) provide a structured assessment format that includes both client-specific and environmental issues that are seen as protective factors. Some of this literature is sex-offender specific (e.g., Bremer, 1998; Boer et al., 2012), while other assessment tools focus on violence in general but likely are applicable to sex offenders as well, such as the *Short-Term Assessment of Risk and Treatability* (START; Webster, Martin, Brink, Nicholls, & Middleton, 2004) and the SAPROF (de Vogel et al., 2009). Although not designed for sexual offenders, many of the factors in both the START and the SAPROF seem generically applicable to all sorts of offenders, including sexual offenders. Indeed, research has shown that the SAPROF, although initially designed for use with non-sexual violent offenders, also works well with sexual offenders (e.g., Yoon, Spehr, & Briken, 2011). However, other authors (e.g., Boer et al., 2012) have focused on specific populations with their risk and protective factor assessment instruments.

The question of what exactly constitutes a protective factor warrants some attention. The authors of the SAPROF (de Vogel et al., 2009) provided an interesting discussion regarding the theoretical issues related to the nature of risk and protective factors that the authors of the START did not broach, such as the theoretical mechanisms by which protective factors may work to decrease current risk. However, these issues were not resolved by de Vogel and colleagues and the literature has not yet reached a consensus as to the nature and definition of a protective factor, or an understanding of the underlying mechanism by which protective factors work to decrease risk. The question of whether protective factors serve as a buffer against or play a mediation role in mitigating risk (see Fitzpatrick, 1997 for a longer discussion) raises interesting and important theoretical issues. However, the resolution of such questions is possibly unrelated to the question of whether client or environmental factors better promote increased risk management, and which, therefore, functionally serves as a protective factor. It is perhaps noteworthy that studies examining protective factors among sexual offenders have not always found the expected effect of factors purported to be protective (e.g., Spice, Viljoen, Litzman, Scalora, & Ullman, 2013).

In the present paper, a client or environmental factor is viewed as protective when the *presence* of such a factor could or does result in decreased risk. However, although it is possible that some protective factors are the simple opposites of certain risk factors, the relationship between even similar factors is usually more complex. For example, if an offender does not have a substance abuse problem (and never had one), his risk is clearly not increased due to substance use – but is this *lack* of a problem equal to the action of a protective factor? It adds little for us to assume that *not* having a problem decreases risk, and especially as the offending behavior occurred in the absence of that particular risk issue in the first place!

Illustrating a different kind of relationship, although a history of sexual deviance is a well-known risk factor the completion of sex offender treatment that includes learning skills by which to manage sexually deviant urges *is* protective (assuming such treatment is effective for the individual in question). Nevertheless, following such treatment, the history or presence of deviance does not go away nor do learned skills by which to manage deviant urges eliminate deviance entirely or necessarily actively decrease risk – yet, these new skills are protective. However, it is the client's decision to use these skills in a situation that could otherwise result in a new offense that is actually protective, in which the client's use of skills validates the nature of those skills as protective.

In action, it seems reasonable to assume that protective factors either primarily mediate *between* client risk factors and offending behavior (thus interrupting the otherwise linked relationship between risk and harmful behavior), or they buffer the client from the effects of client or environmental risk factors and, in either case, either decrease or eliminate the potential for offending behavior (de Vogel et al.,

2009). In the case of either mechanism of action, the relative absence of a protective factor should result in an increased risk for the offending behavior to occur, as nothing then serves to intervene between risk and actual harmful behavior.

Of course, it is up to the assessor to ensure that the presence or absence of a protective (or risk) factor is accurately evaluated. Indeed, the relevance of any such factor to risk can be determined only when evidence is available regarding the presence or absence of a risk or protective factor in the life of each individual. That is, there must be evidence that a risk or protective factor exists. Furthermore, the importance of any one factor in the individual case will depend on its risk-relevance in each case.

### ■ The Intertwined Effects of Risk and Protective Factors

In reality, offense risk is a complex outcome of intertwined and interactive client and environmental variables. For example, low levels of intelligence, described by authors such as de Vogel et al. (2009) as increasing risk for reoffending, may result in greater levels of environmental support in an individual case, thereby serving to actually mitigate any risk that an intellectual disability for may have otherwise created for that particular individual. A similar individual without a similar level of support may have a much higher level of risk due to the lack of such support. Of course, the relationship between low levels of intelligence and sexual (and non-sexual violent) offending is a complex and misunderstood, and certainly not a straightforward, issue as noted by Lindsay (2009) in a discussion well beyond the scope of the present paper.

Another issue that may complicate matters is that all (to my knowledge) risk assessment measures for adult offenders (e.g., the START, ARMIDILO-S) that include both risk *and* protective factors, also incorporate both client and environmental factors in the same instrument. Indeed, the START puts all of the items, including both client and environmental factors, into one lengthy list and the assessor must rate each item in terms of the risk and protective strength level it presents for the client. The SAPROF (which includes only protective factors, and is not a risk assessment instrument per se) classifies variables into internal, motivational, and external (environmental) factors, in which items are evaluated only in terms of the degree or level of protection that each item provides to the client. However, the ARMIDILO-S provides a hybrid of both approaches: environmental (or external) factors are itemized in a category separate from client factors (like the SAPROF), but both environmental and client factors are scored from a risk and a protective strengths perspective (like the START).

### ■ Consideration of Contextual and Protective Factors in the Development of a Good Lives Plan (GLP)

As noted earlier, a comprehensive GLP will cover how an offender can best attain various relevant primary goods by means of secondary “goods” without harming self or others in the process. In addition, also previously described, Ward (2010)

<sup>1</sup> An AUC, or area under the curve, value of .71 and above is considered to have moderate predictive validity, and .80 and above to be moderate to strong.

proposed that the development of a comprehensive GLP requires an evaluation of the individual's environmental circumstances, as well as an analysis of his main primary goods. Basically, a comprehensive GLP will contextualize the primary and secondary goods issues for each individual offender who may be living in the community or being considered for release, so that primary goods may be pursued and obtained in the lowest risk and most supportive environment available. For example, if an adjudicated sex offender is being released to the community, a comprehensive GLP will assess risk-relevant aspects (both risk and protective) of possible environments in which the offender may live so that he can safely pursue his goals.

The initial steps in an environmental analysis thus require an overview of available community resources and supports that can help the offender attain his goals in a safe manner, as well as an analysis of risk issues present in that setting. However, although the GLP contextualizes the offender's goals by considering them in the community setting, it cannot account for all possible risk-relevant environmental variables, as these variables will themselves be as unique as each individual sex offender and it is safe to say that not all environmental factors are risk-relevant in every case. That said, the protective factor literature does provide a great deal of guidance in terms of what factors are risk-relevant.

In summary, risk is context specific in which aspects of the environmental context may be risk-relevant, possibly serving as either risk or protective factors. Some of the critical protective environmental issues are described in the next section of this paper.

### ■ Essential Ingredients: Support, Occupation, Accommodation, Programs, and Plans (SOAPP)

While risk factors are perhaps most commonly analysed when considering release of a sexual offender into the community setting (for example, presence of elementary schools in the case of a predatory pedophile), possible protective factors should also be as assiduously assessed in order to help formulate a GLP. In my view, the majority of environmental factors of a protective nature fall into five categories: support, occupation, accommodation, programs, and plans (SOAPP).

There is a literature supporting each of these areas in terms of protective factors, but it is worth noting that it would be naïve to suggest that any of these may not also be potentially risk-enhancing, rather than risk-reducing. For example, if an offender's main source of social support is a group of fellow criminals who offer him accommodation and a job selling drugs, then his risk for criminality has not been reduced. Similarly, a church group can offer an offender support, but if that well-meaning group provides access to children and the offender is a pedophile, the support may also serve to increase risk by providing the offender with access to children that he might not otherwise have. Obviously, the risk-relevance of each SOAPP area must be evaluated to ensure it is functionally protective, rather

than risk enhancing, in the community in which the offender intends to live or within which the offender is already living.

As noted in the Sexual Violence Risk-20 instrument (SVR-20; Boer, Hart, Kropp, & Webster, 1997), "realistic plans" involve the offender's "explicit, stable and reasonable" stated intentions (i.e., plans) regarding how he intends to live in the community in regard to "(supportive) relationships, employment, place of residence (accommodation), health care, and compliance with supervision conditions (e.g., community-based programs)" (p. 79). Of course, "plans" are offender generated and client-based rather than environmentally-based. Nevertheless, it is how the offender develops plans to engage with his current or proposed community that is the focus in this article or, basically, environmental planning as formulated by the offender.

As briefly discussed above, although SOAPP factors are described below as positive and protective, we can nonetheless visualize "risky" variants of each factor. For example, as described, if an offender's social support is an antisocial group who provide him with accommodation as long as he sells drugs for them, then risk for criminality has not been decreased. In fact, it has been increased. Again, risk and protective factors are context dependent.

#### 1. Social support

Social support is incorporated into the ARMIDILO-S, SAPROF, and START as an important protective factor, whether as a stand-alone item (in the START, for example) or as an over-arching construct present in a number of related items. The SAPROF, for instance, includes several external factors that are related to social support, namely social networks, intimate relationships, and professional care. Alternatively, the ARMIDILO-S reviews various aspects of support persons who look after the client (usually staff or parents), including communication between support persons, the attitude of support persons toward the client, the knowledge of support persons regarding the issues of individual clients, and the consistency of supervision and intervention provided by support persons.

Borowsky, Hogan, and Ireland (1997) noted that supportive friendships and connections with adults in school, church, and police agencies are protective factors for adolescents who have been sexually aggressive. However, the authors of the START and ARMIDILO-S noted that a relationship may serve either a risk increasing or risk decreasing (protective) function, depending on the nature and quality of the relationship. For instance, as described above, attending a church or an educational center may serve a risk increasing or a decreasing function depending on how attendance is managed by the offender, in collaboration with the church or educational center.

#### 2. Occupation

A person's occupation is anything he or she does that is experienced as a productive use of their time, whether it is an actual job or some sort of activity that increases that person's self-esteem and is viewed by others as useful and unrelated to criminality. Volunteer work, leisure activities (e.g.,

sports), paid work – all of these activities occupy a person's time and are generally contraindicative of offending. Of course, if a person is a pedophile and seeks work in a child-care center, the environmental risk is obvious. As is always the case, the nature and quality of the occupational setting needs to be assessed.

Indeed, many of the structured professional guidelines describe a poor history of employment as a risk issue (e.g., Boer et al., 1997). For instance, the SAPROF includes work and leisure activities as "motivational (protective) factors," and the START describes occupational issues serving either a risk increasing or protective function. Conversely, the ARMIDILO-S includes occupational issues as a "unique consideration" rather than a stand-alone item, but again recognizes occupational issues serving either a risk increasing or protective function.

#### 3. Accommodation

There is a relatively large literature on the importance of accommodation as a protective environmental factor. For example, Baldry (2005) found that having housing arranged prior to release reduced recidivism. O'Leary (2013) similarly found evidence relating stable accommodation to reductions in recidivism, although also raised some interesting questions about how accommodation acts to reduce risk. The nature of causal mechanisms aside, the risk reducing effect of housing, or accommodation, is significantly determined by the geographical setting, nature, and quality of the housing. If an offender with a drug habit is being released from prison to live in an area frequented by other drug users and sellers, for instance, then the protective nature of his accommodation is clearly compromised.

The SVR-20 notes that realistic planning regarding "place of residence" (i.e., accommodation) is important. However, although accommodation itself is not treated as a risk or protective factor in either the SVR-20 or the START, in the SAPROF "living circumstances" is viewed as a protective factor. In the ARMIDILO-S, a change in accommodation (i.e., "situational changes") is considered to be an acute (or possible rapidly changing) environmental factor, although may also be thought of as a stable environmental "unique consideration". In the ARMIDILO-S, accommodation is also linked to "victim access," as an acute environmental factor, in which changes in accommodation may provide increased access to victims without any action on the offender's part to gain such increased access.

#### 4. Programs

Andrews and Bonta (2010) have for over two decades promulgated the idea that effective offender rehabilitation is premised on the basis of "risk, need, and responsivity." Indeed, these authors provide convincing proof that effective correctional programs, based upon the principles of risk, need, and responsivity, reduce recidivism for a variety of offenders, sex offenders included. Oddly, however, effective treatment and/or case management programs are not included as protective factors in any of the instruments described in this paper. The pro-

vision of effective programs prior to release or following release in the community may be construed as one form of support, but effective programs clearly offer more than pro-social support. Such programs also provide treatment, information, structure, guidance, and in many cases, monitoring and/or supervision, as well as access to needed services and a helping hand and helping relationships when needed.

## 5. Plans

Realistic planning (or lack thereof) has been espoused in a number of instruments as either a risk issue (e.g., the SVR-20, which describes poor and unrealistic planning) or as a protective feature (the START, for example, describes planning that is feasible and realistic, and the SAPROF describes appropriate life goals). Similarly, Andrews and Bonta (2010) noted that offenders who fail to create and implement realistic and feasible plans are more likely to reoffend upon release.

There is some evidence supporting this idea. For example, Willis (2010) examined a number of variables in assessing the role of pre-release planning in reducing sexual offender recidivism. She found that offenders who devised feasible plans with regard to post-release accommodation, employment, and pro-social support reoffended at a lower rate than those offenders who did not develop feasible plans. Although the exact nature of these variables was not defined, and offender planning was not necessarily related to reduced recidivism for offenders treated in community-based settings, these data provide tentative support for the contention that the development of realistic and strong plans is an essential ingredient in effective and safe community reintegration and a key element in the SOAPP approach to reintegration.

## ■ Summary

Over the years, various legal, research, and treatment forums have asserted that acceptable and effective release planning is contingent on meeting the majority of issues identified in instruments such as the SVR-20 as examples of future planning. These include having supportive relationships (including socially supportive pro-social relationships such as friendships, family relationships, intimate partners, therapists, probation officers, caregivers, etc.), an acceptable risk-reducing occupation (paying jobs, educational placements, work experience placements, school attendance, sports, leisure activities, etc.), an acceptable place of residence or accommodation that is risk-reducing, and/or does not increase risk, enrolment in or completion of a risk-relevant treatment or correctional program, and feasible life plans (how the offender plans to engage with the community in terms of support, occupation, accommodation, and programs).

Perhaps it is self-evident to most readers, but it is nevertheless important to note that each aspect of the SOAPP not only addresses individual risk and protective-relevant issues, but also overlaps with every other aspect of the SOAPP as these issues are not mutually exclusive. For example, a good occupational setting provides social support, and a

pro-socially supportive person or organization will likely help an offender find an occupation and possibly provide or help find accommodation. Support persons, such as social workers, help offenders locate risk-reducing occupational environments and appropriate accommodation, prescribe relevant programs, and review the offender's plans. In turn, realistic and feasible plans are necessarily malleable and the offender can make his plan more and more feasible with regard to potential occupational choices, places to live, supportive organizations, and programs that are currently relevant.

As noted earlier in this paper, the initial steps in the environmental analysis that must be completed to construct an effective Good Life Plan (GLP) require a review and understanding of the resources and supports in the community that will help the offender attain his goals in a safe manner. Indeed, it is proposed here that the majority of environmental issues that are or might be protective in nature are addressed by a number of currently available structured professional guidelines for the assessment of risk, such as the SVR-20, the SAPROF for the assessment of protective factors, and for the assessment of risk and protective issues, the START and the ARMIDILLO-S. Together, the elements assessed by these and other similar instruments can be subsumed under the SOAPP acronym (Support, Occupation, Accommodation, Programs, and Plans). Meeting and satisfying the SOAPP criteria – having realistic, risk-reducing plans that provide for support, occupation, accommodation, and programs – provides a strong foundation for the formulation of an effective GLP, and thus the safe pursuit of the many primary goods that help to define a Good Life.

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## Taking a Developmental Approach to Treating Juvenile Sexual Behavior Problems

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### Abstract

While theories on the etiology of sexually problematic and offending behavior have become increasingly developmental in their perspective, treatment approaches that are utilized to address these issues have not significantly changed to address this thinking. Adolescent behavioral problems are especially linked to a wide range of personal and developmental factors that can often be marginalized or overlooked when taking a behavior management approach to address these issues. This article presents an argument for treatment that explicitly places problematic sexual behavior in a developmental context. This approach prioritizes the assessment of developmental strengths and deficits and identifies treatment progress as the acquisition and integration of developmental skills and not just the absence of problematic behavior. Special consideration is given to research on the impact of trauma and attachment disruptions on neurodevelopment and overall developmental progress.

### Keywords

Sexually abusive youth, juvenile sexual behavior problems, sexual abuse treatment, developmental treatment, neurodevelopment, attachment, trauma-informed treatment

While theories on the etiology of sexually problematic and offending behavior have become increasingly developmental in their perspective (Chaffin & Friedrich, 2000; Stinson & Becker, 2013; Ward & Gannon, 2006; Ward & Seigert, 2002;), treatment approaches, especially those directed toward juveniles, have not significantly changed in a manner that reflects this thinking. Surveys of treatment providers continue to identify cognitive-behavioral treatment as the primary and best treatment approach for adolescents (and adults) with sexual behavior problems (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010), despite the fact that our understanding of child and adolescent brain development, adolescent learning, and the impact of trauma on neurodevelopment and behavior has grown dramatically over the past decade.

Research that points to improved treatment outcomes when families are involved in the treatment process (Borduin & Schaeffer, 2002; Huey, Henggeler, Brodino, & Pickrel, 2000) should also serve to remind us that adolescent behavioral problems are greatly influenced by the adolescent's family and social environment as well as the demands that are inherently present in all adolescent development. Rather than separating our understanding of adolescent sexual behavior problems, and our treatment of the adolescents themselves, from our understanding of what promotes "normal," healthy adolescent development, I believe it makes more sense to embed our treatment perspective and our treatment goals firmly within the framework of what we know fosters growth and resilience in child and adolescent development.

### ■ Why a Focus on Development?

Using the "normal" developmental process as the basic framework for treatment provides a number of advantages. Perhaps first and foremost it reminds the treatment provider and the broader systems involved with these youth (juvenile justice, social

welfare, educational) that adolescence is a developmental period of considerable growth and change and that many of the difficulties that we are prone to identify in our clients (e.g., limited empathy, self-absorption, easily influenced by peers, taking limited responsibility for personal behavior, high degree of interest in sex, accessing pornography, etc.) are also problems for many other adolescents who do not have serious behavioral difficulties. This is not to argue that the youth we treat do not have significant behavioral and emotional issues, but it is a reminder that the process of development and maturity is "on our side" and some of the issues that we pathologize in adolescents who enter treatment also exist, to a greater or lesser degree, in most adolescents and may diminish or resolve without significant therapeutic intervention.

A developmental framework for treatment also provides considerable guidance for identifying and targeting those particular issues or deficits in skills that create obstacles to a positive developmental trajectory. The basic premise behind all developmental theory is that development proceeds from the simple to the complex, and that the positive engagement in early developmental tasks leads to the acquisition of skills and traits that provide the foundation for higher level skill acquisition and the ability to engage in and carry-out more complicated tasks in later development. In utilizing an understanding of normative childhood developmental as our treatment framework, we are looking to assess for the "foundation" skills that may be missing or limited in the particular adolescent we are treating, and this directs the treatment provider in prioritizing the focus of our interventions. This approach also leads us away from a "one size fits all" model of treatment and facilitates a more individualized treatment approach since the developmental experiences and the level of foundation skills and deficits is likely to look different for different adolescents.

Utilizing a developmental framework also clearly informs our understanding of what constitutes "progress" in treatment and helps the treatment provider, the family, and others in the involved system maintain a holistic focus on the needs of the adolescent and his/her family. Quite often, the various systems that are involved with these youth are largely driven by a behavior management approach in conceptualizing treatment, treatment goals, and treatment progress, rather than the broader goals of a more holistic approach to treatment. More specifically, the adolescents we treat are identified for treatment because they have engaged in a particular, or, more frequently, a variety of problematic, abusive, or illegal behaviors. Treatment progress is therefore most typically identified and measured by the degree to which the identified problematic behaviors either diminish or desist. The most obvious example of this would be to measure the success of particular treatment programs or particular treatment interventions by their ability to produce lower rates of recidivism for abusive and illegal sexual behaviors and in some instances lower rates of general delinquent or illegal behaviors. While lowering or eliminating the amount of abusive or illegal sexual behavior in which these youth engage is clearly a legitimate, important, and even primary goal of treatment, we should also acknowledge that it is a very narrow goal, and especially when considered in the context of research that indicates already low sexual recidivism rates for most adolescents (Reitzel & Carbonell, 2006, for example). I would posit that the system's focus on a behavior management view of sexual behavior problems has led to the creation of treatment programs for these youth where progress is measured by "the absence of bad" rather than the acquisition and growth of the necessary, adaptive, and pro-social developmental skills and experiences required for these adolescents to move forward in their lives in a positive and competent manner.

Adopting a developmental approach suggests that treatment goals focus, not only on eliminating bad behavior, but also upon promoting and facilitating: (a) the presence of stable and supportive family relationships, (b) the presence of a stable and safe living environment, (c) the adolescent's ability for self-regulation, (d) the ability to engage in adaptive, pro-social problem solving, (e) the development of academic and/or vocational competence, (f) the capacity to make and sustain positive pro-social relationships, and (g) the capacity for intimacy and an understanding of healthy sexuality. It would also mean that research on long-term treatment outcomes is set up to capture and measure (at least to some extent) the presence or absence of these developmental goals in the lives of the children and adolescents we treat.

I believe it is fair to argue that a focus on these broader developmental goals will not only serve to address the issues of problematic and abusive sexual behavior, but will also more directly address the significantly higher rates of recidivism in general and non-sexual delinquent behavior that current

research has identified for this population (Caldwell, 2007, 2010; Letourneau & Miner, 2005). More importantly, a focus on developmental treatment goals is more consistent with our goals for adolescents in our society in general and does not equate a positive, successful, or “good” life with simply not harming others or staying out of jail.

### ■ How Trauma Can Impact Development

Emotional and behavioral regulation, promoted by a sense of safety and parental engagement, are important developmental foundations for pro-social functioning. Numerous studies have identified the immediate and long-term effects that a wide range of adverse experiences, some of which may be viewed as specifically traumatic, can have on child development (American Academy of Pediatrics, 2002; DeBellis et al., 1999; Egeland, Sroufe, & Erickson, 1983; Maughan & Cicchetti, 2002; National Child Traumatic Stress Network, 2003; Perry, 2001; Teicher, Andersen, Polcari, Andersen, & Navalta, 2002). These adverse childhood experiences may include pervasive neglect, emotional abuse, physical abuse, sexual abuse, exposure to family violence, parental substance abuse, parental mental health problems, and loss of immediate family members through death or abandonment. Some of the developmental problems associated with the child’s experience of persistent stressors include attachment difficulties, academic problems, poor peer relationships, developmental delays, and significant deficits in self-regulatory functioning and inhibitory control (DeBellis et al., 2009; Granic & Patterson, 2006; Raine et al., 2005; Schwartz, Cavanaugh, Prentky, & Pimental., 2006; Stinson & Becker, 2013).

Schwartz et al. (2006) document the evidence that high levels of neglect, family violence, psychological abuse, physical abuse, and sexual abuse are experienced by large percentages of adolescents identified with serious aggressive and sexual behavior problems. The Centers for Disease Control, through their ongoing ACES study (see Middlebrooks & Audage, 2008), has shown that cumulative harm appears to develop as a child is exposed to a higher number of instances of adverse experiences. While I am not arguing that every adolescent who engages in problematic or abusive sexual behavior necessarily has a history of abuse, neglect, or exposure to family violence, I would argue that those adolescents who present the greatest level of systemic challenges and concerns, as well as the greatest risk for future sexual and non-sexual offenses, are adolescents who present with these experiences.

Many of the individual and social problems that have been associated with adverse or traumatic childhood experiences can also be related to the neurodevelopmental impact of neglect and abuse on brain regions associated with interpersonal attunement/attachment, emotional and behavioral regulation, and adaptive problem solving. These include the amygdala, H-P-A axis, anterior cingulate cortex, hippocampus, different regions in the

prefrontal cortex, and broader left hemisphere development (DeBellis, 1999; Perry, 2001; Teicher et al., 2002; Raine, Mellinger, Liu, Venables, & Mednick, 2003; Raine et al., 2005). The obstacles and influence generated by these neurological processes are, I believe, essential factors to consider, not only in understanding the etiology of child and adolescent sexual and other serious behavioral problems, but also in developing treatment programs and treatment interventions that allow youth to more effectively learn and integrate new experiences and skills into their capacity for meeting the demands of everyday living in a pro-social manner.

### ■ Attachment and Development

A common factor that lies at the intersection of neurodevelopment, emotional and behavioral self-regulation, social development, capacity for intimacy, traumatic experiences, and the risk for engaging in delinquent or antisocial behavior is the presence (or absence) of a consistent, supportive, emotionally available adult relationships in a child’s life. This is especially true of early parent-child secure attachment relationships that lay the foundation for the social and regulatory responses required for later pro-social adaptive functioning (Bowlby, 1969; Hart, 2011; Schore, 2002; Sroufe, 2000).

The presence or absence of secure attachment relationships has not been identified through research as directly determining those individuals who will engage in sexually abusive behavior or differentiating individuals who commit sexual offenses from non-sexual offenders. However it is noteworthy that integrated models for understanding the etiology of sexual offending frequently point to the role that parent-child relationships play (Barbaree, Marshall, & McCormick, 1998; Marshall & Marshall, 2000; Prentky et al., 1989; Smallbone & Dadds, 2000; Ward & Seigert, 2002) or more recently to the neurological dysregulation resulting from the lack of secure attachment relationships (Stinson & Becker, 2013; Ward, Polaschek, & Beech, 2006) in the development of sexually abusive behavior.

Numerous theorists and researchers have pointed out that one of the most important functions of the human attachment system is to generate a system for self-regulation within the child. Hart (2011) writes:

*In the attachment relationship, the child learns to regulate emotions through interactive affect regulation, which helps differentiate neural patterns. The goal is to increase the capacity for self-regulation, which enables the child to simultaneously be himself or herself and to be in touch with the other in a relationship. (Hart, 2011, p. 3)*

As we are focusing on increasing our clients’ capacity for emotional and behavioral self-regulation, it is important that we understand that the experience of secure attachment in relationships is a central element in facilitating the growth of these capacities. It should not be surprising that in examining the research on resiliency in childhood, or when identifying factors that protect against engagement in

future delinquent behavior, the presence of a stable caring relationship with at least one other person is often cited, along with a capacity to self-soothe and a sense of personal competence, as a key protective process (Egeland, Carlson, & Sroufe, 1993; Masten & Coatsworth, 1998; Resnick et al., 1993; Widom, 1991).

Research from the National Child Traumatic Stress Network (2003) notes that the seven most frequent types of developmental insults contributing to post-traumatic behavioral difficulties in children include: emotional abuse (59%), loss of important relationships (56%), impaired caregivers (47%), exposure to domestic violence (46%), sexual abuse (41%), neglect (34%), and physical abuse (28%). I suggest that at least five of these “developmental insults” directly involves disruptions in the parent-child attachment relationship and, depending on the circumstances of an individual case, all seven of these factors may specifically involve parent-child interactions.

Because of the importance of attachment relationships in facilitating broader neurodevelopment, disruptions or direct insults to early attachment relationships, such as parental abuse and neglect, can also have the effect of creating obstacles to experiencing personal competency and mastery. DeBellis et al. (2009) note that childhood experiences of abuse and neglect can lead to a range of learning disabilities, including significantly lower IQ and specific problems in reading, mathematics, complex visual attention, visual memory, language, verbal memory and learning, planning, and problem solving. Research has shown that 30% or more of children who have suffered abuse and neglect develop specific learning difficulties (Streck-Fisher & van der Kolk, 2000). In a study of the Vermont Correctional System (2000), 95% of youth under age 22 incarcerated in the adult prison system lacked a high school diploma and 48% had a history of special education in school.

Given that positive engagement in school and the development of personal competency are among the strongest protective factors for youth at risk for problematic and antisocial behaviors, learning issues can present as an important and frequently overlooked obstacle to treatment progress. Appreciating the role that attachment relationships can play in facilitating school engagement and cognitive performance is an important factor in addressing these issues.

### ■ Translating a Developmental Perspective into Assessment and Treatment

If there is agreement that a holistic view of the adolescents we treat most effectively informs our understanding of their current behavior and future risk for sexually abusive behavior, it also appears that viewing the youth within the context of his or her developmental history and optimal developmental trajectory is an essential underpinning for the entire assessment and treatment process.

### Incorporating a Developmental Approach into the Assessment Process

Integrating a developmental approach into the assessment process largely entails utilizing information regarding normative developmental skill acquisition as the baseline for evaluating an individual client's strengths and weaknesses. This does not preclude the gathering of information involved in a more typical assessment of adolescents with sexual behavior problems. The assessment will still involve gathering information about the reported problematic sexual behavior, family history, school history, social history, cognitive functioning, etc. What may prove different is that our interpretation of this information is now focused on how these behaviors or experiences either enhance or create obstacles to pro-social growth and development. Also, information from specific test instruments such as personality inventories, intelligence tests, and other normed scales can be incorporated and provide some reference of the individual's functioning when compared to other adolescents of the same or similar age. Additionally, current instruments designed to structure the clinician's assessment of risk for future sexual offenses such as the JSOAP-II, the ERASOR, or the J-SORRAT-II, continue to be viewed as useful tools, although, arguably, these tools are inherently limited because, by design, they identify collective risk factors rather than individual dynamics (Latham & Kinscherff, 2012).

We would argue that the research on adolescents with behavioral problems suggests that the more typical assessment battery will additionally include an evaluation of specific trauma symptoms (e.g., Trauma Symptom Checklist for Children, Child Post-Traumatic Symptom Scale), an adaptive behavior/life skills scale (such as the Vineland or the Casey Life Skills Assessment), testing for executive functioning skills (for example, the Behavior Rating Inventory of Executive Function, Wisconsin Card Sort, or the Conner's Continuous Performance Test), and a sensory assessment or sensory screening completed by or in conjunction with an occupational therapist (OT). A sensory assessment is helpful because many clinicians fail to consider sensory issues in the children and adolescents they evaluate, and symptoms are often overlooked or more simply viewed as another aspect of disrupted or dysregulated behavior. Ideally, an OT would be available for at least a screening for all youth, or the clinician will include a basic screening instrument in the assessment process. Although these additional instruments are aimed at assessing for a wide range of specific trauma and neurological conditions, they also yield a sense of each youth's capacity to function at a developmentally expected level and are targeted at those issues that frequently create significant developmental obstacles for behaviorally troubled youth.

An important aspect of the assessment process is gaining information, either through direct observation or through feedback from the client, family, school, and other involved parties, regarding the

client's observed developmental competencies in relation to his or her chronological age. It is important to engage in this process with clients, families, schools, etc., because it is frequently the case that when developmental deficits are present, they are not necessarily global in nature. That is, individuals may present as developmentally "on track" in several aspects of their life (such as social interests or physical coordination) and yet have significant, but sometimes less visible, gaps in other developmental areas (for example, language skills, and accurately reading social cues).

There are a variety of resources available that identify specific developmental skills (physical, cognitive, social-emotional) that are generally related to different developmental periods in a child and adolescent's life (e.g., Victoria State Government, 2008; Institute for Human Services, 2007). Utilizing such a reference as a framework for discussing the youth's current functioning, integration of expected developmental gains, and developmental progress can achieve a variety of goals.

1. It places the adolescent's current functioning into context and often informs parents and other involved parties about realistic expectations and typical issues for children at particular developmental stages.
2. It allows for a more holistic view of the adolescent that identifies strengths as well as weaknesses, and also identifies deficits or obstacles that may not have been attended to or not previously recognized.
3. It can stimulate discussion with the client and the family regarding events or experiences in the adolescent's life that may have inhibited, enhanced, or influenced development at particular ages.
4. It helps the evaluator to place the adolescent's sexual behaviors and understanding of appropriate sexual behavior into a developmental context.
5. It helps identify and prioritize the focus of treatment and treatment goals.
6. It provides an ongoing framework for recognizing and measuring treatment progress.

Using a developmental perspective as the framework for guiding assessment not only encourages the clinician and the client to focus on adaptive and pro-social functioning as the goal of treatment, rather than just the "absence of bad," but also encourages the other involved systems to adopt a similar focus. I have found that adopting a developmental perspective during the assessment period can also enhance family engagement and openness to a greater extent than an assessment process that is largely framed by pathology and behavioral problems.

Adding a developmental focus to assessment, including the evaluation of sexual risk, broadens and deepens our perspective, and allows us to see each youth as a person in the midst of a developmental process. In turn, this focus, and the resulting view of the client, can not only help us to better assess

the possibility of future troubled behavior, but also evaluate what the young person may need in treatment, and what can be expected of the young person entering treatment.

### Treatment in the Context of the Developing Brain

Adopting a developmental framework not only helps in identifying treatment needs and establishing treatment priorities, but also can help specifically guide the treatment process and treatment interventions. When considering a treatment plan and treatment interventions, we have come to use the sequence of brain development and child development as an indication of where to focus treatment priorities and how to best facilitate the delivery of treatment interventions. As with the developmental process in general, this means a focus on foundation skills and experiences before more complex tasks and the utilization of treatment modalities that move from the bottom (body based, sensory based and experiential) to the top (analytical and insight oriented).

### The Basics of Brain Development

During fetal development, neurons are created and migrate to form the various parts of the brain. As neurons migrate, they also differentiate, so they begin to "specialize" in response to chemical signals (Perry, 2002). This process of brain development occurs in a specific sequence from the most basic parts to the most complex parts. The lower brain (brainstem and cerebellum) develops first. The brainstem is responsible for basic survival functions like breathing, heartbeat, and reflexes while the cerebellum is responsible for controlling physical movement, balance and coordination. The limbic system develops next and is responsible for the processing of emotions, while the cerebral cortex develops last and is responsible for conscious, voluntary action.

Along with this bottom to top orientation for brain development, there is simultaneously a developmental process moving from the right hemisphere to the left hemisphere and from the back of the brain towards the front of the brain. In broad terms, the right hemisphere of the brain is more focused on global tasks while the left hemisphere is more focused on logic and analysis. Typically tasks like facial recognition, spatial orientation, color recognition, music, rhythm, rhyme, and art are considered right hemisphere dominant tasks and these tend to be prioritized in early infancy. Skills such as language, logic, sequencing, and analysis are considered more left hemisphere dominant and generally emerge later and more gradually. In addition, when examined from back to front, there is a sequential development of the visual cortex, the somatosensory cortex, the auditory cortex, the motor cortex, and then the pre-frontal cortex that tends to guide the way in which infants experience and interact with the world around them.

When considering the executive functions of the pre-frontal cortex, the *right pre-frontal cortex* is involved in the task of recognizing faces and the

meaning of expressions; interpreting others emotions from tone, posture, and gesture; reacting appropriately to negative tones and gestures; and interpreting stimuli and coordinating the feelings of risk states. These skills provide a basis for the more analytic executive functions of the left pre-frontal cortex. The *left pre-frontal cortex* is engaged in analyzing information; planning and preparing to execute plans; identifying obstacles and adjusting solutions; interpreting experiences and modifying emotions; and controlling impulses and deciding how to meet needs (Siegel, 1999).

We feel that the process of brain development provides something of a template for how developmental tasks and experiences are best learned and integrated. Reminding ourselves of this process can substantially inform our understanding of what treatment needs might take priority and what modalities might best facilitate treatment for different issues or at different points in the treatment process.

### A Developmental Approach to Treatment

A developmental approach to treatment utilizes our understanding of tasks associated with different developmental stages and our understanding of neuro-development and neuro-processing to create the framework for treatment. In treatment, this means attending to the earliest developmental tasks first (attunement, attachment, body awareness, physiological regulation, and accurate reading and interpretation of social cues) before moving to higher level developmental tasks, such as learning and integrating social rules and skills, higher levels of personal responsibility, and understanding the impact of my behavior on others. The acquisition of these skills can then lead to addressing still more complex issues such as understanding the dynamics of individual behavior, active and adaptive resolution of family and social conflicts, the development of empathy and broader moral development. Obviously, in treating adolescents with sexual behavior problems many of these issues must be addressed simultaneously; nevertheless, a developmental perspective suggests that for the adolescent to effectively integrate and independently utilize higher level skills, he or she must first experience and build competencies in the “foundation” skills.

An understanding of neuro-development directs the clinician and the system as a whole to work toward treatment interventions that are multi-modal in nature. For instance, if, through assessment, the client is seen as having deficits in early developmental skills such as self-regulation and accurately reading social cues, this should direct us to consider more body based or sensory-based treatment interventions, over an immediate or exclusive use of more cognitive based interventions. This would mirror our “bottom to top, right to left, back to front” understanding of how skills such as social attunement, negotiating personal space, and regulating physiological arousal are first learned and integrated. As another example, research on the impact of trauma has indicated that one conse-

quence of childhood trauma can be a lack of left hemisphere development, and also deficits in left-right hemisphere integration (Teicher et al., 2002). This may mean that many of the adolescents with whom we work are better at visual learning and kinesthetic or experiential learning than they are at verbal learning. Relying exclusively or heavily on “talk therapy” may, in fact, limit treatment progress for many clients. Educational research also indicates that all adolescents are likely to be more engaged in the learning process, and better able to integrate information, when it is presented in a variety of modalities (Jensen, 2000).

It is important to note, that the assessment and treatment process identified above does not suggest that every adolescent starts treatment with a focus on the same treatment issues or with the same treatment interventions. Rather, the clinician should start treatment with an understanding of the adolescent’s developmental deficits/gaps and strengths with the goal of facilitating pro-social growth and progress. As with normal child development, the more limited the developmental capacities the greater the need will be for adult engagement, direction, structure, and supervision. Conversely, a higher degree of developmental skills would suggest a focus on later developmental tasks, such as personal responsibility, improved independent decision-making, pro-social peer interaction, and a greater degree of moral development. As stated earlier, the adolescents we treat frequently present with a high level of developmental competencies in some areas, but also with significant gaps in others. The difficult task for the clinicians, families, teachers, and others involved with these youth is creating the proper balance among the family, school, and social contexts of the youth’s life in order to enhance the developmental strengths of each youth while “back-filling” enough of the early developmental experiences to provide the necessary foundation for future growth and progress.

Accordingly, applying a developmental framework to treatment, or viewing the client through a developmental “lens,” can help us, not only to better understand our clients and their behaviors, but also what they need in treatment, and when and how to build and deliver treatment interventions.

### ■ Integrating a Developmental Approach with Risk, Needs, and Responsivity

Bonta and Andrews (2010) write that interventions with individuals exhibiting externalizing, criminal behavior are most effective when the intensity of services is determined by the individual’s risk factors and when treatment targets risk-relevant dynamics. In addition, they highlight the importance of providing services in a manner that recognizes and is responsive to individual learning styles and learning needs. The principles of Risk-Needs-Responsivity (RNR) have become a central component in the development of treatment programs for adult sexual offenders (for instance, see Looman & Abracen, Wilson & McWhinnie, and Yates, this issue), and to a somewhat lesser degree are identi-

fied in the formulation of treatment programs for adolescents.

Among the primary difficulties in effectively translating RNR principles to the treatment of adolescent sexual abusers is that the research on risk factors for adolescent sexual recidivism is quite unclear and frequently conflicted (McCann & Lussier, 2008; Spice et al., 2013; Worling & Långström, 2006). Further, many of the risk factors presenting the greatest predictive strength for sexual re-offending cannot be distinguished from risk factors related to non-sexual offending (Cottle, Lee, & Heilbrun, 2001). Given the lack of clarity resulting from various meta-analyses of risk factors for adolescent sexual abuse that have yielded different results and conclusions, in many ways it seems more productive to examine individual developmental progress, family dynamics, developmental insults, personal competencies, and offense-specific dynamics to make a determination of risk for each particular adolescent. While this assessment can clearly be informed by factors identified in previous research (e.g., atypical sexual interests, early exposure to pornography, antisocial peer group, etc.), it strikes me that these issues would emerge anyway as concerns in an individualized assessment that focused on an adolescent’s developmental trajectory.

An assessment and treatment process that views sexually troubled adolescents in the context of normal adolescent development is quite compatible with and remains guided by RNR principles. Indeed, a developmental perspective takes into account the risk for continued troubled behavior, the individualized needs of each client and obstacles to pro-socially meeting these needs, and the likely responsivity of each youth to different forms of treatment at any given point. From this perspective, *risks* are viewed as risks to successful, pro-social development, whereas *needs* are viewed in the context of the resources, supports, and experiences that each adolescent requires in order to successfully manage his or her specific developmental needs and demands. A developmental approach to treatment directly leads us to addressing issues of *responsivity* (e.g., neurological issues, learning disabilities, learning style, co-morbid mental health problems, cultural issues, etc.) as an essential aspect of our initial assessment.

A developmental approach is, therefore, consistent with the principles of risk, need, and responsivity, and in fact advances the meaning and value of each principle when each young person is seen through a developmental lens.

### ■ Conclusion

While I’m sure that most clinicians and treatment programs working with adolescents exhibiting sexual behavior problems would say that they take a holistic approach to treatment, and that they regularly consider adolescent developmental issues in their assessment and treatment of their clients, my experience tells me that quite often basic developmental needs and issues are not considered in placement and treatment decisions involving these

youth. This seems especially true for the adolescents whose lives are more significantly determined by decisions made by larger involved systems (juvenile justice, social service, education). By using our understanding of healthy, normative child and adolescent development to explicitly guide our treatment of these adolescents, I believe we increase our understanding of the etiology of sexually abusive behavior; we become more successful at individualizing treatment; we make better, more rational, and more consistent systemic interventions; and we offer clearer direction, support, and motivation for the adolescents and families that we treat.

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## Using Mindfulness in the Treatment of Adolescent Sexual Abusers: Contributing Common Factor or a Primary Modality?

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### Abstract

Although mindfulness has become a mainstream methodology in mental health treatment, it is a relatively new approach with adolescents, and perhaps especially youth with sexual behavior problems. Nevertheless, clinical experience and several empirical studies are available to show the effectiveness of a systematic mindfulness-based methodology for treating adolescents who engage in sexual and physical aggression. In this article, the authors first explore the elements of mindfulness that are inherent in traditional cognitive-behavioral therapy (CBT) and then review how mindfulness has been systematically incorporated into several “third wave” cognitive-behavioral therapies – ACT, DBT, MBCT, and MDT – each of which have been applied with adolescents. While it can be argued that mindfulness is a “common” therapeutic factor across approaches, mindfulness can also be considered to be, and applied as, a primary modality to enhance the effectiveness of most therapies with adolescents who engage in problem behaviors, including sexual offending. The key, however, is making modifications to accommodate the unique developmental needs of adolescents. A case example is presented to demonstrate the clinical application of mindfulness with an adolescent victim and perpetrator of sexual abuse.

### Keywords

Mindfulness, sexually abusive youth, sexual offender treatment, cognitive behavioral therapy, mindfulness-based therapies, “third wave” cognitive therapies

Although the practice of mindfulness is centuries old, it was not applied as a stand-alone technique in clinical psychology until Fritz Perls (1969) attempted to unify mind, body, and spirit with Gestalt Therapy. Drawing from his studies of Zen Buddhism, Perls emphasized the principle of enhanced awareness in the present moment. Perls valued all forms of immediate awareness – sensation, perception, emotion, thought, behavior, and bodily feelings – and understood the natural therapeutic effects of staying with here-and-now experience. In the 1970s, others began to use the term “mindfulness” and began to apply mindful awareness in a systematic fashion (Kurtz, 1990; Kabat-Zinn, 1990). By the late 1990s, mindfulness had become a commonplace term in the field of mental health and is used today as a mainstream technique. The application of mindfulness to adolescents, however, is a relatively recent development and its recognized value with sexually abusive teenagers is just emerging (Apsche & DiMeo, 2010, 2012).

Mindfulness has been defined as the “intentional process of observing, describing, and participating in reality nonjudgmentally, in the moment” (Greco & Hayes, 2008, p. 4). In their definition for adolescents, Jennings and Apsche (2013, p. 5) define mindfulness as “being fully aware of your immediate present experience and accepting yourself as you are in this moment without judgment.”

Although some empirical support for the direct use of mindfulness with adolescent sexual abusers is available, the first half of this article reviews the many indirect ways in which mindfulness has been incorporated into other mainstream cognitive treatment approaches that have been applied with adolescents. This raises the question of whether mindfulness is a method unto itself, or reflects a “common factor” across therapeutic approaches.

The second half of the article presents empirical studies of mindfulness with adolescents, and presents a case example of how it can be applied in work with sexually abusive youth.

### ■ Mindfulness as a Therapeutic “Common Factor” in Traditional CBT

Of all the psychotherapies in mental health today, cognitive behavioral therapy (CBT) has become the predominant approach and, for better or worse, is the principal approach in the field of sex offender-specific treatment (Jennings & Deming, 2013). As such, our discussion of mindfulness begins with traditional CBT, which uses four main strategies to change thinking and behavior: skills training, exposure therapy, cognitive therapy, and consistency management (Young, Weinberger, & Beck, 2001). The exposure therapy component of CBT can be viewed as a process of immediate awareness. Although it may be intended differently, it contains the essential elements of an intense focus on immediate awareness, incorporating mental, physical, and emotional experience, and can yield therapeutic effects through the “acceptance” of the immediate discomfort and irrationality. More broadly, the classic CBT process of identifying and challenging the validity of cognitions can also be seen as a sort of mindfulness to the degree that the client is systematically and repeatedly “exposed” to his or her disturbing and dysfunctional thoughts and emotions and, hopefully, becomes increasingly able to tolerate and accept disturbing cognitions without negative self-judgment (Heimberg & Ritter, 2008). From a mindfulness standpoint, the key therapeutic element in CBT is having the experience of non-judgmental acceptance during the process of challenging negative cognitions, which occurs in the context of a mutually “mindful” relationship

with the CBT therapist (Glass, Arnkoff, Woodruff, Maron, McMorran, Monahan, & Hirschhorn, 2013).

Over fifteen years ago, Martin (1997) argued that mindfulness can be seen as a “common factor” that cuts across therapeutic orientations, including CBT, psychodynamic, humanistic, and family systems therapy. The presence and value of mindfulness across treatment approaches has been similarly asserted by Bell (2009). With regard to CBT, specifically, it is argued that a mutual process of mindfulness is occurring on the part of both the therapist and the client (Glass et al., 2013). Mindfulness for the CBT therapist takes the form of consistent and focused attention on the client’s thoughts and experiences, while consistently providing nonjudgmental acceptance of the client’s reports of dysfunctional thoughts and behavior. Mindfulness for the CBT client takes the form of improving one’s awareness of inner thoughts and experience, observing and gaining more tolerance and acceptance of negative thoughts and emotions, and learning to regard one’s dysfunctional cognitions as distinguishable from one’s core self and value as a person.

### ■ Mindfulness as an Explicit Technique in the “Third Wave” of CBTs

While there may be mindfulness elements in traditional CBT and other forms of psychotherapy, the explicit effort to integrate mindfulness and acceptance into traditional CBT has clearly revolutionized the field and spawned the so-called “third wave” of cognitive behavioral therapies (Baer, 2006). Among other therapies, these include, in published chronology, Mindfulness Based Stress Reduction (Kabat-Zinn, 1982); Acceptance and Commitment Therapy (Zettle & Hayes, 1986); Dialectical Behavior Therapy (Linehan, 1993); Mindfulness-Based Cognitive Therapy (Teasdale, Segal, & Williams, 1995); and Mode Deactivation Therapy (MDT) in 2002 (Apsche, Evile, & Castonguay, 2002).

**Mindfulness Based Stress Reduction (MBSR).** MBSR is a behavioral medicine program that translated the Zen Buddhism meditation techniques of Thich Nhat Hanh into a secular, classroom-based psychoeducational program for stress reduction. It was first introduced in 1979 as a treatment for chronic pain by Jon Kabat-Zinn (1982). In 1979, MBSR is not a therapy per se, but rather a group-based training curriculum that has been successfully applied to various clinical syndromes, including depression and anxiety. MBSR continues to be a widely used program, but it is mentioned here for its important historical role in popularizing mindfulness meditation and bringing it into mainstream clinical psychology.

**Acceptance and Commitment Therapy (ACT).** Developed by Steven Hayes and his colleagues in the mid-1980s, ACT retains the essential CBT focus on cognition, but shifts the focus from challenging or controlling cognitive distortions to simply noticing and “accepting” the occurrence of negative thoughts and emotions. ACT teaches clients to first become mindful through intensive focus on immediate awareness and then to accept their experi-

ences, rather than suppressing or avoiding them as unacceptable and judgmentally “bad.” One of the strongest principles of ACT is helping clients to see themselves as being separate or different from their current negative thoughts and behaviors (Gutierrez & Hagedorn, 2013). ACT applies six core principles of acceptance, cognitive diffusion, contact with the present moment, observing the self, values, and committed action (Hayes, 2004; Hayes, Strosahl, & Wilson, 2013) and has been systematically applied to adolescents (Greco & Hayes, 2008).

The combined ACT principles of *contact with the present moment* and *acceptance* are virtually synonymous with the definition of mindfulness used in this article: immediate awareness of experience with acceptance (i.e., without judgment). The goal in ACT is to help clients to stay aware of their private memories, thoughts, and feelings without the need to change or avoid their experiences. *Cognitive defusion* is learning to reduce the tendency to reify thoughts, emotions, and memories by instead recognizing the transitory nature of thoughts, putting them into context, and making the distinction between one’s dysfunctional thoughts and one’s core self (Gutierrez & Hagedorn, 2013). *Observing the self* is learning to tap into a transcendent sense of self that is able to neutrally observe one’s ever-changing experiences and emotions without judgment (acceptance). At its optimum, the person taps into a calm, deeper continuity of consciousness that is, in the Buddhist tradition, one’s “true self,” able to view oneself as universal and detached from current behaviors and private experiences. In turn, this transcendent perspective provides the opportunity for the client to discover and clarify his or her most important *values*, and then take *committed action* toward those valued life goals.

**Dialectical Behavior Therapy.** Published in 1993, Marsha Linehan’s Dialectical Behavior Therapy (DBT) is a variation of CBT that teaches skills to cope with stress, regulate emotions, and improve relationships with others. Key components of DBT include cognitive behavioral therapy, validation, dialectics, and radical acceptance. Given her primary clinical population of borderline personality-disordered and suicidal clients, Linehan sought to modify CBT to accommodate their characteristic features of extreme emotional reactivity, high sensitivity to perceived rejection, and inability to self-soothe. To the degree that CBT repeatedly challenges the empirical and logical validity of the client’s beliefs, Linehan’s borderline clients felt as if their emotional pain was being discounted as not real, that their essential competency as a person was under attack, and that they were being rejected (as we will see later, this is a similar limitation of CBT with adolescents). Therefore Linehan adapted CBT by using *validation* as a way of showing an acknowledgement of the client’s experience of real pain. The DBT therapist affirms that the client’s illogical or maladaptive actions make sense as a valid attempt to relieve suffering and promotes cooperation with the client in finding healthier alternatives. Linehan, Cochran, and Kehrer (2001) describe the DBT principle of *dialectics* as on-going dynamic application of various therapeutic strategies. Dialectics is

the principle that all things are interconnected, that change is constant and inevitable, and that opposites can often be integrated to form a closer proximity to the truth. For example, the DBT therapist and client work together to resolve what seems to be a contradiction between self-acceptance of oneself as is and changing oneself to be better. *Radical acceptance* is helping the client to allow her or himself to have all sorts of thoughts, urges, and ideas (even negative or forbidden thoughts that are typically suppressed), which spontaneously appear in the present immediate moment, but without negative self-judgment.

**Mindfulness-Based Cognitive Therapy.** Partly inspired by the mindfulness-based stress reduction program first developed by Jon Kabat-Zinn (1990), Mindfulness-Based Cognitive Therapy (MBCT) was created as a group program for the treatment of depression (Segal, Williams, & Teasdale, 2002). Like CBT, MBCT seeks to interrupt habitual (“automatic”) negative thinking patterns that can trigger a depressive episode. Whereas traditional CBT focuses on negative thinking in order to challenge its validity, MBCT teaches the person to open his or her awareness to all sorts of incoming stimuli and to simply observe and accept all thoughts and experience without judgment. In MBCT, the clients are taught mindfulness in an eight-week group session format, learning to concentrate attention on their immediate experience, including negative, dysfunctional, and ineffective thinking and beliefs – but without judgment. By allowing and acknowledging the presence of negative thoughts and emotions without judgment or avoidance, the person gains a decentered, objective perspective that is better able to cope with emotional distress and more resistant to depression.

**Mode Deactivation Therapy.** Apsche developed MDT specifically to overcome the limitations of traditional CBT with disturbed adolescents, especially conduct disorder and aggressive youth. Apsche integrated Beck’s (1996) theory of “modes” and schema therapy from traditional CBT with elements from Linehan’s DBT and Functional Analytic Behavior Therapy (Kohlenberg & Tsai, 1993). Beck conceived of “modes” as powerful sub-organizations of the personality. Modes are comprised of integrated networks of cognitive, affective, motivational, and behavioral components, which originally developed as protective strategies and beliefs in response to traumatic and abusive life experiences. Modes are emotionally charged and become ingrained, maladaptive, “automatic” responses to perceived threats. Indeed, because clinically dysfunctional adolescents are instantaneously flooded with powerful anxiety, rage, and fear, Apsche et al. (2005) found that they were unable to override their primal, automatic “mode” responses by employing CBT-like cognitive controls. Given their volatility and histories of victimization, such youth are distrustful, guarded, fearful, and acutely sensitive to adult-child power issues in the therapeutic alliance. Like Linehan’s borderline clients, Apsche found that traditional CBT was frequently counterproductive and alienating for adolescents. No matter how delicately it may be done, the CBT pro-

cedure of repeatedly challenging faulty thoughts and beliefs is negatively experienced by the youth as an attack on his or her fragile sense of self-esteem and world-view, which frequently backfires into increased resistance and distrust. This is especially problematic with dysfunctional adolescents, who have developed rigid beliefs and automatic dysfunctional “mode” responses to protect themselves from the pain and fear of trauma and abuse. Given the developmental primacy of autonomy for adolescents, even non-clinical teens can be highly sensitive to power dynamics with adults and may react with oppositional defiance when their beliefs are challenged.

To accommodate this inherent “oppositional” dynamic with adolescents, MDT adopted the principles of validation, radical acceptance, balancing, and mindfulness from DBT. Rather than challenging cognitive distortions and irrational beliefs, the goal is to join with the youth in collaboratively discovering how the individual’s belief system is a legitimate reflection of his or her life experience, relationships, sense of self, and world view. MDT *radically accepts* the adolescent’s beliefs as truths in his or her life, no matter how irrational, and even if there is only a “grain of truth.” MDT continually *validates* the adolescent’s perception of reality, accepting the youth for who he is based on his beliefs, which builds trust and collaboration with the therapist. Then MDT collaboratively applies *cognitive balancing* to introduce increasing flexibility or balance into the individual’s rigid and maladaptive dichotomous (either/or) beliefs by opening consideration to a continuum of truth or a continuum of possibilities.

In particular, MDT uses direct training in *mindfulness skills* as a major intervention in the process of deactivating the adolescent’s ingrained maladaptive “mode” responses (i.e., emotional deregulation). Given the resistance and reactivity of severely dysfunctional adolescents, Apsche and Jennings (2013) developed a diverse “toolkit” of non-threatening ways of teaching mindfulness skills, including breathing exercises, guided imagery meditation, visual concentration tasks, nature walks, sensory explorations, and intentionally fun exercises that incorporate sports and adventure to engage youth. The diversity of tools offers more ways of engaging youth and gives them the autonomy of choosing mindfulness exercises that they prefer. Since the mindfulness exercises are relaxing in nature, they do not trigger the emotional disruptions and oppositional reactivity of “modes.” Moreover, the mindfulness exercises typically do not involve traditional “talking” therapy, which can often be experienced as aversive, intrusive, boring, or upsetting for teen clients.

Most importantly, the mindfulness training component of MDT serves multiple therapeutic purposes. Research with adolescent offenders has shown deficits in identifying, labeling, and managing emotions (Moriarty, Stough, Tidmarsh, Eger, & Dennison, 2001). Mindful focusing on immediate experience directly promotes the development of introspective awareness and helps the adolescent to learn to tolerate emotional pain, negative emo-

tions, and the anxiety of new experiences without avoiding them or losing control. Like DBT, the MDT mindfulness exercises provide opportunities for adolescents to regulate their emotional reactivity and let go of defensive hyper-vigilance. Through calm, neutral observation, adolescents learn to “accept” whatever experiences enter awareness – without negative judgment, reactive fear, aggressive outbursts, or harsh self-criticism – ultimately leading to greater self-acceptance and self-confidence in controlling dysfunctional behavior and emotional reactivity.

### ■ Applications of Mindfulness with Forensic and Offender Populations

Although limited, there has been a recent increase in efforts to apply mindfulness and acceptance-based techniques with forensic and offender populations. In their review article, Gillespie, Mitchell, Fisher, and Beech (2012) focused on the potential value of mindfulness with adult sex offenders, in particular, because negative affect and deficient regulation of emotional states often have a causal role in pathways to sexual offending (Hudson, Ward, & McCormick, 1999). In particular, they hypothesize that mindful breathing concentration applies directly to the neurobiological centers of emotional control. Howells (2010) has likewise recommended expanding the “third wave” of mindfulness-based cognitive therapies to include forensic mental health populations. In applying mindfulness to the treatment of anger and aggression, for instance, Wright, Day, & Howells (2009) state that “acceptance based approaches attempt to teach clients to feel emotions and bodily sensations more fully and without avoidance, and to notice fully the presence of thoughts without following, resisting, believing or disbelieving them (p. 398).” Samuelson, Carmody, Kabat-Zinn, and Bratt (2007) directly applied Mindfulness-Based Stress Reduction with male and female inmates to reduce hostility and mood disturbances and to improve self-esteem.

Berzins and Trestman (2004) reviewed six different adult forensic programs that used group-based psychoeducational programs in Dialectical Behavior Therapy, of which two had an explicit mindfulness training component. The Colorado Mental Health Institute program delivered three mindfulness sessions (8% of the total of 37 DBT group sessions) to male forensic patients, while the Correctional Services of Canada program delivered 6 mindfulness sessions (14% of the 42 DBT group sessions) to female forensic patients. No outcome data was reported for either program, but it appeared to help reduce overall physical and sexual aggression and rule-violations.

Finally, in a series of several studies, Singh and his colleagues (Singh et al., 2010) have used mindfulness to treat the aggression problems of adults with mental illness and adults with intellectual disabilities, as well as to manage deviant sexual arousal with adult sex offenders and adolescents with intellectual disabilities. Of particular interest to this discussion, the Singh group used five consecutive days of 30-minute training in mindfulness-based

“meditation on the feet” to train three adolescents with autism to self-manage their physical aggression, reducing hitting from 14–20 events per week to 1 per year over three years of follow-up (Singh et al., 2007).

### ■ Applications of Mindfulness with Adolescents

The recent growth of interest in mindfulness interventions for youth is reflected in two recent reviews by Black, Milam, and Sussman (2009) and Burke (2010), who conducted the first systematic review of the available research. At that time, Burke found a total of only 7 studies of mindfulness with children and 8 studies with adolescents, most of which were preliminary and exploratory. One large randomized study applied the standard Mindfulness-Based Stress Reduction course (Kabat-Zinn, 1990) as an adjunct to “treatment as usual” (TAU) for a group of 102 adolescent outpatients with heterogeneous psychiatric diagnoses (Biegel, Brown, Shapiro, & Schubert, 2009). Participants self-reported greater reductions in symptoms of anxiety, depression, and somatic distress, and increased self-esteem and sleep quality compared to the TAU control group (without MBSR). Similarly, Zylowska et al. (2008) applied the same 8-week MBSR adult mindfulness training course with a mixed group of 24 adults and 8 adolescents with attention deficit hyperactivity disorder, which reduced self-reported symptoms of ADHD, anxiety, and depression, while improving performance measures in attention and cognitive inhibition tasks. Other examples of research showing the application of MBSR with youth include reduction of childhood anxiety (Semple & Lee, 2010) and improving behavioral control and attention for adolescents with ADHD (Van de Weijer-Bergsma, Formsma, de Bruin & Bogels, 2012).

In a broader meta review, Black, Milam, and Sussman (2009) reviewed 16 empirical studies of the health-related effects of “sitting-meditation” interventions with youth aged 6 to 18 years in medical, school, clinic, and community settings from 1982 to 2008, encompassing a total population of 860 participants. They found median effect sizes were slightly smaller than those for adults, ranging from 0.16 to 0.29 for physiological outcomes and 0.27 to 0.70 for psychosocial/behavioral outcomes (0.5 is considered a medium effect size, and a value of 0.8 or more is considered a large effect size). More specifically, 5 of the 7 studies of anxiety showed improvement, 1 of 3 studies of depression showed improvement, and 7 of 9 studies related to social-behavioral problems showed improvements in various measures of attention, attendance, self-esteem, and school behavior.

Overall, the application of mindfulness with children and youth is becoming well-established and growing, although most of it is focused on stress reduction and/or occurs in medical and school settings and typically entails group-based, classroom training like that of MBSR. The clinical application of mindfulness with adolescents with psychiatric disorders, however, is limited, with perhaps two exceptions. To the degree that DBT and ACT are mindfulness-based therapies, there is a sizeable

literature dedicated to both the use of DBT with multi-problem suicidal adolescents (e.g., Miller, Rathus, & Linehan, 2007) and the use of ACT with children and adolescents (e.g., Greco & Hayes, 2008), but such a review would exceed this discussion. Moreover, neither DBT nor ACT is acknowledged as evidence-based practice for sexually reactive or sex offending adolescents.

### Modifying mindfulness to meet the needs of adolescents

Although none of the above mindfulness studies involves adolescent sex abusers, a recent study by Jennings and Jennings (2013) is notable for its practical recommendations by which to modify traditional adult mindfulness training to meet the differing developmental needs and interests of adolescents. Each of these modifications can be valuable in work with sexually reactive and sexually abusive adolescents. The first, and most important, assertion is that adolescents respond well to *guided imagery* protocols that incorporate mindful breathing concentration (as long as the skills training is delivered in relatively brief sessions and has appealing content). Based on the methods of MDT, mindfulness guided imagery is a spoken protocol that guides adolescents through an imagined mountain climbing adventure, or a day at the beach, or some other peaceful and safe scenario, while frequently drawing attention to focused breathing and acceptance throughout (Apsche & Jennings, 2013). Youth thus enjoy the relaxing sensations of the experience while actively learning the mindfulness skills of focused breathing, meditative concentration, and acceptance. Critics might reject this guided approach as too structured, arguing that “true” mindfulness should be completely open-ended, allowing any thoughts, images, or feelings to spontaneously enter awareness. Instead, this modified approach for adolescents endeavors to create conditions that are conducive to mindful attention and acceptance, using guided protocols that frequently acknowledge the appearance of spontaneous thoughts and instructing the youth to simply notice the thoughts and let them pass on.

The second recommendation from Jennings and Jennings (2013) is that the content of the guided imagery should be *fun and engaging* and should offer a varied “toolkit” of mindfulness exercises and activities that have an innate appeal to youth, such as sports, nature, adventure, and discovery (Apsche & Jennings, 2013). As practiced in MDT, it is important to present adolescents with *multiple pathways* for learning mindfulness skills, which better accommodates the differing learning styles and preferences of individual teens. This toolkit approach also fosters the adolescent’s developmental need for autonomy because each teen is allowed to try various mindfulness tools and choose the ones that work best for him or her.

The third recommendation from Jennings and Jennings (2013) is to deliver mindfulness skill training in *shorter experiential sessions*, which is better suited to the shorter attention spans of youth. Traditional adult programs for mindfulness training require about eight weeks of extended class sessions

(Carmody & Baer, 2009; Segal, Williams, & Teasdale, 2002). In fact, the most widely used program of Mindfulness-Based Stress Reduction entails one 6-hour class and eight 2.5-hour classes (Kabat-Zinn, 1990). However, Jennings and Jennings allowed a teenager to select and deliver a series of mindfulness exercises to a non-clinical group of eight high school peers in just four 50-minute sessions. Results from the 3-week pilot study showed a surprisingly strong reduction in cognitive anxiety and mild reductions in social anxiety. Given the prohibitive time demands of attending an eight week program like MBSR, other researchers have begun testing mindfulness interventions that require fewer hours and/or a shorter period of time. In fact, a recent review showed no evidence that shortened versions of MBSR were any less effective than longer formats with adults (Carmody & Baer, 2009).

### ■ MDT: Applications of Mindfulness with Adolescent Sexual Abusers

To the best of our knowledge, Mode Deactivation Therapy is the only mindfulness-based treatment that has been empirically validated with sexually abusive adolescents. There is a strong body of research studies and meta-analytic studies that show the effectiveness of MDT with a variety of disturbed adolescents. In one randomized controlled experiment, Apsche and his colleagues (Apsche et al., 2005) compared the effectiveness of traditional CBT, Social Skills Training (SST), and Mode Deactivation Therapy (MDT) for 60 male adolescents with serious sexual and physical aggression problems, with an average length of residential treatment of 11 months. While all three therapies were effective in reducing rates of physical aggression, only MDT, with its focus on mindfulness, demonstrated a significant reduction in rates of sexual aggression. Two years following treatment, the recidivism rate for the MDT group was 7% with no serious offenses, such as sexual offenses or physical assaults (Apsche, Bass, & Siv, 2006). By comparison, 20% of the CBT group engaged in chargeable offenses, including sexual aggression and physical aggression, auto theft, and drug sales, while 49.5% of the SST group committed offenses, including attempted murder, rape, aggravated assault, and other serious offenses.

In another study, Apsche, Bass, Zeiter, and Houston (2009) compared the effectiveness of Family MDT with “treatment as usual” (TAU) family therapy and CBT family therapy for 40 adolescents with sexual and physical aggression problems and oppositional behavior. After 18 months, the 20 adolescents in the MDT group showed three incidents of physical aggression compared to 12 incidents for the TAU group.

Apsche and DiMeo (2010) conducted a meta-analysis of the effectiveness of MDT over the course of ten years of application, which included data from all published MDT studies as well as yet unpublished studies. Of the total of 458 male adolescent cases reviewed in the meta-analysis, more than half had sexual offenses (55.5%), while roughly half were diagnosed with conduct disorder (52%),

oppositional defiant disorder (45%), and Post-traumatic Stress Disorder (51%). Collectively, 92% of the adolescents had experienced four types of abuse, 54% had witnessed violence, and 28% presented with parasuicidal behaviors. The meta-analysis showed large effect sizes for the use of MDT for the categories of Sex Offender/Physical Aggression (1.78), Conduct Disorder/Physical Aggression (1.85), Total Physical Aggression (1.82), and Sexual Aggression (1.80), in which, as previously noted, effect sizes of 0.5 are considered medium and values over 0.8 represent large effect sizes. This suggests that a mindfulness based approach, such as MDT, is effective in treating complex conditions and behaviors, including sexually troubled behavior.

Subsequently, Apsche, Bass and DiMeo (2011) conducted a larger meta-analysis of MDT effectiveness with a total of 573 adolescents, including 369 adolescents with sexual aggression. The results again showed large effect sizes for Sex Offender/Physical Aggression (1.81), Conduct Disorder/Physical Aggression (1.85), Total Physical Aggression (1.86), and Sexual Aggression (1.94).

Based on the empirical and meta-analytic data, there is strong support that MDT, a mindfulness-based treatment, is effective with a variety of disturbed adolescents, including sexually reactive and sexually offending adolescents, and demonstrates that a systematic mindfulness-based methodology can reduce both sexual and physical aggression in adolescents (Apsche & DiMeo, 2010, 2012; Apsche, Bass & DiMeo, 2011).

Thus, by helping adolescents to stay focused in the here-and-now, rather than in the past or future, as suggested by Apsche and DiMeo (2012), mindfulness can enhance the effectiveness of most therapies with adolescents who engage in problem behaviors, including sexual offending.

### ■ Case Example: Applying Mindfulness with an Adolescent Sexual Abuser

The following transcript of a therapy session with an adolescent sexual abuser, excerpted from Apsche and DiMeo (2012), illustrates a blended application of traditional CBT techniques with mindfulness and acceptance techniques from ACT, DBT, MBCT, and MDT as briefly described earlier and shown in table 1 below. The client is a 16-year-old male, who was arrested for having repeated intercourse with an underage female. As a child, from ages 7 to 9, he was abused and repeatedly raped by his stepfather. After failing to respond to outpatient treatment, he had also been terminated from a day program and residential treatment for aggression and fighting. This therapy session was conducted in a subsequent residential program for sexually abusive youth, using various techniques drawn from CBT, ACT, DBT, and MDT (presented in italics).

**Therapist (T):** Let’s take a second and do some breathing before we talk about anything. [*Typically, the MDT therapist both begins and ends the therapy session with a brief five-minute practice of mindful breathing.*]

**Adolescent (A):** Okay...

FIVE MINUTES LATER...

- (T): Open your eyes and allow yourself to get focused in this moment. [*Use of mindful here-and-now awareness.*] Are you good?
- (A): I feel like I am moving through these painful feelings and thoughts in a different way than I have in the past with other therapists. [*Based on prior mindfulness training, the adolescent has learned to allow painful memories and emotions to enter awareness and observe them without judgment.*] Now what?
- (T): Well, let’s talk about it. You have let yourself think these thoughts and feel the pain and you are still here. [*Acceptance and validation.*] So, is it possible that you can accept that these painful thoughts and feelings are part of you, whether it sucks or not? [*Cognitive diffusion: distinguishing core self from the experience of dysfunctional thoughts and painful emotions.*]
- (A): Yeah.
- (T): And, it’s clear you can experience them and not fall apart. [*Validation.*] Can you then commit yourself to move on with all of your pain and thoughts and not let them control your life? [*ACT commitment and cognitive balancing.*]
- (A): I can try, but this isn’t easy.
- (T): You are right. It’s not easy. [*Validation.*] However, you have just successfully accepted that they are part of you and you can move on with your life. [*Acceptance and cognitive diffusion.*]
- (A): Yeah, I did.
- (T): So, maybe there are also times when there are no painful feelings and thoughts? [*Cognitive balancing.*]
- (A): Maybe, sometimes there are.
- (T): In the last session, we discussed how you couldn’t feel anything.
- (A): Yeah, I am numb. Empty.
- (T): You endorsed the beliefs “Anything is better than feeling unpleasant” and “Whenever I hurt, I do what it takes to feel better” as “Always.” Remember? [*CBT. The therapist is referring to an earlier assessment of beliefs endorsed by the client.*]
- (A): Yeah, so?
- (T): Let’s talk about your emptiness and numbness.
- (A): Okay.
- (T): Tell me what your numbness feels like. [*Mindful here-and-now awareness.*]
- (A): It feels like nothing.
- (T): And, where is the nothing?
- (A): What do you mean, where?
- (T): Where on or in your body do you notice the nothing—the emptiness and numbness? [*Mindful here-and-now awareness.*]
- (A): [Points to chest.]
- (T): Where on your chest? [*Mindful here-and-now awareness.*]
- (A): Here, right in my chest.
- (T): Describe how the numbness feels. What does the emptiness feel like in your chest? [*Mindful here-and-now awareness.*]
- (A): It feels like an empty hole.

- (T): What do you notice about this emptiness? Is it there to protect you from pain? [*MDT validation of the protective function of dysfunctional modes.*]
- (A): What pain?
- (T): The pain of your past physical and emotional abuse. The pain you feel from your mother not being able to take care of you. [*MDT validation of the protective function of modes. While this intervention appears overly directive, it is referring to insights gained by the youth during preceding treatment sessions.*]
- (A): No, there was pain there, but I cut it off.
- (T): Okay, describe that pain that was there. [*Mindful here-and-now awareness.*]
- (A): It was like a burning hole in my chest, like my heart had hot burning lava in there.
- (T): Okay, let yourself experience that pain. The hot lava right here [points to chest]...right now. Let's sit with it. [*Mindful here-and-now awareness and acceptance.*]
- FIVE MINUTES LATER...
- (T): What are the painful thoughts that go with this numbness and pain? [*CBT.*]
- (A): I am alone—no good. I am shit, like trash.
- (T): Let yourself experience these thoughts and pain. [*Mindful here-and-now awareness and acceptance.*] You know that you have spent your life avoiding these painful thoughts and feelings. They are really hard as hell to deal with. [*Validation. This seemingly directive intervention is referencing insights gained by the client in previous sessions.*]
- (A): Yes, it really sucks sometimes that I have to live with pain and bad memories, but at least I can live with them and finally move on in my life. [*Acceptance and ACT commitment.*]
- (T): It's not easy, but you have just successfully accepted that they [painful feelings] are part of you and you can move on with your life. [*Validation and cognitive balancing.*]
- (A): Yes, I did.
- (T): So, you agree that you can experience painful or numb feelings and be okay at times? [*CBT and cognitive balancing.*]
- (A): This time.
- (T): It makes sense that you are in therapy given your history. Your childhood was filled with hurt and anger and being on your own most of the time. [*Validation.*]
- (A): You know it.
- (T): So you being here with all these feelings of anger and hurt makes sense and it is where you need to be, but you also can experience your painful thoughts and emotions and be okay. [*Acceptance, validation and cognitive balancing.*]
- (A): I don't know if I can.
- (T): I mean right now in this moment, you can experience unpleasant feelings and be okay. [*Mindful here-and-now awareness.*]
- (A): Right now, yeah.

- (T): Tell me how much you really believe you are okay experiencing these painful thoughts and feelings on a scale of 1 to 10, right now. [*CBT.*]
- (A): Maybe a 6.
- (T): So, 60 percent of the time, you, in this moment, are able to experience unpleasant feelings and be okay. [*CBT and cognitive balancing.*]
- (A): Yeah, I need more work with this shit, though.
- (T): You will keep working on it, because it works and you are important and can experience some good stuff in life. [*Validation and cognitive balancing.*]
- (A): Okay.
- (T): Can I ask one more thing? You had endorsed the belief "Always," for "Whenever I hurt, I do what it takes to feel better." Right? [*CBT. The therapist is referencing an earlier assessment of beliefs endorsed by the client.*]
- (A): Yeah.
- (T): So, before, what did you do to feel better? [*CBT.*]
- (A): Fight, drink, smoke weed. You know, stuff like that.
- (T): Okay, but you just experienced painful thoughts, hurtful feelings and that hot lava—and you said you could deal with it 60 percent of the time, right here and now. Right? [*CBT and cognitive balancing.*]
- (A): Yeah, so?
- (T): So, is it possible to hurt and be okay with it in this moment? [*CBT and cognitive balancing.*]
- (A): Yeah, right now I can.
- (T): So right here and right now in this moment, you can hurt and be okay and not have to fight, drink, smoke weed, or any other stuff like non-consensual sex? [*Mindful here-and-now awareness and cognitive balancing.*]
- (A): Yeah, right now with you.
- (T): That's where it starts. Good work for today! We'll continue working on this next session so you can feel numbness and pain and be okay in the moment... Now, let's end the session with a breathing mindfulness exercise...

### ■ Conclusion: Mindfulness as a Common Factor across Therapies or a Primary Modality?

Besides discussing and, we hope, demonstrating the value of a mindfulness approach in the treatment of sexually abusive youth, an essential question posed is whether mindfulness is actually a "common factor" that permeates all effective CBT and other therapies, or whether mindfulness is, in itself, a primary and distinctly separate modality that can be used in combination with CBT and other third wave cognitive therapies, and perhaps other models of therapy as well. For instance, we believe that a practitioner of traditional cognitive therapy would be comfortable with the therapy session presented above, which appears familiar as an appropriate effort to identify, challenge, and correct irrational beliefs such as "I am shit" and "I cannot

**Table 1.** Techniques and principles of applied cognitive behavioral therapies

Therapy Model	Main Techniques or Principles
Cognitive Behavioral Therapy	<ul style="list-style-type: none"> <li>• Skills training</li> <li>• Exposure therapy</li> <li>• Cognitive therapy</li> <li>• Consistency management</li> </ul>
Acceptance and Commitment Therapy	<ul style="list-style-type: none"> <li>• Contact with the present moment</li> <li>• Acceptance</li> <li>• Cognitive diffusion</li> <li>• Observing the self</li> <li>• Values</li> <li>• Commitment</li> </ul>
Dialectical Behavior Therapy	<ul style="list-style-type: none"> <li>• Validation</li> <li>• Dialectics</li> <li>• Radical acceptance</li> <li>• Skills training (emotional regulation)</li> </ul>
Mode Deactivation Therapy	<ul style="list-style-type: none"> <li>• Mode deactivation</li> <li>• Validation (radical acceptance)</li> <li>• Mindfulness skills</li> <li>• Cognitive balancing</li> </ul>

experience painful feelings without getting high or sexually abusing someone." However, from a "common factor" perspective, a mindfulness component is both implicit and pervasive in CBT through its repeated focus on dysfunctional beliefs and the mutual mindful attention of both client and therapist on the client's inner thoughts and experience. This is mindfulness in action, and embedded into CBT at its deepest level. From this perspective, mindfulness is central to all forms of therapy that address self-awareness, and is, accordingly, a common factor in effective treatment, described by Martin (1997) as cutting across all therapeutic orientations.

From the "primary modality" perspective, however, the above therapy session shows that mindfulness can be actively and deliberately applied "on top" of a session (rather than occurring as an on-going common underlying factor) to: (1) continually maintain the youth's focus on immediate experience, and (2) to observe dysfunctional cognitions and affect with non-judgmental acceptance. Absent of any empirical research, however, it is not possible to do any more than conjecture whether the mindfulness experience is a common factor or is itself a treatment modality applied to, but not necessarily an underlying element, that is central to all forms of effective cognitive behavioral therapy.

In either case, our belief is that the mindful, here-and-now focus on immediate experience is the essential therapeutic condition that makes it safer and more meaningful for the youth to explore, accept, and overcome dysfunctional cognitions and maladaptive behavior. Thus, although mindfulness can be applied to any form of psychotherapy, including cognitive behavioral therapies, to increase the impact of treatment interventions, it is also clear that treatments that fail to introduce a component of mindfulness are less likely to be as effective. We can think of mindfulness, then, as both a principal modality that can be added to a therapy to increase its effectiveness and as a common underlying factor in effective treatments.

Themes and discussions of mindfulness have become more present in the literature of the field of sex offender-specific treatment; we hope that this article furthers and helps strengthen that direction, and the field's increasing recognition of the importance and centrality of mindfulness in treatment. Moreover, we believe that mindfulness training is especially valuable in the treatment of sexually abusive and sexually reactive adolescents, both victims and perpetrators, because it provides a non-threatening therapeutic experience that is less likely to trigger extreme emotional reactivity and oppositional hostility, while promoting personal safety and trust in the therapeutic relationship.

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## Expensive, Harmful Policies that Don't Work or How Juvenile Sexual Offending is Addressed in the U.S.

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### Abstract

In this policy paper we briefly review the historical predecessors of modern sex crime legislation. We then review modern policies, focusing on those that have been applied to youth who have sexually offended and for which there is at least some empirical evaluation. These include sex offender civil commitment, registration and public notification. None of the existing research validates the use of these strategies with juveniles and indeed there is growing evidence of harm. As such, we recommend that policies be revised to either exclude juveniles altogether or to mitigate the negative effects of policies when applied to juveniles.

### Keywords

Sexually abusive behavior, sexually abusive youth, juvenile sexual offenders, juvenile sexual offending, sexual offense treatment, juvenile public policy, juvenile, sex offender registration

Punishing youth for and suppressing their sexual behaviors is neither new nor rare. However, relative to other democratic countries, particularly Scandinavian countries, the United States approaches the suppression of adolescent sexuality with particularly aggressive zeal. Adolescents are considered incapable of providing consent for sex until they reach a given state's age of consent (typically between 16 and 18 years of age) and these prohibitions frequently include sexual activity with consenting age mates (Sutherland, K., 2003). Moreover, since the early 1980's, the U.S. government has actively promoted and funded abstinence-only-until-marriage sexual education curricula, despite evidence that such programming leaves youth at greater risk for unprotected sex (Dailard, 2006).

The U.S. also takes a heavier hand toward juvenile delinquency than is true of most other democratic countries, only recently prohibiting applications of the death penalty and life imprisonment in juvenile cases, broadly permitting the prosecution of minors as adults, and essentially failing to set a lower age below which children are considered not culpable of delinquent or criminal offending (i.e., some states prosecute children as young as 6 years of age; Muncie, 2008).

Perhaps not surprisingly, the U.S. sets itself apart from other democracies to an even greater extent with policies that conflate adolescent sexual behavior and juvenile delinquency – that is, with policies that respond to a broad range of adolescent sexual behavior as juvenile sexual offending. Although the U.S. is not alone in subjecting juveniles who have sexually offended to far-reaching policies (e.g., at least two Australian states curtail the future career options of youth who have sexually offended), there simply is no other democratic nation in which youth adjudicated as minors for sexual offenses face penalties as severe as those found in the U.S. For this reason, the present policy review limits itself to modern U.S. policies. But first, we begin with some history.

### ■ U.S. Sex Crime Legislation: 1880s-1980s

As described previously (Letourneau & Levenson, 2010), the U.S. has experienced three waves of sex crime legislation over the past 100 or so years. The first wave spanned from the late 1800's to the end of World War II, during which time sex offenders, other criminals, and the mentally ill or incapacitated were subjected to indefinite institutionalization and sterilization. These policies were jointly influenced by the fields of sexology and eugenics (Ordovery, 2003). Specifically, sexologists promoted the view that even minor forms of sexual misbehavior predicted future sexual violence and homicide (Jenkins, 1998), whereas eugenicists promoted the view that criminal behavior was genetically determined (Ordovery, 2003). In combination, these fields shaped a view of sexual offending as intractable, resistant to change, and escalating, convincing policy makers to enact extreme interventions to limit society's immediate exposure to danger from an offender (via institutionalization) and future exposure to danger from an offender's offspring (via forced sterilization). When eugenics became associated with Nazism, forced sterilization of U.S. citizens fell out of favor (Ordovery, 2003) and in 1942 its use for punishment was ruled unconstitutional (*Skinner v. Oklahoma*), although its use for eugenics continued for four more decades. Of relevance to this discussion, sterilizations programs often targeted children, many of whom resided in congregate care facilities such as prisons and reform schools (Owens-Adair, 1922; Silver, 2003-2004). Take for example the case of John H. who at the age of 17, was sterilized while imprisoned in an Oregon State Penitentiary (Owens-Adair, 1922). The reason given for his sterilization was "allowing other prisoners to commit sodomy on his person." The operation was considered a success by the warden, who noted that "at least we have had no further trouble with the boy" (p. 145). These and similar anecdotes were considered to support the positive effects of steril-

ization, which were heavily promoted by the book's author. Overlooking the homophobic response to male-on-male sodomy for a moment, one wonders just how consensual these experiences were from the perspective of a 17-year-old boy housed with many older, and possibly more violent, prisoners.

The subsequent two waves of sex crime legislation can each be attributed, in part, to specific, highly publicized and gruesome sex crimes that helped fan fears of sex crime epidemics. In Wave II, which spanned, approximately, from the late 1930s through the late 1960s, the public's fears about sex offenders were inflamed following publicity of horrendous crimes committed by Albert Fish against children in the late 1930s (Schwartz, 2011). Fish's crimes and the resulting media also coincided with the rise of forensic psychiatry, which sought to increase its relevance to and influence with the courts by promoting certain forensics-based interventions. Among these was the treatment of so-called "sexual psychopaths" whom, it was argued, required psychiatric intervention rather than incarceration (Lave, 2009; see also Sutherland, E. H., 1950<sup>1</sup>). Between 1937 and 1967, 26 states and the District of Columbia passed so-called sexual psychopath laws, in which sex offenders who were deemed mentally ill and lacking the power to control their sexual impulses could be institutionalized prior to and in lieu of incarceration (for an in-depth review, see Lave, 2009). Pre-incarceration commitment policies fell out of favor relatively quickly when it became clear that the criteria for distinguishing between sexual psychopaths (who needed help) and other sex offenders (who needed punishment) were flawed, and because treatment was viewed as ineffective (Lave, 2009). As in Wave I, juveniles were also subjected to the indefinite commitment policies of Wave II, despite the fact that these policies were predicated on fears about adult sex offenders. Consider the case of Elvry Stoneham. At 12 years of age, he was made a ward of the juvenile court because he was in danger of "leading a lewd and dissolute life" (*In re Stoneham*, 232 Cal. App. 2d 337). At 17 years of age and following a series of unspecified parole violations, he was returned to the California Youth Authority, which found him to be a mentally disordered sex offender, a prerequisite to involuntary commitment. According to Mr. Stoneham's petition for relief from commitment, he had never been convicted of an actual sexual offense.

<sup>1</sup> One hesitates to cite Sutherland as an authority on sex crime policy when, in this same text, he dismisses the possibility of forcible rape as "practically impossible unless the female has been rendered practically unconscious by drugs or injury" (p. 545), an argument eerily similar to recent controversies within the U.S. Republican political party about the likelihood of pregnancy following "legitimate rape" (e.g., see for brief overview the Wikipedia entry at [http://en.wikipedia.org/wiki/Rape\\_and\\_pregnancy\\_controversies\\_in\\_United\\_States\\_elections,\\_2012](http://en.wikipedia.org/wiki/Rape_and_pregnancy_controversies_in_United_States_elections,_2012)).

## ■ Modern U.S. Sex Crime Legislation: 1990s-Present

Wave III of sex crime legislation is ongoing and dates to the late 1980s when the public's fears about sex offenders resurfaced, fanned again by sensational media coverage of exceptional cases and belief in a sex crime epidemic. Numerous policies were enacted at local, state and federal levels, including post-incarceration civil commitment for so-called "sexually violent predators" (SVP), sex offender registration, and public notification. In addition to these policies, states and local jurisdictions have attached numerous collateral legal consequences to registration requirements, including residency and employment restrictions, GPS monitoring, and others (Lester, 2006; Levenson & D'Amora, 2007). However, for purposes of this paper we restrict review to those policies with at least one published study evaluating policy effects on juveniles, which (as detailed later) include civil commitment, registration, and notification.

**Civil commitment.** Modern civil commitment laws date to the horrific case of Earl Shriner who made no secret of his intention to torture and mutilate children upon his release from the Washington State prison in 1987 where he was confined due to his prior abduction and assault of two teenage girls. Prior to this conviction, he had served 10 years in a psychiatric hospital for the murder of a teenage girl and was also known to have choked and assaulted a younger girl. Despite efforts to keep him committed under existing "imminent danger" mental health civil commitment policies, Mr. Shriner was released and subsequently raped, mutilated, and left for dead a 7-year-old boy (LaFond, 2005). The boy did not die and Shriner was rearrested. However, the child's parents and community members were outraged that the state had been unable to prevent this crime from happening in the first place and a grassroots organization urged the governor to develop new policies to address this gap in community safety. In 1990, Washington State passed the first modern sex offender civil commitment policy, which also included components of sex offender registration and public notification<sup>2</sup>. Since then, a total of 21 states, the District of Columbia, and the federal government have enacted civil commitment policies targeting the "worst of the worst," or so-called "sexually violent predators" (National District Attorneys Association, 2012). Policies vary but typically require that, prior to release from confinement, convicted sex offenders undergo evaluation to determine whether they meet a state's criteria of being both mentally disordered and likely to commit violent sexual crimes. If evaluated as such, legal proceedings ensue that will make the final determination as to whether or not the offender will

be committed. While committed, offenders are to receive specialized treatment until such time as they are considered to pose little threat to community safety. Commitment is indefinite and release is rare. For example, an audit of Minnesota's civil commitment program, which had been operating for 10 years, revealed that not a single offender had ever been discharged from treatment (Office of the Legislative Auditor, State of MN, 2011).

In many states, youth adjudicated delinquent for sexual offenses are or can be evaluated for civil commitment. A recent example is the case of Thomas S, who, at the age of 10, was adjudicated delinquent as a minor for sexually abusing a younger relative. From ages 12 to 17, he was incarcerated in a South Carolina juvenile detention facility, and when, in 2008, he was finally considered eligible for release by the juvenile parole board, he was automatically evaluated for civil commitment per that state's SVP policy. Despite having just one known victim whom he molested when he himself was very young, Thomas was found to meet criteria as a SVP and subjected to a jury trial to determine commitment. At that initial trial, a representative of the civil commitment facility itself argued against commitment, fearing among other things that Thomas would be targeted by the older, more violent offenders housed in that facility and also because the representative did not feel Thomas' profile fit that of an SVP. Nevertheless, the jury voted to commit. Each year thereafter, the civil commitment facility supported Thomas' petition for release, and in each of three subsequent trials juries voted to continue his commitment. Eventually, Thomas' attorney successfully argued to the state supreme court that he should never have been committed in the first place, due to introduction of non-expert testimony at the first commitment hearing. By the time his release was ordered by the state supreme court in 2013, Thomas had spent five years in the locked, high-security civil commitment facility. Of note, South Carolina's cost for civil commitment averages (US)\$63,000 per year, per patient (Smith, 2010), for a total of \$315,000 across Thomas' five years of commitment. Estimating the cost of his prior 5-year juvenile incarceration as approximately \$75,000 (based on \$15,000/year/inmate, the going rate for that state's adult incarceration; see <http://www.doc.sc.gov/pubweb/faqs.jsp>), then this state "invested" approximately \$400,000 in Thomas. This amount, however, likely underestimates true expenses, given that it does not include any legal costs related to arrest, prosecution, probation, or the juried and non-juried trials. Predictably, Thomas' childhood was characterized by parental and non-parental abuse and neglect. Had the state provided Thomas and his family with evidence-based prevention programming – including even several of the costliest prevention programs –

it would have spent twenty times less than it did on his incarceration and commitment alone<sup>3</sup>.

**Sex offender registration and notification.** Sex offender registration and notification were components of the Washington State law but, unlike its civil commitment policy, registration and notification were not initially widely adopted by other states. This changed in the mid-1990s when for the first time the U.S. federal government required states to create sex offender registries and, shortly thereafter, required states to provide information on sex offenders to the public. These statutes carry the names of the victims in whose memory they were created. In 1989, Jacob Wetterling was abducted by a masked gunman and has never been seen since. His mother founded the Jacob Wetterling Foundation (now the Jacob Wetterling Resource Center), which among other activities urged the state to develop sex offender registration policies on the reasonable assumption that the gunman had likely offended before. The state did so, and the policy was taken up at the federal level as the Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act (enacted under the federal Violent Crime Control and Law Enforcement Act of 1994). The federal Wetterling Act established registration requirements for all states and other jurisdictions and permitted public notification. In 1994, Megan Kanka was lured into the nearby home of a convicted sex offender who then raped and murdered her. Convinced that they could have protected their daughter had they known about the offender's presence in their neighborhood, Megan's parents petitioned the state to establish a community notification policy in which community members are notified when a convicted sex offender moves into the community. The federal version of "Megan's Law" was enacted in 1996 and amended the Wetterling Act by mandating public notification requirements.

As originally defined by these and related federal statutes, states had considerable leeway in crafting their registration and notification policies, including whether or not to include juveniles. However, the more recent Adam Walsh Act of 2006 (AWA) was developed and implemented specifically to reduce between-state policy variations and, for the first time, required the registration and notification of juveniles adjudicated delinquent by virtue of certain sex crimes. The public notification requirement elicited strong negative reactions from enough quarters that it was eventually dropped from the Act (Docket No. OAG 134; AG Order No.

<sup>2</sup> Several states (e.g., California, Minnesota) retained their original sexual psychopath laws, but adopted an updated SVP policy.

<sup>3</sup> For example, given Thomas' parents' poverty and substance abuse disorders, early primary prevention/family strengthening strategies such as Nurse Family Partnership for Low Income Women (\$9,118) and Early Childhood Education for Low Income 3- and 4-Year Olds (\$7,301) might have been worthwhile; given his later school difficulties and delinquency, Multisystemic Therapy (\$5,681) might have been helpful. Together, these programs sum to \$22,100 (Aos, Lieb, Mayfield, Miller, & Penucci, 2004).

3150-2010), but juveniles 14 years of age and older who are convicted of certain sexual offenses must still register for 25 years or life, depending upon their offense and offense history. States that refuse to comply with this or other aspects of AWA are penalized by the loss of certain federal funds. A recent review of state policies indicated that 35 states have juvenile registration requirements (not infrequently for life) and 25 states include juvenile registrants' information in online registries (Pitman & Nguyen, 2011), demonstrating that the AWA has significantly increased the scope of juvenile registration (Chaffin, 2008).

Because registration and notification of juveniles is both recent and now commonplace, anecdotes about youth affected by these policies abound. One case that was widely publicized by the New York Times involved "Johnnie" (Jones, 2007). When Johnnie was 11 years old he molested his younger sister. Unsure of what to do, his mother turned to law enforcement for help. They arrested Johnnie, and he was adjudicated and placed in specialized residential sex offender treatment for 16 months. Upon his return to family care, his information as a registered sex offender was made public on his state's online registry. Johnnie's first suicide attempt occurred two weeks later, after classmates began to harass him based on his registration status. He made at least two more suicide attempts, shuttled between family and non-family care, and had to switch schools repeatedly following ongoing harassment.

The costs of registration and notification have not been well documented. However, prior to implementing the Adam Walsh Act registration and notification requirements, several states attempted to quantify these costs, in an effort to determine whether the cost of complying with the Act exceeded the potential loss in federal funds tied to noncompliance. Estimates varied widely. For example, an Ohio fiscal impact evaluation indicated that enacting the Act's registration and notification requirements would result in one-time expenditures of \$475,000 and annual expenditures of \$85,000, solely to update and maintain the registry. It was also assumed that unspecified but substantial increases would occur in legal and incarceration expenditures related to implementation (127<sup>th</sup> General Assembly of Ohio, 2007). By comparison, a Virginia fiscal impact statement that included estimated increases in some legal and incarceration costs estimated an outlay of nearly \$12,500,000 during the first year of implementation, and nearly \$9,000,000 each year thereafter (Department of Planning and Budget, 2008). What is less clear from these and other fiscal impact statements is the per-person cost of registration and notification. Because the Adam Walsh Act increased the frequency of mandatory in-person re-registration, the amount of information collected, the procedures required for verifying the information, the dura-

tion of registration requirements, the types of offenses that trigger registration, and the penalties for registration errors and omissions, now to include a minimum one year of incarceration for the first infraction, the per-person costs of the Act's registration and notification requirements are substantial. We argue that these additional costs, though poorly documented, very likely exceed \$9,000 per-person, which is the average cost of evidence-based treatment programs targeting juveniles who have sexually offended (Aos, Phipps, Barnoski, & Lieb, 2001).

### ■ Do Modern Policies Improve Community Safety?

Modern sex crime policies have, at their core, the aim of reducing the risk of sexual recidivism posed by known offenders. Civil commitment policies aim to reduce recidivism risk by extending the incapacitation and treatment of offenders until such time as they might safely be returned to their communities. Registration policies aim to reduce recidivism by making it easier for law enforcement to scrutinize sex offenders. Notification policies aim to reduce recidivism by empowering regular citizens to scrutinize offenders and report suspicious behaviors. Additionally, it is hoped offenders view registration and notification as increasing the risks of getting caught should they reoffend, thus altering their own personal risk-benefits evaluation of future offending.

The success of these policies rests, in no small part, on the accurate identification of high risk offenders. Additionally, focusing expensive interventions on high risk youth also improves the likelihood of cost effectiveness. Thus, accurate recidivism risk prediction is a necessity. Yet recidivism risk prediction for juveniles is complicated by numerous factors. First and foremost, juvenile sexual recidivism has very low base rates: the fact is that the vast majority of youth adjudicated for a sexual offense will not sexually reoffend, even across decades-long follow-up (e.g., Caldwell, 2010; Letourneau & Armstrong, 2008; Worling, Litteljohn, & Bookalam, 2010; Zimring, Jennings, Piquero, & Hays, 2009). Furthermore, even a highly effective intervention is unlikely to significantly reduce the recidivism rates if those rates are already very low. Undoubtedly, another source of difficulty is the extensive developmental change that occurs during adolescence. Adolescents experience the onset of sexual impulses and the intensification of other appetitive impulses, undergo tremendous changes in social reasoning and susceptibility to social influences, and develop a greater capacity for impulse control and mature social reasoning (Sisk & Foster, 2004; Steinberg, 2004, 2010; Steinberg, Albert, Cauffman, Banich, Graham, & Woolard, 2008; Steinberg, & Monahan, 2007). Thus, risk-taking and inappropriate social behavior are likely to be unstable in adolescence and hence more difficult to predict. Moreover, adolescents who engage in sexual offending behavior

constitute a heterogeneous population (Worling, 2001) and the dynamics that produce sexually inappropriate behavior are likely to be diverse and combine in highly individualized ways. Additionally, risk factors may be developmentally sensitive, requiring an age-graded approach to risk assessment (Quinsey, Skilling, Lalumière, & Craig, 2004; Sampson & Laub, 1997).

For these reasons, the accurate identification of high risk youth has been elusive. Even among the sexual recidivism risk instruments that have some support of predictive validity, the support appears to be fueled in large part by the correct identification of non-recidivists, who comprise the majority of all evaluation samples. Thus, fewer than half of youth identified as "high risk" to sexually reoffend actually do so (e.g., Worling, Bookalam, & Litteljohn, 2012). Failure to correctly identify high-risk youth also extends to civil commitment evaluation procedures and registration and notification evaluation procedures, as described below.

### ■ Civil Commitment

To our knowledge just one publication rigorously evaluates and fails to support the accuracy of a civil commitment evaluation process designed to identify juvenile sexually violent predators. Caldwell (2013) examined the recidivism rates of youth who met and did not meet one state's commitment criteria. All but three of the 54 youth who met criteria were nevertheless released to the community, as were all of the 144 youth who were eligible for commitment but did not meet criteria. Results of recidivism analyses indicated that, across approximately 5 years of follow-up, youth who met commitment criteria were significantly *less* likely to be charged with subsequent offenses (of any kind) than youth who did not meet criteria, and groups did not differ significantly with respect to charges for violent or sexual offenses. Results did not change appreciably when the three committed youth were included in the analyses with the assumption that each would have committed a sexual offense if released. If youth selected for commitment as sexually violent predators are not, in fact, at any higher risk of recidivism than youth not selected, then including youth in SVP screening procedures and subjecting them to civil commitment does not improve community safety (Caldwell, 2013).

Even with poor detection of high risk youth, is it still possible that the treatment received by civil commitment youth reduces their recidivism risk? We think not. Even if civil commitment was focused on high-risk juveniles, there are several reasons to doubt its potential treatment effectiveness. Congregate care is detrimental for adolescent offenders in and of itself (Freundlich & Avery, 2005) and any positive effects of interventions delivered in artificial settings are less likely to generalize to real-world settings (Frensch & Cameron, 2002). Further, although not necessarily related to the civ-

il commitment process, residential, group-based juvenile treatment is likely to over-emphasize individual-level factors that may or may not be related to recidivism (e.g., victim empathy) while neglecting to address important risk and protective factors within the many settings in which youth are embedded (family, peer, school, community). Indeed, the only intervention for youth who have sexually offended that is supported by multiple randomized controlled trials, Multisystemic Therapy (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009), is a parent-focused intervention delivered in youths' homes, schools, and other settings (Borduin, Henggeler, Blasko & Stein, 1990; Borduin, Schaeffer & Heiblum, 2008; Letourneau et al., 2009; Letourneau et al., in press). With youth who have sexually offended, MST achieves its positive effects by improving caregiver factors (e.g., appropriate discipline) and addressing peer factors (e.g., reducing association with delinquent peers; Henggeler, Letourneau et al., 2009). Effectively treating youth in specialized residential facilities, sometimes far from their homes and communities, seems, therefore, an unlikely proposition.

### ■ The Effects of Registration and Notification

Caldwell and his colleagues also evaluated the ability of federal and state protocols to identify high risk youth (Caldwell, Ziemke, & Vitacco, 2008). To do so, they retrospectively assigned Adam Walsh Act tier designations, as well as scores for three state-developed risk assessment protocols, to juvenile sex and nonsex offenders who had been released from a secure treatment facility for an average of nearly six years. Neither the federal tier system nor any of the state protocols significantly predicted any type of recidivism, with one exception: youth evaluated as meeting the federal requirements for registration were significantly *less* likely to be charged with new violent offenses.

These results were replicated and extended in a study by Batastini and her colleagues (Batastini, Hunt, Present-Koller, & DeMatteo, 2011) in a study of 112 adjudicated juvenile sexual offenders followed for a two-year period post treatment. Sixty-seven of the participants (62%) met the criteria for SORNA Tier 3 registration. Youth who met federal registration criteria ( $n=67$ ) were no more likely to reoffend, sexually or nonsexually, than youth who did not meet registration criteria ( $n=41$ ). In fact, only 2 youth reoffended with a new sexual offense across the 2-year follow up period. These results indicate that federal and several state protocols not only misidentify most low-risk youth as higher risk, but also (in the case of the federal protocol), misidentify higher risk youth as low risk. Thus, the federal strategy might actually result in increased risk to community safety.

Given the inability of federal and state risk assessment protocols to correctly identify youth at higher

risk of recidivism, it should not be surprising that the four research studies evaluating the effects of registration and notification on recidivism fail to find any evidence that these policies reduce juvenile recidivism. For example, using data from South Carolina, Letourneau and colleagues completed two evaluations of that state's juvenile registration and notification policy on sexual and nonsexual recidivism. In the first study (Letourneau & Armstrong, 2008) 222 registered and nonregistered male youth were matched on year and type of initial sexual offense, age at offense, race, and prior offenses. Recidivism was assessed across an average 4-year follow-up. The sexual offense conviction rate was less than 1% (just two events for 222 youth). The nonsexual violent offense conviction rates did not differ between registered and nonregistered juveniles.

In a second study (Letourneau, Bandyopadhyay, Sinha, & Armstrong, 2009b), the sexual and nonsexual recidivism rates of registered male youth ( $N=574$ ) and nonregistered male youth ( $N=1,275$ ) were compared across an average 9-year follow-up period. Results indicated that registration had no influence on nonsexual violent recidivism. Results also indicated that registration increased the risk of youth being *charged* but not convicted of new sex offenses, and being *charged* but not convicted of new nonviolent offenses. The authors concluded that not only does registration fail to reduce recidivism, it also appears to be associated with increased risk of new charges that do not result in new convictions – possibly indicating a surveillance or “scarlet letter” effect for youth subjected to these policies.

Caldwell and Dickinson (2009) compared the recidivism rates of registered ( $n=106$ ) and unregistered ( $N=66$ ) juveniles across a 4-year follow-up period. They reported that registration status was unrelated to new sexual or violent charges. Registered youth were significantly less likely to be charged with new non-violent misdemeanor offenses. Follow-up analyses revealed that registered youth were lower risk as evaluated by juvenile risk assessment tools and thus their lower general recidivism rate is attributable to actual risk, versus some deterrent effect of registration.

Registration and notification could still be effective, even in the absence of a recidivism effect, if these policies deterred initial sex crimes. However, the single study that has evaluated this question failed to find any support for a policy effect on general deterrence. Specifically, Letourneau and colleagues (Letourneau, Bandyopadhyay, Armstrong, & Sinha, 2010) examined more than 3,000 juvenile sex offense cases from 1991 through 2004. Trend analyses modeled the effects of South Carolina's initial registration law (which did not include online registration) and subsequent revision (that permitted online registration of registered youth) on first-time sex offenses. If either the original or

amended policy deterred first-time juvenile offenses, then rates of first-time sex crimes should have declined following policy enactment. However, results indicated no significant deterrent effect for either the original or the revised registration policy. Thus, neither the threat of registration nor the threat of notification was associated with deterrence of first-time juvenile sex crimes.

The available evidence indicates that juvenile registration and notification policies are not associated with the intended effect of reduce sexual offending. These policies are, however, associated with several unintended effects. One of these is the unfair targeting of registered youth for unnecessary arrest. As noted above, Letourneau and colleagues (Letourneau et al., 2009b) found that South Carolina's registration policy was associated with increased risk of new charges but not new convictions. This effect was strongest for nonviolent offenses. Specifically, registered youth were significantly more likely than nonregistered youth to be charged with relatively minor, misdemeanor offenses (e.g., public order offenses). While it is possible that the burdens related to registration actually increased youth misbehavior, the authors believed it is more likely that these findings reflected a surveillance effect. That is, youth who are required to register with law enforcement agencies, and who thus become known as “registered sex offenders,” are likely to be viewed (inaccurately) as more dangerous than youth with the same history of sex offending but without the registration label. This perception may cause law enforcement agents to arrest registered youth for behaviors that do not trigger the arrest of nonregistered youth, and that ultimately do not result in new convictions. Requiring youth to register multiple times per year with law enforcement therefore has a significant negative consequences and not merely an inconvenience.

A second unintended effect of registration and notification is to reduce the likelihood that youth are held accountable for sexual offenses. Two related studies support this unintended effect. In an initial study, Letourneau and colleagues (Letourneau, Bandyopadhyay, Sinha, & Armstrong, 2009a) examined the effects of registration and notification on the likelihood that prosecutors would choose to pursue versus drop or dismiss juvenile sex offense charges. Prosecutor decisions and final dispositions were examined for more than 5,500 juvenile sex offense cases across a 15-year time period. Results indicated that prosecutors were significantly less likely to pursue sex offense charges after policy implementation. Specifically, there was a 41% decline in prosecution of these cases following implementation of juvenile registration. The authors interpreted this finding as evidence that prosecutors were trying to protect some youth from that state's lifetime registration and notification requirements.

In the second study, Letourneau and colleagues (Letourneau, Armstrong, Bandyopadhyay, &

Sinha, 2013) examined the effects of registration and notification on the likelihood that juvenile sex offense charges would be pled down to lesser, non-sex offense charges. Examining data from nearly 3,000 youth initially charged with sex offenses, they identified dramatic and significant increases in plea bargains corresponding with enactment of South Carolina's registration policy. Specifically, there was a 124% increase in plea bargains leading to non-sex offense charges from the period predating registration to the period following initial enactment of registration, and another 50% increase in plea bargains following enactment of online registration notification. Thus, even when deciding to pursue juvenile sex offense charges, judicial actors, including prosecutors, defense attorneys, and judges, appear to evidence a protective mindset and permit many youth to plea responsible to charges that will not trigger registration requirements.

The public branding of some youth as registered sex offenders or sexually violent predators is likely to result in a host of other negative collateral consequences to these youth and their family members (Chaffin, 2008). A recent Human Rights Watch report (2013) detailed the results of nearly 300 interviews with people affected by juvenile registration and notification requirements. The collateral consequences attributed to these policies are appalling and included stigma, isolation, shame, and depression. Suicidal ideation was not uncommon and suicide attempts, both completed and not completed, were identified. Reports indicated that youth and their family members had been beaten, shot at, and even murdered. Youth and young adults have been denied access to education, faced frequent moves, and been unable to find or maintain stable employment or housing. Parents, spouses, and even the children of people registered for juvenile offenses, all reported being affected. Many were unable to navigate complicated registration requirements and sustained new, felony-level "failure to register" convictions.

Another publication reported on the issue from the perspective of four mothers whose sons had been required to register after adjudication for offenses committed between the ages of 13-18 (Comartin, Kernsmith, & Miles, 2010). The mothers each reported a strong desire to protect their sons from further harm, but also feeling powerless to help their sons, fearing that new, and even false, allegations might be lodged against their sons. They also described the stigma and shame they and their sons experienced, caused by the public sex offender label and the low self-esteem of their sons. Finally, the mothers reported that they became isolated and that their sons had difficulty finding employment and achieving financial dependence.

Survey research has long documented these types of extra-legal collateral consequences for registered versus unregistered adults (Levenson & Cotter, 2005; Levenson, D'Amora, & Hern, 2007; Merca-

do, Alvarez, & Levenson, 2008; Sample & Streveler, 2003; Tewksbury, 2004, 2005; Tewksbury & Lees, 2006; Zevitz & Farkas, 2000), but has not yet done so with youth. However, in an ongoing study (Harris & Letourneau, 2013) practitioner perspectives are being evaluated regarding the collateral consequences of juvenile registration and notification. A sample of 219 professionals who provide clinical services to juveniles who have sexually offended has completed the survey to date. Respondents rated whether they disagreed, neither agreed nor disagreed, or agreed that specific negative outcomes were more or less likely to occur to registered versus unregistered youth and (separately) to youth subjected to public notification versus youth not so subjected. With respect to the effects of public notification, a majority of respondents agreed that notification was likely to be associated with 27 of 30 negative outcomes. For example, most practitioners agreed that youth subjected to notification would experience more shame and embarrassment (92%), feel more alone (91%), and be more afraid for their own safety (89%). With respect to registration, a majority of respondents agreed that registration was likely to be associated with 20 of 30 negative outcomes. For example, 87% believed registered youth would have less hope for the future. In the same study, the investigators are also surveying youth who have sexually offended but the current sample size is too small to present even preliminary findings.

### ■ Conclusions

The accumulated scientific evidence to date has demonstrated that, when applied to juveniles, sex offender registration and notification and civil commitment laws fail to achieve their stated goal of improving community safety. They fail for several reasons. First, statutory schemes fail to identify youth who are at high risk for sexual recidivism. There is some evidence that they may identify youth who are at lower overall risk for criminal behavior. Second, these policies appear to have no deterrent effect, either on the youth subject to them or on potential future juvenile sexual offenders. Here again, there is some evidence that these laws may actually increase the risk of arrest or offending in some circumstances. Third, these policies appear to reduce the likelihood that juvenile sexual offenders will be fully adjudicated for a sexual offense, resulting in a reduced likelihood that these youth will receive sex offender treatment services. Fourth, these policies have a wide array of damaging collateral effects. The juveniles subject to them face significant obstacles to their successful reintegration into a productive conventional lifestyle. However, what is often overlooked is the fact that the sex offender's employer, cohabitants, neighborhood, and school are often effectively "registered" along with the sex offender in that the addresses of registrants' housing, employers, and schools are often listed on the registry. The collateral damage to those who

associate with a registered sex offender has only recently been the subject of systematic study (Human Rights Watch, 2013), which, as noted earlier, identified ongoing and serious negative consequences attributed to public registration.

In addition, these policies carry with them considerable opportunity costs. Maintaining a registration and community notification system is a costly project that will likely increase in cost as the census of those subject to registration grows. Similarly, the cost of indefinite civil commitment of a young sex offender is staggering. In most states, state-of-the-art treatment services with demonstrated effectiveness could be provided to scores of youth and their families for less cost than these demonstrated ineffective and counter-productive programs.

Although the existing research is remarkably consistent in finding these policies ineffective, this should not be taken as an indication that further research has nothing to offer. Specifically, additional research into the collateral consequences of these laws will help to fashion future laws that minimize unintended consequences to juvenile offenders, their families, and members of the community. In addition, more detailed costs-benefits analyses will enable policy makers to fashion more cost-effective alternatives.

Perhaps the most striking aspect of these policies is the degree to which they rest on false assumptions about the persistence and intractability of juvenile sexual misconduct. Sexual violence remains among the most serious social problems in this and most western countries. However, there are few serious adolescent behavioral problems that have proven to be more responsive to treatment and maturation. Further, the extant research into what aspects of adolescent development are most relevant to the development of appropriate sexual behavior, and how best to foster and enhance adaptive sexual behavior, remains in its infancy. Similarly, effective treatment methods have been identified, but much more study is needed to develop methods that are flexible and effective with a variety of youth, and that can be delivered most efficiently, while assuring community safety to the maximum extent possible.

### ■ Policy Recommendations

A fundamental characteristic of the policies discussed is the exercise of society's power to enforce convention, through the identification, supervision, and exclusion of those who are identified as abnormal. Indeed, the power of society to establish and enforce the parameters of convention is fundamental to any well-ordered and civil society. Nearly all societies regulate the sexual behavior of adolescents in some way, and the exclusion of sexual violence and coercion is an important sign post of a modern just and egalitarian society.

However, the policies described here rely heavily on the expulsion of out-group "others" from con-

ventional society. In many aspects, these policies appear to enact a modern version of the “stultifera navis” (ship of fools), discussed by the French philosopher Michel Foucault (1965), in which Renaissance era villages would place their unwanted citizens on barges that took them downstream, expelled and forgotten by the “normal” social order of the village. The difficulty of this approach is that members of a modern society cannot simply be shipped away. Society instead retains the costs and consequences of policies designed to subject individuals to constant observation or expulsion.

Fortunately, society also employs mechanisms to enforce convention that serve the purpose of re-integrating those who violate social norms. In the area of juvenile sexual misconduct, treatment and rehabilitation services have demonstrated a clear value advantage over the policies described here. Policies that promote proven treatment strategies and minimize long-term stigmatization of adolescents who are charged with sexual offenses should be adopted. The resources devoted to juvenile sex offender registration and community notification and civil commitment would be far more effective in improving community safety if they were devoted to effective prevention and treatment strategies.

Of importance, however, even within the framework of existing policies several, relatively minor, improvements may mitigate much of the collateral harm caused by these policies. First, with respect to civil commitment, policies should be altered to ensure that offenses committed by minors do not automatically trigger SVP evaluation. Rather, commitment should be considered only in rare cases where a juvenile offender appears to represent an ongoing (i.e., post-treatment) threat of harm to the community and community supervision of sufficient oversight is unavailable. In such cases, commitment decisions should be thoroughly re-evaluated frequently (e.g., every 6 months). With respect to registration and notification, policies should be altered to specifically exclude minors. Failing that, we recommend that, registration for adolescents should be based on a competent individualized risk assessment, not on the characteristics of the offense. The dynamics of adolescent sexual misconduct are far too varied and influenced by situational factors for any simple offense-based scheme to effectively identify higher risk adolescents. Second, adolescent sex offenders should never be subjected to community notification, and in particular should never be placed on public registries. The majority of the serious collateral harm related to adolescent sex offender registration is due to the public nature of the registry. Third, if adolescents are to be registered at all, it should be for a short term, no longer than age 18. The existing evidence is that significant maturationally-driven transitions take place in the later teen years, and the risk of sexual recidivism in an adolescent is greatest over the short-term (Caldwell, 2010; Worling & Curw-

en, 2000). Fourth, private registries that maintain and publicize sex offender registry information should be eliminated. These registries commonly ignore the removal of individuals from the official public registry and require removed individuals to pay substantial fees for removal from the private registry. Fifth, placement on a registry should be contingent on treatment: that is, youth who complete competent treatment avoid registration, whereas youth who fail effective services (for reasons other than inability to pay for treatment) would then face registration. In placing an individual on a registry, the state is indicating that the individual is a risk to the community. If the state has identified an individual as a risk to community safety, it has an obligation to take reasonable steps to ameliorate that risk. For this reason, placement on a registry should entitle the individual to competent treatment and rehabilitation services. It is well documented that registration often disrupts employment and significantly limits the income of those subject to the registry. At the very least, states should guarantee that all registered youth have access to effective treatment, regardless of their ability to pay for those services.

Lastly, all states should have a reasonable process for individuals to be removed from the registry when it is determined that continued registration does not substantially contribute to community safety. The mechanism for this should be similar to the process for removing individuals from involuntary mental health commitments.

There is no question that sexual violence in society demands a concerted and sustained effort from the state, devoted to improving community safety. The research that has emerged over the past decade has identified effective prevention and treatment programs that do just that. Conversely, while possibly well intentioned, the body of research developed over the past decade has shown that sex offender registration and notification and civil commitment policies, when applied to juveniles, are costly and ineffective, and produce serious unintended collateral harm. They clearly require substantial reform, at a minimum. However, it may be far better to abandon approaches that assume juvenile sexual offenders are intractable and must be isolated and monitored for life altogether. Rather, it may be more effective to begin anew, with a foundation on those measures that have proven effective at improving community safety, and that attempt to reintegrate the individual into a healthy and productive conventional lifestyle.

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## The Risk Need Responsivity Model of Offender Rehabilitation: Is There Really a Need For a Paradigm Shift?

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### Abstract

The current paper critically reviews the Risk-Need-Responsivity (RNR) and Good Lives Model (GLM) approaches to correctional treatment. Research, or the lack thereof, is discussed in terms of whether there is a need for a new model of offender rehabilitation. We argue that although there is a wealth of research in support of RNR approaches, there is presently very little available research demonstrating the efficacy of the GLM in terms of the impact that programs based on this model of rehabilitation have on observed rates of recidivism among offender populations. Additionally, the emphasis of the GLM approach on the principles and techniques of positive psychology is untested in the area of forensic psychology. Evidence with reference to the assessment and treatment of sexual offenders is discussed as this is a particular focus of the GLM approach. We conclude, in agreement with the developers of the GLM approach, that the RNR model needs to be adapted in order to incorporate recent research related to the factors associated with recidivism among sexual offenders. However, we argue that the GLM is largely an empirically untested model, and further offers little in terms of adding to or replacing the RNR model.

We recognize that a revised version of the RNR based approach is necessary, incorporating an integrated approach to treatment, and we introduce and briefly describe the RNR-I (Integrated), a model developed by the authors and supported by a variety of empirical research, including a number of outcome studies produced by our team and others.

### Keywords

Sexual offenders; sexual offender treatment; sexual offender treatment models; good lives model, risk, needs, and responsivity; RNR, GLM

The Risk, Need and Responsivity (RNR) model (Andrews & Bonta, 2010) has been the prominent approach to the treatment of offenders in Canada, as well as other parts of the world (e.g., the U.K, New Zealand, and Australia) for three decades. The RNR approach and the theoretical model on which it is based have resulted in measurable gains in terms of the reliable assessment of offenders, as well as significant reductions in rates of recidivism among offenders treated in programs that have adopted this perspective (see Andrews & Bonta, 2010 for a summary). Treatment approaches consistent with the RNR principles have been demonstrated to lead to reductions in sexual offense recidivism (Hanson, Bourgon, Helmus & Hodgins, 2009), violent recidivism (Dowden & Andrews, 2000), and general recidivism (Andrews, Zinger et al., 1990). However, in the past decade this approach to correctional programming has been criticized (e.g., Laws & Ward, 2011; Ward & Stewart, 2003) as being too focused on risk management.

Ward and his colleagues (2003; Laws & Ward, 2011) have argued that the primary focus of RNR based approaches to treatment has been on the reduction of various deficits present in the individual, and that the RNR model pays insufficient attention to the person and the idiosyncratic goals that he/she may wish to address. They argue that these agentive needs must become a focus of contemporary treatment programs. The model proposed by Ward and his colleagues is influenced heavily by developments in the area of positive psychology, as opposed to a cognitive-behavioral/social learning framework, which has been the basis of RNR oriented programs. The purpose of this paper is to provide a brief outline of

both the RNR approach and the theory of offending on which it is based, as well as a discussion of the Good Lives Model of treatment which has been advocated by Ward and his colleagues. Laws and Ward (2011) state that the Good Lives Model (GLM) they advocate represents a new theory of rehabilitation, the principles of which can be applied in a myriad of ways. Whether the model translates into genuinely new approaches to treatment in practice has not been addressed in detail to this point.

### ■ Risk, Need and Responsivity

The RNR model is not a theory of intervention in itself, rather the RNR perspective represents principles of effective correctional intervention (Andrews & Bonta, 2010), within which a wide variety of therapeutic interventions can be used. Andrews and Bonta argue that a number of factors need to be considered in any comprehensive theory of criminal behavior, including biological/neurological issues, inheritance, temperament, and social and cultural factors, making note of the fact that criminal behavior is multi-factorial. From this general outline (which these authors label as the Psychology of Criminal Conduct), Andrews and Bonta have delineated three principles of effective corrections, termed Risk, Need and Responsivity. These principles have resulted in several decades of research that has revolutionized the practice of assessment and treatment of offender populations, and in which factors associated with RNR are clear, concise and empirically verifiable. We will return to the issue of empirical support when discussing the GLM.

**Risk:** With reference to the concept of risk, Andrews and Bonta (2010) argue that treatment should be

reserved for higher risk groups of offenders, as assessed by actuarial assessment instruments. There are now many decades of research demonstrating that actuarially assessed risk is superior to unstructured clinical judgment (e.g., Hanson & Morton-Bourgon, 2009).

**Need:** With reference to the concept of need, Andrews and Bonta (2010) are referring to criminogenic needs, established by the empirical literature as associated with recidivism in criminal populations. They identify eight central risk/need factors (the "Big Eight") for the development and maintenance of criminal behavior:

1. History of antisocial behavior characterized by early involvement in a number and variety of antisocial activities and settings. This is considered to be a strength when absent.
2. Antisocial Personality Pattern, characterized by impulsive, adventurous, pleasure-seeking, and aggressive behaviors, and callous disregard for others. Associated risks consist of weak self-control, anger-management, and problem solving skills. One target of treatment, therefore, is to enhance these skills.
3. Antisocial cognition, including attitudes, values, beliefs, and a personal identity favorable to crime.
4. Antisocial associates and relative isolation from prosocial individuals, in which the quality of relationships and the influence that associates have on the individual (e.g., favorable/unfavorable to crime) are important.
5. Problematic circumstances of home (family/marital)
6. Problematic circumstances at school or work
7. Few if any positive leisure activities
8. Substance abuse

Thus, the RNR Model considers personal, interpersonal, and social factors as being involved in the acquisition and maintenance of criminal behavior (Ogloff & Davis, 2004). Further, Andrews and Bonta (2010) argue that treatment should focus on criminogenic needs. Non-criminogenic needs such as low self-esteem and personal distress are viewed as tertiary and should not be the focus of treatment except as they are relevant to the third principle of effective correctional treatment; that is the *Responsivity* Principle.

The **Responsivity** Principle consists of two components: general and specific responsivity. The general responsivity principle states that effective interventions tend to be based on cognitive, behavioral, and social learning theories (Smith, Gendreau, & Swartz, 2009), while the specific responsivity principle suggests that the treatment offered is to be matched not only to criminogenic need but also to those attributes and circumstances of cases that render them likely to profit from that treatment (Andrews, et al., 1990).

### Support for the RNR Approach

Research indicates that treatment services designed in accordance with these principles are more effective than those that are not, and that the treatment

effect is linearly related to the number of principles to which the treatment model adheres. Andrews, Zinger et al. (1990) conducted a meta-analysis of 80 studies examining the effectiveness of correctional programming. They found that treatments coded as appropriate (i.e., designed and delivered according to RNR principles) were associated with larger effect sizes, whereas treatments coded as inappropriate or associated with criminal sanctions were both associated with negative effects.

Dowden and Andrews (1999) performed a meta-analysis on 25 studies of treatment for female offenders, and found that the delivery of *any* treatment programming yielded a significantly stronger effect than criminal sanctions alone. They also found that treatment services adhering to all of the RNR principles were related to the greatest reductions in recidivism, while treatment rated as inappropriate had the weakest effects. Effect sizes were also larger when needs related to associates and peers, attitudes, self-control, and family and family process were targeted, than when they were not. Thus, this meta-analysis suggests that the majority of criminogenic needs identified for men are also applicable for female offenders. Dowden and Andrews also found that targeting vague personal/emotional issues and other non-RNR based treatment targets were associated with no reduction in recidivism. In fact, non-criminogenically focused family interventions were associated with an increase in recidivism.

Dowden and Andrews (2000) conducted a meta-analysis of 35 studies of violent offenders and again found that programs adhering to RNR principles were more effective than those which did not. Specifically, they found that criminal sanctions alone, in the absence of treatment programming, yielded no effect on recidivism, while *any* human service delivery resulted in a significant positive effect. Programs that targeted criminogenic needs were associated with a moderate effect size, while those which did not produced no significant reduction in recidivism. When examining results according to the degree of adherence to the RNR principles, those programs deemed inappropriate were associated with no effect on recidivism, while those that adhered to all three principles produced the largest effect sizes. They found that greater effect sizes were achieved through systematic targeting of criminogenic needs, while iatrogenic results were obtained when non-criminogenic needs were targeted.

More recently, Hanson, et al. (2009) coded 23 studies of sexual offender treatment outcome for adherence to the RNR principles. In addition to the criminogenic needs for general recidivism described above, Hanson et al. considered criminogenic needs specific for sexual recidivism to be deviant sexual interests, sexual preoccupation, attitudes tolerant of sexual crime, and intimacy deficits (e.g., conflicts with lovers, emotional congruence with children). Non-criminogenic needs were considered to be factors such as internalizing psychological problems (e.g., depression, anxiety), denial, low victim empathy, and social skills deficits. Hanson et al. reported that for sexual recidivism,

programs were more effective if they targeted criminogenic needs (need principle) and were delivered in a manner that was likely to engage the offenders (responsivity principle). They also reported that sexual offender treatment programs that adhere to RNR principles resulted in greater reductions in recidivism, and that this effect was linearly related to the number of RNR principles incorporated into the treatment program. In fact, programs that adhered to none of the principles resulted in a negative treatment effect. This meta-analysis indicates that the RNR approach to program development and delivery applies equally to sexual offenders as it does to other types of offenders.

Relapse Prevention (RP) approaches to sexual offender treatment remain popular within the field. The 2009 survey of North American programs conducted by the Safer Society Foundation (McGrath, Cumming, Burchard, Zeoli & Ellerby, 2010) found that over 65% of programs reported the use of a Relapse Prevention Model. This is likely an under-estimate, however, given that the survey differentiated between RP and cognitive-behavioral approaches. Given that RP tends to be a cognitive-behavioral approach in practice (Andrews & Bonta, 2010), this distinction may have been problematic for survey respondents. Initially developed for substance abusing clients, the RP model has been adopted for use with sexual offenders. This perspective assumes that relapse is predictable and that if clients pay attention to so-called high-risk situations they can dramatically reduce their risk of recidivism. High risk situations are typically those that would be considered criminogenic needs within Andrews & Bonta's (2010) model (e.g., alcohol or drug abuse, criminal associates).

Dowden, Antonowitz, and Andrews (2003) conducted a meta-analysis of treatment programs which employed an RP approach in the delivery of treatment. They coded 24 studies, seven of which involved sex offender treatment, and found a moderate overall effect size for RP programs. When coding programs for the presence of various aspects of the RP approach to treatment (i.e., offense chain, relapse rehearsal, identification of high risk situations, coping with failure situations, etc.), Dowden et al. found that the development of the offense chain, training significant others to help, and relapse rehearsal were associated with treatment effectiveness, while booster sessions and coping with failure situations were not. Overall, the greater the number of RP components employed in treatment, the stronger the treatment effect ( $r = .38, p < .01$ ). These authors also examined the contribution of RNR principles to treatment effectiveness. They found that RP programs adhering to all three RNR principles had the greatest impact, while those that adhered to none of the principles had no impact on recidivism.

Thus, taken together, these meta-analyses indicate that: 1) adherence to RNR principles in the development of correctional treatment programs leads to greater reductions in recidivism; 2) programs that address non-criminogenic needs tend to be either less effective or ineffective in reducing recidivism, or may even be associated with increased

rates of recidivism; 3) RP approaches, delivered within the RNR framework, are effective in reducing recidivism; and 4) these results apply to general recidivism, violent recidivism, and sexual recidivism, as well as to female offenders.

### Criticism of RNR by Ward et al.

As noted above, the RNR approach to treatment has been criticized over the past 10 years, in particular by Ward and his colleagues (Laws & Ward, 2011; Ward, Mann & Gannon, 2007; Ward & Stewart, 2003). These authors point to a number of concerns with what they term the "risk-need model" (Ward & Stewart, 2003). They argue that, due to the primary focus of treatment on individual risk, the risk-need model views individuals as "disembodied bearers of risk rather than as integrated agents" (p. 354). Ward and his colleagues argue that by addressing only criminogenic needs offenders are left with gaps in their lives. What the RNR approach neglects is "the need to understand the primary human goods associated with the commission of an offense and the need to ensure that these goods are met in more socially acceptable and individually satisfying ways" (pp. 254 – 255). That is, Ward and colleagues argue, the personal needs of the offender are not considered as relevant targets in the RNR model.

Ward and Stewart (2003) argue that the risk-need model couches its approach to treatment in negative terms. That is, the focus is often on the elimination of negative attitudes, the reduction of cognitive distortions, and the extinction of deviant sexual interests. Ward and Stewart (2003) propose that, in contrast, the Good Lives Model (GLM) promotes the enhancement of strengths, skills and abilities rather than the suppression of negative behavior, in an attempt to promote a "good life."

Ward and Stewart (2003) also note that the risk-need model does not address the role of personal identity in the change process. That is, Laws and Ward (2011) note that offenders who desist tend to adopt a personal identity inconsistent with offending. Rather than targeting individual risk factors, which they argue is the focus of the risk-need perspective, the GLM advocates that change results from a "holistic reconstruction of the 'self'" (Laws & Ward, 2011, p. 189).

Critiques of the RNR approach also emphasize that the model concentrates on the causes of offending (e.g., criminogenic needs), as opposed to acknowledging the role of human agency. The GLM sees people as practical decision-makers who formulate plans and intentionally modify their environments and themselves to achieve goals. Thus, from this perspective, correctional rehabilitation should be focused on helping offenders to "acquire core competencies constituting valued activities such as being intimate, managing stress and so on" (Laws & Ward, 2011, p. 176). In this regard, proponents of the GLM argue that the role of responsibility is not sufficiently addressed in the RNR model. They (Ward & Stewart, 2003) claim that with the focus of RNR on criminogenic needs, important issues that may impact on the ability to participate in treatment and motivation for treatment are neglected.

## ■ Good Lives-Desistance Model

The most current version of Ward's model incorporates theory related to the GLM, desistance theory, and positive psychology, and has been presented by Laws and Ward (2011; Ward & Laws, 2010) as a Good Live-Desistance approach. This model is derived from an integration of Ward's Good Lives Model and research regarding desistance of offenders from crime (e.g., Maruna, 2001; Sampson & Laub, 2005). In brief, the research concerning desistance from offending indicates that the majority of men who become involved with criminal justice systems in their teens and early 20s do not continue to commit crime. Sampson and Laub make the argument that desistance is the norm and that only a minority of offenders continue to re-offend at a high rate across their lifespan. Ward and Laws argue that the same applies to sexual offenders. In their review of the literature, Ward and Laws (2010) identify 12 influences that contribute to the desistance of offenders: 1) aging, 2) marriage, 3) work and job stability, 4) military service, 5) juvenile detention, 6) prison, 7) education, 8) cognitive transformation (i.e., changes in how the person views himself), 9) the Pygmalion effect (i.e., the high expectations of others lead to greater self-belief), 10) "knifing off" (i.e., cutting off bonds with a criminal past), 11) spirituality, and 12) fear of serious assault or death. Ward and Laws (2010) list a 13<sup>th</sup> factor, which is sickness and incapacitation, noting that a criminal lifestyle is associated with unhealthy and dangerous behaviors (e.g., smoking, substance use, violence) and that some criminals may desist simply because they are unable to continue with this lifestyle.

The GLM is based on the notion that humans are practical decision makers who formulate plans and intentionally modify themselves and their environments in order to achieve goals (Ward & Laws, 2010). The environment in which people function includes social, cultural, biological, and physical materials that provide the resources necessary to implement their plans. The GLM asserts that the purpose of correctional rehabilitation ought to be helping offenders acquire the core competencies they require in order to engage in valued activities such as being intimate, managing stress, and so on, and more effectively coordinate and adjust their goals depending on prevailing contingencies. Laws and Ward (2011; Ward & Laws, 2010) argue that the GLM takes an agency centred approach to rehabilitation. That is, it is concerned with the ability of individuals to select goals, formulate plans, and act freely in the implementation of those plans. Ward and Laws argue that the GLM is founded on the ethical concepts of human dignity and rights. Human dignity, they claim, is the acknowledgement of the capacity of human beings to act in pursuit of their own freely chosen goals. By human rights they refer to ensuring that the resources required for people to make their own decisions are available and that they are not unjustifiably restricted from living the life they choose. Ward and Laws (2010) acknowledge that offenders face legitimate restrictions on their freedom of movement and other rights; however, they argue that the majority

of human goods, such as core freedom and well-being, should be guaranteed by the fact that offenders possess universal human rights that are protected.

Another assumption of the Good Lives model, rarely stated overtly, is that "most [sexual offenders], apart from their sexual deviance, are not criminals" (Laws & Ward, 2011, p. 4). This assumption, of course, greatly affects the perspective that GLM proponents take on the matter of offender rehabilitation, as it leads to the additional assumption that "They hunger for the same things that we all do; a good education, a decent job, good friends, homeownership, family ties, children, being loved by someone and a stable life" (p. 4). Thus, their approach may not adequately account for highly criminalized individuals who do not share these goals.

Ward and colleagues (Ward & Stewart, 2003; Ward & Marshall, 2004; Laws & Ward, 2011) claim that, rather than addressing criminogenic needs, the focus of treatment should be on the enhancement of offenders' abilities to obtain Primary Human Goods. These goods, as described by Ward and Maruna (2007), have their origins in human nature and have evolved in order to help people establish strong social networks, survive, and reproduce. They argue that people derive a sense of who they are and what matters from the things they do and that, therefore, during rehabilitation the goal should be to provide offenders with an opportunity to acquire a more adaptive personal identity.

Yates and Willis (2011) describe eleven Primary Human Goods:

1. Life (including healthy living and optimal physical functioning, sexual satisfaction)
2. Knowledge
3. Excellence in work (including mastery experiences)
4. Excellence in play (including mastery experiences)
5. Excellence in agency (i.e., autonomy and self-directedness)
6. Inner peace (i.e., freedom from emotional turmoil and stress)
7. Relatedness (including intimate, romantic and family relationships)
8. Community
9. Spirituality (in the broad sense of finding meaning and purpose in life)
10. Happiness
11. Creativity

For each of these primary goods the authors identify secondary goods, which provide the means of acquiring the primary good. For example, for the primary good of Knowledge the secondary goods may include attending school, participating in training or belonging to a discussion group. For the primary good of Excellence in Work the secondary good may be engaging in an apprenticeship or training. Thus, from the GLM perspective offending may result when a person attempts to acquire a primary good by means of an antisocial or inappropriate secondary good. For example, someone

may try to acquire the good of Relatedness through sexual activity with a child.

From the GLM perspective criminogenic needs are internal or external obstacles that frustrate and block the acquisition of primary human goods (Ward & Marshall, 2004). That is, crime occurs when the individual lacks the ability to obtain a good in a prosocial manner and is unable to think about his or her life in a reflective manner. From this perspective, criminogenic needs reflect a deficiency in agency and conditions that support agency.

Laws and Ward (2011) identify two routes to offending. The first is the direct route, in which offending is a primary focus in the individual's life plan. That is, the person may intentionally seek certain types of goods through criminal activity. For example, an offender may lack the relevant competencies and understanding to obtain the good of intimacy with an adult. Thus, for this person offending may represent a striving for the fundamental good of intimacy which he intentionally seeks through criminal activity. Along the indirect route to offending the pursuit of a good increases the pressure to offend. For example, a conflict between the goods of relatedness and autonomy may lead to the break-up of relationship, which leads to loneliness/distress, which leads to alcohol use, which eventually results in offending.

From the GLM perspective there should be a direct relationship between goods promotion and risk management, in which rehabilitation consists of a holistic reconstruction of the self. For instance, Ward and Laws (2011) argue that a focus on the promotion of goods is likely to automatically eliminate or modify risk factors. Thus, in the GLM intervention is an activity that adds to an individual's repertoire of personal functioning rather than simply removing or managing a problem. This assumption of the model is critical and will be discussed in more detail below. For the moment, suffice it to say that this view is in keeping with humanistic traditions but may be at variance with cognitive-behavioral orientations where the focus is on the modelling of appropriate skills that are directly addressed in treatment.

Laws and Ward (2011) also indicate that, from a GLM perspective, therapy should be tailored to match the individual client's life plan and his or her risk factors (Ward & Brown, 2004). The GLM also focuses on approach goals rather than avoidance of risk factors. The view of the offender is that he may lack many of the essential skills/abilities required to achieve a fulfilling life, and that criminal behavior results from an attempt to achieve desired goods. Alternatively, criminal behavior may arise from an attempt to relieve a sense of incompetence, conflict, or dissatisfaction that arises from not acquiring valued human goods.

### An Analysis of the GLM-Desistance Perspective

Laws and Ward (2011) claim that the absence of certain goods is more strongly related to offending than the absence of other goods. These include: 1) Self-efficacy/sense of agency; 2) Inner peace; 3) Personal dignity/social esteem; 4) Generative roles

and relationships (work, leisure); and 5) Social relatedness (associates). However, they offer no data to support this claim. In addition, the first three of these goods are similar to factors identified as non-criminogenic in extant research. For example, personal dignity is similar to self-esteem, which research previously cited indicates is non-criminogenic (e.g., Hanson & Morton-Bourgon, 2005).

Laws and Ward (2011) indicate (p. 202) that the GLM has empirical support; however, they fail to offer any citations to support this claim. Although there appears to be evidence supporting some of the principles of positive psychology this cannot be taken as evidence that such approaches are effective with offenders. For example, Deci and Ryan (2000) summarize research which indicates that in the general population self-determination is positively correlated with personal well-being. However, there is no evidence to indicate that these research findings can be applied to sexual offender populations (Andrews et al. 2011), and, in fact, the meta-analyses summarized above suggest that they cannot. That is while positive psychological approaches may be relevant for the general population, it is less apparent that they are relevant for clinical populations, and even less so for sexual offender populations. For example, the meta-analyses summarized above found that treatment addressing non-criminogenic needs, such as self-esteem, low self-worth, or vague feelings of personal distress, was not associated with any treatment effect.

### Studying the GLM

In terms of support for the GLM, Ward and colleagues have described case examples to illustrate the application of their principles to interventions with offenders; however, these do not tell us whether or not these interventions are effective in reducing recidivism or more effective in addressing criminogenic needs than other approaches. A central tenet of the GLM is that the model is compatible with RNR based perspectives (See Ward & Maruna, 2007 for a discussion). Nonetheless, we are not aware of any large scale investigations involving offender populations that have compared and contrasted these two approaches in terms of the direct impact that each might have on recidivism.

In terms of case studies intended to demonstrate the effectiveness of the GLM, Whitehead, Ward, and Collie (2007) describe the case of Mr. C, described as a gang member with a long criminal history of violence, including sexual violence. It was noted that he had engaged in RNR based interventions during previous sentences, but that he remained in the pre-contemplation stage of change and held rigid antisocial attitudes and continued drug use at those times. Mr. C. was provided treatment according to the GLM, and his outcome 14 months following release was discussed. He had enrolled in university but dropped out due to "transportation difficulties," but had made arrangements to re-enroll. Whitehead et al. also noted that he disclosed two post-treatment violent incidents. "The first involved a retaliatory action after being pushed to the ground at a party. ... The second

relapse occurred in response to his partner being insulted and offended. Mr. C's reaction included 'smashing' the victim and entering an emotional state synonymous with the abstinence violation effect" (p. 593). Whitehead et al. noted that he had remained "conviction free except for a minor driving charge" (p. 594).

Two studies addressing the effectiveness of GLM approaches to treatment in contrast to "treatment as usual" approaches have been conducted to date, although neither involved investigation of the direct impact of treatment on recidivism rates. The first of these was conducted by Harkins, Flak, Beech, and Woodhams (2012). This study compared 76 men who participated in community sexual offender treatment structured on a GLM model to 701 who participated in a relapse prevention RNR oriented program. Harkins et al. compared the groups on a psychometric assessment battery administered pre- and post-treatment that consisted of measures that previous research had demonstrated to be associated with recidivism (Beech, 1998; Beech, Friendship, Erickson, & Hanson, 2002). Harkins et al. assessed program effectiveness by examining attrition rates, the facilitator's perception of the program and offender's motivation, and the participant's perception of the program, as well as pre-post changes on the psychometric battery. It was found that attrition rates did not differ significantly between the GLM and the RP oriented programs. There were also no differences in rates of change on psychometric measures. Overall, the facilitators liked the GLM-based module better than the RP based, but 63.7% did not think it would be appropriate for high-risk/unmotivated clients. Regarding the clients' ratings of the extent to which they improved their understanding of their offending, 80% of RP group rated their understanding as improved compared to 46% of the GLM participants.

In contrast, when rating the extent to which clients had developed a better understanding of the positive aspects of themselves, 61% of the GLM participants indicated that they had a better understanding of themselves compared to 20% of RP participants. Participants were also asked to rate the extent to which they had altered their thoughts and attitudes so that they might be better able to manage their behavior. For the RP-based module 80% thought that they had, compared to 27% for the GLM module.

In summary, the GLM module led to offenders who feel better about themselves and their future; however, the results of interviews indicated that they had less awareness of risk factors and self-management strategies. Furthermore, there were no differences overall in terms of attrition or change on risk factors.

The second study comparing the GLM to a standard RNR/RP approach was conducted by Barnett, Manderville-Norden, and Rakestrow (2013). This study was conducted in follow-up to the Harkins et al. (2012) study described above, after the GLM component of the program was redesigned based on the findings of the former study. Barnett et al. examined psychometric testing results from two samples of offenders who participated in commu-

nity based sexual offender treatment programs that included either an RP module or a GLM module. In total, 321 men participated in the RP programs and 202 in the GLM. It was noted that, on average, men participating in the RP program scored significantly more deviantly on the measures at pre-treatment than the men in the GLM program. Results indicated that there was no significant difference overall in the amount of change achieved on the measures between the two groups. In addition, there was no systematic difference in the number of men who achieved clinically significant change on the measures. However, it was noted that for those who had pre-treatment functional scores and attended the GLM module tended to remain functional at a higher rate than those who attended the RP module. It was noted that neither the GLM nor the RP approaches effected change in the majority of those requiring change (i.e., the majority of both groups did not achieve "treated status" on the measures). In addition, attrition rates were not different between program approaches.

A final article addressing the application of the GLM, although not a treatment evaluation, is a study reported by Willis and Ward (2011) assessing the extent to which attainment of Goods impacts on adjustment to the community following release in a sample of 16 treated child molesters. Study participants were contacted in the community one, three, and six months post-release and interviewed regarding their attainment of Goods and their adjustment to the community. The researchers also assessed the participants' re-entry experiences, and in particular their experiences related to accommodation, employment, and social support.

Overall, Goods fulfillment ratings indicated the partial or complete fulfillment of goods among the subjects. They also noted that the acquisition of the good of Independence (autonomy) was strongly affected by the offender's ability to find employment and permanent accommodation and the goods of Achievement (excellence in play and work) and Belonging (relatedness) were least fulfilled among participants at one month post-release. The offenders reported that difficulty finding employment was a barrier towards achievement, and that they indicated that joining cultural, sporting or other groups to fulfil the good of belonging were long-term goals, but that other goals such as securing permanent housing and employment took precedence.

When correlating the mean Goods rating with the Re-entry Experience rating, it was found that a higher Goods score (greater acquisition of Goods) was positively related to Re-entry Experiences. It was also found that dynamic risk ratings were negatively associated with the mean Goods achievement. In other words, offenders with higher dynamic risk had lower achievement of Goods upon release.

### Evaluating the Evidence for GLM

Evidence that the GLM approach is more effective than the approach taken by RNR/RP is lacking, based on the empirical research reviewed above. For instance, the case study of Mr. C. does not support the claim that the GLM approach is more

effective, or as effective as the case study appears to imply. While Mr. C. was not arrested for a serious offense in 14 months following release, he reported having assaulted at least one person (he “smashed” a man who was disrespectful toward his partner), and becoming involved in a fight with another. However, Whitehead et al. (2007) interpreted these incidents as relapses with which Mr. C. had successfully coped. Mr. C. also attempted to attend university, but withdrew and had not yet re-enrolled. In contrast to the positive evaluation provided by Whitehead et al. (2007), a cynic might say that Mr. C. tried, but failed to attain prosocial goals and that he had in fact re-offended, at least with respect to violence. Further, as reported, the incidents suggest that the client still exhibited a number of significant cognitive distortions that may have not been adequately addressed in treatment.

The Harkins et al. (2012) and Barnett et al. (2013) papers demonstrate that a GLM oriented program can lead to changes on psychometric measures. The observed changes on psychometric instruments are, however, the same as those achieved in a comparable RNR/RP program. This later finding is important, as the GLM is held out as a model which would *improve* treatment outcome over the typical RNR oriented approach (e.g., Laws & Ward, 2011, p. 202). Harkins et al. reported that offenders completing the GLM program were less likely to report feeling they understood their offending and their risk factors than those who completed the RNR/RP based program, although they reported feeling better about themselves and their futures. Nevertheless, “feeling better” about oneself (i.e., increased self-esteem) has been demonstrated in meta-analyses to be unrelated to recidivism (Hanson & Morton-Bourgon, 2005; Andrews & Dowden, 2006). Thus, these evaluations suggest that overall the GLM program may not have met the objectives of preparing sexual offenders to manage their own risk in the community.

Finally, examining the results of the Willis and Ward (2011) paper, this study provides support for RNR risk factors as much as it does for the GLM. For instance, the offenders who were assessed most poorly on the re-entry rating were also those presenting with the highest dynamic risk as assessed by the Stable-2007 (Fernandez, Harris, Hanson, & Sparks, 2012), illustrating the validity of the risk-need principles of RNR. Conversely, offenders reporting the most satisfactory re-entry were also those most able to achieve employment and stable housing, which, while related to GLM Primary Goods, are also two of the Big Eight risk factors central to RNR. Thus, while these findings can be taken as support for the GLM, they are equally supportive of the RNR approach.

A further criticism of the GLM is related to its approach to treatment. Although not explicitly stated, it appears that Ward and colleagues (Ward & Stewart, 2003) are advocating for a humanistic approach to treatment (e.g., Rogers, 1951). The issue here is that there is extensive meta-analytic support for the assertion that cognitive behavioral approaches to treatment are the most appropriate for offender populations. The non-directive, unconditional-

ly accepting approach to treatment advocated by the Humanistic approaches can be detrimental in working with offenders, for which a concrete, directive and structured approach is preferred (Andrews & Bonta, 2010).

In summary, while some of the assertions of the GLM have support, the extant research in support of the model is scant, and does not provide evidence of the greater effectiveness of the GLM as Ward and colleagues claim. At best, the model provides change equal to as that achieved via an RNR approach; however, this change has yet to be shown to be associated with reduced recidivism. In contrast, the RNR approach has been shown to be related to reduced rates of both violent and sexual recidivism, and is supported by a mature research literature as reviewed in several meta-analytic reports referenced above.

### ■ GLM vs. RNR

When comparing RNR and GLM approaches, it is critical to determine whether or not the GLM adds anything new to the offender rehabilitation literature or its models. In the preceding pages we examined the primary assertions of both of the models. In the current section we will provide a direct comparison of the claims.

The GLM proposes that criminal behavior arises from an attempt to relieve a sense of incompetence, conflict, or dissatisfaction that arises from not acquiring valued human goods, while, in their RNR model, Andrews and Bonta (2010) argue that crime results when the personal, interpersonal, and community supports for behavior are favorable to crime. If we examine these statements closely it is apparent that the claims of both models are similar, though the assumptions underlying the models (i.e., humanistic in the case of the GLM versus cognitive-behavioral in the case of RNR) may be at odds with one another.

Andrews and Bonta (2010) focus on the Big Eight risk factors, addressing such needs as lack of education and employment and lack of supportive, rewarding, and prosocial familial and marital relationships. The GLM identifies eleven “primary goods,” which upon examination have a great deal of inverse overlap with the Big Eight. For example, the Primary Good of Knowledge has its RNR counterpart in “Problems Related to Work/Schooling,” and Excellence in Play and Work have their RNR counterparts in “Employment/Schooling” and “Problematic use of Leisure Time.” Similarly, the GLM Inner Peace primary good is inversely related to the RNR factors of Antisocial Attitudes and Antisocial Personality Pattern. On the surface at least, it appears that GLM Primary Human Goods are inverse restatements of the Big Eight risk factors, viewed from the lens of humanistic psychology.

Indeed, it may be said that the RNR does use different terminology than the GLM, and that the language of RNR is focused more on what we may call deficits, as opposed to the language of positive psychology used by GLM. However, RNR is not a treatment model and does not address or prescribe how practitioners must or should apply the three

principles. Its concepts, although perhaps framed in terms of deficits, nonetheless address the same or similar concepts as the GLM, and in this regard GLM offers very little that is new, even if couched in different terminology. In fact, regardless of language, the clear goal of RNR is not simply to avoid deficits but to eliminate them, as in the “N” and second “R” of the RNR model.

In fact, in terms of approaches to rehabilitation, both models discuss the importance of acquiring skills, although Ward et al. assert otherwise for the RNR approaches. The GLM asserts that by acquiring the skills to appropriately obtain desired Goods, an individual’s risk for re-offense is reduced (Laws & Ward, 2011). While the designers and proponents of the GLM present the RNR approach as focused on managing deficits and risk factors (Laws & Ward, 2011), the RNR approaches this, in fact, by working to change, and not simply repress, antisocial attitudes and by addressing personality and behavioral deficits, thereby developing the necessary skills to obtain prosocial employment and associates (Andrews & Bonta, 2010). As Wormith et al. (2012) state, some of the professed shortcomings of RNR and alleged differences between RNR and GLM are illusory and mostly semantic.

As noted, Laws and Ward (2011; Ward & Laws, 2010) have recently added the consideration of desistance to their model. They argue (Laws & Ward, 2011) that rehabilitation should capitalize on desistance processes by providing the skills to enable clients to be able to choose to remain crime free. However, looking at the desistance levers identified by Laws and Ward (2011), to a large extent these appear to be related to Andrews and Bonta’s (2010) Big Eight risk factors. Laws and Ward identify factors such as marriage, work and job stability, education, cognitive transformation (i.e., changes in how the person views himself) and the Pygmalion effect (i.e., the high expectations of others leads to greater self-belief) among the desistance levers identified in the research. Marriage, work stability and education are directly listed among the Big Eight risk factors.

The need to use approach goals and positive language as suggested by proponents of the GLM (Ward & Laws, 2010) is a contribution; however, it is simply a reminder of what a good clinician should be doing. It is true that the field of sexual offender treatment is too often focused on the negative; however, this is not a natural result of RNR approaches. Rather it is a by-product of early views of sexual offenders and offending (e.g., Salter, 1988).

Ward and Stewart (2003) claim that their model is “theoretically and empirically guided” (p. 222). However, we believe that the proposed model is not empirically supported at present, as described above. Further, we believe that the authors of the GLM pay insufficient attention to the relevant empirical literature. There is mounting evidence, for example, that many offenders have a history of serious mental illness. Similarly, it is becoming increasingly clear that many higher risk offenders have a history of trauma stemming from an early age (Abracen & Looman, 2006; Looman & Abracen, 2012). These data are in keeping with a large

number of publications (e.g., Adams & Ferrandino, 2008; Lamb, Weinberger, & Gross, 2004) and meta-analytic studies (e.g., Douglas, Guy, & Hart, 2009) that have demonstrated the very high rates of serious mental illness in offender populations and the relationship between these conditions and recidivism. We question whether asking such clients about “inner peace” will make much sense to such client groups and contribute to a feeling of clinical rapport. Our task might be best described as helping such clients make progress with reference to one or more concrete therapeutic goals (e.g., decreasing their use of alcohol and/or drugs).

This criticism can also be leveled against the RNR perspective. For instance, Andrews and Bonta (2010) pay no attention to issues associated with trauma. Further, they argue that there is no research showing a link between mental illness and recidivism in spite of the fact that even a very cursory review of the literature (see above) demonstrates that this is contradicted by the findings of more recent research.

### ■ Conclusions

The GLM is increasingly viewed as an alternative to the RNR approach. However, a close inspection of the relevant research suggests that many of the assumptions associated with the GLM have already been incorporated into the model established by Andrews and Bonta (2010). Further, there is now a mature literature providing empirical support for RNR based approaches to rehabilitation. The approach advocated by Andrews and Bonta has resulted in reliable reductions in recidivism among offender populations as indicated in the numerous meta-analyses that have been published to date, indicating the efficacy of these approaches with groups of general offenders, sexual offenders, and female offenders. Further, although Ward and his colleagues have argued that the RNR model focuses on deficit reduction, in practice both the GLM and RNR based approaches help clients establish relevant skills to live in a more prosocial manner. One fundamental difference between the approaches, however, is that the RNR approach employs a cognitive-behavioral orientation whereas it is not clear what orientation the GLM approach advocates. When one reads Ward et al.'s writings regarding the GLM, one gets the impression that these authors may be advocating a more humanistic orientation to treatment. Although this approach may seem a pleasant counterpoint to some of the confrontational approaches that have sometimes been used with offender populations in the past, such approaches have nonetheless not been subjected to rigorous long-term evaluation studies. Further, from our perspective, cognitive-behavioral approaches to treatment (such as RNR and RP based techniques) need not be confrontational, or rigidly delivered. Issues associated with the therapeutic alliance and motivational interviewing should be considered central to all approaches to working with offenders (e.g., Miller & Rollnick, 2012, Marshall, Marshall, Serran & O'Brien, 2011).

Further, we agree with the perspective taken by Wormith, et al. (2012); the RNR model is both

more parsimonious than the GLM and has decades of research in support of its efficacy. We should be wary of abandoning a model that has resulted in such significant improvements in the lives of the clients with whom we work. In the end, perhaps the most humane perspective is one that achieves the goals that the RNR approach has demonstrated - that is, allowing clients to live more productive lives while at the same time ensuring the safety of the citizens whom we in corrections have a mandate to protect.

### ■ Afterword

We believe that the RNR model needs to take into account some of the recent empirical literature regarding the therapeutic alliance and the changing needs of offender populations (Abracen & Looman, 2012), including prior trauma and other adverse developmental experiences, as well as issues of mental health and mental disorders. Indeed, we believe that such changes can be incorporated into a revised RNR based perspective, which we (the authors) have called RNR-I, in which the “I” denotes a more integrated approach to Andrews and Bonta's (2010) RNR model. Ironically, the general outline of this model is based on an earlier version of some of the work that Ward and Beech had published (Beech & Ward, 2004).

We have included quite a number of new elements to this model, which specifically discusses issues associated with complex trauma and mental illness, and believe that it is necessary to provide a model that directly lists factors that must be addressed by clinicians working in the field. Further, we believe that every element included in the model has been subjected to empirical scrutiny. The model is also in keeping with a harm reduction perspective (e.g., Marlatt, Larimer, & Witkiewitz, 2012). In these ways the model is very different than the perspective adopted by Ward and his colleagues.

Another feature which we believe critical is an understanding of how various risk factors work together to increase a client's risk of offending. One difficulty with the RNR perspective is that risk factors identified appear to operate in virtual isolation of one another. It is likely not the intent of Andrews and Bonta (2010) to have communicated this idea, but they nevertheless can be faulted for not encouraging more research into the ways in which risk factors interact to increase risk of recidivism. The RNR-I addresses the ways in which high-risk behaviors interact with one another and interfere with the client's ability to achieve gains with respect to desired outcomes. That said, our approach focuses on domains that the research has shown to be related to reduced rates of recidivism, and does not address domains that have not been empirically linked with recidivism, such as inner peace.

By limiting ourselves to a focus on issues that have been associated with reduced rates of recidivism, we believe that this model is heuristic and potentially more relevant to clinicians than the GLM approach or the current RNR model. The RNR-I model, though based in part on the RNR perspective, is far more inclusive than the approach advocated by Andrews and Bonta (2010).

The RNR-I is based on several decades of experience working with sexual offenders and what they have told us are issues of concern for them, and is supported by a large number of studies conducted both by our team and others, and is amenable to empirical scrutiny in which the model and approach can be compared to other approaches to treatment. In fact, we have already subjected our model to a variety of outcome studies (See Abracen, Looman, & Langton, 2008; Abracen, Looman, Ferguson, Harkins, Mailloux, & Serin, 2011), all of which have demonstrated that the RNR-I approach appears to be useful in reducing offenders' risk of sexual recidivism. However, a further description of the RNR-I is well beyond the scope of this article, and will be further described in additional papers to be published.

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## A Community Treatment Model for Adolescents Who Sexually Harm: Diverting Youth from Criminal Justice to Therapeutic Responses

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### Abstract

The costs of treating youth who sexually harm others can exceed \$200,000 Australian (US\$220,000) per annum when they are placed in a residential type facility in either Australia or North America. Following the financial meltdown of the past two years, North American based residential-style programs have found themselves under increasing financial pressure, with some well-known facilities in the U.S. having closed their doors. Other facilities have experienced drops in their referral numbers of up to 50%, resulting in substantial staff lay-offs, and shorter lengths of stay for clients.

Community-based programs can offer a low-cost alternative model of treatment that may match or exceed the success and recidivism rates achieved through facility-based residential treatment, dependent on sound assessment and consideration of the viability of the young person to: a) continue to reside in the community, and b) to continue to reside in their family home while undertaking treatment.

This article describes the state-wide community-based Sexually Abusive Behavior Treatment Services (SABTS) operating in Victoria, Australia, driven by the legislatively innovative Therapeutic Treatment Order (TTO) model in effect since 2007. This program, delivered to children and adolescents aged 10-14, is currently being extended to the 15-17 year age group due to its success in accomplishing its goals. The effectiveness of the program demonstrates the capacity to design and implement treatment programs that are able to safely keep and treat young persons with sexually harmful behavior in the community, and at a far reduced cost when compared to residential treatment costs, and with similar to lower sexual recidivism rates.

### Keywords

Sexually abusive youth, youth who sexually harm, community-based treatment, sexual treatment programs, problem sexual behaviours

It is only in the past two decades or so that a comprehensive approach to the management and treatment of young people who sexually harm others has emerged (e.g., Australian Crime Commission, 2008; Haaven, Lilte, & Petre-Miller, 1990; Longo, 2001; Rich, 2003, 2006). Indeed, prior to widespread recognition that children and adolescents are capable of sexually abusing other children, other “waves” of understanding about sexual assault and abuse were dominant.

Between the late 1800’s and the present, our understanding of adult sexual crimes progressed from early notions of adult sexual offenders as “sexual perverts” through to “sexual psychopaths” (mid-late 20<sup>th</sup> century) and, in more recent times, “sexually violent predators” (Letourneau, 2011). When it was initially recognized that “kids do this too” (Scott & Swain, 2002), the only available treatment and management models were based on adult, top-down models, effectively resulting in young people being labelled and treated as “mini-pedophiles” (Pratt, Miller, & Boyd, 2010).

### ■ The Development of Adolescent Treatment Models

With our increasingly sophisticated understanding of, and responses to, sexual offending by adults came an understanding that, in addition to punishing adults for the sexual crimes they have committed, there is also a need to rehabilitate them and provide treatment to reduce recidivism rates for those who have a history of sexual criminality. Early treatment approaches were criticized for non-uniformity, as well as (somewhat unfairly) “not working” (Mar-

tinson, 1974). This notion directly challenged the existing treatment field and resulted in a clearer understanding that treatment did, in fact, have a positive impact on sexual criminal recidivism. At that time, however, there was no understanding that “... juvenile risk assessment and treatment was a different proposition than that of assessing [and treating] risk in adult sexual offenders” (Rich, 2009, p. 60).

### The Development of Positions: Ethical Standards and Position Papers

By 1990, there was acknowledgement that adolescents who sexually abused were somehow different from adults who sexually abused; however, still unclear was *how* they were different. Early treatment models used in adolescent programs lacked proven efficacy or were weak due to research derived from small samples, a lack of information about or understanding of normative child sexual behavior, limited expert input from developmental and pediatric specialists, and/or responding to and providing treatment in a climate where moral panic abounded about “sexually violent predators” and “juvenile super predators” (Letourneau, 2011; for an Australian example from the 2000s, see Dowsley, 2006: Melbourne Herald-Sun: *Boy, 4, a ‘sex-fiend’*).

By 1993, the U.S.-based National Adolescent Perpetrator Network (NAPN) had released a revised report addressing juvenile sex offending. In part, this report recommended interventions based upon legal mandates, and emphasised youth accountability, electronic monitoring, use of the polygraph, and inclusion of youth on sex offender registries. It can be clearly seen that these concepts and ideas

were closely aligned with, and based upon, adult concepts and models of sex offender treatment and management. In a similar vein, in 1997 the Association for the Treatment of Sexual Abusers (ATSA) *Statement of Ethical Standards and Principles* noted the importance of comprehensive assessment of sexual offenders, with no distinction between adults and juveniles. By 2000, however, ATSA’s public policy statement noted distinct differences between adults and juveniles who sexually offended.

This understanding of youth who sexually abused, which was based on adult sex-offender theory and treatment models (Creeden, 2006; Rich, 2003) lasted through to the early 21<sup>st</sup> century. In 2003, Longo asserted that the adult sex offender treatment field ignored developmental stages and moral development. It was only into the first decade of the 21<sup>st</sup> century that it was recognized that youth who sexually abused were different than adult sex offenders, and also that treatment outcomes for youth with sexually abusive behaviors were generally very positive (Chaffin, 2008). A small number of studies (e.g., Alexander, 1999; Prescott, 2006; Worling & Curwen, 2000) indicated lower recidivism rates for treated adolescent sexual abusers when compared to treated adult sex offenders, with increasing understanding that the influence of adult models may have been keeping youth in treatment far longer than may have actually been warranted or necessary (Prescott & Longo, 2006).

By 2001, ATSA was recommending that assessors take age into account and acknowledged that, compared to adult assessment, far less was known about the meaningful and valid assessment and treatment of juveniles. By 2006, ATSA was not only recognising the developmental differences and uniqueness of adolescents as compared to adults, but also recognising a fairly new category of pre-pubescent children presenting with what was now termed *Sexual Behavior Problems* (Chaffin et al., 2008). Clearly, the field had moved rapidly to an understanding that adolescents and children required different assessment and treatment approaches to those used with adults who sexually offended.

### A Developmental Approach to Understanding Young People Who Sexually Abuse

We now understand that child development is not complete upon reaching adolescence. In fact, adolescents are “...still developing physically, emotionally, cognitively and behaviorally” (Pratt et al., 2010, p. 13). Accompanying this understanding of development is a more sophisticated understanding and acceptance of the impact of violence, abuse, trauma, and neglect upon developmental pathways. Indeed, over the past decade much has been written about the impacts of trauma upon brain development and the subtle interactions among trauma, attachment, and brain development (see for example Creeden, 2006; Friedrich & Sim, 2006; Perry, 2006; Rich, 2006, 2011; Schwartz et al., 2006). These interactions can result in a distortion of a youth’s belief and values systems, with a resulting deviation from optimal/positive developmental trajectories, and with one potential consequence being the emergence of sexually abusive behaviors.

These behaviors can be viewed in a number of ways through a developmental lens, such as:

- A method of “stimulation seeking” to replicate past intense feelings stemming from a traumatized emotional system
- An attempt to “self-soothe” through the relief of sexual release
- A re-enactment of past traumatic sexual abuse events
- A consequence of dysregulation and the inability to self-manage intense emotion and behavior.

Why would dysregulation lead to a youth committing sexually abusive behaviors? Given the complex interactions between experiencing trauma, attachment styles, and brain development why is it that a youth would engage in sexually abusive behaviors rather than either aggressive or violent behaviour, or perhaps more self-focused negative behaviors, such as self-harm, depressed state, or suicidality? Perhaps in a majority of cases, youth who engage in sexually abusive behaviors are exhibiting one potential negative behavioral outcome out of the myriad of possibilities rather than the only certain outcome.

Creeden (2006) and Perry (2006) state that sub-optimal early life attachment interactions result in deficits in neuro-development, neurological functioning, and language development. The poor quality of the attachment relationships observed and understood in this group of youth result in them lacking in the “...most important mitigating factor against trauma-induced disorganization” (van der Kolk, 2003, p. 294). Difficulties in their ability to regulate emotions, maintain interpersonal connections, and experience intimate relationships (including sexually intimate relationships) result from neurobiological impacts associated with insecure attachment patterns and traumatic childhood experiences (Creeden, 2004; Rich, 2006).

Looking through a developmental lens assists us to understand why youth who sexually abuse are different from adult sex offenders, and provides us with an understanding that punishment and treatment approaches for both populations should be different. By utilizing the developmental lens, youth can be posited to have deviated from a healthy developmental pathway and require a therapeutic response designed to restore them to that healthy track. For a small number, containment may assist in ensuring no further harm is caused to vulnerable people around them. However, in this paper we assert that, for the majority of young people, well-designed treatment and rehabilitation without containment should result in the same outcome. While any committed sexual assault – whether committed by an adult or an adolescent – is one too many, and should not be tolerated, the focus of sanctions for youth should revolve around rehabilitation rather than containment, in the majority of cases. Clearly, a response to youth sexually harming others based solely on criminal sanctions and confinement for all does not adequately allow the incorporation of a developmental lens.

### ■ Contain and Treat. A Residential Approach to Treatment: Victoria, Australia and the U.S.

In the United States during 2003, approximately 1.3 million youth under the age of 18 were arrested (U.S. Dept. of Justice, 2004), and over 130,000 were placed in secure residential facilities (Lambie, Robson, & Barriball, 2010). Lambie and colleagues assert that U.S. criminal courts have increasingly relied on residential programs to provide (a) treatment opportunities due to the lack of community based programs, and (b) containment due to fears regarding community safety and management issues in the community context.

In the United States, there seems to be a “see-saw.” On one hand, an increasingly punitive “law and order” agenda has led to greater demands on government through its law enforcement agencies to crack down on crime, contain youth, and provide a harsher response to youth who break the law. From this point-of-view, youth who sexually offend may be seen as deviant, and in need of punishment and containment, as well as regulation, through their inclusion on sex offender registers. Additionally, from time to time, particularly heinous sexual crimes committed by youth result in public outcries and campaigns calling for youth to be tried as adults to ensure they receive a higher level of punishment. On the other hand, some regions of the United States have been moving away from this response to youth, instead advocating for and introducing more developmentally appropriate punishment and treatment strategies, such as California, Massachusetts, and Colorado. In this case, such strategies might include trauma-reduction focused treatment in secure group programs (for example, Germaine Lawrence school for girls, NEARI school, MA, and Whitney Academy, also in Massachusetts).

In many instances, U.S. residential treatment programs are semi-secure facilities providing live-in services to between 6 and 200 youth (however, the majority of residential programs tend to be on the smaller size, averaging 20 to 50 youth), with schooling and treatment often provided on-site. Youth may be several hundred miles from their homes and as a result may have limited contact with their families and no contact with their communities. Costs for this model of containment and treatment commence at approximately \$130,000 per youth per annum and are more usually in the \$200,000-plus per annum pricing range. Clearly, this cost places a high burden on the community as funding is generally provided by government agencies and departments, with money raised directly through the taxation system.

In Australia, during 2008-9 approximately 103,000 youth under the age of 20 years were recorded as criminal offenders (Australian Bureau of Statistics, 2009). Youth offenders comprise nearly one-third of the total offender population, and are over-represented by population by a factor of two. In regard to specific rates of offenses recorded for sexual assault by youth, for those under 20 years of age the offense rate is approximately 50 in 100,000 (Australian Bureau of Statistic, 2009). Currently, it is

estimated that approximately 500 youth require treatment for sexually abusive behavior issues each year in the state of Victoria, Australia.

In regard to residential facilities, it has now been several decades since Victoria “de-institutionalized” its mental health and child and youth services. At that time, there was a shift from traditional large scale lock-down residential facilities to a model of “group homes” more representative of a home-based model of care, with small numbers of youth being cared for by professional staff within the community. Among a total of approximately 5000 youth receiving services from the Victoria child protection system, approximately 10% (500) reside in the residential out-of-home-care system on any given day, in which the majority reside in group homes with between 1 and 5 youth, staffed by professional carers on a roster system. The cost of providing such care varies; however, the general cost is between US \$120,000-\$200,000 per child per annum. While only a small percentage of these 500 youth exhibit sexually abusive behaviors, regular audits of client presenting issues, as well as incident reports received from residential units, make it clear that sexually abusive youth are over-represented in these settings with placement often more related to difficulties associated with housing them within foster care and family based environments due to perceived risk issues.

Unlike American residential facilities, this Australian residential model does not include a treatment component – it is simply focused on housing youth who cannot reside in their own homes, a kith and kin placement, or a foster care setting. Additionally, the model exists within the State Government Child Protection framework as opposed to a youth justice (criminal justice) framework, as in many U.S. and other Australian jurisdictions. Within the model used in the state of Victoria, youth entering the residential housing system do so only if they are at risk to or from others in their former home settings. However, sexually abusive youth who reside in residential settings are able to access treatment, although this is not attached to nor provided by their residential placement.

### ■ A Changing Response to Sexually Abusive Behaviors

While Victoria – and generally Australia – tends to follow U.S. trends, a number of reasons explain why therapeutic responses to young people who sexually harm have primarily replaced criminal sanctions in Victoria. Nevertheless, the reasons initially had less to do with “enlightened thinking” based on principles of child developmental, and rather more to do with frustrations arising from inadequate legal sanctions regarding these youth and the practicalities of getting non-mandated youth into treatment.

#### The Problems of Tying Treatment to Criminal Sanctions

At what age do children understand that what they are doing is right or wrong? Australian jurisdictions have a uniform minimum age of criminal responsibility of 10 years. However, additional to the legal age is a concept known as *Doli Incapax*,

a legal determination of whether youth can be charged, based on their understanding of whether their behavior was *seriously* wrong. For youth up to the age of 14, a determination that they do not understand the severity leads to criminal charges being dropped prior to being tried in court (Australian Institute of Criminology, 2005). Mainly due to *Doli Incapax* findings, the conviction rate for sexually abusive youth aged between 10 and 14 years was extremely low. However, without a criminal justice-mandated treatment order it was unusual for both the families and the youths themselves to commit to treatment, in which the prevailing attitude was “If it wasn’t proven in court, it didn’t happen.” Thus, the system required a better pathway into treatment that was not solely reliant on justice system mandates.

Consistent with adult concepts of crime and punishment, as community awareness of youth who sexually harmed grew (once they reached the age of criminal responsibility in whichever country they resided), these youth became subject to the criminal/juvenile justice system of that country or locale. In Victoria, Australia, this meant that children aged 10 and above who sexually harmed other children faced criminal sanctions. And, up until 2007, this was the *only* way into state-funded treatment programs. This legal process was also their only way into what was then known as a “sex-offender treatment program.” Alongside this process, if the young person had assaulted a sibling, or had non-victimised siblings residing in the home, then he or she would have to leave the family home prior to a treatment service accepting the referral. This would occur without assessment, and was ideologically based upon adult models of understanding sexual crime.

### Why Focus On Youth Who Sexually Harm?

It is now accepted that child abuse by strangers occurs at a much lower rate than abuse by family, friends, and people known to the victims. Additionally, despite a perception that fathers and step-fathers are the main perpetrators of this abuse, the majority of intra-familial abuse is perpetrated by siblings, with over 70% of sexual abuse perpetrated by first-time adolescent offenders (Rayment-McHugh & Nisbet, 2003). Given these rates of sexual abuse involving children and adolescents, it is clear that treatment and management strategies must address the issue where most needed.

### New Legislation: The Children, Youth and Families Act

Introduced in 2005, the CYFA (Victorian Consolidated Acts, 2005) contained important legislative changes to how reports of sexually abusive behavior were processed by the child protection system. Rather than focusing solely on children “at-risk” of physical, emotional, and sexual harm being perpetrated upon them as the previous act had done, the new act had substantially changed to the point where it not only considered physical, sexual, and emotional harm to children, but also importantly incorporated the concept of developmental harm. A young person who had sexually harmed others was now seen as him or herself in need of a protective response by the child protection system and,

vitaly, that young people who sexually harmed others were in need of therapeutic treatment that would enable them to manage their sexual behaviors and return to a healthy developmental pathway.

Thus, CYFA (2005) established the authority to protectively intervene in situations involving young people with sexually abusive behaviors. While the Act allowed most youth to attend treatment voluntarily, under section 248 of the Act courts were also able to issue a Therapeutic Treatment Order (TTO) directing a young person aged between 10 and under 15 years with sexually abusive behaviors to attend an appropriate treatment program. No criminal order, or indeed, further legal action, was required. The purpose of the TTO legislation was to provide young people with every opportunity to access treatment without criminal justice intervention.

### Now You Have the Framework, Set Up the Service System

As previously stated, prior to the TTO (Therapeutic Treatment Order) legislation being enacted, the only formalized pathway into treatment was through a criminal justice order. While the enactment of TTO legislation was obviously a positive shift developmentally, inasmuch as it provided a framework by which to enable treatment, the service system that provided such treatment still did not exist on a scale that would allow a comprehensive response and provision of treatment to several hundred youth exhibiting sexually abusive and problem sexual behaviors per year. By placing the treatment of youth into the realm of government funded programs, there was a clear need to provide a state-wide cost-efficient and cost-effective system that could be set up and maintained over the long term, and was not seen as competing for money with long established victim/survivor focused services. How was this to be achieved?

The state of Victoria has a well-established programmatic response to the needs of victims and survivors of sexual assault and sexual abuse. Initially set up in the 1970s as Rape Crisis Centers, these feminist-based advocacy centers eventually developed into a state-wide system of Centers Against Sexual Assault (CASAs) and child-focused, hospital-based services (e.g., Gatehouse Centre, Royal Children’s Hospital) that expanded to offer counseling and therapy, as well as advocacy. Currently, there are 15 such centers across the state, ensuring that access is available in both metropolitan and remote rural regions. The CASAs are non-government organizations funded by the state health system, and as such offer no-cost services to their clients. A small number of not-for-profit children’s counseling services also offer no cost counseling to child victims of sexual assault, including the Children’s Protection Society (CPS), the Australian Childhood Foundation (ACF), and Berry Street.

Prior to the introduction of the TTO legislation, several CASAs had recognized the link between a history of childhood sexual abuse and later sexual acting out in childhood and adolescence, and had set up community-based programs for youth exhibiting both sexually abusive and problem sex-

ual behaviors. Although youth aged 10 years and over still required a criminal order to access the services, and there were issues when youth resided with sibling-victims or potential victims (leading to “Sophie’s choice” type decisions for parents), the programs were – on the whole – very successfully providing treatment to youth with SABs and PSBs. Thus, while somewhat controversial given the feminist ideological underpinnings of sexual assault centers, the CASA system expressed interest in providing sexually abusive behavior treatment services (SABTS) across the state, to both children under 10 years of age (problem sexual behaviors) and youth aged 10-14 years (sexually abusive behaviors) in the legislated TTO treatment model. In this way, the SABTS system ensured a “seamless” response to all children and youth up to 14 years of age.

Actually, placement of treatment services for sexually abusive youth within the CASA system was an inspired idea. Rather than having to re-invent a system and fund stand-alone services for treatment of sexually abusive youth, by placing the treatment within the CASA system a state-wide response was ensured. Additionally, the existing workforce had great expertise in working with children and young people in general, and was immediately able to provide service to very young children through to adolescent youth.

However, there were many more sound reasons to place the TTO response to sexually abusive youth in the CASA system. It allowed the voice of the victims – and their experience – to remain salient within the treatment of the sexually abusive youth. Given the great experience of the CASA workforce in working with victims and survivors of sexual abuse, there was also the ability to have the victim/survivor perspective “in their heads,” as well as the needs of the sexually troubled youth. This dual perspective added another dimension to the work with youth exhibiting sexually abusive behavior.

### ■ The Assessment and Treatment Model

With the legislation in place it was important to provide a best-practice model of assessment and treatment as suggested by current research (e.g., Burton, 2013; Prescott & Longo, 2006; Rich, 2006, 2009). Given that treatment was to be undertaken solely within the community, it was important to first adequately assess the severity and duration of the sexually abusive behaviors in order to form an opinion of what treatment was necessary, and what level of risk was posed by the particular youth being assessed.

Niels Bohr remarked that “prediction is very difficult, especially if it’s about the future,” which helps us to understand that – in terms of risk prediction – we are extrapolating from past events what may occur in the future. Further, risk prediction and assessment of children and adolescents must also consider the additional task of determining what will effectively return a youth to a positive (i.e., non-offending) developmental pathway. As such, in assessment we are considering five questions related to future risk:

1. Who is at risk of being victimized?
2. What are they at risk of?

3. When is the risk likely to be present?
4. Why is there potential risk?
5. What do we need to do to enable the youth to manage the risks identified in questions 1 to 4?

### A Brief Description of the Treatment Model

Any selected treatment paradigm must at its core be flexible enough to accommodate the developmental needs of all children and young people and their families; able to include children with learning and language disabilities/difficulties, developmental delays, and intellectual disabilities; and, able to accommodate both mandated and non-mandated clients, and able to provide the same treatment model to both groups.

Providing a detailed description of the treatment model in use in Victoria is beyond the scope of this article. However, work with children and young people with SABs and their families embraces and is an adaption of the *Four Pillars of Trauma-Sensitivity (Sanctuary)* model (see Bloom & Farragher, 2010), a trauma-informed model that emphasizes the development of supportive and safe therapeutic communities. In application, use of this model addresses the deficits that underpin the sexually abusive behaviors rather than just the behaviors themselves.

Delivered to children and adolescents in community-based care (such as natural homes, foster care, community group homes), the treatment model has an expected duration of twelve months broken into several phases, and is comprised of group work and individual work that is dependent on each youth's progression and engagement in treatment. Additionally, it is vital throughout treatment to include family members and/or caregivers whenever safe and appropriate to do so, as in community-based care, much, or most, learning will occur in the youth's living environment, rather than in the 1-3 hours of work with the therapist each week. Therapists must not only see themselves as supporting their clients' learning to manage their sexually abusive behaviors, but also as a support for the family of the young person in treatment.

### ■ To Separate or Not: Can Sexually Abusive Young People Stay at Home?

A key issue that has caused consternation for treatment providers and child protection practitioners involves questions about what factors precipitate decisions to either keep a young person who has sexually abused a sibling within the family home versus removal of that youth. However, it is only in the past 5 to 6 years that this choice point has moved from one stemming mainly from the family violence field (in which treatment providers would not work with victims who were still residing with "offenders") to one based on assessment of actual risk, or the potential that the "offender" in the home will re-offend the victim. Nevertheless, at times questions appropriately arise as to what constitutes the framework for assessing risk. Perhaps basic to any question about risk, is risk purely physical and/or sexual, or does it and should it also encompass emotional risk, where, for instance, a child who has been abused sees her or his abuser still residing in the same house as them.

Thus, a first consideration in assessing this situation must be ensuring that the abused child is receiving support and counseling from a professional who understands sexual abuse, and feels safe in his or her home. Nevertheless, it is easy for an inexperienced, uninitiated, or non-savvy therapist to misunderstand how easily a young person can submit to unspoken pressures from adult family members to not "tear the family apart" or cause undue hardship to their family group (see Summit, 1983, accommodation syndrome, for a more comprehensive discussion of the dynamics at play for young children who are abused). These feelings may be based on a quite accurate assessment of the difficulties families face when one child is removed, and thus familial resources are split in attempting to support siblings who may now reside in varying locations.

A second issue to consider is the actual relationship between the child who has sexually abused and the victim of that abuse. While from a top-down, or adult, perspective it may seem that an abusive sibling would not have a positive relationship with his or her victim(s), it may be that the abuse was the unwanted 5% of the relationship, but also that the other 95% of the relationship was quite valued. We – in our roles as treatment providers – have on many occasions heard a child exclaim words to the effect that "I wanted it (the abuse) to stop, but I didn't want this (the separation) to happen." Removal of the sexually abusive sibling may then place the victim of the behavior into a situation in which he or she feels responsible for breaking up the family.

There are still other issues to consider in the assessment of safety:

- What factors, relationships, or circumstances in the home environment might either enable or support a high risk situation in which further abuse may occur, or promote a safe environment for all family members?
- Are parents and other family members aware of the youth's potential for, and actual perpetration of, sexually abusive behaviors?
- What has been the reaction of the parents to the disclosures? Adult family members may have varied reactions, with initial reactions ranging from minimization and disbelief to extreme anger and revulsion regarding the behavior – or directed toward the youth engaging in the abusive behavior. These reactions may change after the initial shock has diminished.
- Is there a highly sexualized family environment (Is pornography accessible by children? Do parents/adults in the home engage in sexual activity in front of children? Are there discussions of sex beyond what is developmentally appropriate for the children?)
- Are there distorted family expectations regarding gender, particularly if family culture links masculinity to positive views of aggressive sexual activity and denigration or devaluing of women and children?
- Have any adults previously been convicted or charged with sex offenses?

- What parenting style is utilized in the home? For instance, is it permissive and disempowering of authority, in which a child may not have learned to respect boundaries and/or lacks caring or concern about the feelings and views of others?
- Is the sexually abusive youth "privileged" within the home, perhaps resulting in a sense of over-entitlement?

More concrete concerns that, of course, must also be taken into consideration regarding safe placement of the sexually troubled youth include the duration and severity of the behaviors, the ability of the youth and his or her parents to manage emotional and behavioral dysregulation, and the ability of the parents to physically supervise the ongoing situation.

### Considerations for Success in Community Treatment

Independent of the youth's safety in the home or community, there are a number of other markers for determining whether treatment has a good chance of being successful within a community setting. While it obviously helps when a youth is willing and able to engage in treatment on a purely voluntarily basis, we recognize that the carrot and stick always plays a role in the background in these cases. The carrot is the possibility of remaining in the home, a deferral of criminal charges, and eventually (via treatment) the setting aside/dropping of the criminal matters. The stick is that if a youth does not engage in treatment, criminal sanctions will likely be imposed/re-imposed, and this includes the possibility of facing registration as a sex offender. Factors that foster success are briefly discussed below.

*Good assessment assists our understanding of each case.* It is vital that assessment formulation accurately outlines the issues to be dealt with in treatment. Assessors should consider that the sexually abusive behaviors are symptoms of underlying issues. Thus, multi-session and multi-source assessment is required, involving the youth, the family, and other key persons and domains in his or her life. All should be explored and considered.

*Inclusion and a holistic approach to treatment.* Ongoing therapeutic work must place youths within the context of their broader lives. At times, youths who have sexually abused have been treated in a vacuum, placing them, not *at* the center of the issue, but *as* the issue itself. Dysfunction, trauma, and developmental context are not recognized within such a vacuum. Alternatively, holistic therapeutic work provides the best chance of a successful outcome, in which the family – whenever safe to do so – is also included in the therapy.

*Attached carers.* Effective carers understand the youth with whom they live and whom they will most likely continue to parent. Attached carers provide an emotional "safety net." They "get" the personality and the uniqueness of the youth. Without this type of attached, connected, and caring relationship, youths may feel that the world has given up on them, and so give up on themselves.

**A committed treatment team.** A committed treatment team is also vital for success. Committed, understanding, and trauma-savvy treatment providers do not give up at the first sign of resistance or a display of problem behaviors. Rather, they see these moments as windows of opportunity to work with the youth toward a different outcome, and thus help create altered neurobiological pathways.

**A “Good Lives” framework.** While the Good Lives model (e.g., Ward & Stewart, 2003) is an adult sex-offender treatment model, a good lives philosophy certainly has a place in the successful treatment of youth exhibiting sexually abusive behaviors. Briefly, the good lives model considers that (adult) sexual offenders are most likely to be effectively rehabilitated when a central part of their treatment focuses on social and personal goals that they themselves desire, and acquiring the skills to overcome barriers to pro-social social and personal success and/or satisfaction. Similarly, youths should be taught to meet their wants and needs in a healthy and pro-social manner, in which others are not objectified or abused for personal satisfaction or any other reason, and youths in treatment must themselves be treated with dignity while reaching for these goals.

### Considerations for “Non-Success” in Community Treatment

We can not only point to factors that increase the chances for successful treatment, but can as easily point to factors that impede, or even prevent, effective treatment in the community environment.

**Outdated or reactive crisis plans.** Crisis driven plans should be just that – short interventions designed to moderate and manage a crisis. At times, however, crisis plans are put into place but are not adjusted once the crisis is over. Indeed, the longer-term goal of the crisis plan is not simply to immediately prevent dysregulated behavior, but also to create “teachable moments” by which the youth and treating staff can learn before the behavior arises again.

**The tyranny of distance.** Rural and isolated settings present greater barriers to treatment success than metropolitan based services. The lack of rural resources, long travel times that inhibit regular treatment meetings, and the sole worker model in rural treatment agency settings are all problematic. This work is difficult and good supervision and peer interaction is vital. The experience with the TTO (Therapeutic Treatment Order) model has been that when a sole worker model is employed in a rural setting, the worker may suffer burnout within a year and leave. The relationships he or she has built up with their clients, as well as their gained experience, is then completely lost and difficult to replace. Good supervision, peer interaction, and ongoing support within their agencies are vital for members of the rural workforce.

**Conduct disordered youth.** A young person who engages in multiple types of crimes and happens to commit sexual crimes as part of this general pattern of antisocial behavior may require a different treatment approach, and potentially a higher level of containment than offered in a community treatment model. Focusing on sexually abusive

behaviors and ignoring all other criminal behaviors may not make sense and reduces the potential for a positive outcome. Assessment should identify what treatment interventions, over and above those aimed at management of sexually abusive behaviors, are required for conduct-disordered youth.

### Outcomes: 2007-2012

A recent state-wide data audit of clients who entered treatment between the commencement of the SABTS (Sexually Abusive Behavior Treatment Services) program in 2007 and early 2012 indicated the generally promising outcomes accomplished by the community treatment model. Between 2007 and 2012, 1611 children and adolescents were served, the majority of whom fell into the 10-14 year age group and most male. Services were consistently spread across both rural and metropolitan regions of the state, in which almost one-third of clients reside in rural Victoria.

Approximately 12.5 percent of clients were identified as suffering a disability, among whom the four most common and distinct categories were autism/Asperger’s syndrome, ADD/ADHD, developmental delay, and intellectual disability. It is a sad fact that these four groups are consistently over-represented in populations of youth who sexually harm others. While work has progressed in regard to treatment for youth with intellectual disabilities (Ayland & West, 2003; Blasingame, 2005; Briggs, 1995; Creeden, 2004, 2006), it is only recently that we have seen the development and emergence of treatment considerations for ADD/ADHD youth and youth whose social functioning falls within the autism spectrum.

Even though the data set is incomplete due to data recording constraints over the time period, with data for a total of 831 served youth, the data set is nevertheless large enough to show trends. The data for case outcome shows that over 92% of clients fully, substantially, or partially reached their goals of treatment (73% either fully or substantially), a figure consistent across gender. When measured across age groups, outcomes indicate that treatment success is highest for the 0-9 year age group, among whom approximately 88% of clients fully, substantially, or partially reached their goals of treatment (79% either fully or substantially). Among the 10-14 age group approximately 91% of clients fully, substantially, or partially reached their goals of treatment (68% either fully or substantially).

While perusing these figures, it is important to keep in mind that the goals of treatment encompass far more than managing to not sexually harm another person, with anecdotally reported low sexual recidivism rates. For example, only 5% of females and 8% of males fall into the “no treatment goals reached” group. If we posit that these youth, who failed to achieve their treatment goals, may also continue to engage in sexually abusive behaviors, these figures sit within the well-established recidivism rates for youth who sexually harm, which, in the United States, is typically in the 10-15% range (see, for instance, Reitzel & Carbonell, 2006). However, SABTS sexual recidivism rates have not been reported because the number of youth who have been re-charged due to recidivism may not

accurately reflect the actual recidivism rate, given the issue of underreporting of sexual abuse in the community.

As shown by outcome data, this lower cost, community-based treatment model offers a promising alternative to long term, secure, or “lock-down” residentially-based treatment, which is both expensive and invasive, as well as severely limiting adjustment to community-based conditions, and which itself has never been proven effective. While further assessment is required, it appears that youth who complete treatment in community-based programs are achieving at least similar results to those treated in more secure and more costly settings. Similar results are being achieved for under \$10,000 U.S. dollars per annum per youth as those treated and housed at a cost of over \$100,000 per annum.

There are a number of issues remaining to be addressed in the community treatment model, particularly in regard to the cohort of clients resistant to engagement with treatment services. In some cases, these youth may not be subject to any further sanction, an unacceptable outcome given their potential to cause further harm. A second group includes those youth who commence treatment and then, for a range of reasons, “slip away.” It remains unclear whether youth in this group have completed enough work in most circumstances to equip them to manage their sexually abusive behaviors, although the limited research that is available suggests that they are at greater risk for recidivism than those who do complete treatment (for instance, Worling, Bookalam, & Litteljohn, 2012). Furthermore, the reason why this group does not complete treatment requires further analysis so that better ways to bring them back into treatment are formulated.

### The Future

Through the provision of an extra \$7.1 million in funding over the next four years, written into the 2012-13 State Budget, the Victorian State Government has indicated its confidence in the community-based response to youth who sexually abuse. This additional funding effectively doubles available treatment placements to over 500, and also includes a training budget for the workforce.

### Conclusion

With the enactment of the Therapeutic Treatment Legislation, the Victorian Government has enabled the development and implementation of an integrated system approach that incorporates all youth up to 15 years of age in community treatment for the issues of problem sexual behavior and sexually abusive behaviors. The low cost aspects of the model provide the best possible chance of sustainability, as long as recidivism rates remain relatively low. Importantly, the treatment appears to be at least as effective in reducing recidivism as residentially-based treatment programs commonly utilized in the United States. Indeed, based on the success of the program, sexually abusive youth aged between 15 and 17 years are being considered for inclusion within the SABTS system.

The SABTS provides a state-wide system that is relatively low cost and as such can be funded without

cutting corners, without over-burdening the state. Furthermore, the community treatment model aims at, whenever possible, either keeping families together safely from day one, or reintegrating families safely and in as short a time frame as possible.

Of significance, the successful community-based program demonstrates that treatment for many youth with histories of sexually harmful behaviour can be provided in the community, with neither the costs nor the artificiality of the highly controlled residential treatment environment. The advantages of community treatment are self-evident – as long as the treatment is effective. Results thus far indicate the effectiveness of the Victorian model.

The move away from residential care to community care reflects shifts in our thinking and approach to treatment, especially obvious when we think of where we have come from over a quite short period of time. We have moved from top-down adult models that potentially treated youth as “mini-pedophiles” to a contemporary view in which we see youth who sexually harm others as veering away from a healthy developmental pathway rather than as sexual deviants. This still evolving shift may not only serve treatment outcomes well, but also be of particular importance for adolescents who may have previously carried the burden of a sexual offense conviction with them, as well as the possibility of sex offender registry into adulthood. Through the effective treatment of these youth, we are working towards ensuring not only the prevention of further sexually abusive behavior, but also the possibility of social success and achievement.

Although penned several hundred years ago, the words of William Shakespeare seem so developmentally appropriate as we apply them to behaviorally troubled youth who have the opportunity to successfully engage in treatment, and thus steer their way back onto a positive developmental pathway: “Presume not that I am the thing I was.”

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## The Rashomon Dilemma: Perspectives on and Dilemmas in Evidence-Based Practice

David S. Prescott

*Becket Family of Services*

### Abstract

Professionals working with adolescents who have sexually abused are under ever increasing pressure to engage in evidence-based practice (EBP), or treatments that have demonstrated proof of their efficacy. While the quest for EBP is certainly praiseworthy, it has been an elusive concept for many professionals. Further, development of evidence-based treatment curricula has prompted questions as to their best usage, in light of actual practice and at the level of each individual client. When one examines the data on groups of clients, the evidence for such curricula can be impressive; however, questions remain about specific applications and the human frailties of those administering and providing these treatment curricula. The Rashomon dilemma adds to these questions the effect and impact of differing interpretations shaped by the legitimate, but often different, perspectives held by different stakeholders in any given case.

### Keywords

Evidence based practice, sexually abusive youth, juvenile sexual offenders, sexually abusive behavior, sexual offender treatment

To place what follows into context, consider the following vignette. During a chance encounter in a hotel coffee shop, a conference attendee who had attended a workshop presented the author the previous day on assessing and treating adolescents who have sexually abused commented, "I thought your field was more evidence-based." The workshop itself had focused on the considerable research that has emerged in the past two decades. What prompted the dismissive tone of the attendee, however, was the fact that no available treatment manuals have been empirically proven to be effective under the stringent conditions of a randomized clinical trial.

This article explores the dilemmas professionals face at the front lines of assessing and treating adolescents who have sexually abused. It explores how the varying perspectives on "evidence-based treatment" can both help and hinder our field. As with the characters depicted in the 1950 Akira Kurosawa film *Rashomon*, different professionals and other stakeholders in treatment may see dramatically different things when observing the same client, or considering different aspects of the same model of treatment. In *Rashomon*, different characters experience widely different views of exactly the same incident, showing us that there may be significantly different interpretations of the same circumstances, each of which are credible even though quite different from one another. Perhaps none are actually the "correct" version or interpretation; alternatively, perhaps each version is accurate in its own right when seen from that particular perspective. Using a case example to illustrate the points made, this article addresses that very phenomenon as we consider the basis for and actual application of evidence based treatments, and perhaps can help us prevent unnecessary arguments in our attempts to build healthier lives for the young people who come into our care, and safer communities. Indeed, *Rashomon* ends with the rescue of a child after much arguing among the adult characters, mirroring our presumed goal in treatment.

### ■ What Exactly is Evidence-Based Practice (EBP)?

Use of the term "evidence-based" has expanded dramatically in the past two decades. In 1994, it turned up about three times in scholarly publication titles in the behavioral health literature. Ten years later, the number of titles using this term grew closer to 600 (Chaffin, 2007). There are good reasons why stakeholders would want evidence that what they are delivering, referring clients to, and/or are paying for actually works. For example, in 2001 the United States Surgeon General published findings purporting to show that residential treatment is ineffective in reducing youth violence (U.S. Department of Health and Human Services, 2001). The failure of programs such as DARE, Scared Straight, and boot camps to produce the desired outcomes of reduced drug abuse, criminality, and re-offense is a sobering reminder that not all of society's efforts have borne fruit (Smith, Goggin, & Gendreau, 2002).

In 2007, Mark Chaffin defined evidence-based practice in the field of treating adolescents who have sexually abused as "the competent and high-fidelity implementation of practices that have been demonstrated safe and effective, usually in randomized controlled trials (RCTs)" (Chaffin, 2007, p. 661). For the purposes of working with adolescents who have sexually abused, the words "safe and effective" appear particularly important. Indeed, some researchers have questioned the extent to which interventions with youth can actually cause harm (e.g., Dishion, Poulin, & McCord, 1999; Lilienfeld, 2007; McCord, 2003). For example, more recently, Chaffin (2011) examined the use of the polygraph, questioning its effectiveness and whether it can help protect adolescents from the consequences of re-offending. Also of note, Chaffin acknowledges, "Fidelity to an intervention protocol raises questions of how strictly protocols or manuals must be followed and the extent to which practitioner creativity, idiosyncratic practice styles, and individualized treatment approaches can be retained in EBP" (Chaffin,

2007, pp. 661-2). This is not merely an academic question. Some evidence-based methods are more prescriptive (e.g., aggression replacement training: Goldstein, Glick, & Gibbs, 1998) than others (e.g., motivational interviewing: Miller & Rollnick, 2013). Chaffin's observation about strict adherence to protocols is worth exploring further. Although it has yet to receive much attention in research, there is a serious question about the generalizability of findings from their original setting to another. While a school-based curriculum developed in one state can likely be used with same-aged students in the classroom of a neighboring state, strict adherence to protocols can result in unanticipated problems in other situations. In one example from the author's experience, a protocol developed in one part of the northeastern U.S. was implemented in another. A significant difference, however, was that it was now to be applied in home-based services rather than an outpatient clinic, where the manual had been developed, changing the circumstances under which the model was to be applied and creating potential, but unforeseen, obstacles to providing effective treatment. For instance, as a part of fidelity monitoring, deemed vital by the developers to service delivery, each therapist was required to videotape every session. One clinician summarized the experience:

*I've been through video-based fidelity monitoring before; I know how it works and I'm no longer afraid of the feedback. What's getting lost in the implementation of this curriculum is the fact that we're entering people's homes. That's the greatest honor a clinician can have.... That's a big deal, because this family is in pain and they're embarrassed about their situation. Now I need to set up my video camera to prove to someone outside of there that I'm doing it right. So right then the family is seeing that I'm not there for them, and that I'm also there to perform for the consultant. Whose treatment is it? Then it gets worse because the family, in granting permission, is saying out loud "we'll do this for you," when I'm the one who should be doing things for them. "We'll do this for you even though we don't really want to" is an abuse-enabling dynamic and that's what I'm trying to stop.*

In the author's experience, it is not uncommon to hear that a video review of session material is vital to ensure fidelity to a model. Indeed, video review has been part of the author's supervisory practice. Explored from another angle, however, other questions emerge. For instance, how should treatment programs understand treatment failure when it occurs under the conditions briefly described above? Is it a failure in implementation or of the clinician's allegiance to the model? In terms of fidelity to the model, where does "strict adherence" begin and end, and does fidelity in the case described, in which video recording is required, also serve as an obstacle to treatment? Addressing issues like this, Wampold (2001) and Duncan, Miller, Wampold, and Hubble (2010) have written extensively on the factors involved in treatment, including the therapeutic alliance and the allegiance of clinicians to an approach or model (as opposed to the specific techniques within that model). Their findings are important for any program considering EBP implementation, and lead to several questions:

- How should we understand the value of empirically supported treatments, such as Multisystemic Therapy (Borduin, Henggeler, Blaske, & Stein, 1990; Sawyer & Borduin, 2011) when studies of these approaches by people other than the developers do not find the same results (e.g., Harpell and Andrews, 2006; Leschied & Cunningham, 2002; Littell, 2005)?
- Evidence-based treatment approaches can be challenging to implement. In fact, doing so can take years and result in staff turnover (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). They can also be very expensive. At what point to the costs outweigh the benefits?
- At one level (e.g., CBT versus an unspecified “treatment as usual”) a specific approach might seem to present a significant advantage. However, what should professionals make of the fact that when all bona fide treatments are compared to other treatments-as-usual, all treatments appear to do equally well (Wampold, 2001)? For example, a recent implementation of cognitive-behavioral therapy (CBT) across Sweden did not produce evidence of improved psychotherapy outcomes over other therapeutic approaches (Miller, 2013; Werbart, Levin, Andersson, & Sandell, 2013).
- Given that adolescents who have sexually abused are a heterogeneous population (Hunter, 1999; Longo, Prescott, Bergman, & Creeden, 2012; Rich, 2011;), does it make sense to seek out a single, evidence-based treatment method?
- Does a treatment proven effective with one client population in a particular treatment setting retain its evidence based status when used with a different client population and/or in a different treatment setting?

Returning to Chaffin’s (2007) definition of EBP as “the competent and high-fidelity implementation of practices that have been demonstrated safe and effective, usually in randomized controlled trials (RCTs)” (p. 661), it is also possible that this definition might include practices for which there is an evidence base but are not comprehensively manualized. For example, journaling has demonstrated its contributions to psychotherapy outcomes, although in itself it is not nor does it provide a comprehensive treatment curriculum (Pennebaker & Chung, in press). Therefore, the focus of many professionals on finding a single treatment package that works well for all clients in all treatment settings may preclude their discovery or use of other safe, effective, and evidence-based treatments that can serve as components of a broader and perhaps more versatile and comprehensive treatment package.

In 2008, a task force of the American Psychological Association for EBP with children and adolescents stated that, “(EBP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Task Force on Evidence-Based Practice with Children and Adolescents, 2008, p. 5). Like Chaffin’s (2007) definition, the APA emphasizes the evidence base even as it emphasizes

the role of clinical expertise and the individual characteristics of the client. Far from having all adolescents of a certain background receive the same treatment, this definition virtually demands individualized treatment (i.e., “patient characteristics, culture, and preferences”). This brings with it an inherent dilemma. On one hand, EBP requires tailoring treatment to the individual characteristics of each client. On the other hand, while many curricula provide some flexibility in order to accomplish this, there is still the problem that making too many adjustments can compromise the integrity and effectiveness of the model, at least according to the developers of many treatment curricula.

Balancing the APA’s triad of research evidence, clinical expertise, and individual characteristics at the front lines of treatment becomes more challenging than it might appear when reviewing the evidence base of a treatment approach in a scholarly journal article. As an example, the author was called upon to consult in a case in which a 13-year-old set fire to an empty building. This followed a series of horrific events, including the sudden and unexpected death of the boy’s father when the child was aged 9, the absence of his mother from his life following repeated physical abuse since around the same time, placement with ineffectual relatives, and – most recently – the death of a classmate in a traffic accident. This young man was taking medication for Attention Deficit Hyperactivity Disorder and receiving special education services. There were also concerns that he and a foster brother had engaged in unspecified sex play. However, the case manager and other professionals involved in the case were under fierce pressure from their superiors to provide only evidence-based treatment. Further, the state agency’s mandate was such that it would prioritize only the most urgent treatment needs due to budgetary constraints. In other words, treatment for trauma and complex grief reactions was less a concern to the state agency than the fire setting that arguably stemmed from experiences of trauma and loss, and the focus on only an evidence based treatment narrowed the choice for a treatment approach. The result was a referral from the agency’s area manager, over the objections of the front-line clinician who had worked with the family, for MST to address the boy’s fire setting. Whether MST under these circumstances would be helpful was open to debate. However, the use of an evidence-based treatment approach to address only antisocial behaviors or traits, in the absence of a comprehensive assessment or accommodation for the other factors in this adolescent’s life, meets only one of the three prongs of the APA’s definition of EBP.

The different perspectives of each player in this situation are worthwhile considering. The area manager was aware of MST’s successes, although maybe not its practical and scientific limitations. The clinician recognized the many stresses in the young man’s life and hoped that the family-based focus of MST would result in some larger benefit for each family member, as well as the young man. Representatives of the legal system would be reassured by the confidence of the area manager in the status of MST as evidence-based. However, questions remain, perhaps beginning with the fact that, despite a highly engaging MST specialist who clearly be-

lieved in the model, in this case no one asked the young man or his family whether, as stakeholders, they felt MST was a good way forward. Under these circumstances, in which the family may themselves may not be fully on board, and considering the different perspective held by different stakeholders, whose responsibility is it if the intervention fails? Do we blame the poor fit between the model and the client, or do we attribute failure to poor implementation? Depending on the personalities involved, some might go so far as to blame the professionals involved, or the client himself.

Summarizing to this point, the current usage and concept of EBP remains quite new in comparison to the general study of psychotherapy, which dates back many decades. In fact, the definition of EBP has been in flux and only more clearly defined and settled within the APA in recent years. At the front lines of practice, ideas about what does and doesn’t count as EBP vary based upon circumstances and the perspectives of those involved. Finally, while there is no question that many of the available evidence-based curricula, protocols, and techniques have performed admirably in the settings where they were developed, implementation in newer or different settings, or with different client populations, can be challenging at best. Indeed, a treatment model that is evidence based, or empirically validated, in one setting or under a defined set of treatment circumstances may not be empirically validated or proven in a different setting, even though it may remain “evidence informed.”

### ■ An In-Depth Examination: A Case Example

A case study can help to illustrate some of the dilemmas, competing demands, and differing perspectives about the same case, involving many different aspects of or related to the case. In the case presented below, we can see that approaches to assessment and treatment, and their resulting outcomes, may be shaped and experienced very differently by different stakeholders in the case, and that different perspectives can not only drive treatment, but also our view of what counts as evidence based practice and what does not.

#### The Case of Nick

Further exploring the dilemmas in EBP in practice, consider the case of an adolescent who had sexually abused his cousin. “Nick” came into residential treatment at the age of 15. Nick’s full-term pregnancy was the result of a sexual assault by his mother’s boyfriend, whom Nick never met. His mother’s subsequent boyfriend was also periodically abusive, with the result that Nick was exposed both to violence and neglect from an early age. However, he generally reached developmental milestones on time or a little early, and started kindergarten at the age of 5. By the time he was in first grade, his mother had a new partner, who sexually abused Nick on a number of occasions. Records are unclear about how this came to the attention of the authorities, but Nick was placed with his uncle and aunt at the age of 8, where he stayed until his placement in residential treatment at the age of 15. Also in their home was his cousin, who was five years younger than Nick.

By most appearances, Nick's ability to adjust to his new home was remarkable. His uncle and aunt had very clear, predictable routines within their family. Nick's uncle worked in construction, and his aunt maintained a small Internet web design business, which allowed for considerable flexibility and attention to Nick's needs. For his part, Nick seemed to flourish in the home, but had difficulties in school. He was diagnosed with Attention Deficit Disorder and received low doses of stimulant medication with mixed results. Results from educational testing were not firmly conclusive, but suggested an expressive/receptive language learning disability. From everyone's perspective, however, Nick appeared to have a very difficult time making new friends and trying new social activities. While he could appear diligent and task-focused with schoolwork despite his difficulty focusing, he seemed unwilling, even uncurious, about socializing with same-aged peers. From the ages of 8 until 11, this was less of a concern for his (by now) adoptive parents, but by the age of 12, it became a concern: Nick did not see himself as competent within his peer relationships and did not seem to relate to others. He also continued to hold on to hobbies that others appeared to be shedding as they matured, or at least he was still quite open about his affection for fantasy-based card games. This would make him something of an outlier among his peer group in the coming years.

Although he rarely expressed these thoughts, Nick frequently worried that he would never fit in anywhere. Despite his adoption into a stable and supportive family, the process of disclosing abuse, as well as his subsequent placement and adoption, seemed, on a daily basis, to reinforce Nick's belief that he is not like others. From an early age, he looked at education as being his only ticket to a better life somewhere, despite his struggles. However, he tended to view himself as childlike and wanting to have the kinds of experiences that other children seemed to have. When others were growing up, he simply wasn't quite ready to join their ranks. He enjoyed the company of those younger than himself and felt more at home with them, despite aging into early adolescence. Of note, Nick's cousin was significantly younger as well. Nick spent considerable time after school with his cousin. They would play in the refurbished basement of their home while their father was at work and mother focused on her tasks upstairs. When Nick was 13 and 14, and his cousin was 8 and 9, he talked and cajoled her into a variety of sexual activities, primarily involving fondling over and underneath her clothes, and occasionally involving oral sex. Eventually, his cousin objected and told her parents, who immediately called the police. Nick was placed in a crisis shelter, where he responded very poorly. Frightened for his safety, he engaged in a number of highly problematic behaviors, including opposition, defiance, and sexually provocative to others. Between this and the fact that his adoptive parents were adamant about keeping their daughter safe, Nick was placed in residential care.

An initial risk assessment concluded that Nick was generally at low risk for continued sexually abusive behavior. Using the *Estimate of Risk for Adolescent Sex Offender Recidivism* (ERASOR; Worling, 2004;

Worling & Curwen, 2001), the evaluator found that Nick presented with only a handful of risk factors, each of which were easily addressed with treatment. Much of Nick's relatively good prognosis resulted from the fact that his adoptive parents were committed to his successful treatment and reunification (the cousin entered into her own treatment and made excellent progress). However, as a part of the initial assessment process, Nick presented with two issues of serious concern. The first was that he appeared to lack empathy for his cousin and her experience of abuse. The second was the fact that even at his age of 14-going-on-15, he was clear that he was more sexually attracted to prepubescent girls than he was to young women his own age or older. The evaluator confirmed this latter concern through the use of a viewing time measure to assess sexual interest.<sup>1</sup>

*Dilemmas and Differing Perspectives.* Concerns regarding Nick's apparent lack of empathy presents its own dilemma. From one perspective, it appears manifestly obvious that empathy for others would be a protective factor against further abuse. On the other hand, there is little research in the field of treating sexual aggression to support this (e.g., Curwen, 2003). From another perspective, sexual offenders themselves have described empathy as a very important component of treatment (e.g., Levenson & Prescott, 2009; Levenson, Prescott, & D'Amora, 2010). An additional perspective is that there is little or no evidence that empathy can be "taught," although it is clearly a developmental process that can be enriched through experiences within other empathic relationships with adults (Longo, Prescott, Bergman, & Creeden, 2012). In summary, it appears that working on empathy should be part of EBP, and yet the evidence for this is thin. On the other hand, the evidence for improving one's capacity for empathy may have more to do with the *responsivity principle* of effective correctional programs (Andrews & Bonta, 2010), which holds that treatment should be tailored to the characteristics of the client, as well as the *needs principle*, which asserts that risk must be understood and treatment geared toward the individual needs of each client. In Nick's case, by improving his capacity for empathy, other interventions will have a greater impact on his life. We thus see two very different evidence-informed aspects of empathy. In one case, there is little to no empirical evidence that empathy is an important target in treatment; in the other, there is evidence that treating empathy, on an individualized basis, may be an important target in treatment.

A second set of related dilemmas related directly to the assessment process is the nature, accuracy, and application of the risk assessment itself. While the term itself has a longer history and larger evidence base in the assessment of adults, it is nonetheless important to referring agencies to have some sense of how best to prioritize cases and treatment needs. However, it can be easier to use available risk assessment measures than meaningfully interpret and convey their findings and limitations to other professionals. An additional dilemma for risk as-

essment is that outside agencies and professionals are anxious to have concrete recommendations upon which they can rely, while the most truthful reports will emphasize the difficulty of the task and urge caution in interpreting findings (Prescott, 2006; Rich, 2009). Another frequent quandary is how best to interpret research findings. From one perspective, a recent meta-analysis of risk assessment instruments for adolescents found them to have predictive validity that is rather close to those of adults (Hanson & Morton-Bourgon, 2005; Viljoen, Mordell, & Beneteau, 2012). However, the empirical study of risk assessment instruments for adults who have abused has involved many more studies and larger samples. A final dilemma for professionals may well lie in terminology, where risk assessment for adults typically involves judgments and predictions made regarding the next ten years to the rest of one's life, whereas the authors of the current measures for adolescents emphasize the importance of short-term assessment of risk and re-assessing youth as often as every six months. Risk assessment is simply different for adolescents than for adults, even as virtually every adult desires a way to predict the future behavior of young people. Under these conditions it is easy to misinterpret findings.

Given Nick's placement in residential care, a further dilemma involves the nature of residential treatment programming. Around the United States, the demand to implement "evidence-based treatment" has never been higher, including within institutions. At the same time, residential treatment is itself a venue that has no evidence base of its own. As mentioned earlier, the United States Surgeon General's report on youth violence (U. S. Department of Health and Human Services, 2001) found that residential treatment is ineffective for reducing youth violence. One might believe that this would settle any argument, until one considers the number of young people that cannot function under any circumstances without this level of care. The question for professionals may not be whether residential treatment should be abolished, but rather what is its best use. It might be that the best use of such programming is to stabilize young people enough that they can return to their communities and complete a sequence of meaningful treatment. While it can be easy to fault residential programs from a distance, their value becomes apparent when a family or agency is in desperate need for services that will prepare a young person to change, or provide an environment in which treatment and change can occur. Questions about residential treatment remain, however.

Research has shown a contagion effect from placing troubled young people in close proximity to one another (Dishion, Poulin & McCord, 1999), although this needn't be the case in all situations (Weiss, Caron, Ball, et al., 2005). After all, at their age young people are often more easily influenced by one another than by the adults who treat them. Seen from this perspective, the wisdom of implementing an evidence-based treatment curriculum in a program that hasn't first fully studied the research on contagion effects and taken every precaution to ensure that its treatment milieu is itself evidence-based seems questionable. Unfortunately,

<sup>1</sup> The Abel Assessment for Sexual Interest and Affinity Measure of Sexual Interest are two commonly used measures of viewing time.

more of the systems for evaluating programs are based on juvenile correctional facilities (e.g., the Corrections Program Assessment Inventory; Gendreau & Andrews, 2001) than on residential centers treating adolescents referred by child welfare and other agencies.

**Residential Placement.** Nick's placement into residential treatment highlighted another dilemma in attempting to provide the most evidence-based services to Nick. Decades of research have pointed to the importance of three basic principles of treatment design and implementation. The *risk principle* holds that programs should allocate the most intensive services to those who need it the most. The *need principle* holds that treatment should target known risk factors for recidivism, and in particular needs related to each individual client, and, as mentioned earlier, the *responsivity principle* holds that treatment should be tailored to the individual characteristics of the client. Failure to adhere to these principles can, according to research, result in diminished effectiveness (for instance, Hanson, Bourgon, Helmus & Hodgins, 2009). In Nick's case, one could argue that, as a low-risk client, placement in a program in which he was surrounded by higher risk clients could actually elevate, rather than mitigate, his risk. However, his referring agency had little choice in this matter due to the absence of other services. Attempts to correct this mismatch of risk level and service provision were taken into account, and the professionals involved actively sought to keep his placement as brief as possible. However, a possible flaw in this plan was that in order to make the most of his therapeutic experience he needed to form a positive alliance with his treatment team despite knowing that he would not work with them for long.

While in the program, Nick received a number of services, including Aggression Replacement Training (ART; Goldstein, Glick, & Gibbs, 1998), which is recognized as an evidence-based practice. Among EBT curricula, ART is less flexible than many other approaches, including explicit instructions on arrangement of the tables in the room. In Nick's case, this worked well, and he appeared to benefit from the directive approach of the facilitator, which resulted in little ambiguity about physical or psychological safety during the class. To this end, ART was clearly beneficial where it might have been far more difficult to implement in a more traditional outpatient setting, suggesting that in this case, although ART is itself an evidence based practice, it may have been less effective, or ineffective, if not delivered in residential care.

As suggested earlier, there remain questions at the individual case level about what actually works in a situation like ART. Given that meta-analytical research in general psychotherapy has found that specific techniques and models account for very little of the variance in treatment outcome (Asay & Lambert, 1999; Wampold, 2001, 2010) this is no small consideration. Was it the thinking skills learned in ART that made the difference? Or did the relationship he formed with the confident, directive facilitator provide him with an experience in which he came to believe that he could build a better life for himself? Additionally, did the provi-

sion of ART in the residential treatment environment make a difference, adding to the effectiveness of ART in Nick's case, even though the provision of residential care is not considered to be evidence based? In other words, did the protocol itself actually make the change, or did Nick change himself based on the therapeutic factors of hope, expectancy, placebo, and self-talk to the effect of "I've completed that class and the facilitator even seemed to like me. I guess I can be a real person after all," and was the power of these factors more salient in the residential environment compared to an outpatient treatment setting?

Nick was discharged after several months and returned to his family. The ART and other forms of treatment had addressed his overall self-management skills and whatever attitudes and beliefs he had that were tolerant of sexual abuse. Nick completed a heartfelt process that involved accepting complete responsibility for his behavior in the presence of his cousin. He explained that he had worked in treatment to discover how he had come to abuse, and made a commitment to doing whatever it would take to prevent further abuse. Often known as "clarification," it has no direct evidence base whatsoever, but few who work with families where abuse has occurred doubt the importance of careful attempts at reconciliation and safety for the person who has been victimized.

**Trauma Treatment.** In order to ensure a smooth transition back to his home, Nick was provided with in-home services. In the state where this family resided, there was a major incentive towards providing an evidence-based treatment curriculum for addressing past trauma. Following on the heels of successful approaches such as exposure therapy (Foa, Hembree, Cahill, et al., 2005), the idea was that Nick would discuss thoughts, behaviors, and emotions related to having survived abuse. As a part of this, he would develop his capacity to describe his trauma history. However, for his part, Nick wanted no part of it. He was now 16 years old and wanted only to stand up for himself, complete his schoolwork, and get on with his life. With each day that passed, Nick felt more confident that he could make his mark on the world successfully. He had developed a number of social skills and – having been provided with a fresh start at the residential program – was eager to make begin again with a new peer group his own age.

The adults in Nick's life saw things differently. They were of the belief that if Nick did not re-visit and work through his past trauma he might be at risk for psychological distress later in his life. Although it is common for survivors of abuse and the professionals who treat them to emphasize the importance of allowing survivors to enter treatment in their own time and in their own way, the belief within the treating agency and the family was that it was better to provide this treatment now and make sure. Part of the logic was that no harm could come from expressing one's self and exploring one's life. Sadly, the available evidence does not support this perspective. It is now well established, for instance, that discussing traumatic events too soon after they occur can actually cause harm (Lilienfeld, 2007; Mayou, Ehlers, & Hobbs, 2000).

It was in the provision of trauma treatment that the numerous disparate perspectives on EBP became most clear. The therapist, Jackie, who had been included on a grant to roll this evidence-based curriculum out across the state, worked closely with a consultant. Following a typical pattern, Jackie would participate in telephonic supervision every two weeks. After a requisite period of time attempting to engage Nick in the process, she brought to the consult call the fact that Nick was adamant he did not want to recount his trauma history in the immediate or the distant future, and that he wanted to "move on" with his life. Familiar with this scenario, the consultant provided excellent assistance on how to overcome client reticence in an apparently collaborative fashion. The consultant was quite self-confident. Assuring Jackie that this was a common experience, the consultant hinted that the best way to break down client resistance was for Jackie to overcome her own internal resistance to pushing the client in this direction. However, the consultant's advice about pushing Nick in the direction of recounting his trauma history placed Jackie in a bind. She was not as convinced that this was the right time for Nick to discuss these experiences, and was concerned that she might lose whatever therapeutic alliance she had worked to build. Although the consultant's advice seemed certain to work in the short term, Jackie was concerned about the longer term work that she was endeavoring to complete with Nick. Further, Jackie felt divided in her allegiances. She had an ethical obligation to Nick, whose position was clear, and a contractual obligation with the consultant. At the same time, she had to cope with the unwritten expectations of the agency's licensors and funding sources that had made a commitment to this curriculum as part of a state-wide initiative. The consultant had already subtly suggested that it would reflect poorly on Jackie if she was unable to gain Nick's buy-in to telling his story about his traumatic experiences. After all, many high-quality therapists had overcome this challenge. To this point, Jackie and the consultant understandably saw Nick's case differently. The consultant was responsible for successful implementation of the curriculum, while Jackie was responsible for the case. In fact, Jackie had a license to practice in this state, while the consultant almost by definition was not engaged in actual practice.

Jackie took her concerns to her clinical supervisor, Vanessa, at the agency, who agreed that if Nick was not ready to discuss his history, alternative situations should be pursued. Vanessa was additionally concerned about the pressure from the consultant to follow the protocol, and questioned whether the vested interest in the curriculum didn't, in itself, pose a subtle conflict of interest. Further, Vanessa wondered about the possibility of boundary confusion: was the consultant providing consultation on curriculum implementation or the case itself? If it was the latter, Vanessa wanted it to be explicitly clear that she, not the consultant, was responsible for the supervision of the case.

Vanessa asked this question during the next consult call, and as a result of the discussion the consultant sent an email to the agency director and deputy commissioner to express concern that the curriculum was not being implemented properly

and that he was meeting with resistance from the agency. This led to the agency director ensuring that the staff would continue to work diligently to ensure that implementation would continue as quickly and efficiently as possible. He directed Vanessa and Jackie to continue implementing the curriculum and that should the treatment start to appear detrimental they could stop. The agency director did, however, express some frustration that the consultant had included so many stakeholders in his email rather than coming to him with concerns directly.

Jackie continued to work with Nick and eventually persuaded him to engage in a lengthy self-disclosure process. Nick agreed reluctantly, secretly hoping it would get the adults in his life off his back forever. The process was difficult; Nick lost sleep and became withdrawn. His new friends at school noticed that things weren't right with him, but felt he could not discuss what was happening with him. His adoptive parents became concerned and wanted to withdraw him from treatment, but felt compelled to continue as it was an expectation in order to prevent legal action due to his crime. Jackie noticed that Nick's presentation in treatment had taken on a slightly rote, even dissociated quality. Despite having earned considerable praise from the consultant, Jackie and Vanessa were concerned that treatment had done more harm than good in the long run. When treatment was over, Nick and his family requested – and received – a new therapist from a different agency.

There remains a question of how professionals account for their failures in administering evidence-based treatment curricula. Indeed, in Nick's case the application of one evidence based model, the trauma model that was provided despite Nick's resistance to it, seems to directly contravene the tenets of motivational interviewing, another evidence based model, which asserts that treatment providers should “roll with resistance,” rather than pushing through resistance (White & Miller, 2007). Moreover, in this instance one could argue that the high-fidelity trauma curriculum was not EBP as applied to Nick because it met only one of the three criteria of the American Psychological Association's definition. Despite the curriculum's excellent basis in research, it was applied in a situation where clinical expertise suggested it was a poor choice, and it did not match the unique characteristics of the client. When treatment failed, the consultant could easily blame the implementation efforts, the deputy commissioner of the state agency could easily blame the treatment team, the agency director could blame circumstances, Vanessa could blame the consultant and/or Jackie, and Jackie could blame either the consultant or herself. Nick could say that he never wanted it in the first place. Only those furthest from actually working with Nick could console themselves with the fact that the approach had, at least, been evidence-based.

Like the movie *Rashomon*, each of the players in this situation had a unique perspective. The deputy commissioner was rightly desirous of making a science-based approach available to traumatized youth across the state; the science seemed clear that this approach would help the greatest number of adolescents for the money involved. The consul-

tant legitimately wanted to contribute to creating better lives for as many children and adolescents as possible. The agency director's perspective was to help as many young people as possible, while keeping the agency growing. Vanessa, the supervisor, wanted the highest quality of care for Nick, and to remain poised to assist Jackie's long-term professional development as a clinician. Jackie wanted Nick to have a good life and to do her job well. Nick and his family's perspective may have been that he was forced to accept an unwanted treatment that met the agency's needs and mandates more than Nick's, and that the agency considered Nick's needs and preferences to be unimportant. Each of these views shaped the approach to and experience of treatment for each of the stakeholders, and the application what we might consider to be, or not to, evidence based treatment.

**Outpatient Treatment and Sexual Interest.** Having displayed no further behavioral issues, Nick's adoptive parents and case manager agreed that he could participate in outpatient treatment. Throughout his residential and in-home treatment programs, he had not addressed the sexual interest in prepubescent girls that had been revealed in his initial psychosexual assessment. To his credit, Nick was open with his outpatient therapist, Matt, and acknowledged that he continued to find young girls sexually interesting, even as he was now also dating a girl his own age. The therapist used cognitive behavioral therapy, as well as a computerized system for measuring overall therapeutic progress; this system had demonstrated its effectiveness in psychotherapy outcome studies. Just the same, the therapist was concerned that, despite Nick's improved self-management abilities, he still stated that he found young girls attractive.

Matt consulted with other professionals, and found a software package that used aversive video vignettes paired with client self-recorded sexual fantasies. The evidence for this approach was slim (only one unreplicated study many years earlier), but enough that it seemed worthwhile. For his part, Nick was very interested in completing this process, as difficult as he sometimes found it to be. Where many therapists might have found it a questionable and intrusive practice, and certainly not an evidence based treatment, Nick nevertheless made it explicitly clear that it helped:

*All the other things I've learned in treatment with you have helped. When I see little girls, I have these new tools for keeping myself away from trouble and focused on the things that matter. Before, I just had my thoughts and my coping skills. Now I actually have these images that come into my mind whenever I notice a little girl. It's actually making my relationship with my girlfriend better, which I never would have expected. This stuff is really hard, but it is really helping me.*

Nick's adoptive parents were initially concerned by the process, but reassured by Matt's confidence and Nick's positive descriptions of his gains, and happy enough with the results. In order to have tangible results to bring back to the case manager, Matt requested a re-examination of Nick using the same measures in order to provide assistance in determining next steps. Nick's risk assessment scores

indicated even less risk than before, which was not surprising given his investment and progress in treatment. His clinical outcome scores also indicated progress. However, there was no change in his sexual interest scores when assessed by viewing time measures, which continued to demonstrate sexual interest in younger girls. Nick was deeply confused by this. This was not news to him, and he had been telling people all along that he was interested in younger girls, but was also grateful for the skills he had acquired, rehearsed, and enacted in order to manage that interest. At the same time, Matt was disheartened and concerned that this sexual interest hadn't been completely eliminated as he had hoped. Nick's parents silently wondered what it would take for the professionals in Nick's life to be satisfied with the progress that he'd made, but were reluctant to say anything due to their concerns that they might appear to minimize any treatment needs that might exist.

In this case, the *Rashomon Dilemma* has to do with differing perspectives on assessment and treatment. Nick had twice been assessed as being at low risk, and all indicators pointed to his having made considerable progress in treatment. The therapist was focused on Nick's risk and needs, whereas Nick and his family were more focused on his future, as well as his newly developed self-management skills. On the other hand, many professionals might have justifiably considered the use of the intrusive and aversive visual imagery introduced by the treatment software to be potentially harmful, as well as unproven. Nevertheless, Nick, who was discharged from treatment and entered a community college several months later, found the treatment to be highly valuable.

Here we see several different perspectives: Nick was focused on changes that he made, which allowed him to recognize and manage a problem. His parents' perspective was that Nick had made clear progress and was moving in the right direction, and that the continuing problem of sexual interest was now far less of a concern. Nick's clinician recognized and appreciated the progress made by Nick, but nevertheless had to balance the perspective provided by a risk assessment instrument that indicated lowered risk against the perspective provided by viewing time measures that indicated continued concerns with sexual interests. Other professionals may have taken the perspective that, despite Nick's positive experience with the treatment software in developing protection against troubling sexual interests, the use of the treatment protocol was not empirically validated and therefore not evidence based, and perhaps an example of treatment “quackery” (For instance, Mann & Barnett, 2013).

## ■ Conclusion

The advent of evidence-based practice definitions and empirically validated treatment protocols and curricula has enabled professionals working to prevent sexual violence to ask questions that would have been unimaginable twenty years ago, and ideally deliver treatment interventions that have provided evidence of their efficacy. In many ways, however, this work points to the remarkable work that lies ahead, described by Fixsen et al. (2005) in

terms of the immense amount of work that goes into successful implementation. However, our understanding, our development, and our application of evidence based treatments is far from complete, and as I hope we have seen remain subject, not only to continuing questions but also to the different, and sometimes subjective, perspectives brought to bear by different stakeholders in the application and interpretation of evidence based practice. The *Rashomon dilemma* address this very issue, an issue with which we must contend in our practice of evidence based treatment.

Further, studying specific the application of EBP on a case-by-case basis, as illustrated in this paper, can help guide our efforts to integrate science with clinical expertise, per the recommendations of the American Psychological Association (2008), while accommodating individual client characteristics, supported by the evidence-based principles of risk need, and responsivity. Where once a central concern was whether professionals had the data to show that treatment works, it is now time for every professional to ask whether they have the data that show that what they are doing works at the level of each specific client. Described by Hogarty, Scuoole, and Baker as far back as 1997, it is now "professionally correct to conclude that the results of controlled clinical trials should inform but not dictate practice" (p. 1107). Here, we must consider the effect and application of evidence based treatments in "the relatively uncontrolled environment" (Hogarty et al., p. 1107) in which our clients actually function and treatment is actually delivered, and in which we must address the *effectiveness* of a treatment, or how well as a treatment actual works in practice, at the level of the client.

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## Youth Sexual Offending: Context, Good-Enough Lives, and Engaging With a Wider Prevention Agenda

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### Abstract

In this article we reflect on developments in our thinking and practice concerning youth sexual offending. We put the case that context is critical to understanding and responding to the problem, and accordingly that a social ecological model provides the most suitable conceptual and practice framework for clinical efforts with this population. We argue that, since the primary goal of clinical forensic intervention is to prevent recidivism, clinical efforts should focus on a limited number of specific individual, situational, and ecological risk and protective factors. Finally, we describe how our clinical fieldwork has led to the discovery of serious endemic problems with youth sexual violence and abuse in two different communities, and outline our approach to designing, implementing and evaluating a suite of locally-tailored preventive interventions to reduce the prevalence and impact of these problems.

### Keywords

Juvenile sexual offenders, sexually abusive youth, youth sexual offending, sexual offender treatment, social ecology of sexual abuse, field-based practice, sexual abuse prevention

In this article we reflect on developments in our thinking and practice concerning youth sexual offending. In doing so we develop three arguments: 1) context is critical in conceptualizing and responding to the problem; 2) clinicians should be circumspect about the goals of clinical forensic intervention - so long as recidivism can be prevented or reduced, "good-enough" lives are good enough; and 3) field-based clinical practice allows for direct observation of the ecological context of youth sexual offending, and thereby presents important opportunities to engage with a wider prevention agenda.

### ■ Context, Context, Context

Conventional thinking and practice concerning youth sexual offending has its historical roots in psychiatric and clinical psychological approaches to adult sexual offending. Clinical services for youth sexual offenders proliferated from the late 1980s, and were originally based on models developed for their adult counterparts. Thus specialized, intensive, long-term, group-based treatment programs became the accepted practice standard for youth sexual offenders (American Academy of Child and Adolescent Psychiatry, 2000; National Task Force on Juvenile Sexual Offending, 1993).

A central feature of this clinical model was its more or less exclusive focus on individual-level explanations, assessments, and interventions. It was not just the offending *behavior* that was seen as unusual and problematic - the young offender himself<sup>1</sup> was presumed to possess some kind of enduring deficit, disorder, or dysfunction that caused the offending behavior, and that distinguished him from his non-sexual-offending peers. Intensive, specialized psychological treatment was therefore needed to

change these presumed individual-level disturbances.

It was not until the mid-2000s that the use of adult sexual offender models for youth sexual offenders came to be widely questioned (Letourneau & Miner, 2005; Zimring, 2004; though see also Chaffin & Bonner, 1998, for an earlier critique). Many programs now give more emphasis to the developmental context of youth sexual offending, and some now also include attention to family and peer relationships. Most modern programs nevertheless retain many of the core features of adult offender interventions. For example, although programs may now highlight the importance of engaging with the youth offender's parents or other guardians, the rationale for doing so often seems to be to strengthen or support the focus on individual-level treatment goals, rather than to target relevant family-level factors themselves. Similarly, a key rationale for group-based treatment is that this format supposedly provides for a focus on peer-level problems (Worling, 2004). However, few programs seem to directly target actual peer problems that may exist outside the rarified atmosphere of the group therapy room - for example, at school or in the neighborhood.

A particularly notable feature of these conventional approaches is that services are almost always located in centralized clinic or institutional settings. The youth offender client is expected to travel to, or reside in, a central location to gain access to assessment and treatment services. The barriers this may present to the youth client seem to be given little consideration, even though in many cases access problems may lead to non-attendance or exclusion. Many programs have stringent exclusion criteria in the first place (e.g., many will not accept "deniers"), and even then often seem to produce astonishingly high program non-completion rates - as many as 50%-70% of youth sexual offenders accepted into some specialized programs "fail" to complete them (e.g., Becker, 1990; Edwards et al., 2005; Hunter &

Figueredo, 1999; Kraemer, Salisbury, & Spielman, 1998; Seabloom, Seabloom, Seabloom, Barron, & Hendrickson, 2003). This is of special concern given evidence that sexual offenders (including youth offenders) who begin but do not complete treatment are more likely to reoffend than are those who don't even begin treatment (Hanson & Bussiere, 1998; Worling, Litteljohn, & Bookalam, 2010). From an individual-level perspective, treatment non-completion may conveniently be construed as a personal failure of the youth concerned, rather than as a failure of the treatment providers to take proper account of contextual factors, including the program model itself.

Clinic- and institution-based services also remove the youth sexual offender from his natural family, peer, school, neighborhood and cultural context. In some cases, this may be necessary to ensure the safety of others, but we suspect that in many cases operating services in central locations is simply a matter of convenience for professionals. Conducting clinical observations of the offender outside the context of his normal living environment may inadvertently and artificially frame the problem in terms of the individual offender alone.

### ■ Conceptualizing (and Contextualizing) the Problem

Youth sexual offenders are referred to clinical forensic services typically because of one or more specific incidents of illegal sexual behavior. In fact it is not the sexual behavior itself, but rather the context in which the behavior occurs, that defines the problem. The kinds of sexual motivations and behaviors involved in sexual offenses - desiring physical and sexual contact with others, making sexual overtures, sexual touching, sexual intercourse, and so on - are commonplace, and are almost always socially or at least legally unproblematic. In this respect, sexual offending in most cases can be conceptualized as ordinary sexual behavior enacted in problematic or illegal ways - either without the consent of the other person concerned, with a person under the age of legal consent (including sometimes very young children), with a biological relative (e.g., sibling), or with violence, trickery, or coercion. Sexual offending, by definition, contravenes laws that prohibit sexual behavior in these kinds of specific contexts.

Conceptualizing youth sexual offending as a primarily legal-criminal problem gives recognition to its conceptual and empirical connections to other kinds of crime - sexual offenses, like other kinds of crime, fundamentally involve irresponsible social behavior, rule-breaking, coercion or deception, exploitation of vulnerable others, unrestrained aggression or violence, and so on. Indeed for many youth (and adult) sexual offenders, sexual offending is part of a much broader involvement in antisocial or unlawful behavior (Smallbone, 2006a; Smallbone & Wortley, 2004). This is a very different way of thinking about the problem than from the conventional psychiatric and clinical psychological perspective that construes sexual offending primarily as a form of sexual psychopathology (see e.g. Laws & O'Donohue, 2008) - more akin to cross

<sup>1</sup> We use the male pronoun when referring to sexual offenders in this article. We acknowledge that females comprise a small proportion of sexual offenders.

dressing and odd fetishes (which may be perfectly consensual) than to theft, assault, or armed robbery (which by definition are not).

There have, of course, been very significant conceptual and empirical developments outside the clinical sexual offending silo. Arguably, the most relevant and important of these have been in developmental criminology (e.g., Loeber & Farrington, 1998), environmental criminology (e.g., Wortley & Mazerolle, 2008), clinical approaches to serious youth antisocial behavior (e.g., Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998), child maltreatment prevention (e.g., Belsky, 1980), and public health approaches to violence prevention (e.g., Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Far from limiting their focus to the individual characteristics of offenders, the common thread in these approaches is that they situate individual offenders and victims within their natural ecological context. Thus, risk and protective factors are theoretically and empirically located at various levels of the social ecological systems in which the offender and victim develop and live – the same environments, of course, in which the problem behavior occurs. The causes of youth sexual offending therefore exist not just within individual offenders, but also within the family, peer, organizational, neighborhood, and sociocultural systems within which offenders and victims are socially embedded.

According to social ecology theory, the more proximal the system is to the individual concerned, the more direct and therefore more powerful its influence (Bronfenbrenner, 2005). The most proximal elements of any behavior, including sexual offending, are of course those present in the immediate setting in which the behavior is enacted. Recognizing the role played by immediate situational factors adds a crucial element to clinical and wider prevention efforts. Instead of conceptualizing the problem in terms of *individuals* within their social ecological context, we can conceptualize the problem in terms of *person-situation interactions* that occur within, and are shaped by, the wider ecological context. Situations include physical features of the setting and in-the-moment interactions between the offender and victim, as well as the presence/absence and behavior of third parties such as guardians, co-offenders, and bystanders.

We accordingly conceptualize youth sexual offending in terms of proximal interactions of individual and situational factors that occur within the wider context of the offender's and victim's social ecology. We have set out our integrated theory in detail elsewhere (see Smallbone, 2006b; Smallbone & Cale, in press; Smallbone, Marshall, & Wortley, 2008), and provide only a brief summary of key propositions here.

First, our theory assumes a universal biologically-based potential among adolescent and adult males to engage in sexual violence and abuse (see also Marshall & Barbaree, 1990). This behavior does not need to be learned because it has been naturally selected in our ancestors' environment of

evolutionary adaptedness. Unlike in conventional clinical formulations, for example, the potential to behave in such ways is therefore not confined to a deviant subset of individuals. The reason that comparatively few people actually do commit sexual offenses is because human socialization and social control systems (e.g., personal and social attachments, individual and social controls), together with natural ecological and situational barriers (e.g., guardianship, risk of detection), are under most circumstances remarkably effective in constraining this potential.

Second, our theory points to risk and protective factors at various levels of offenders' and victims' natural social ecologies; that is, the particular family, peer, organizational, neighborhood, and sociocultural systems within which they are socially embedded. For example, although families generally offer the front line of protection to children, family homes are also the most common place for sexual abuse to occur. Youth's peers will often provide important protections (e.g., by looking out for one another), but they may also endanger one another (e.g., by encouraging irresponsible or risky behavior). Similarly, organizational settings such as schools usually provide safe environments for children, but sometimes expose children to risks for peer or adult sexual abuse.

Third, our theory recognizes immediate situations (or, more precisely, immediate person-situation interactions) as the most proximal causes of sexual offending. We construe situations not just as a passive backdrop that presents opportunities to an already-motivated offender, but also as containing highly dynamic properties that can precipitate offense-related motivations that would not otherwise occur, at least not at that particular time or place (Wortley & Smallbone, 2006). This opens the door to employing situational and place-based strategies as part of the clinical and prevention armory. From an ecological-situational perspective, changing immediate environments themselves is often key to preventing undesirable individual behavior.

Finally, sexual offending behavior, like other operant behavior, is shaped by its consequences and enabled or constrained by its situational determinants. Youth sexual offenders are more likely to commit further such offenses if their early experiences with sexual offending are positively or negatively reinforcing, and if relevant opportunity structures and precipitating conditions continue to be presented. They are less likely to persist if the original incidents were unrewarding, if opportunities are blocked or reduced, and if the relevant precipitating conditions are no longer present.

### ■ Responding to the Problem

If, as we argue, youth (and adult) sexual offending is caused by the interaction of individual and situational factors in the context of offenders' and victims' natural social ecologies, it makes sense that clinical assessments and interventions should focus on these three aspects of the problem (i.e., individual, situational, and ecological). The precise

mix of appropriate interventions will of course be informed by a careful assessment of the individual, situational, and ecological factors relevant to the particular case, and how these may interact to produce the specific outcome of sexual offending. In many cases, restoring a secure attachment with a parent, enhancing and focusing guardianship, reducing involvement with antisocial peers (or increasing involvement with prosocial peers), removing barriers to school engagement, or reducing exposure to specific risky situations, may be more important than achieving conventional individual-level treatment goals such as overcoming denial, increasing general or victim-specific empathy, or improving general self-regulation. This is not to say that individual-level interventions are irrelevant – on the contrary, in many cases individual-level interventions may be crucial components of the treatment and risk management plan. The point is to understand how individual behavior generally, and sexual offending behavior specifically, is influenced by its social and immediate situational context. Without attending to this context, the goal of individual-level treatment may amount to little more than trying to make the youth offender somehow resistant to what may be powerful criminogenic influences in his living environment.

Multisystemic therapy (MST) provides a proven model for addressing individual and systemic factors known to be associated with serious antisocial behavior (Henggeler, et al., 1998), and in fact MST has been shown to be effective specifically with youth sexual offenders (Borduin, Schaeffer, & Heiblum, 2009; Letourneau et al., 2009). However, MST is an intensive, family-based treatment and may not be readily transferable to institutional settings (in fact, it is often promoted as a community-based alternative to youth detention) or to community settings where clinicians cannot be present or available on a continuous basis. Family-based treatment is also clearly problematic in circumstances where there are severe breakdowns in the youth offender's family relationships. Nevertheless, MST's strong conceptual and empirical foundations, even if not its prescribed methods, may provide clear direction to clinicians in the diverse range of circumstances in which they may be working with youth sexual offenders.

In our own case, we provide court-ordered assessments and interventions both in institutional (youth detention) settings and in a diverse range of community settings. We give priority to cases initially assessed as high risk (in accordance with the so-called risk principle), and to cases from regional and remote locations (because alternative services are least likely to be available in these locations). Of the more than 400 youth referred to our service over the past 12 years, 82% were serving community youth justice orders (i.e., only 18% were serving detention orders), requiring treatment to be provided in the community rather than in institutional settings. This is in large part the result of concerted efforts by Australian legislators, courts, and youth justice authorities over the last two decades to use detention only as a last resort for youth offenders.

By far the bulk of our assessments and interventions are therefore conducted in community settings, including with very complex-needs, high-risk offenders, and sometimes in geographically difficult-to-reach places.

Ours is a state-wide field-based service, covering a vast geographical region of more than 1.85 million square kilometers – an area larger than Alaska – and with a population of about 4.5 million. Our client population is small, geographically dispersed, and culturally diverse. More than one third (37%) of our referrals have involved Aboriginal or Torres Strait Islander (Australian Indigenous) youth and their families, and 27% of these resided in remote or very remote locations (as rated by the Accessibility/Remoteness Index of Australia). Clearly, it would not be possible in these circumstances to provide the kind of continuous, intensive intervention prescribed by MST. Instead, significant modifications have been needed to develop an ecological practice model suitable to our particular geographical and social context.

Our response to the challenge of providing specialized interventions in regional and remote locations has been to establish a system of local collaborative partnerships (see Smallbone, Rayment-McHugh, Crissman, & Shumack, 2008). These may be informal (e.g., with parents, extended family members, or other responsible community members) or formal (e.g., with local professionals and paraprofessionals), and are organized according to the circumstances of each individual case.

Collaborative partnerships involve much more than simply the sharing of information or the co-ordination of otherwise disparate efforts; rather, the work involves focusing and systematic monitoring of specific tasks in accordance with individualized treatment and risk management plans. The great advantage of working with local partners is that they bring crucial local knowledge and leverage, as well as enabling a continuity of intervention that would not otherwise be possible. An especially valuable contribution, particularly in remote indigenous communities, has been advice on local cultural matters that might otherwise present an impenetrable barrier to visiting non-indigenous professionals. For our part, along with the expertise we hope to bring to bear on individual cases, we aim to impart specialist knowledge and skills that may build local capacity to prevent or respond to similar problems in the future.

This field-based model, whereby our clinicians travel to the client (rather than vice versa), along with the ecological framework that guides our assessments and interventions, we believe preserves the ecological validity of assessments and interventions in ways that centralized clinic-based practice simply cannot. Spending time “on the ground” in our clients’ communities, meeting with families in their own homes or neighborhoods, engaging with local community leaders and service providers, and so on, allows us to directly observe the ecological context in which the offending has occurred, and in which the risk of further offending is most relevant.

Recruiting local collaborative partners and working with the youth offender himself within his own community in turn allows for treatment and risk management interventions to occur in the setting that is most relevant to the youth concerned.

### ■ Continual Expansion of the Sexual Offender Treatment Model

In the previous section we raised a number of problems, as we see them, with conventional clinical approaches to youth sexual offending, namely: (a) the creation of a sexual offending clinical and research “silo” wherein youth sexual offending has been conceptually linked to adult sexual offending, with little attention given to its obvious conceptual and empirical connections with general delinquency, crime, and violence; (b) a narrow focus on individual-level explanations and interventions that is out of step with developments in closely related fields; and, (c) a system of centralized service delivery that may optimize convenience for service providers, but also creates serious barriers for clients and diminishes the ecological validity of clinical services. Another major problem with this conventional approach, which again came with the ill-considered transposition of adult sexual offender clinical models to work with youth sexual offenders, is the seemingly ever-increasing length and complexity of these individual-level treatment programs.

Laws and Marshall (2003) and Marshall and Laws (2003) outlined a history of cognitive behavioral approaches to sexual offending. Their historical account begins with the application of simple behavioral methods (e.g., aversive conditioning) in the 1950s and 1960s, through the addition in the 1970s of cognitive therapy components (targeting offense-related attitudes and beliefs, cognitive distortions, rationalizations, assertiveness, and social skills), and culminating in the 1990s with the so-called “comprehensive” treatment program models. In addition to the earlier treatment targets, Marshall and Laws listed sex education, empathy, relationship skills, self-esteem, substance abuse, anger management, and relapse prevention as further points of focus in comprehensive programs. To this already-extensive list, even more treatment targets were added in the 1990s, such as attachment problems, intimacy deficits, sexual coping, denial, and implicit theories. Marshall and Laws described these trends as “a continuous expansion in treatment and assessment targets” (p. 98), and saw the adoption of these models for youth sexual offenders as part of the natural and proper progression of the field.

However, a big problem with this history of thinking and practice is that, while there has been no shortage of new ideas and techniques, these have almost always been promoted as additions to, rather than as replacements for, previous approaches. Progress has thus been characterized by accumulation, rather than revision and refinement. The upshot is that while there is now evidence that some such programs do “work” in terms of reducing recidivism (Lösel & Schmucker, 2005; however

see also Långström, et al., 2013 for a less optimistic analysis), it is not at all clear which of the many aspects of these programs produce positive outcomes (and indeed, which components may be ineffective or even harmful). No-one seems to be prepared to discard old ideas or techniques to make way for new approaches.

One of the most influential recent developments in the sexual offending field has been the so-called good lives model (GLM) developed by Ward and his colleagues (e.g., Ward & Brown, 2004). Early expositions seemed to present the GLM as a viable alternative to the widely accepted and empirically supported Risk-Needs-Responsivity (RNR) model of offender rehabilitation (Andrews & Bonta, 1998). However, following a round of vehement criticisms, rebuttals, and counter-criticisms from the two camps (see Andrews, Bonta, & Wormith, 2011; Ward, Yates, & Willis, 2012; Wormith, Gendreau, & Bonta, 2012), the position of the GLM appears to have been clarified as yet another addition to, and not a replacement of, existing models based on RNR principles.

The major difference between the GLM and earlier developments is that its proposed additions are much more complex and wide-reaching, seeming to amount to a more or less wholesale change in treatment philosophy and purpose. In addition to the RNR goals of preventing recidivism by targeting a limited number of specific, empirically-based, or theoretically valid risk factors, the GLM seems to frame the purpose of clinical treatment with sexual offenders primarily in terms of helping offenders to achieve a “good life”, defined as achieving a wide range of personal, interpersonal, and social goals (Willis & Ward, 2011). Taken at face value, GLM appears to adopt the position that individual-level interventions, even while acknowledging the wider context of relationships and community, still provide the best path to preventing future sexually abusive behavior. There seems to be no expectation that clinicians assess or intervene directly with the offender’s family, peer, organizational or neighborhood systems.

We do, of course, see merit in the “positive, strengths-based” approach espoused by the GLM. Indeed, we suspect this may be a key reason for its popularity among clinicians who work in otherwise punitive, risk-averse criminal justice or youth justice systems. However, in this respect the GLM seems to offer little that is new. For instance, in terms of work with adolescents, MST also explicitly proposes a strengths-based approach (Henggeler, et al., 1998). The key advantage of MST, though, is its foundation in social ecology theory and an extensive evidence base concerning risk and protective factors associated with serious youth antisocial behavior. For us, a positive, strengths-based approach has always been a key mechanism for engaging with our youth offender clients, families, and relevant others (Smallbone, Crissman, & Rayment-McHugh, 2009), and we see no incompatibility with maintaining a clear focus on the primary goal of preventing recidivism; indeed, we think it contributes greatly to achieving that goal.

## ■ A Good-Enough Lives Model

A major challenge for us in our own clinical practice with youth sexual offenders has been to find the proper line between under-involvement and over-involvement with individual cases. Many of our youth offender clients present with serious and complex personal and life problems, and we recognize the temptation to take their referral as an opportunity to try to “fix everything.” In accordance with the RNR model, we aim in our individualized assessments and case formulations to distinguish between those factors that may be associated with risk for recidivism, and those that may not be – so-called criminogenic and non-criminogenic needs. Where it is feasible to do so we try to refer to other services to attend to serious non-criminogenic needs so that our own work can concentrate on the specific referral problem – the sexual offending behavior. In the context of operating a specialized service with inevitably limited resources, time spent on non-essential work (i.e., work not directly focused on preventing recidivism) is time that could be spent on essential work with other cases. The worst-case scenario would be that we become so preoccupied with “fixing everything” for our existing clients that we cannot accommodate new referrals for other young offenders, which seems to us neither fair nor appropriate. Denying access to services for some offenders so that we can spend additional time on non-essential interventions with existing clients seems to us frankly irresponsible.

We have found the continuous expansion in treatment and assessment targets that has characterized clinical work with sexual offenders a potential distraction from the central goal of preventing recidivism. At the same time, we have found the frequent preoccupation in this field with individual-level problems and interventions as theoretically and professionally impoverished. Our clinical challenge has been to identify and target, on a case by case basis, a limited number of specific individual, situational, and ecological factors associated with the risk for recidivism. We think of our own practice model, somewhat tongue-in-cheek, as a “good-enough lives” model. For us, a “good-enough” life for our youth sexual offender clients is one in which they cause as little harm as possible to others (and indeed to themselves).

## ■ Engaging with a Wider Prevention Agenda

Our clinical assessments, case formulations, and interventions with referred youth sexual offenders are focused on the specific individual, situational, and ecological factors associated with their risk of sexual (and other serious) recidivism. This work is generally undertaken in the field – in the community in which the offender presently lives (or, for youth in detention, situational and ecological assessments are undertaken in the community to which they will return on release). Our ecological assessments span family-, peer-, organization-, and neighborhood-level factors. In most cases,

these assessments point to a circumscribed set of factors associated with the systems most proximal to the youth offender – typically their family and peer systems, but also often including school-level factors. Interventions are accordingly typically directed to these proximal systems. However, occasionally a wider set of neighborhood-level factors is identified as significant. In this section we describe two such circumstances, and explain how we are organizing a prevention initiative that aims to reduce the prevalence and impacts of youth sexual violence and abuse in these two communities.

### Identifying Neighborhood-Level Problems

The first setting of concern is a small, remote Aboriginal community. A few years ago we received referrals concerning a number of young males who had been convicted of sexual offenses in this community. All of these referrals were received at the same time – referred youth were co-offenders in a number of incidents. Initial assessments (conducted mainly in the community, but also in detention with two of the youth involved) indicated that the specific incidents for which these young people had been arrested were part of a much more pervasive problem with youth sexual violence and abuse in this community.

Two problems quickly became apparent. First, while it seemed clear that a mix of individual (e.g., general and sexual self-regulation), family (e.g., family violence, low supervision) and peer factors (e.g., attachments to antisocial peers, peer norms supportive of sexual violence) was associated with the problem behavior for each of the young people involved, there were also a number of serious community-level risk factors, including severe breakdowns in local formal and informal social control systems, high levels of neighborhood crime and violence, and low capacity for community guardianship. This was a stark example of how conventional individual-level conceptualizations would miss key aspects of the context of the problem behavior, and how focusing exclusively on individual-level interventions would therefore be patently ineffective.

Second, it was clear that, even if we were successful in preventing further sexual offending by the individual referred youth, clinical interventions with these youth alone would do little to solve the wider community-level problems. Many other young people in this community were clearly at risk of sexual offending or sexual victimization, and we were aware there were likely to be other active but undetected offenders. In any case, it was clear that the individual referred youth would quickly be replaced by other children and young people who had not yet commenced sexual offending but were at high risk of doing so as they grew older and were exposed to the same individual, situational, and ecological risk factors associated with our referred cases.

The second setting of concern is a suburban precinct in a regional city. We had received 19 individual referrals concerning young people residing in this area since 2002. Unlike in the Aboriginal community described above, our awareness of

possible endemic community-level problems in this locale developed over a period of some years as the individual referrals accumulated. A review of the 19 individual cases from this area indicated somewhat similar individual-, situational, family-, peer-, school- and neighborhood-level risk factors to those observed in the remote Aboriginal community. On the other hand, because of the different context, there were many different features. Perhaps the most obvious of these was that the problems were nested within an otherwise mainstream urban setting. The striking similarity, though, was that once again it became clear that (a) individual-level intervention alone would not address the wider systemic problems, and (b) many children and young people in this community, other than our individually referred offender clients, were at high risk of sexual offending or victimization if these wider systemic problems were left unaddressed.

In 2011 we obtained funding from our state government to more systematically investigate the scope, dimensions, and dynamics of youth sexual violence and abuse in these two communities. We used a mixed methods approach involving official (police, youth justice, and health) data, file reviews, interviews with local professionals and community members, and direct site observations to identify problem behavior hotspots and hot-times. Due to the sensitivity of our findings, our report is currently subject to a publication embargo and we cannot name the communities or present detailed findings at this stage. Suffice to say here that our analyses confirmed serious problems at both sites, and provided some early direction to the task of designing, implementing, and evaluating specific preventive interventions.

### Design and Implementation of Prevention Strategies

In 2013 we were awarded a large grant from the Australian government to design, implement, and evaluate a suite of individual, situational, and ecological interventions aimed at reducing the prevalence and impacts of youth sexual violence and abuse at the two communities of concern. This new project brings a team of researchers and practitioners together with local community members, local non-government organizations, local councils, and key state and federal government agencies, in a focused effort to redress identified problems. The project will draw on public health and crime prevention concepts and methods (Smallbone, Marshall, & Wortley, 2008), and will be guided by “realist” evaluation principles (Pawson & Tilley, 1997) whereby interventions aim to address the questions: what works for whom, in what circumstances and in what respects, and how?

Table 1 sets out a comprehensive prevention matrix, together with some examples of the kinds of prevention activities that may target the various aspects of observed problems. As shown in the table, this prevention model directs potential interventions to four essential targets – (potential) offenders, (potential) victims, situations, and com-

**Table 1.** Prevention matrix

	Primary Prevention	Secondary Prevention	Tertiary Prevention
<b>Offenders/ Potential Offenders</b>	<ul style="list-style-type: none"> <li>Reduce exposure to known developmental risk factors</li> <li>Introduce school-based sexual ethics programs</li> <li>Increase school attachment/ reduce school disengagement</li> </ul>	<ul style="list-style-type: none"> <li>Re-engage school-disengaged youth</li> <li>Therapeutic services, particularly for boys exposed to known risk factors</li> <li>School-based support and intervention with at-risk boys</li> <li>Reduce number of new gang affiliations</li> </ul>	<ul style="list-style-type: none"> <li>Incapacitate most prolific / serious youth offenders</li> <li>Expand offender rehabilitation services</li> <li>Provide means to exit antisocial peer groups/ gangs</li> </ul>
<b>Victims/ Potential Victims</b>	<ul style="list-style-type: none"> <li>Reduce exposure to known developmental risk factors</li> <li>School-based resilience-building programs</li> <li>Reduce prevalence of school disengagement</li> </ul>	<ul style="list-style-type: none"> <li>Interventions with at-risk girls (personal safety, guardianship, sex education)</li> <li>Increase support and assistance for marginalized children/youth</li> </ul>	<ul style="list-style-type: none"> <li>Improve reach and effectiveness of victim support and treatment services</li> <li>"Cocoon" the most vulnerable victims</li> <li>Focus therapeutic efforts on preventing re-victimization</li> </ul>
<b>Situations</b>	<ul style="list-style-type: none"> <li>Create safe, attractive places for children and youth</li> <li>Increase legitimate use of public spaces</li> </ul>	<ul style="list-style-type: none"> <li>Improve natural surveillance in "at risk" places</li> <li>Increase planned/ legitimate/ supervised activities in "at risk" public locations</li> <li>Community night patrols targeting specific problem locations/times</li> <li>Targeted problem-oriented and community policing</li> </ul>	<ul style="list-style-type: none"> <li>Improve targeting of police patrols (hot spots; hot times)</li> <li>Disrupt problem youth group activities/ movements</li> <li>Disrupt access to alcohol/ substances</li> <li>Target hardening to reduce alcohol thefts</li> </ul>
<b>Community</b>	<ul style="list-style-type: none"> <li>Mobilize and focus community concerns about sexual violence</li> <li>Parenting programs tailored for the local context</li> </ul>	<ul style="list-style-type: none"> <li>Responsible bystander training (youth and adults)</li> <li>Problem-solving with community leaders to reduce barriers to community guardianship</li> <li>Intensive interventions with multi-problem families</li> </ul>	<ul style="list-style-type: none"> <li>Mobilize and focus community concerns about sexual violence</li> <li>Community engagement focused on improving extended guardianship</li> <li>Appoint school engagement officers</li> </ul>

munities - across three prevention levels: primary, secondary, and tertiary (see Smallbone et. al., 2008, for a more detailed rationale and discussion of this model). Note that in practice it may be feasible to focus only on a limited number of separate intervention activities, and in this respect the matrix provides a menu of inter-related options rather than a specific prevention plan. Note also that the prevention matrix highlights how clinical interventions with identified offenders (offender-focused, tertiary-level prevention) is but one aspect of prevention. This does not, of course, diminish the importance of clinical work with known offenders (indeed we ourselves place a high value on this work) – it simply situates clinical forensic interventions within a much wider scope of potential prevention activities.

All indications are that, to be successful, preventive interventions in these two communities must be designed and implemented in authentic partnership with the communities themselves. For the earlier research project we established local advisory groups in the two communities to advise on data collection and interpretation and on local cultural and social matters. For the present prevention project these groups will be re-formed, probably with some new members as appropriate, and their role expanded to establish new Local Implementation Groups (LIGs) at both sites. It is in collaboration with these LIGs that decisions will be made about the prioritization of target problems, and the selection and design of specific intervention activities.

LIGs will also advise on practical matters concerning opportunities and constraints, access to local resources, and local cultural and social matters.

A prevention plan will be developed for each site, in collaboration with the LIGs. These plans will be informed by "what works" crime prevention research, professional experience, local knowledge, accessibility of suitable resources, and initially by the findings of our earlier research at the two sites. Prevention plans will be continuously monitored and periodically revised as new data are obtained and interim outcomes considered. We anticipate that interventions will include existing evidence-based strategies, as well as innovative evidence-informed strategies as appropriate in the particular circumstances. This will allow us to test the effectiveness of proven approaches in these particular contexts, as well as developing and testing new methods. We aim to implement a minimum of five separate intervention activities at each site, with priority given to interventions likely to have the highest feasibility and potential impact.

As a result of our field-based clinical work in these communities, a network of relevant existing services has already been established in both communities. This network will be maintained and further developed over the course of the prevention project. Members of the project team will work to improve the targeting and effectiveness of these existing services through written agreements, close consultation, monitoring intervention fidelity, supervision, training, and "on the ground" co-ordina-

tion. Members of the project team are also likely to be involved in the direct implementation of some interventions (e.g. therapeutic services).

### Evaluation

Our "realist" evaluation model (Pawson & Tilley, 1997) involves a theory-driven method that requires clarity and explicitness about what each proposed intervention activity is expected to bring about by way of outcomes, in the specific context of the locale for the activity. Relevant data will be defined and specified by expected outcomes and are likely to include quantitative and qualitative data from records, observations, and interviews. These data will be used to monitor both the expected outcomes and the processes through which they were produced, as well as providing information on the conditions necessary for the activities to produce desired outcomes.

We aim to implement the project and disseminate findings in a manner that facilitates the transferability of the prevention model to other sites, and to other related problems. This will be done by evaluating each intervention activity, as well as the prevention model itself, and particularly by identifying likely mechanisms and relevant contextual factors associated with observed outcomes.

### Conclusions

We have endeavored to present the case that context is crucial to understanding and responding to the problem of youth (and adult) sexual offending. We have argued that the limited focus on individual-level conceptions and interventions in this field is out of step with developments in a range of closely related fields. For some decades now, the social ecological framework has dominated thinking and practice in fields such as developmental criminology, environmental criminology, clinical approaches to serious youth antisocial behavior, child maltreatment prevention, and public health approaches to violence prevention. The ecological model has given rise to a wealth of empirical evidence concerning individual, situational, and ecological risk and protective factors associated with crime and violence, and to a range of evidence-informed approaches to crime and violence prevention.

However, clinical approaches with detected sexual offenders seem to have been little influenced by these conceptual, empirical, and practice developments. An important exception has been the application of multisystemic therapy (MST) – an ecological method of clinical intervention originally developed for working with serious antisocial youth – to youth sexual offenders. While we have adopted a similar conceptual framework in our own clinical work with youth sexual offenders, we have found aspects of MST's practice framework unsuitable to our particular circumstances. We have instead developed an ecological, collaborative, field-based practice model whereby our clinicians work with youth offenders, their families, and relevant others, in their local communities.

We believe that our model preserves the ecological validity of clinical assessments and interventions in

ways that centralized clinic- or institution-based practice simply cannot. Further, our work in the field has led to the discovery of serious endemic problems associated with youth sexual violence and abuse that likely would otherwise have remained hidden. This has presented opportunities for us to engage with a wider prevention agenda, focused on two specific communities.

There can be no argument that preventing such offenses from occurring in the first place is much more desirable than intervening after such offenses have occurred. It remains to be seen whether our prevention efforts are successful in achieving this.

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## Why Prevention? Why Now?

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### Abstract

In 1995, the American Medical Association declared sexual abuse a “silent, violent epidemic.” Since that declaration, there has been a growing acceptance and awareness of the need for a broader public health approach to preventing sexual violence. However, it is only recently that individuals and organizations are beginning to look at the root causes of sexual violence and how to prevent first time perpetration of sexual violence - preventing sexual abuse before anyone is harmed. This article provides an overview of the shifts in our language, perspective, and policies regarding how we view preventing the perpetration of sexual abuse, and argues that we must adopt and invest in a prevention approach whose goal is to, first and foremost, prevent sexual violence before anyone is harmed.

### Keywords

Sexual abuse, Sexual violence, Sexual abuse prevention, Sexual violence prevention, prevention, sexual offender treatment, sexual offenders, public health

Only in the last 30 years has U.S. society begun to fully recognize the extent of sexual violence in America. In these last few decades, research has documented the lifelong impact of sexual abuse, state and federal legislators have enacted policies and funded programs to both protect victims and hold offenders accountable for their crimes, and the media has begun to portray the trauma of sexual violence in the news, movies, and on television. There has also been an explosion of personal stories and blogs about sexual violence that has begun to shift how people think and talk about the issue. Yet as awareness of sexual abuse and those who abuse has grown, there has been little focus on - and even less funding for - how to prevent the perpetration of sexual violence. The lack of funding for prevention is in stark contrast to the amount of funding available for other community safety programs, such as civil commitment, prison, GPS bracelets, and other management strategies.

A landmark 2010 study showed a 58% decrease in the number of substantiated cases of child sexual abuse in the U.S. between 1992 and 2008 (Finkelhor, Jones, & Shattuck, 2008). Finkelhor et al. suggest that the decline highlights the possible impact of two decades of prevention, treatment, and criminal prosecutions. However, even with this good news, questions remain about which prevention programs are having significant and meaningful impact and how the impact of prevention programs can be measured effectively.

In 1999, James Mercy, a senior scientist at the Centers for Disease Control and Prevention (CDC) published an important call to action:

*Imagine a childhood disease that affects one in five girls and one in seven boys before they reach 18; a disease that can cause dramatic mood swings, erratic behavior, and even severe conduct disorders among those exposed; a disease that breeds distrust of adults and undermines the possibility of experiencing normal sexual relationships; a disease that can have profound implications for an*

*individual's future health by increasing the risk of problems such as substance abuse, sexually transmitted diseases, and suicidal behavior; a disease that replicates itself by causing some of its victims to expose future generations to its debilitating effects.*

*Imagine what we, as a society, would do if such a disease existed. We would spare no expense. We would invest heavily in basic and applied research. We would devise systems to identify those affected and provide services to treat them. We would develop and broadly implement prevention campaigns to protect our children. Wouldn't we? Such a disease does exist.... it's called child sexual abuse.” (Mercy, 1999, p. 317)*

Others have echoed the importance of investing in preventing sexual violence. Just as Mercy so eloquently describes the need for a comprehensive response to childhood sexual abuse, Aldinger et al. (2011) echo the importance of investing in prevention. These authors describe how sexual violence affects a large proportion of the population, threatens the lives and physical and mental health of millions of people, and overburdens health systems. These studies also suggest that violence, and especially interpersonal violence, undermines the ability of people to thrive (human capital formation), impacts the social fabric of our communities, and ultimately slows economic and social development.

The reasons to invest in prevention are compelling. Michael Seto (personal communication, July 23, 2013), a well-respected researcher in forensic psychology, recently commented:

*I'm swayed by the overwhelming evidence and logic behind the idea that it is better to intervene early than it is to intervene late, whatever the problem or target might be. Better in terms of more effective, more cost-efficient and morally superior (enhancing human potential instead of making the best of a bad situation). Prevention is all the more compelling in the field of sexual violence because it could prevent sexual abuse from happening in*

*the first place, rather than not happening again as with offender treatment.*

Researchers and advocates have begun to document the successes of certain prevention efforts, some of these efforts will be discussed further in this article. Yet, the question remains, why do we invest so heavily in the punishment of sexual offenders and so little in the prevention of these same crimes? And more importantly, how do we begin to shift attention and investment towards preventing these crimes from being committed in the first place?

### ■ A Picture of What We Know About Sexual Violence

The picture of sexual violence in the U.S. is only partially painted, with large gaps of information remaining. The scope of what we know about reported case of sexual violence is well documented: the National Crime Victimization Survey estimates 250,000 victimization incidents each year (U.S. Department of Justice, 2007); the Federal Bureau of Investigation records over 100,000 local and state arrests for sex crimes each year (U. S. Department of Justice, 2010); and as of 2011, there were approximately 747,408 convicted sex offenders on the sex offender registry (Pitman, 2013). The impact of sexual violence on the victims is also well documented. For example, The Adverse Childhood Experiences study showed the emotional and psychological consequences of sexual violence and the profound negative impact on health throughout a trauma survivor's life. This lifelong impact of sexual violence may include depression, anxiety, heart disease, suicide, and increased alcohol and drug abuse among many other symptoms (Felitti & Anda, 2009).

Retrospective studies have provided information about victims of child sexual abuse. These studies indicate that one in three to four girls and one in six to ten boys are sexually abused before the age of 18 (Finkelhor, 1994). Younger children appear to be at greater risk of familial abuse and older children are typically more at risk of non-familial abuse (Fisher & McDonald, 1998; Smallbone et al., 2008). Looking at victimization through sexual violence across the lifespan, nearly one in five (18.3%) of women and one in 71 men (1.4%) reported experiencing rape at some time in their lives. When asked whether they had experienced sexual violence other than rape (e.g., sexual coercion, being made to penetrate someone else, etc.) in the last 12 months, approximately one in 20 women and one in 20 men (5.6% and 5.3% respectively) experienced sexual violence other than rape (Centers for Disease Control and Prevention, 2012).

What is known about those who perpetrate sexual abuse? Criminal justice reports and surveys of victims consistently identify males as the primary perpetrators of sexual violence (although women also commit sexual abuse). The majority of the crimes are perpetrated by someone the victim knows. In cases of child sexual abuse, one-third of the cases are perpetrated by a family member and two thirds

by someone the victim knows (Snyder, 2000). In addition, it is clear that, although the majority of sex offenses are committed by adults, a significant proportion of child sexual abuse (20-50%) is committed by adolescents, and to a lesser extent, children (Barbaree & Marshall, 2006; Finkelhor, Ormrod, & Chaffin, 2009; Knight & Prentky, 1993). Most children and teens do not sexually abuse, and research shows that children and adolescents who have sexually abused have more in common with children or adolescents with general delinquency than with adult sex offenders. For instance, only a small proportion of teens, including those who engage in sexually abusive behavior, are primarily aroused by significantly younger children or violent and aggressive situations (Hunter & Becker, 1994). Most adolescents, including those who engage in sexually harmful behavior, have more normative interests which is good news for prevention and may also clarify why sexual re-offense rates for teens are relatively low. Because research has demonstrated considerable differences between adults and most adolescents who sexually abuse, decidedly different intervention and prevention strategies will be needed for these distinct populations. A number of studies have begun to look more closely at the correlative and potentially causal risk factors for sexually abusive behavior in those who have sexually abused (Knight & Knight, 2009). The CDC also coordinated the first meta-analysis of risk and protective factors, for first time perpetration (Whitaker et al., 2008). Whitaker and colleagues found that common risk factors for first time perpetration include poor coping skills, low self-esteem, and sexual attraction to children and teens and/or sexual preoccupation. On the social level, the study also identified as risk factors for first time perpetration the relationship of the individual to family and friends, including difficulty establishing and/or maintaining appropriate intimate relationships; a chaotic, unstable, or violent home environment; and difficulty developing meaningful peer networks.

Unfortunately, the data above represent just a small portion of what is known about the scope and prevalence of sexual violence. And, because the majority of sexual violence remains unreported to authorities, the scope of sexual violence is almost certainly much larger than the reported numbers indicate. Studies show that between 80-90% of the cases of sexual abuse are never reported to authorities (Hanson et al., 1999; Tjaden & Thoennes, 2006), and the National Crime Victimization Survey shows no significant change in the rates of victimization not reported over the last 11 years (Truman & Planty, 2012). Shame, fear, and threats of physical violence are among the many reasons why victims have not reported the crime (ECPAT International, 2008; London, Bruck, Ceci, & Shuman, 2005). In addition, only a small percentage of reported sex crimes ever go to trial and are successfully prosecuted (Abel et al., 1987; Stoud, Martin, & Barker, 2000). Consequently, the information researchers,

practitioners, policymakers, and the public have about those who sexually abuse is based only upon the small percentage of abusers who have been detected, apprehended, and ultimately convicted.

Given the hidden nature of this population, the significant challenges prevention initiatives face involve promoting a greater and more complete understanding of sexual violence and, in particular, the adults, adolescents, and children who abuse, and ultimately determine how best to use this information to prevent sexual abuse and keep communities safe. As such, much remains unknown about the individuals who are at risk to sexually abuse others but perhaps have not yet crossed that line, or who have committed sexual abuse but have not yet been detected or entered the legal system. Also problematic is the misinformation about those who abuse, and depictions of all offenders, at any age, as the same, and as "monsters" with hundreds of victims who will inevitably reoffend. These misperceptions reinforce the myth that prevention programs and members of the general public have no hope of reducing the risk posed by known offenders, successfully intervening with at-risk individuals, and ultimately preventing sexual abuse.

### ■ Toward a Comprehensive Understanding and Response

In recent years, there has been a growing movement toward a more comprehensive understanding and response to sexual violence, including the importance of prevention efforts (Kaufman, 2010; Smallbone, 2008; Tabachnick & Klein, 2011). Indeed, sex offender management professionals, victim advocates, researchers, and the public increasingly seek a deeper understanding of the factors that contribute to the initiation of sexually abusive behaviors, how to identify which individuals are at risk for first time sexual offense or sexual reoffending, and how to effectively intervene, especially before abuse and harm occur. In a 2010 survey, the Center for Sex Offender Management found that *"The vast majority of [the public] (83%) expressed a desire for more information than they currently have regarding how to prevent sex offending in their communities."* (Bumby, Carter, Gilligan, & Talbot, 2010, p. 5).

The media's reflection of sexual violence has shifted from near ignorance of the issues to regular coverage of individual cases, and more recently to the role and responsibility of institutions in creating a culture where sexual abuse can exist. Before the 1970's, sexual violence only appeared in the media in isolated cases; widespread societal attention was not focused on the problem. Beginning in the 1970's and 1980's, survivors of sexual abuse began to tell their stories and describe the impact of the trauma on their lives. Through the emergence of these stories, it became clear that sexual violence is present within every community, every economic class, every race, and every faith community in America, and recently the media attention has forced the U.S. military to implement new mea-

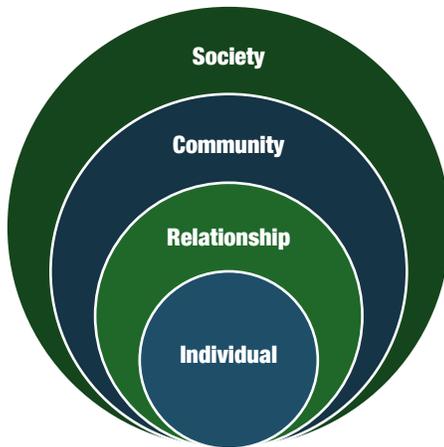
asures to encourage the reporting and prevention of sexual violence. By the mid-1990's to early 2000's, legislators began to craft a number of responses to the growing recognition of the problem. In 1994, the Child Abuse Prevention and Treatment Act (CAPTA) was passed, creating a clearinghouse on child abuse and neglect and establishing mandated reporting of cases across the U.S. The horrifying crimes perpetrated against a number of children, including Jacob Wetterling, Megan Kanka, Jessica Lunsford, and Adam Walsh, framed much of the legislation in these decades. Nevertheless, even though all of the research points to the fact that people who abuse are people we know and often care about in our families and communities, legislators have constructed a series of laws to isolate, control, and punish those individuals who abduct and offend against strangers, often called "sexual predators" by the media.

In the current decade, new research about the effectiveness and consequences of existing sex offender legislation and policies has raised questions about the broad and unequal application of these laws and policies to every adult, adolescent, and child who has sexually abused (Tabachnick & Klein, 2011). Victim advocacy organizations have questioned the large expenditures of funds on sex offender management programs and tools that may not really protect communities (e.g., residency restrictions, GPS bracelets, etc.) while resources and services are being cut for victim services (Tabachnick & Klein). The impact of sexual violence upon U.S. society has begun to be clearly documented through personal stories, through media attention and coverage, and through the research on the long term health consequences of sexual violence. Researchers have documented the economic impact of sexual violence in terms of the health costs to the victim and their families, as well as the high costs for prosecution and prison. More is discussed in a later section of this article, but most importantly, for the first time, the public is beginning to ask what can be done, and what should have been done, to prevent various crimes rather than just respond to each horrendous case of sexual abuse in the community or in an honored institution such as a university, the government, or within the armed forces.

### ■ A Public Health Approach to Sexual Violence Prevention

With the growing body of research in sexual violence and sex offending behavior, it is now possible to consider prevention programs from a public health point of view, seen through the lens of preventing the perpetration of sexual abuse. According to the CDC, public health interventions are viewed through three prevention categories based on when the intervention occurs (*Centers for Disease Control and Prevention, 2004*).

- **Primary Prevention:** Approaches that take place before sexual violence has occurred in order to prevent initial perpetration or victimization.



**Figure 1.** Social-ecological model of violence (Krug et al., 2002)

- Secondary Prevention: An immediate response after sexual violence has occurred to deal with the short-term consequences of violence (note that some experts choose to define secondary prevention as those at risk to abuse, rather than a response to abuse.)
- Tertiary Prevention: A long-term response that follows sexual violence, designed to deal with the lasting consequences of violence and provide treatment to perpetrators.

According to the CDC definitions, secondary and tertiary prevention strategies are implemented *after* sexual violence has been perpetrated, in order to reduce or ameliorate the negative effects of the violence and, in some cases, preventing a recurrence of violence, whereas primary prevention strategies are implemented *before* sexual violence has been perpetrated. Given the “less than perfect fit when looking at violence” the CDC report (2004) simplifies the discussion by suggesting we make the distinction between interventions designed to prevent violence *before* it is perpetrated from those that take place *after* violence has already been perpetrated. This simplified framing of prevention strategies into those focused on preventing sexual abuse *before* someone is harmed or those that *follow after* the perpetration of sexual abuse will be used throughout this article.

A second helpful public health approach, the social-ecological model (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002), describes programs and policies directed at four levels of intervention:

- Individuals
- Relationships
- Communities
- Society

Illustrated in figure 1, the social-ecological model expands prevention efforts beyond typical education and individual self-help or treatment models by encouraging a broad range of activities. The model shows interventions at any level influence and affect the entire system. The authors of this

**Table 1.** Prevention matrix

	Individual	Relationship	Community	Society
<b>Before</b>	New parents understanding and talking about healthy sexual development and concerning behaviors for their child (0-18)	Bystander campaigns (e.g., MVP, Bringing in the Bystander, Green Dot)	New standards for youth serving organizations (e.g., screening applicants, code of conduct, etc.)	Laws requiring YSOs to have policies in place to receive public funding
<b>After</b>	Adult and adolescent sex offender treatment services	Support groups for the families of sex offenders	Community engagement programs (e.g., Dunkelfeld project, Circles of Support and Accountability)	Public policies directed towards offenders (e.g., registration, public notification, etc.)

model argue that for true social change, interventions need to be targeted at each of these levels. Thus, public health interventions targeting the macro society or community levels will also have effects at the levels of the individual and social relationships and, in fact, the effects of interventions felt at every level are ultimately necessary for success.

Indeed, as demonstrated by a number of successful public health campaigns, prevention programs that address all four levels are more likely to change the targeted behavior(s). No smoking campaigns, for example, which began as efforts to educate adults and teens that smoking was bad for their health, showed only limited success when targeted as an *individual* education campaign. However, the campaign successfully and significantly reduced smoking across the entire country when its efforts were tied to reports that second hand smoke affected the friends, families, and coworkers of the smoker (appeal to the people in *relationship* to a smoker), to *community* initiatives such as smoking bans in offices, restaurants, etc., and to public policies (*social* approaches) that added a tax on cigarettes, for instance, and prohibited advertising directed at children and teens.

As shown in table 1, blending the two public health frameworks together – (a) prevention strategies that target behaviors *before* they occur and interventions implemented *after* sexual abuse is perpetrated with (b) an intervention approach that targets all the four levels of the social ecological model – results in the creation of a comprehensive effort to prevent the perpetration of sexual violence. Although there are many different approaches at each level, table 1 provides a prevention matrix to consider, each aspect of which is explored below. Most of the perpetration prevention initiatives aimed at preventing further sexually abusive behavior, applied *after* the harm is done, will be more familiar to those working with sex offenders. However, initiatives applied *before* sexual abuse is perpetrated are those now being considered because their goal is to address and build the skills, knowledge, and policies that will help ensure that adults, teens and children do not become sexually abusive (Ryan, 2005).

## ■ Prevention Strategies at the Individual Level

When considering a new prevention initiative, most people think about educating individuals. Education programs typically do not need extensive funding, can be initiated by an individual, and can help create a broader movement for change. A typical prevention initiative *before* sexual violence is perpetrated providing parents and other caregivers the information they need to understand healthy sexual development. In recent years, there is a growing volume of information available for parents and educators to address healthy, concerning and problematic behaviors across the lifespan of each child (Cavanagh Johnson, 2013; Haffner, 2001; Roffman, 2001; Rosenzweig, 2012). Even more important is the inclusion of guidelines for an adult’s response to all of these behaviors in a child – whether healthy or problematic. The expansion from a purely victim centered focus to one that includes a perpetration prevention focus can be explained by how one talks with a child. Instead of just explaining to a child that “no one has the right to touch your body in a way you don’t want” one can add “and you don’t have the right to touch someone else..” This approach allows trainers from victim centered organizations to include perpetration centered strategies into their programs without a major redesign.

Treatment interventions aimed at adults, adolescents, or children that follow sexually abusive behavior are considered prevention initiatives at the individual level as their goal is the prevention of further abuse. The assumption behind interventions at the individual level is that these individuals can learn to manage their behaviors, and thus return safely back into their communities. Through treatment, the individual offender is provided the information, the tools, the strategies, and the social skills needed to ensure that he or she does not sexually abuse again.

## ■ Prevention Strategies at the Relationship Level

A crucial development in the past few years has been the broadly accepted “bystander intervention” programs on college campuses. Similar to the MADD (Mothers Against Drunk Driving) Campaign, with the slogan that “Friends don’t let

friends drive drunk,” these programs are based upon the assumption that the friends of those who are at risk to be abused, and friends of those who are at risk to sexually harm, might also intervene before an act of sexual abuse has been perpetrated. The *Mentors in Violence Prevention* (<http://www.mvnpnational.org>) program begun at Northeastern University in 1993 is the longest standing program, but more recently the *Bringing in the Bystander* (<http://www1.uwindsor.ca/womensstudies/bringing-in-the-bystander>) program and the *Green Dot* program (<http://www.livethegreendot.com>) have been more widely adopted at other universities and colleges. These programs each provide education and training programs designed to teach students about risk factors for sexual abuse, empower peers to intervene when they see risky situations or inappropriate behaviors, and, when necessary, report sexual assault to college authorities. Although these and similar programs are primarily focused on reducing victimization, they have begun to embrace the importance of addressing those who might perpetrate harm as well, by running participants through scenarios about how to talk with someone who might be at risk for harming someone or being harmed. These do not necessarily include scenarios that directly depict violence, but rather describe situations where someone might take advantage of or harm someone who has had too much to drink, for instance. As these programs more fully embrace preventing the perpetration of sexual violence, the scenarios may also include what can be done after the direct intervention (e.g., talking with a young man the next day after a party about his behaviors, about consent, and other ways to behave respectfully.) These programs operate at the relationship level of the social-ecological model because they address what peers, athletes, student leaders or friends can do for peers/friends in a college or university setting.

After an incident of sexually abusive behavior has been reported, interventions at the socio-ecological level of relationships can be introduced, with the goal of preventing further sexually abusive behavior through the development and strength of personal and interpersonal relationships. It is well documented, for instance, that pro-social supports for those who have abused help ensure their safe re-entry back into the community (Levenson, 2007; Levenson & D’Amora, 2007; see also Wilson & McWhinnie, this issue). In these cases, a sex offender returning to the community with the support of family, peers, and other community members not only has many reasons to never again engage in abusive behavior, but of equal importance, has people who are watching, and who can be taught how to intervene when they see situations that might be of some concern. This is particularly true for adolescents and children who rely on the social supports of family and other institutions for their social, psychological, and physical needs. Unfortunately, over the last few decades, the number of programs that are funded to offer support

groups or other resources for the families of offenders has dropped dramatically. At least at this point in time, the resources for this important prevention and intervention strategy are limited and need further attention.

### ■ Prevention Strategies at the Community Level

Organizations in the community serving young people include churches, synagogues, and temples; private and public schools; youth sports programs; and other educational, recreational and institutional programs. But, until recently, little information was available for youth-serving organizations, or tools they could use to protect the children in their care. Given the lack of attention to this important prevention strategy, in 2004 the Centers for Disease Control and Prevention held a think tank to discuss possible strategies that can be implemented by the community and/or organizations in order to prevent sexual abuse. Their report (Saul & Audage, 2007) provided one of the first policy recommendations for youth serving-organizations and covered a variety of topics, including education and training for staff, volunteers, youth, and parents; screening volunteers and employees; responding to and reporting sexual behavior of concern; and creating a code of conduct. Since this report, a number of media stories covering sexual abuse within youth serving organizations have highlighted the need to implement CDC and similar recommendations, such as the Sandusky trial at Penn State, continued reports of sexual abuse within the Catholic Church, and sexual assaults within well-respected private high schools. Partly in response, a growing number of programs are being developed and put into place to help organizations ensure the safety of their youth (e.g., the Canadian Government sponsored *Commit to Kids* (<http://www.commit2kids.ca/app/en/>), the Enough Abuse Campaign’s *Gatekeepers for Kids* (<http://www.enoughabuse.org/index.php/the-campaign/gate-keepers-for-kids>), and faith based initiatives such as *Balancing Acts*, a comprehensive policy initiative through the Unitarian Universalist Association (<http://www.uua.org/safe/children>).

The number of community-level strategies targeting perpetrators and those at risk to perpetrate sexual abuse are also growing, especially outside of the United States. One program, the *Prevention Project of Dunkelfeld* in Berlin, Germany (Beier et al., 2009) has created a social marketing campaign that speaks to the general public: “If you think about children in a way you shouldn’t... Call for help.” The program offers both treatment and pharmaceutical options to anyone who stepped forward looking for help, and the success of the project has been impressive. Between 2005 and 2008, over 800 individuals contacted the program and after a thorough assessment, 200 of these callers were invited to participate in a one-year treatment program (Beier et al.). Stop It Now! is a similar concept in the United States that reaches out to abusers, those

at risk to abuse and their friends and family. The program may be more limited by mandated reporting laws and the increasing number of punitive sex offender laws, but the initial pilot programs showed significant responses (Tabachnick & Dawson, 2000). Equally impressive are the *Circles of Support and Accountability* (COSA) which began in a Mennonite community in Canada. After overcoming significant resistance to the concept, the initial pilot program results showed that the offenders who participated in COSA had significantly lower rates of any type of reoffending (including sexual and non-sexual re-offense) than did the offenders who did not participate in COSA (Wilson, et al., 2005; see also Wilson & McWhinnie, this issue). Since the pilots, these programs have spread into some communities in the U.S. and many programs throughout the world. Given the public response to these programs – in a public survey, 68% of respondents reported they would feel safer if they found out that a high risk sex offender in their community belonged to a Circle (Wilson et al.) – it is time for the U.S. to adopt or develop more of these successful community-level intervention responses in order to ensure a safe re-entry whenever a convicted sex offender returns to the community.

### ■ Prevention Strategies at the Society Level

Most of the interventions aimed at the societal level are implemented *after* the harm has been done, often created primarily though state and federal legislation. As mentioned earlier, with the growing recognition of sexual abuse, legislators have passed a significant number of laws based upon the belief that all sex offenders are extremely dangerous must be isolated and controlled to ensure community safety. These laws address the most violent sex offenders through registration, public notification, GPS bracelets, residency restrictions, civil commitment, and many other similar containment and control strategies (Bumby, 2008; Levenson, 2007; Levenson & D’Amora, 2007; Tabachnick & Klein, 2011; Velázquez, 2008). These relatively new sex offender laws present a significant cost to the taxpayer without evidence of increased safety to the community (Justice Policy Institute, 2009; Levenson, 2007; Levenson & D’Amora, 2007; see also Letourneau & Caldwell, this issue). However, with burgeoning costs, legislators and the public are beginning to ask questions about whether a proposed piece of legislation will affect the safety of the community and whether there is evidence to support that effectiveness (Goldman, 2009; Grinberg, 2011; Prescott & Rockoff, 2012).

However, many would consider debate and policy at the societal level key to preventing sexual violence, teaching children information and values related to “healthy sexuality” and safe and healthy relationships *before* sexual harm is done. Indeed, in the 1980s federal funding supported programs designed to teach children, teens, and their families about preventing child sexual abuse. However,

today, New Jersey remains the only state that fully funds a child abuse prevention program in all of its 21 counties, with over 200 facilitators trained through the New Jersey Child Assault Prevention (NJCAP: <http://njcap.org/>). More recently, a new initiative being considered by a number of states and a few grant makers will require any organization working with children or adolescents to establish clear child safety policies as a condition for receiving state, federal, or, in some cases, private foundation funding. This legislation will essentially require every youth-serving organization to have specific child protection policies. A similar model has already been passed in Australia (2006 amendment, s8C, to the Children's Protection Act of 1993) and, thus far, there do not seem to be any significant obstacles preventing organizations from coming into compliance as a requirement for funding. Although the Australian law is relatively new, the discussions alone have raised the visibility of this issue – preventative interventions and policies at the macro societal level. Legislative efforts such as these make it less safe, and less possible, for people to abuse within these institutional settings.

### ■ Do Interventions Work?

Each of the programs and interventions briefly described above, at the individual, relationship, community, and societal level, focus on preventing the perpetration of sexual violence. These programs complement already well developed initiatives to prevent victimization by sexual violence (*Centers for Disease Control and Prevention*, 2004). However, while there is considerable investment in interventions that follow the perpetration of sexual violence to contain, manage, and punish offenders, funding needs to be made available and allocated for the evaluation of these interventions. Without evaluation we lack the information required to make clear decisions about which interventions or legislative responses are effective at significantly reducing sexual violence and can therefore help keep communities safe. At the prevention level, *before* the act of sexual abuse, more research is also needed to examine risk factors for first time perpetration, as well as factors that protect against first-time risk, in order to establish programs based upon these factors. These in turn also need to be evaluated in terms of which are most effective. This investment, *before* the harm is done, makes good common sense and will ultimately reduce the system costs and serve to protect the well-being of future generations.

### ■ Why Now?

As mentioned, public attitudes toward those who abuse are beginning to change; the public wants more information than they currently have about how to prevent, and not simply respond to, sexually abusive behavior *before* it has occurred (Bumby et al., 2010). Indeed, to a great extent, the public and legislators rely on the media for their information, and the personal opinions that form out of these

media images and snapshots of sexually abusive behavior directly affect the kind of legislation that is then passed (Sample & Kadleck, 2008). However, in this past year the media coverage of sexual violence and, in particular, child sexual abuse cases, has begun to change. In particular, the cases of sexual abuse within institutions have shifted media and public perception alike about who perpetrates sexual abuse. Even more radical is the notion that people within institutions, and the institutions themselves, have a responsibility for *preventing* sexual abuse. For instance, the Berkley Media Group conducted a study of how the media reported sexual abuse before and after the Penn State tragedy (Dorfman et al., 2010), noting a significant shift in reporting in this case, involving *Jerry Sandusky*, a former Penn State football coach. That is, before the Penn State case entered the media conversation, Dorfman et al. describe reports of sexual abuse in the media as infrequent and episodic, tied to a “moment” in the criminal justice process, and often discussed in vague and imprecise terms (e.g., providing a general statement that a child was sexually abused, rather than describing the violence involved or nature of the abuse). However, after the Penn State tragedy, the volume of media reports increased dramatically; many journalists new to the issue now covered the story, many of whom were not criminal justice reporters; specific descriptive language was taken from the investigative reports, used in the news and a media discussion was started, which continues to be discussed, about the *institutional* role in the tragedy and its impact on the safety of children. For instance, perhaps for the first time in a major national publication, more graphic and literal language was used, describing “anal rape in the shower” rather than the less specific and more sterile, “sexual abuse of a child.” Following this tragedy, stories began to emerge of sexual abuse in other respected institutions of higher education, and in sports other than football; many youth-serving organizations began to respond by putting into place their own policies, and a number of insurance companies now encourage youth-serving organizations to put these policies into place. In addition, the amount and frequency of sexual abuse in the U. S. military has also risen to the top of the news, and continues to be an active discussion, with the media (and public) asking, not only about its many victims and how this could happen, but also how to prevent sexual abuse in the first place. Similarly, we have seen the media address with regularity the sexually troubled and sexually abusive behavior of elected public officials, at the highest and most visible levels of local, state, and federal political institutions. Of course, the tragedy of child sexual abuse in the church is now well established, globally. An awareness of sexual abuse, then, of children and adults, and its debilitating effects, is now far more visible in the media and public eye than ever before.

As a result, the nearly exclusive image of the sex offender as monster with multiple counts and mul-

iple victims (Cheit, 2003) is now being replaced by new and more diverse images of priests, coaches, teachers, teen football players, politicians, and a wide selection of well-respected members in communities across the United States and abroad. In part, through increased and increasing media coverage, the growing number of stories of sexual abuse within families and communities, and emerging sexual abuse research also covered by the popular media, the public has begun to recognize that not all people who abuse are “monsters.” Indeed, many, and perhaps most, are otherwise non-descript, or even well-respected, members of the community. People are asking about sex offenders, and want to know how to keep safe (Knight & Sims-Knight, 2009); nevertheless, they still tend to more frequently ask these questions when a particularly horrendous case of sexual violence is reported in the media or a high risk sex offender is being released into the community. A prevention model allows and provides a means for communities to have these conversations, and for the public to learn more about the adults, teens, and children who engage in abusive behavior *before* the emotions of the moment bring people to fear and rage. These prevention strategies and programs are growing in many communities where agencies, organizations, and individuals see that they too have a responsibility to protect children. These individuals recognize that sexual abuse is something that can affect the children in their care and be perpetrated by people they know. Within these broader conversations, there is a growing recognition that some people who abuse (and especially children and teens) can learn to control their behaviors and live healthy productive lives. Perhaps of more importance, the public is beginning to ask what can be done, and what should have been done, to prevent various crimes from occurring in the first instance rather than just responding to each horrendous case of sexual abuse in the community or in an honored institution.

### ■ The Use of Framing and Language to Foster a Prevention Narrative

As the media and the public begin to ask about the individuals who abuse and what can be done to prevent sexual abuse in the future, we find an opportunity to frame the debate in terms of prevention, based on what we already know and what the research can tell us. “Framing” refers to a set of concepts, collections of anecdotes, and the stereotypes that people rely on to understand, respond to, and ultimately make sense of the world around them. Effective framing techniques help the individual connect to what they already know, and point to what they need to learn. To a great degree, the choices that members of the public make, and legislation that is passed, is influenced by the frame within which people live.

As noted, the existing frame for sexual abuse for many years was steeped in fear, rage, and helplessness, resulting, in part, in legislative measures

and public/legal policies that responded in a heavy handed fashion to sexually abusive behavior after it occurred. However, the fear of strangers that was taught (e.g., “*don’t take candy from strangers...*”) was a fear of the “dirty old man,” a stranger lurking at the edge of the playground in a trench coat. This image of the sexual offender still lurks in the media, but now he is on the edges of the Internet, as well as the edges of school playgrounds and parks, ready to invade our homes and steal our children. These concerns and characterizations are legitimate, of course, but from this frame all sex offenders are “monsters,” unlike the rest of us, who will never change, with the accompanying myth, of an enormously high re-offense rate. Finally, in this frame, we are all helpless to protect ourselves and our children, and a prevailing attitude that we will never be safe unless all of these monsters are locked up forever.

Traditionally, the sex offender treatment community has responded to questions raised by the media, but has not been proactive in reaching out to the media or addressing the underlying issues or public and media frame. For example, many will argue that the recidivism rates for sex offenders are close to 12-24% (Hanson & Morton-Bourgon, 2005). However, although this information about actual sexual recidivism is important, it does not address the underlying public fear and/or belief that many people who sexually abuse are very dangerous and most likely to reoffend. Once this belief becomes fixed in the public mind, accurate information about sexual offenders and sexual recidivism no longer fits with or matches public perception, and more accurate information can thus be easily ignored or dismissed. Rather than talking about recidivism rates, it is important that we instead acknowledge that, although a small percentage, some sex offenders *are* violent and dangerous this then allows a conversation with the public about the *majority* of sex offenders, which includes those with very low sexual recidivism rates, such as adolescents. Without these distinctions, the myth that all sex offenders are the same and all are monsters will remain.

The helplessness the public feels is echoed in language used by professionals, as well. For example, the CDC definitions for prevention typically use passive language about preventing sexual abuse before and after sexual violence “has occurred” (*Centers for Disease Control and Prevention*, 2012). In my experience, many professionals talk about preventing sexual violence before “it” happens, again, using the passive voice. This passive voice removes accountability for sexual violence from the individuals who perpetrate the violence and responsibility from the communities surrounding these individuals and/or their families and friends. It makes sexual abuse something that happens, rather than something that can be prevented. The argument for talking directly rather than passively, and framing exactly what we mean, was first articulated by Ju-

lia Penelope, an internationally recognized linguist and feminist and described extensively in the work of Jackson Katz, author and founder of Mentors in Violence Prevention (Keren, 2012). Katz speaks about how we report the number of women who were raped last year rather than how many men raped these women. Or, we speak about how many girls are sexually harassed in the school system, rather than how many boys or girls harassed these girls. A simple exercise, used by Katz, although here describing a sexual offense, illustrates how passive language moves the focus away from those who actually commit the violence. By focusing on how our shifting language flows, Katz shows how we move away from difficult questions about who is accountability for harm to reports about the number of victims. Hence, when we shift from “John raped Mary” to the expression that “Mary was raped by John,” we use a passive voice and the focus moves away from the perpetrator of violence, the person responsible for the behavior. Similarly, from a semantic perspective and the intrinsic meaning of the statement, when we say that “Mary is a victim,” we completely eliminate John (the rapist) from the picture, and lose the opportunity to ask questions about why John chose to do such a violent act or how other people could have intervened. Although as a society we seem comfortable punishing the perpetrators of sexual violence, we don’t seem comfortable talking about the people who perpetrate sexual violence and instead shift the conversation, consciously or unconsciously, to the victims of sexual violence and a passive speaking voice.

Throughout this article, the active voice is used in discussing the prevention of sexual violence (e.g., preventing the perpetration of sexual violence before a child or adult is harmed rather than the more common expression of preventing sexual violence to children and adults before “it occurs” or before “it happens”). This direct approach in the use of language and frame helps to focus attention on the social contexts in which sexual abuse against children and women is perpetrated; the context of families, organizations, communities, and the larger society, which together can create social norms that help stop the *initial* perpetration of sexual abuse.

For example, if we not only say that “John raped Mary,” but also that “Mary’s rape was a result of a failure in social and public policy,” we not only begin to ask questions about John, but we also ask the surrounding community about what they saw and perhaps what they did or could have done to prevent the sexual abuse before it was perpetrated. The frame thus expands from a possibly isolated focus on Mary to placing responsibility on John and offers the possibility of actively engaging the entire system of individuals, organizations, social responses, and social norms to potentially prevent abuse at its root levels.

In terms of preventing further abuse, this framing of language may be helpful when talking with any-

one who has been victimized by sexual abuse, and particularly helpful when talking with or about individuals who have perpetrated the sexual abuse. For the offender, the focus on what actions were taken allows the individual in treatment to talk about his or her behaviors (e.g., what he or she did, the triggers for the behaviors, and a safety plan for the future), rather than the labels that these behaviors might trigger. It also allows the people surrounding an offender to learn from those behaviors.

## ■ Perpetration Prevention Opportunities

Drawing upon definitions of sexual violence prevention described by the Centers for Disease Control (2004), we can identify a number of strategies that are preventive, including victim-focused prevention, situational prevention, community focused approaches, criminal justice interventions, and the treatment and management of adult and adolescent offenders (see Smallbone, Marshall & Wortley, 2008). Taken together, these strategies, aimed at varying levels of the social-ecological environment, create a large spectrum of interventions designed to prevent sexual violence from occurring in the first place or from recurring, stretching from healthy sexuality curricula for young people to reaching victims and abusers after sexual abuse has been perpetrated, to public policies and public education, community supervision, and community-based programming for convicted adult sex offenders. However, by broad definition every sex offender management or treatment program is *already* a prevention program. That is, whether an adult civil commitment program or a group treatment program for adolescents, all sex offender management programs are designed to prevent sexual re-offense. However, of significance, we are talking about the importance and urgency of creating strategies that intercede *before* an act of sexual violence occurs, or prevents continued sexually abusive behavior among individuals who have not yet been apprehended. Nevertheless, the lack of funding, attention, and research directed towards prevention strategies is striking.

Given the lifelong impact of sexual abuse on children, adolescents, and adults the true cost cannot be estimated, even in dollars, in emotional and behavior health, lost educational opportunities, and lost income, and especially the quality and experience of life, not measurable in dollars. What is clear is that investment in prevention is an avenue of value that has not yet been fully explored. It is time to begin to invest in prevention; determine which prevention programs are most promising, based upon the most current research; and evaluate whether such programs can indeed effectively reduce the incidence of sexual abuse. It is time to begin to shift the public perception away from waiting for the next horrific incident and the endless and repeated consideration of what went wrong, to a model designed to prevent sexual harm before it is perpetrated.

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## Implications of our Developing Understanding of Risk and Protective Factors in the Treatment of Adult Male Sexual Offenders

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### Abstract

This paper summarizes our developing knowledge of factors that contribute added risk of sexual recidivism (risk factors) and factors that are associated with a reduced risk of sexual recidivism (protective factors). Specific implications for the design of future treatment programs are drawn. This information is contrasted with the common foci of sexual offender treatment programs that were designed before these research findings emerged, and suggestions made about how common clinical tasks might be re-visited and revised in the light of this new knowledge.

### Keywords

Criminogenic need, sexual risk factors, protective factor, sexual offender treatment, sex offenders

Sexual offender treatment had firmly evolved as a specialty by the mid 1990s, so much so that it was possible for Hanson et al. (2002) in their review of evaluations of sexual offender treatment to distinguish “modern” forms of treatment, which were deemed to be somewhat effective, from older forms of treatment, which were deemed ineffective. Common elements of treatment regarded as “modern” around that time included the use of cognitive-behavioral methods and clinical tasks such as: (a) eliciting accounts of past deviancy and offending, (b) challenging denial and self-serving cognitive distortions, (c) developing empathy for victims, (d) analyzing past offenses to identify offense precursors, (e) developing a relapse prevention plan designed to be relevant to the identified offense-precursors, and (f) rehearsing skills for putting this plan into practice. More developed programs might also have included behavior therapy designed to modify offense-related sexual arousal patterns and anger management.

This paradigm for treatment was evolved prior to the completion of much foundational research into the treatment of sexual offenders, so it relied heavily on the clinical common sense of practitioners combined with some borrowing of ideas that were then current in related fields like substance abuse treatment. However, since around 2000, there have been a number of seminal developments. First, Hanson, Bourgon, Helmus, and Hodgson (2009) demonstrated that the Risk-Need-Responsivity (RNR) model (Andrews & Bonta, 2006) was applicable to sexual offender treatment. As is widely known, the RNR model indicates that treatment will be more effective if it is concentrated on medium and higher risk offenders (Risk principle), if it seeks to address factors that are linked to recidivism (Need principle), and if therapeutic methods and therapist behaviors are responsive to the learning style of the individual being treated (Responsivity principle).

The second seminal development was the demonstration by Marshall and colleagues (Marshall et al.,

2002; Marshall et al., 2003a; Marshall et al., 2003b) that much of what is known about effective therapist style in general psychotherapy also applies to the treatment of sexual offenders. This finding will hardly surprise anyone grounded in general psychotherapy, but it was startling to many of those within the field since a more aggressively confrontational style had formerly been seen as required for this “special” population. Marshall et al.’s findings provided important information about how the Responsivity principle could be met. The third seminal development has been a series of studies empirically identifying psychological risk factors for sexual recidivism (Mann, Hanson, & Thornton, 2010). Finally, the fourth seminal development, still in its earliest stages, is the identification of factors that protect against sexual recidivism (e.g., de Vogel, de Ruiter, Bouman, & de Vries Robbé, 2012; Griffin, Beech, Print, Bradshaw, & Quayle 2008).

The focus of this paper addresses and articulates the implications of these latter two developments in terms of how the Need principle should be applied in sexual offender treatment.

### ■ Psychological Risk Factors

Mann et al.’s (2010) paper uses meta-analyses to summarize the results of recidivism studies that seek to relate psychologically meaningful factors to sexual recidivism. They place the factors studied into one of the following categories: empirically supported, promising, unsupported overall but with interesting exceptions, worth exploring, or factors with little or no relationship to recidivism. A limitation of their paper is that factors are considered one at a time without integrating them into broader categories that might show more general patterns in the data. Accordingly, the Mann et al. results are re-organized here using an updated version of the Structured Risk Assessment (Thornton, 2002) need framework. The result is shown in table 1, which also draws on the earlier, more limited Hanson and Bussiere (1998) meta-analysis and the more specialized and recent Helmus, Hanson, Babchishin, and Mann (2013) meta-analysis. Relevant results from all three meta-analyses are described using the

broad categories of degree of support employed by Mann et al.

The RNR Need principle implies that the effectiveness of treatment will be enhanced by systematically assessing for those kinds of psychological factors that have been empirically identified as related to recidivism and then concentrating treatment efforts on them. To make it easier to apply this idea the overall patterns from table 1, which have more empirical support, are delineated below since these are the areas the clinician will need to concentrate on.

**Sexual interests domain.** In this domain two kinds of psychological risk factors are empirically supported. These are offense-related sexual interests and sexual preoccupation. Offense-related sexual interests are sexual interest in young children and/or the sexualization of violence (arousal to coercion, humiliation, brutality, etc.). Sexual preoccupation includes an intense involvement in impersonal sex (solitary masturbation, recurrent casual sex, excessive use of pornography, etc.), sexualized coping (sexual responses to stressful events or internal distress), and involvement in diverse unusual sexual activities (multiple paraphilias).

Traditionally offense-related sexual interests have been addressed with behavior therapy (olfactory aversion, satiation, directed masturbation, etc.). However, we presently lack evidence that these methods can produce sustained changes in sexual preference (see Laws & Marshall, 2003), and where clear offense-related preferences are present it may be better to regard them as enduring vulnerabilities that must be managed. Efforts at treating sexual preoccupation have been developed both with sexual offenders and outside the sexual offender field, since even legal hypersexual behavior can sometimes lead to distress and interpersonal chaos. Medical approaches to this problem have shown some promise (Garcia, Garcia, Delavenne, Assumpção, & Thibaut, 2013). Anti-androgens such as medroxyprogesterone acetate or cyproterone acetate have appeared to lower sexual interest (Briken & Kafka, 2007), as have luteinizing hormone-releasing hormone agonists (Briken, Hill, & Berner, 2003).

In addition, at least some problematic sexual preoccupation can be understood as a particular response to an underlying psychiatric or related disorder. Studies of men with paraphilias or non-paraphilic hypersexuality suggest an over-representation of dysthymic disorder, major depression, bipolar spectrum disorders, social anxiety disorder, childhood-onset post-traumatic stress disorder, ADHD, schizophrenia, Asperger’s syndrome, psychoactive substance abuse disorders (especially alcohol abuse), fetal alcohol spectrum disorder, and head injury (Briken & Kafka, 2007; Kafka, 2012). A common feature of these disorders is that effective prefrontal/orbitofrontal regulation of impulses and limbic over-reaction is compromised. Effective pharmacological treatment of these conditions may then restore better regulation of sexual impulses (Briken & Kafka, 2007; Garcia et al., 2013; Kafka, 2012).

**Distorted Attitudes domain.** Research has been less successful in distinguishing factors within this domain. We know that in a general sense pro-offending attitudes are related to recidivism and Helmus et al.

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**Table 1.** Meta-analytic results organized within the Structured Risk Assessment (SRA) Need Framework

Domain	Subdomain	Meta-analytic Results
Sexual Interests	Sexual Preoccupation <ul style="list-style-type: none"> <li>Intense impersonal sexual interests</li> <li>Sexual coping</li> <li>Diverse sexual outlets</li> </ul>	<ul style="list-style-type: none"> <li>Sexual preoccupation (S)</li> <li>Multiple paraphilias (S)</li> <li>Sexualized coping (P)</li> </ul>
	Offense-Related Sexual Interests <ul style="list-style-type: none"> <li>Sexual interest in prepubescent and pubescent children</li> <li>Sexualized violence</li> </ul>	<ul style="list-style-type: none"> <li>Sexual interest in children (S)</li> <li>Sexualized violence (P)</li> </ul>
Distorted Attitudes	Victim Schema <ul style="list-style-type: none"> <li>Pro-offending schema about classes of potential victims (e.g., children or women)</li> </ul>	<ul style="list-style-type: none"> <li>Pro-offending attitudes (S)</li> <li>Pro-child molestation attitudes (S)</li> <li>Pro-rape attitudes (S)</li> <li>Generic sexual offending attitudes (S)</li> </ul>
	Rights Schema <ul style="list-style-type: none"> <li>Excessive sense of entitlement</li> </ul>	<p><i>Note that there was insufficient data to look at the predictiveness of more specific attitudes, although all three SRA categories coincided with at least one of the broader categories used in the meta-analyses</i></p>
	Means Schema <ul style="list-style-type: none"> <li>Machiavellianism</li> <li>Violent World schema</li> </ul>	
Relational Style	Inadequate Relational Style <ul style="list-style-type: none"> <li>Dysfunctional self-esteem (inadequate or narcissistic)</li> <li>Emotional congruence with children</li> </ul>	<ul style="list-style-type: none"> <li>Emotional congruence with children (S)</li> <li>Painfully low self-esteem was found consistently predictive in the UK, but not in other jurisdictions.</li> <li>Narcissistic self-esteem hasn't been examined in recidivism studies</li> </ul>
	Lack of Emotionally Intimate Adult Relationships <ul style="list-style-type: none"> <li>Lack of sustained marital type relationships</li> <li>Relationships marred by violence/infidelity</li> </ul>	<ul style="list-style-type: none"> <li>Lack of sustained marital type relationships (S)</li> <li>Marital relationships marred by repeated violence/infidelity (S)</li> </ul>
	Aggressive Relational Style <ul style="list-style-type: none"> <li>Callousness</li> <li>Grievance Thinking</li> </ul>	<ul style="list-style-type: none"> <li>Callousness (P)</li> <li>Grievance thinking (S)</li> </ul>
Self-Management	Social Deviance <ul style="list-style-type: none"> <li>Early onset and pervasive resistance to rules and supervision</li> <li>Lifestyle impulsiveness</li> </ul>	<ul style="list-style-type: none"> <li>Childhood behavior problems (S)</li> <li>Juvenile delinquency (S)</li> <li>Non-sexual offenses (S)</li> <li>Non-compliance with supervision (S)</li> <li>Violation of conditional release (S)</li> <li>Antisocial personality disorder (S)</li> <li>Impulsivity/recklessness (S)</li> <li>Employment instability (S)</li> </ul>
	Dysfunctional Coping in response to stress/problems <ul style="list-style-type: none"> <li>Poor problem-solving</li> <li>Poor emotional control</li> </ul>	<ul style="list-style-type: none"> <li>Poor Coping (externalizing) (P)</li> </ul>

(2013) add the finding that this is specifically true for attitudes condoning either rape or child molestation. It also appears from this meta-analysis that attitudes that have been empirically examined are more predictive for child molesters than they are for rapists, and that prediction was better when the attitude was consistent with prior victim choice. Thus, pro-child molesting attitudes predicted recidivism better for child molesters than they did for rapists, and pro-rape attitudes were the best attitudinal predictor of recidivism for rapists (though this attitude was also predictive of recidivism when expressed by child molesters). Attitudes may therefore be a particularly relevant treatment target for child molesters, but, from our current state of knowledge, less so for rapists.

Sexual offender treatment providers are used to identifying and addressing pro-offending attitudes. Nevertheless, the main difficulty for this domain is distinguishing denial and minimization from more general pro-offending attitudes. Denial, in itself, is not empirically supported as a risk factor for sexual recidivism (Mann et al., 2010), although

it may block some kinds of treatment intervention. For instance, which psychological factors were active during the offense process and identifying and challenging pro-offending beliefs may both be more difficult if the offender is unwilling to discuss the specifics of their offenses in a meaningful way. However, there seems to be a complicated interaction between denial, re-offense risk, and type of offending (Harkins, Beech, & Goodwill, 2007; Langton et al., 2008; Nunes et al., 2007; Thornton & Knight, 2007). In essence, most of these studies suggest that denial may be an important treatment target for incest offenders but not for higher risk child molesters who have a more generalized pattern of offending.

**Relational Style domain.** Within this domain three kinds of problems have been empirically supported as related to recidivism, and as such are appropriate treatment targets. Some offenders feel inadequate in their relationships with adults, but are able to satisfy needs for emotional intimacy by making emotional connections with children. This appears to be a risk factor for those with a history of

offending against young children (Knight & Thornton, 2007), but seems to be irrelevant for rapists. Of more general relevance is difficulty forming and sustaining emotionally intimate relationships with adults. Similarly, a generally callous and/or hostile approach to others appears to be a risk factor for sexual offenders in general. It is important for treatment providers to distinguish this from apparently callous or hostile attitudes towards persons against whom the offender has committed sexual offenses. An apparent lack of remorse and appropriate empathy for the victims of offender's past sex offenses naturally tends to elicit negative judgments about the offender, and this has been a popular target in sexual offender treatment programs. However, research has consistently failed to find any relationship between the degree to which offenders show empathy for past victims and whether or not they go on to offend again (Mann et al., 2010). In light of this, it would be better for therapists to concentrate on encouraging offenders to develop more empathic ways of relating to the people they meet in their current lives, helping them to reduce their tendency to ruminate angrily over past situations in which they felt wronged, and helping them cope with angry feelings without expressing them in aggressive behavior.

**Self-Management domain.** Two main risk factors have been established within this domain, and there is some evidence for a third. The pattern consists of oppositional reactions to rules and supervision manifested in childhood behavior problems, juvenile delinquency, non-sexual adult crimes, and supervision violations. The second well established risk factor is a behavioral pattern characterized by lifestyle impulsiveness, including low tolerance for boredom, making decisions in an impulsive and reckless way, irresponsible lifestyle choices, and generally living without realistic long-term plans. Together, these subdomains represent different aspects of what is sometimes thought of as general criminality, a criminal lifestyle, or social deviance. These characteristics are often easily identifiable from the offender's past history, and often expressed in ongoing functioning in fairly obvious ways. Nevertheless, there are two potential traps for treatment providers trying to work with men high on these risk factors. One is failing to appreciate the relevance of these factors to sexual offending (thinking of the person as primarily a non-sexual criminal) and the second is reacting in an excessively controlling way to the rule-breaking/oppositional reactions and behaviors of this group. While boundaries do need to be maintained, this group in particular responds better to building a therapeutic relationship via an approach grounded in the spirit of motivational interviewing.

Some evidence points to a third kind of risk factor subdomain within the larger self-management domain, involving a pattern of dysfunctional coping (impulsive/reckless reactions) to everyday problems and stresses. There is less evidence regarding the predictive significance of this factor, so it is classified as promising rather than established. Nevertheless, such reactions are often apparent in the ongoing behavior of sexual offenders in treatment and seem appropriate as a treatment target, even if only on the grounds that it is a factor that

can contribute to a more general pattern of externalizing behavior.

### ■ Protective Factors

Protective factors can be defined as social or psychological factors that make recidivism less likely. It is possible to make subtle distinctions between three types of protective factors: (a) factors that are the opposite of risk factors, (b) factors that reduce risk, but for which no concrete corresponding risk factor can be defined, and (c) factors that are only protective in the presence of risk factors. However, in our present state of knowledge these distinctions are not particularly helpful; we are only just beginning to identify protective factors, and are not yet in a position to determine into which of these more subtle categories particular protective factors fall.

The significance of what might be called the “protective factors perspective” can be understood by contrasting it to a perspective that is solely focused on risk factors. Risk factors are generally better understood as long-term vulnerabilities – relatively enduring traits that change only slowly (Mann et al., 2010). Thus, an evaluation focused solely on risk factors is liable to be experienced as oppressive by the person being evaluated since the evaluator seems attentive only to deficit features of his life that are negative and hard to change. Offenders with treatment plans focused solely on risk factors may then be primarily concerned with learning to avoid or not observably express these long-term vulnerabilities. This leads to the ironic position that offenders in treatment basically have an incentive to not to put out or display any noticeable behavior or behavior that may point to personal vulnerabilities.

### A Protective Factors Perspective

The protective factors perspective can be distinguished from a long-term vulnerability perspective in three ways: (a) It attends to positives – factors whose presence is desirable; (b) it attends to environmental factors, in which protection is seen as potentially linked to how well the individual's surrounding environment is functioning, as well as how the individual is functioning; and, (c) it views protective factors in a highly dynamic way, generally focusing on functioning over the last three to twelve months, while also considering likely functioning in future environments toward which the assessment is directed.

From this perspective, risk factors should not be ignored. However, complementing and balancing the attention paid to risk factors with attention paid to protective factors is much more motivating for the people being evaluated or treated, and specifically makes it easier to engage offenders in the evaluation and therapeutic process. An additional desirable consequence is that, in order to demonstrate progress, offenders need to demonstrate the presence and action of protective factors in their lives and so need to engage in observable behaviors that reflect such factors. This should make it easier for both treatment providers and evaluators to judge progress.

### Understanding Protective Factors

These strategic advantages are motivating researchers to begin the painstaking work required to empirically identify factors that play a protective role, although this work is still in its early stages. Work is more highly developed in relation to factors that are protective in relation to general violence, but a review by de Vries Robbé, Mann, Maruna, and Thornton (2013) summarizes what is known about factors that are protective in relation to sexual offending. This review draws on the wider literature on protective factors and desistance, as well as findings with specific measures of protective factors intended for use with sexual offenders.

The following is based on de Vries Robbé et al. (2013), but also takes into account findings from research with ARMIDILO, a risk assessment instrument developed for the evaluation of sexual risk in persons who have intellectual disabilities (Blacker, Beech, Wilcox, & Boer, 2011; Lofthouse et al., 2013). From these sources, positive factors, both personal and environmental, that have been related to reduced recidivism when assessed in an actively dynamic way, are extracted and summarized below under five headings.

1. **Professional support.** Relevant environmental aspects of professional support include the degree of external control it provides, the extent of supervision and treatment services, the attitudes of professionals toward the individual, and how well professionals working with the individual know him, and communicate among themselves.
2. **Social Network.** Among relevant environmental aspects of the offender's social network is the inclusion of well functioning individuals who model effective coping and prosocial attitudes, and at least one person who is an emotionally intimate confidante.
3. **Structured Group Activities.** Relevant aspects of structured group activities include group leisure activities, employment, and education. Involvement in prosocial group activities of this kind provides some informal social policing of individuals' behavior, as well as reducing the time available for potentially antisocial activities. Positive involvement in structured group activities can also contribute to individuals experiencing a sense of being valued and making a valuable contribution, and so increases their investment in living a law-abiding life.
4. **Goal Directed Living.** This involves individuals having a sense of personal agency, actively managing their lives on the basis of realistic medium and long-term goals, resisting short-term temptations to engage in behaviors that would disrupt these plans, and having sufficient problem-solving skills to overcome obstacles that will impede progress toward their goals.
5. **Hopeful and Persistent Attitude to Desistance.** This involves the offender seeing desistance as possible and worth striving for, even in the face of difficulties. It involves developing a more prosocial and “redeemed” identity that competes with the earlier sense of self as cunning and deviant.

It also involves developing the ability to find positives even at times of setbacks, or positives that support the individual's ability to respond resiliently to such setbacks.

The first three of these factors may be thought of as primarily external protective factors, while the last two are primarily internal. It would be a mistake, however, to think of any of these factors as solely external or solely internal. Even when a protective factor is primarily external, its effect will greatly depend on the individual possessing the skills, attitudes, and motivation required to respond well to external protection. For example, the effectiveness of professional support will depend on the individual having positive attitudes toward and cooperating with authority figures, therapists, and the treatment process. Similarly, someone who is suspicious, hostile, and belligerent is liable to have more difficulty finding and sustaining a place in a positive social network.

Further, even when a factor is primarily internal, environments can vary greatly in how far they afford an opportunity for the internal factor to be positively expressed, as well as the degree to which they encourage the development of the internal factor. So, for example, goal-directed living is harder if the environment is overly structured, in which individuals are not allowed to make choices for themselves, or if environmental responses are random and inconsistent in their support as individuals attempt to engage in goal-directed living. Similarly, building and maintaining a prosocial identity is easier when the social messages received from others are consistent with such an identity while it is much harder when others convey that they see individuals as irretrievably deviant.

### Applying a Protective Factors Approach

Thinking in terms of protective factors can materially shift the goals and perspective of treatment. From this perspective, risk is seen as best managed by building up protective factors rather than by solely attending to or containing the risk factors themselves. This more positive focus not only expands the practice of treatment for sexual offenders, but also makes it easier to develop a therapeutic alliance with offenders. While individuals should be encouraged to develop their own external protective factors (especially the social network and structured group activities factors), part of the therapist's role should be to facilitate this process. Ideally, the individual should both be helped to develop these protective factors now and, at the same time, learn the skills required to re-create and build new external protective factors should this be necessary in the future.

Hopefully, therapists will not be working in isolation, but instead will be part of a broader risk management/resettlement team. This team should, of course, be attentive to potential environmental risks hidden in apparently protective external factors – for example, structured activities that increase access to potential victims. Nevertheless, therapists in particular should advocate that excessive reliance on reducing opportunities to reoffend (a classic response in the sexual offender treatment) may also inhibit the development of protective factors, and so paradoxically increase risk.

## ■ Revisiting Classic Treatment Tasks

In opening this article, the classic tasks of sexual offender treatment as they were understood around the year 2000 were identified as: (a) Eliciting accounts of past deviancy and offending, (b) challenging denial and self-serving cognitive distortions, (c) developing empathy for victims, (d) analyzing past offenses in order to identify offense precursors, (e) developing a relapse prevention plan designed to be relevant to identified offense precursors, and (f) rehearsing skills for putting this plan into practice. Since these tasks are still commonly used, it is worth considering both their value and how they might be reshaped in the light of what we now know about risk and protective factors.

From the present perspective, the task of eliciting accounts of past deviancy and offending still has a role, but primarily to identify psychological risk factors most relevant to each individual; to identify the strengths of each individual, which can then be built into protective factors; to become aware of likely victim preferences; and by which to understand past modus operandi so that risks that might otherwise be hidden in apparently protective factors can be identified. This task comes with several dangers, however. One is getting bogged down trying to identify details that do not serve these goals, and so wasting treatment time: when offenders' accounts of their offenses differ from the official account it is only worth seeking to resolve this difference where the discrepancy makes a difference in the identification of psychological risk factors or modus operandi. Another danger is that the individual may be encouraged to over-attribute his offending to fixed and static internal characteristics (such as "past deviancy"). However, this is liable to interfere with the fifth domain of protective factors (Hopeful and Persistent Attitude to Desistance).

Challenging denial and self-serving cognitive distortions likewise comes with opportunities and dangers. Goals relevant to this aspect of treatment include (a) challenging generalized beliefs about women or children that may make it easier to rationalize rape or child molestation, and (b) more realistically identifying psychological risk factors. Conversely, dangers include getting stuck in a battle over denial (something that is better worked around than battled through), and pushing the offender for more ownership of psychological risk factors than may be required. The goal here is only to get enough ownership of psychological risk factors to motivate relevant self-management.

Developing empathy for victims should at most be done with a light touch. Working with offenders until they display what we recognize as victim empathy is likely a distraction, since what we recognize as empathy for victims seems unrelated to risk for sexual recidivism. Some of what has been done in treatment in this area can be refocused on addressing distorted beliefs about women or children, rather than eliciting what we consider to be victim empathy.

Analyzing past offenses by which to identify offense precursors can contribute to identifying those psychological risk factors relevant to the individual, as well as an awareness of likely victim preferences and past modus operandi. The main danger here is

the distraction created by pursuing aspects of this task that aren't relevant to meeting these goals.

Developing a relapse prevention plan designed to be relevant to identified offense precursors is of limited relevance. Having a plan doesn't mean that the plan will be followed. Development of motivation and skills is more critical. Additionally, some relapse prevention plans are so focused on risk avoidance that they define a life few people would willingly live. A more useful equivalent is focusing on what activates the individual's long-term vulnerabilities, how the frequency and intensity of these activations can be reduced, and how to safely return to equilibrium when vulnerabilities are activated.

Finally, rehearsing skills for putting a relapse prevention plan into practice is relevant if it is reconceptualized as learning and practicing the skills needed for managing long-term vulnerabilities.

It is important to emphasize, however, that an individual could engage in and complete each of these now classic treatment tasks in a meaningful way, but still have done little to develop protective factors. Additionally, a one-sided emphasis on managing risk factors is liable to be demotivating. It is recommended, therefore, that education about protective factors begins early in treatment and that work on developing protective factors goes hand in hand with work on identifying, containing, and reducing or eliminating risk factors.

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## Altruism, Empathy, and Sex Offender Treatment

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### Abstract

Treatment programs for serious offenders such as sex offenders typically include an empathy training component as part of a comprehensive intervention package. The reasons for doing so are partly based on research evidence indicating that social disconnection and relationship ruptures related to empathy failures often trigger offending, and also because it is hard for people to grasp how individuals can inflict severe harm on others without lacking empathic capacities. In this paper we examine Philip Kitcher's concept of psychological altruism and altruism failure and consider its conceptual relationship to empathy and morality. We then apply Kitcher's multidimensional concept of altruism to the field of sex offender rehabilitation and argue that it can provide a useful ethical resource through which to approach the various tasks of practice.

### Keywords

altruism and empathy; sex offender treatment

Being able to emotionally respond to other people and to share their experiences is a core psychological skill and an essential ingredient of healthy intimate relationships and strong communities. It enables us to enter into individuals' internal worlds and draw from the knowledge that this imaginative process yields an explanation for their actions and predict what they are likely to do next. The capacity to respond in this way has been called *empathy*, *sympathy*, *emotional knowledge*, *mind reading*, and *mentalizing*, to name just a few of the concepts evident in the research and popular literature (Decety, 2012). The ability to be empathic helps people to act in altruistic ways and to acquire social and moral norms. Its absence is thought to be associated with dysfunctional and destructive social behavior. If you are unable or unwilling to empathize with another person's distress it becomes much more difficult to act in ways that further their interests rather than simply attending to your own. The personal consequences of a failure to empathize with others include social isolation, confusion, and possibly the infliction of formal or informal sanctions by the community.

Given the apparent foundational role of empathy in the establishment and maintenance of social relationships and community cooperation, it is not surprising that developers of programs for sex offenders have included empathy interventions in their list of essential treatment components (e.g., Laws & Ward, 2011; Marshall, W. L., Marshall, L. E., Serran, & Fernandez, 2006; Pithers, 1999). Sexual offenses clearly involve the overriding of another person's best interests by an offender, and hence display, at least on the face of it, empathy deficits. However, despite the face validity of including victim empathy interventions in the treatment of sex offenders there is surprisingly little evidence that sex offenders have enduring empathy deficits, or, more worryingly, that empathy interventions result in reduced reoffending. According to Mann and Barnett (2013)

the problems reside in a weak evidence base and a lack of a coherent model of change.

It seems to us that there are several contestable assumptions underpinning current theoretical and empirical research into the nature and function of victim empathy deficits in sex offenders, and subsequent treatment programs based on this research. These assumptions are: (a) empathy deficits represent specific psychological problems that are reliably present (even if specific to a particular victim or context) in individuals who commit sex offenses, (b) empathy interventions increase the ability of offenders to respond empathically to potential victims, and (c) offenders who successfully resist the desire to reoffend do so, at least partially, because they have become more empathic. In essence, these assumptions boil down to the claim that empathy related competencies (i.e., perspective taking, emotional responsiveness, according others respect, being able to manage one's own emotional distress etc. – see Barnett & Mann, 2012) are necessary and/or sufficient for desistance from sexual offending. The trouble is, we lack the evidence to support these assumptions as well as an account of where empathy figures in the rehabilitation process.

In this paper we examine Philip Kitcher's (2010, 2011) concept of psychological altruism and altruism failure, and consider its conceptual relationship to empathy and morality. We then apply Kitcher's multidimensional concept of altruism to the field of sex offender rehabilitation and argue that it can provide a useful ethical resource through which to approach the various tasks of practice. Importantly, the concept of altruism and its five dimensions shifts the focus away from the concept of empathy, which is plagued with definitional vagueness and is somewhat normatively detached (see below), to the theoretically richer and pragmatically more versatile concepts of psychological and behavioral altruism.

### ■ The Concept of Empathy

According to Oxley (2011) empathy is "both an act and a capacity" (p. 15). Individuals engage in acts of empathy when they imagine how someone else is likely to be feeling in certain situations, or alternatively, anticipate how they would feel in similar circumstances. In order to act empathically individuals require cognitive and emotional capacities, such as the ability to psychologically decenter, emotional knowledge, and the possession of emotional regulation, deliberation, and perspective taking skills. For example, in order to empathize with a friend's sadness following the death of a parent I need to be able to place myself in *her* shoes, so to speak. Taking in account my friend's personality, circumstances, history, relationships with her parent etc., I imagine what she would feel. This is what has been called other-focused empathy (Oxley, 2011). Another possible empathic mechanism is to place *myself* in the situation of my friend and to assume that *my* parent had just died. Ideally, I would experience similar emotions and therefore be able to accurately infer what she was feeling, thinking, and so on. This type of empathic imaginative process has been labeled self-focused empathy (Oxley, 2011). It is pretty obvious that sophisticated, empathic actions of these types have significant epistemic or knowledge generating advantages. It helps people to extend their understanding beyond the limited boundaries of their own minds-and bodies and to establish strong emotional connections to others.

Many definitions of empathy have been offered in the philosophical and scientific literature, although none universally accepted. Maibom (2012) has usefully distinguished between sympathy, emotional contagion, and empathy while others have added perspective taking, simulation, and imitation to the conceptual mix (Decety, 2012; Oxley, 2011). Rather than become bogged down in definitional disputes, we agree with Oxley (2011) that a core component of any definition of empathy is the requirement that a person experiences an appropriate emotion in response to another individual's emotional state. More specifically, Oxley (2011, p.32) formulates a generic working definition of empathy as follows:

*Feeling a congruent emotion with another person, in virtue of perceiving her emotion with some mental process such as imitation, simulation, projection, or imagination.* (italics in the original)

According to this definition, there are a number of possible psychological mechanisms capable of generating an emotional (empathic) response to, for example, a person experiencing sadness. The mechanism could be simple emotional contagion (I feel sad when the other person does, without necessary being aware of the link), imitation (I copy someone's emotional behaviors and as a result experience a similar emotion), or imagination (e.g., I place myself in someone's situation and anticipate how he or she would be feeling). Forms of empathy that rely

on sophisticated cognitive abilities such as self- and - other- focused perspective taking are necessary for morality and complex social functioning.

Empathy is an important motivator for prosocial and moral functioning and therefore it makes sense for treatment programs to devote some of their therapeutic resources to the cultivation of empathy in sex offenders. However, empirical research and theoretical analyses suggest that the presence of empathy on its own does not reliably result in moral and prosocial behavior (Barnett & Mann, 2012; Batson, 2011; Oxley, 2011). In brief, people are more likely to act empathically towards individuals who are similar to them and fail to do so when others are different on relevant dimensions, such as class or culture. Second, people tend to over privilege current circumstances when considering the interests of others and discount longer term factors. Third, empathy helps to *motivate* individuals to take into account others' interests but is not a form of ethical or value based deliberation in itself. In other words, it is *normatively detached* and if it is to lead to prosocial outcomes it needs to be explicitly linked to justified ethical norms. Fourth, people can act in prosocial ways because of their personal commitment to certain ethical norms or due to the anticipated negative consequences of not doing so, rather than because they are empathic. In other words, the occurrence of empathy is not necessary (i.e., other interested actions can occur without the presence of empathy) or sufficient (i.e., the presence of empathy may not result in other interested actions, could reflect bias, etc.) for actions that place other people's interests above those of the person concerned.

Relatedly, there are empirical and theoretical grounds for arguing that people could commit harmful acts against others in the presence of an empathic response. First, the fact that studies have indicated that some sex offenders do not display empathy deficits does raise the possibility that their offending may occur in the presence of an empathy response. Second, clinical data suggest that sex offenders exhibiting a high degree of emotional congruence towards children and related deviant sexual preferences view themselves as empathic and caring individuals who have sex within the context of a relationship (Navathe, Ward & Rose, 2013). They may be accurately identifying a (vulnerable and previously abused) child's emotional states and current needs and responding with a similar emotion. Their failure is not so much a failure of empathy as a moral failure: such individuals have not aligned their actions with consensus norms that are intended to protect children from having sex with adults on the grounds of their vulnerability to exploitation and lack of fully fledged agency.

### The Concept of Empathy in the Sexual Offending Field

But how is empathy conceptualized within the field of sexual offending? In three valuable recent papers on empathy and sexual offending theory, assessment, and treatment Barnett and Mann (2012, 2013; Mann & Barnett, 2013) examined conceptions of empathy in treatment programs, discussing foundational work by theorists such as Marshall, Hudson, Jones, and Fernandez (1995), Hanson, (2003), and Polaschek (2003). Following a critical analysis of competing definitions of empathy, Barnett and Mann (2013a) define it as:

*A cognitive and emotional understanding of another person's experience, resulting in an emotional response for the observer which is congruent with a view that others are worthy of compassion and respect and have intrinsic worth (p.23).*

They state that offenders display victim empathy when they are able "to accurately identify and understand, free from their own biases" what the person they abused was likely to have experienced during the sexual assault (2013a, p.23). After pointing out a tendency to conflate empathy definitions with models of the empathic process, and to confuse general empathy with victim empathy, Barnett and Mann (2012) hypothesize that five sets of processes converge to create an empathic response: (a) the ability to accurately infer what another person is experiencing - perspective taking; (b) the ability to experience an appropriate emotion when confronted with another person's distress or pain; (c) the belief that other persons, aside from the offender, ought to be respected and treated with compassion; (d) the absence of contextual variables or competing motivational states that may override the empathic processes and motivations, and (e) the capacity to modulate any resulting personal distress experienced by the individual concerned so that his or her empathic responses (likely to be generated by the first three processes) are not blocked or avoided. Each of the five types of processes necessary for an empathic response is associated with its own, specific category of empathy deficits. For example, some sex offenders are hypothesized to lack theory of mind capacities, making it extremely difficult for them to accurately infer other persons' emotional and cognitive states.

It is notable that the definition of empathy offered by Barnett and Mann (2012) and the model of the empathy process that is hypothesized to cause empathic states do not align that well with Oxley's definition. There are references to moral status, cognitive distortions, contextual factors, emotional control, and so on in their definition and supporting discussion. These variables are all associated with sexual offending and many are predictors of reoffending. In addition, all have immense clinical utility. It seems to us, in their understandable desire to provide a theoretically coherent and empirically

justified definition and causal analysis of empathy Barnett and Mann have extended the concept beyond its domain of meaning and transformed it into something approximating altruism. This is an excellent idea, but it may be helpful to be clearer and more explicit when doing this. It may be less confusing to use another term and allow empathy to retain its narrower meaning as an appropriate emotional response to another person's emotional state (see above- Oxley, 2011).

In our view, what matters from a treatment perspective is that offenders *act* towards others in an altruistic manner, rather than that they *feel* empathic. Additionally, the trouble with the concept of an empathy response as used in the correctional field is that empathy tends to be viewed as either present or absent within an individual and there is a failure to make room for the important role of context and moral norms. First, human beings are not simply empathic (or altruistic) or not; they tend to exhibit a more fine grained picture varying along a number of dimensions (see Kitcher, 2011). Second, as we will argue below, the concept of psychological and behavioral altruism is underpinned by normative concerns and, by virtue of its multi-dimensional nature, is responsive to issues of context and scope not easily handled by the concept of empathy.

In our view, researchers and practitioners should be concentrating on incidents of *altruism failure* rather than empathy failure. The concept of altruism (psychological and behavioral), as developed by theorists such as Kitcher, is richer and provides a more useful way of linking ethical norms and concern for others to the kinds of psychological and social interventions employed in treatment programs for sex offenders. The fact that its stress is on action is also an advantage; it is what people do, or fail to do, when committing offenses that is of interest to practitioners.

We argue that all of the treatment modules typically implemented with sex offenders play a role in addressing the major classes of problems evident in altruism failure (which includes empathy failure as currently construed). In our view, the multidimensional, rich account of psychological altruism created by Philip Kitcher (2010, 2011) has the conceptual resources to incorporate the contributions and interventions brought into treatment by the concept of empathy, while avoiding its weaknesses.

### ■ A Multidimensional Concept of Psychological Altruism

In the exposition of his ethical theory Philip Kitcher (2010, 2011) distinguishes between biological, behavioral, and psychological altruism. *Biological altruism* occurs when a biological entity promotes the reproductive success of another entity at the expense of itself. Essentially, *psychological altruism* is concerned with the intentions of an agent and is ev-

ident when an individual adjusts his/her actions to take into account the interests and desires of other people. *Behavioral altruists* act to further their own, self-serving interests while seeming to intentionally act in ways that promote others' interests. While this form of altruism does not cohere well with our intuitive understanding of the concept, it may be the only realistic way that some individuals can advance the interests of other people (e.g., individuals diagnosed with psychopathy). Kitcher argues that ethical norms are especially important in preventing altruism failure by prompting people to behave altruistically even if they are not inclined to do so. Ideally, we would all be committed and competent psychological altruists, but given the complexities of modern living, and taking into account our psychological nature, this is unrealistic. In this paper our focus is solely on psychological and behavioral altruism.

We would now like to look at the concept of psychological altruism more closely. Kitcher (2010) states that:

*To be an altruist is to have a particular kind of relational structure in your psychological life – when you come to see that what you do will affect other people, the wants you have, the emotions you feel, the intentions you form change from what they would have been in the absence of that recognition. Because you see the consequences for others of what you envisage doing, the psychological attitudes you adopt are different. (p.122)*

In offering an analysis of psychological altruism Kitcher (2010, p.123) distinguishes between the desires (or other relevant mental states) an altruistic person is likely to have when his/her actions only have consequences for him or herself, and those when his/her actions will have an observable impact on other persons. In this kind of situation (we have paraphrased Kitcher here) he stipulates that: (a) the desires an agent acts on will be more closely aligned with those he/she attributes to another person than it would be if he acted in a solitary context; (b) the desire that leads an agent to act follows from his/her perception of the other person's desires; and (c) the desire that caused the agent to act in this context was not intended to further his/her own interests. Rather, he gives *priority* to the desires of the other persons and relegates his/her own desires to the background. Kitcher makes it clear that there are likely to be other mental states such as emotions that accompany the altruistic person's desires when he/she acts altruistically; for example, compassion or sadness.

Once he has defined psychological altruism, Kitcher states that because altruism is a multidimensional concept it makes little sense to assert that a person is either altruistic or not. More specifically, Kitcher contends that an individual's altruism profile can be established by using five dimensions. The *intensity* of an altruistic response involves the de-

gree to which a person realigns his/her own desires or interests to accommodate those of another. The *range* of someone's profile refers to the list of people whose desires or interests (could involve all human beings or be restricted to family and friends) he/she normally takes into account when acting. The *scope* of an altruism profile denotes the internal and external contexts in which an individual is likely to act altruistically. For example, a male might usually take his partner's desires into account in their relationship unless he was feeling angry or depressed. An individual's *discernment* refers to his/her ability to identify the consequences of his/her actions for relevant others. Finally, someone's *empathetic* skills speak to the ability to accurately infer another person's desires, or, more broadly, relevant mental or physical states. This is similar to the notion of perspective taking and theory of mind ability. Kitcher comments that typically individuals' altruistic profiles consist of an inner circle of valued people whose interests they almost always take into account when acting in ways that are likely to influence them. However, it is likely that the interests of persons on the periphery or beyond this circle would be overlooked or downplayed.

Kitcher presents an analysis of psychological altruism as a multidimensional concept and the point of describing the five dimensions is to encourage researchers to think of the type of psychological altruism individuals display, or alternatively to elucidate the nature of altruism failures. Taking a step back it is possible to transform the concept of psychological altruism into a theoretical framework that is capable of guiding theorists and empirical researchers in the formulation of explanations of altruism (and empathy) failures. From the perspective of this framework, individuals act in ways that disregard the interests of others (altruism failure) in situations where other people's desires and interests should have high priority, when: (1) they do not sufficiently modulate their own desires (etc.) to adequately respond to the situation at hand (intensity); (2) they unreasonably exclude certain classes of people or specific individuals from the list of those towards whom they ought to behave altruistically and therefore would not sexually abuse them (range); (3) they fail to behave altruistically in certain contexts because of the influence of cognitive, emotional, physiological, social, or environmental factors (scope); (4) they are incapable of, or fail in certain contexts to exhibit their capacities to discern the consequences of their actions for the individuals they sexually abuse (discernment); and (5) they lack the capacity to accurately detect the mental states of people they abuse or, if they possess this capacity, they fail to exercise it in certain contexts (empathetic skill). Of course, these claims are abstract and overly general but they function as useful indicators of the social, psychological, and physical variables researchers ought to concentrate their efforts on.

## Relationship Between Empathy and Psychological Altruism

It seems to us that the multidimensional concept of psychological altruism has several advantages over the concept of empathy within the correctional domain. First, conceptualizing altruism in a graduated way means that it is not simply a question of whether a person is responsive to another's interests or is not. It is more likely that individuals will possess their own altruism profile consisting of the weightings on each of the five dimensions described earlier.

Second, empathetic responses and their constituents have a role to play in psychological altruism. For one thing, empathic emotions such as compassion or sadness may accompany a person's desire to take another's interests into account in certain contexts. Furthermore, the perspective-taking component of empathy, as construed in the sex offending literature, is evident in the empathetic skills and discernment dimensions of psychological altruism. The more complex empathy models, such as the one formulated by Barnett and Mann (2012), also map onto the multidimensional concept of psychological altruism or, more accurately, the theoretical framework we derived from Kitcher's analysis. It seems clear that the emotion and perspective taking components of Barnett and Mann's theory map nicely onto Kitcher's dimensions of empathetic accuracy and discernment. Similarly, the claim that emotions can accompany the perception of another's distress incorporates empathic emotions. The assertion that empathic responses are mediated partly by compassion and respect for target persons seems to be directly related to issues of range. That is, individuals who are accorded a certain moral status should also merit our respect and compassion when experiencing hardship. The requirement that contextual variables and competing motivations do not override an empathic response appears to be a straightforward example of Kitcher's notion of context. Finally, Barnett and Mann's assumption that individuals' levels of personal distress be suitably modulated in order for an empathic response to occur is also an example of the importance of context from an altruism viewpoint. One element of Kitcher's concept of psychological altruism that is not mentioned by Barnett and Mann is that of intensity, or the matching of the degree of an altruistic response to the demands of a situation.

Third, problematic aspects of the concept of empathy as formulated by theorists and some puzzling research findings can potentially be accommodated by the employment of the concept of psychological altruism. For example, the finding that some sex offenders appear to lack empathy only for their victims rather than for all children or adult females (for example), may reflect a narrowness of range or problem with scope. That is, in certain contexts an

individual's normal altruism inclinations are overridden. In addition, some sex offenders may lack the ability to accurately discern a victim's mental states and thus suffer from skill deficits, while another offender may have the relevant skills but fails to utilize them when angry, or when sexually aroused (a scope or context failure). Thus an etiological implication of the psychological altruism perspective is that, while sexual offenses can occur in the absence of empathy deficits, every act of sexual aggression displays a lack of psychological altruism. By way of contrast, the altruism framework also predicts that individuals may inhibit sexually aggressive actions and act altruistically without demonstrating the cognitive and affective elements of an empathic response. This could be because they do not want to let their friends down, because they are committed to specific moral norms, or because they calculate that it is in their best interests to do so. In our experience, offenders often give these types of reasons for inhibiting sexually deviant or aggressive desires and impulses.

Fourth, the multidimensional concept of psychological altruism offers practitioners an overarching ethical/psychological framework with which to approach treatment with sex offenders. As we shall demonstrate below, locating problems in the intensity, range, scope, discernment and empathetic skills components of psychological altruism can help to highlight key areas of clinical concern and focus intervention efforts more tightly. The fact that the presence of psychological altruism directly reflects the recognition of others' needs, and also supports the legitimacy of adjusting one's own actions in the light of others' relevant mental states, points to its moral relevance.

Fifth, the concepts of psychological and behavioral altruism have certain advantages over that of empathy when it comes to appreciating the normative laden nature of offender treatment and rehabilitation. An empathic response may motivate individuals to act in an ethical manner because of their awareness of others' mental states and the fact that empathy related emotions (or affective states) such as compassion, guilt, shame, remorse, and concern are action directing. However, if for some reason a person fails to experience empathy in the face of a potential victim's suffering or confusion, it can play no role in accounting for his/her inhibition of sexually deviant desires or inclinations. However, the concept of psychological and behavioral altruism can do so. A person may be strongly inclined not to sexually offend against someone, even in the face of conflicting motivations, because he is committed to acting in accordance with norms that are directed towards the desires and needs of the potential victim. The investment in certain norms, in conjunction with the other requirements for acting in a psychologically altruistic manner, can promote actions despite the lack of empathic emotions. In other words the experience of empathic affective

states is not required for altruistic actions, either of a psychological or behavioral form. In addition, because a primary aim of offender treatment is to reduce the chances of altruistic failures occurring, all of the specific treatment modules delivered to offenders are underpinned by norms that specifically link each to this overarching goal. For example, in treatment sex offenders learn how to establish adaptive social relationships, and by doing so, are less likely to use sex with children as a means of securing intimacy. The specific instructions or norms outlining how treatment ought to proceed are undergirded by a general norm: it is good to establish sexually intimate relationships with adults (and wrong to do so with children). There are both prudential and moral aspects to this norm. On the one hand, adults are more likely to be able to meet offenders' needs for companionship and love, and on the other, sex with children is harmful to them and therefore wrong. Because the overall goal of treatment is to reduce altruism failures-which offending surely represents- and also to increase the chances of offenders experiencing second level altruism, the concept of psychological altruism provides a comprehensive psychological and ethical guide for practitioners.

In conclusion, while empathic responses are useful treatment targets because they can motivate altruistic actions (e.g., inhibit aggressive behavior), people can behave altruistically without feeling empathetic emotions or inclinations. This may be because they are committed to certain norms, they do not want to let down a mentor, or for a number of other reasons. There may in fact be multiple pathways to acting altruistically. An advantage of orientating interventions with offenders around the concept of altruism is that it broadens the range of therapeutic targets and can explain (a) why empathic responses such as sympathy can facilitate prosocial behavior, and also (b) why a person might act in ways that are clearly other serving while not experiencing empathy related emotions such as sympathy. This is not to downgrade the importance of empathy in promoting prosocial behavior, merely to locate it in its appropriate place in the context of offender rehabilitation. An additional issue is that an individual may fail to act altruistically because of the influence of external contextual factors and not because he or she lacks the *capacity* to feel for others or to accurately infer their mental states. Thus it is not sufficient for therapists to assist offenders to cultivate appropriate psychological predispositions such as sympathy, perspective taking, or compassion; it is not simply a question of character or personality development. Sometimes contextual or environmental factors will override someone's normally empathic nature; social isolation or extreme stress, for example. What are required in these instances are social interventions that seek to alleviate problems such as poverty, lack of support, or environmental threats. In our view, the altruism

framework sketched above is able to accommodate these variables with relative ease.

## ■ Psychological Altruism and Treatment of Sex Offenders

### Aims of Rehabilitation

The aims of treatment from the framework of psychological altruism is to make it less probable that an offender will experience altruism failure and therefore fail to take the desires and interests of relevant individuals into account in the course of their daily lives. Failure to do so could adversely impact on them and other members of the community in two ways. First, once in a high-risk situation, disregarding the desires and interests of a potential victim makes it easier for an individual to commit an offense. Second, consistently acting in ways that ignore the preferences and interests of other people is likely to impair the reintegration process because of the corrosive effects on offenders' vocational, social, and intimate relationships (Ward & Laws, 2010). A downstream effect of any subsequent social rejection may well be further offending. Minimizing the likelihood of altruism failures occurring by strengthening the social, psychological, and situational constituents of psychological altruism through correctional interventions should also make it easier for offenders to live more fulfilling and meaningful lives.

### Etiological Considerations

The Risk-Need-Responsivity model (RNR) of offender rehabilitation states that effective correctional interventions should follow the principles of risk, need, and responsivity. While a number of conceptual and practice problems have been identified in this model (Ward & Maruna, 2007), most researchers and practitioners working with offenders agree that ethical and effective practice should be guided by the RNR principles (Yates, Prescott & Ward, 2010; Ward & Stewart, 2003). One core requirement of RNR practice is that clinicians concentrate their therapeutic efforts on managing or eliminating dynamic risk factors. These psychological and environmental variables are thought to causally contribute to the onset of criminal events and their successful reduction typically results in lowered re-offending rates (Andrews & Bonta, 2010). The theoretical framework we derived from Kitcher's multidimensional concept of psychological altruism can easily accommodate the RNR principles in the following way. Criminogenic needs such as offense supportive beliefs and attitudes, intimacy deficits, emotional regulation problems, substance abuse, and impulsivity represent causal variables that are likely to impair the ability of offenders to act in a psychologically altruistic way. For example, offense supportive beliefs, or what have been termed cognitive distortions, typically cast potential victims in ways that permit the offender not to consider them as having the same moral status as them, or else as

possessing desires and preferences that make sexual abuse acceptable. This is a problem relating to the range dimension. Two good examples of this type of cognitive distortion are the belief that women are untrustworthy or dangerous, and that children are sexual agents (Gannon & Polaschek, 2006). The former depicts women as belonging to a class of beings whose desires and interests are not that relevant when engaging in sex and the latter portrays children as competent sexual beings who are capable of making decisions about sex for themselves. We suggest that all of the dimensions of intensity, range, scope, discernment, and empathetic skill can be linked to causal factors resulting in a sexual offense, directly or indirectly (see below).

### Assessment

The aim of the assessment phase of sex offender treatment is to systematically collect clinically relevant information about individuals' offending, functional life domains, personal characteristics, and developmental and social history. Once a sex offender's problems have been identified a case formulation (or mini clinical theory) is constructed in which the nature of the problems, their onset, development, and interrelationships are described. Following the development of a case formulation, clinicians construct an intervention plan in which the various treatment goals, their sequencing, and strategies for achieving them are noted. The components of sex offender treatment in a comprehensive treatment program for sex offenders typically include the following types of interventions: cognitive restructuring/offense reflection, sexual reconditioning, sexual education, social skill training, problem solving, (empathy) perspective taking/constructing victim biographies/victim impact work, intimacy work, acquiring emotional regulation skills, lifestyle/leisure planning and experience, vocational training, and reentry or adjustment planning including relapse prevention (Marshall et al., 2006; Laws & Ward, 2011).

When formulating a case the theoretical framework we derived from Kitcher's altruism dimensions can be used to direct and concentrate clinical attention to certain kinds of problems. Drawing from the assessment data (comprising interview information, psychological measures, archive data, behavioral observations etc.) practitioners can ask the following questions, each covering one of the five dimensions of altruism.

**Range.** Are there any individuals or classes of people explicitly excluded from X's list of altruism targets? Does he hold certain beliefs or attitudes that effectively disenfranchise persons from a consideration of their interests, for example children or young adult women? Does he lack the skills to communicate openly and honestly with adults?

**Scope.** Are there any internal contexts in which X's ability to act altruistically are compromised in

some way? For example, does he find it hard to take account of someone else's interests when feeling angry, sexually aroused, or lonely? What about external contexts? Does X struggle to control his sexually deviant desires and preferences when alone with a child or woman? What about if he is in the company of certain groups of friends? Or when he is socially isolated?

**Discernment.** Does X lack an adequate understanding of the psychological and developmental needs of children? Are his problem solving and inductive reasoning skills of poor quality making it difficult for him to think through the consequences of acting in sexually abusive, or offense reacted ways?

**Empathetic skills.** Does X struggle to accurately identify other people's mental states during an interaction? Is he able to adjust his actions in light of his reading of others' mental states?

**Intensity.** Does X possess the general practical reasoning and self-management skills in order to frame other people's situations in ways that accurately describes what is going on for them? Having done this, can he realign his own desires (and other relevant mental states) and actions in order to respond in an appropriate manner? We view intensity as a more global capacity that builds on the skills, etc. aligned to the other altruism dimensions.

It is anticipated that the answers to the above questions will enable practitioners to pinpoint the reasons why a sex offender acted in ways contrary to the desires and interests of his/her victim. This information can then be recruited in the construction of the case formulation and subsequent intervention plan.

### Practice

In discussing the practice implications of the theoretical framework derived from Kitcher's concept of psychological altruism, we will describe briefly a number of typical sex offender treatment modules and trace their potential for strengthening altruistic actions. The description of the modules' content is based on our clinical experiences and the work by Marshall et al. (2006) and Ward et al. (2007).

#### Understanding One's Offense/ Cognitive Restructuring

The aim of this treatment module is for offenders to acquire an understanding of their offense process and the psychological and contextual triggers and precursors to their offending. With gentle prompting and feedback from the group, often individuals start to question their interpretations of their victim's actions and their own justifications for what they did. Ideally, offenders will exit this phase of treatment with a sense of accountability for their actions, awareness of the problematic nature of some of their beliefs and attitudes, and a grasp of their own suite of risk factors for further offending.

The foci of this model are individual offense supportive beliefs and attitudes and acceptance of responsibility for his/her abusive actions. It is normal to see the emergence of an awareness of their cognitive and emotional barriers to accepting victims as moral equals; beings who merit equal consideration of their desires, needs, and interests when contemplating sex. Furthermore, clinicians may obtain insight into offenders' knowledge of sex and interpersonal relationships, and their level of empathetic skill. Finally, it should be possible to ascertain how emotionally competent individuals are and what relationships exist between emotional states and offending (contextual dimension).

### Empathy Training

The major aim of the empathy module is to encourage offenders to reflect on the impact of sexual abuse on victims and their families. This is achieved through the use of victim biographies, role plays of the index offense, and the assimilation of information about sexual abuse and its consequences for victims. Offenders often describe this as an emotionally devastating experience and report that it helped them to grasp the self-serving nature of their behavior and the callous disregard for the well-being of vulnerable children and unconsenting adults.

Victim perspective taking and appropriate emotional responding are therapeutic targets of this module, and are classical components of an empathy response. In the language of psychological altruism, an expectation is that empathetic accuracy is improved, discernment skills are sharpened, and contextual features of high risk situations that increase the likelihood of sexual crime occurring are discovered.

### Social skills and Intimacy Interventions

The social skills/intimacy module seeks to equip offenders with the internal and external capabilities to adaptively navigate their way through the social world and to learn how to establish and maintain intimate relationships. Research has indicated that some offenders commit sexual offenses because of their feelings of loneliness and social isolation (Ward, Mann, & Gannon, 2007). In addition, there is emphasis on dealing with social conflicts and learning how to communicate feelings in a range of interpersonal contexts, from work to disagreements in close relationships. Frequently, the impact of offenders' early interpersonal relationships are explored and the resulting influence on their internal working models of attachment figures and romantic partners are clearly identified.

The human world is pretty much a social world, and there is no practically possible way to escape or avoid the demands and impact of interpersonal relationships. Offending is an interpersonal event and involves an interaction between at least two people. The offender and the person he or she

sexually assaults. Internal working models of relationships that are characterized by distrust or perceptions of vulnerability may impair offenders' perceptions of children and adults, and result in sexual crimes. Problematic beliefs of these types, and the strategies that accompany them, make it difficult for offenders to function in a psychologically altruistic way. There is frequently a problem of range, where the needs and interests of certain people are dismissed as irrelevant, or else are misperceived in ways that promote sexual offending (empathetic skill). There may also be problems of context (e.g., experiencing altruism failure when feeling lonely) that would benefit from therapeutic attention.

### Emotional Regulation

Emotional regulation modules tend to look closely at offenders' competence on a number of emotional tasks. These include being able to accurately identify and label an emotion, in oneself and in others; once the emotions have been correctly identified, knowing how to act in (adaptive) ways prompted by the emotion in question; and being able to manage powerful emotional states so they do not overwhelm the person concerned.

Powerful emotional states can disinhibit individuals and create immense pressure on them to act non-altruistically. For example, if an offender is experiencing strong feelings of anger, self-control could prove to be particularly challenging. Norms directing him to attend to his potential sexual partner's desires or preferences may be overlooked and his own desires trump all other motivations; he commits an offense. Alternatively, another sex offender could use sex as a soothing activity and when feeling vulnerable, anxious, or depressed seeks out a sexual partner. These kinds of problems are unfortunately relatively common and point to issues with psychological altruism. Perhaps the most obvious issue relates to one of internal context, where failure to effectively modulate certain moods makes it hard for an offender to enter act in a psychologically altruistic manner; his own desires and needs take precedence in a context when the reverse should be true.

### Problem Solving

The final module we will consider is that of problem solving. Basically, in this module offenders learn how to frame problems and work towards effective solutions. The aim is to increase their ability to step back from social and personal crises in order to reflect on the nature of the difficulty, and by thinking in a flexible and pragmatic way arrive at a workable solution. Offenders learn the various phases of problem solving and how to seek relevant information when deciding between a number of options to resolve their difficulties.

The acquisition of good problem solving skills is most likely to improve the way offenders think

about the consequences of their actions (discernment dimension) although it does have implications for the other dimensions as well. For example, when faced with an interpersonal problem or experiencing a negative emotion such as intense fear, the offender would ideally sit back and ask himself what is going on. Creating cognitive space between feeling and acting should open up further opportunities to explore his difficulties and to consider alternative ways of dealing with them. This could result in a shift of focus from his own needs to what the potential victim is experiencing, and ultimately, to a decision to realign his own desires to those of the other person and not to engage in a sexual assault. It is also to be expected that improved problem solving skills could impact in a positive manner on offenders' cognitive distortions and thus contribute to dealing with any possible altruism failures associated with the dimension of range.

### Conclusions

In this paper we have explored the relevance of the concept of empathy for sex offender research and practice. In doing so, it has become apparent that empathy may play an important role in motivating individuals to act in morally acceptable ways, and importantly, to cease offending. After examining empathy and its conceptualization in the sexual offending field more closely, we concluded that the concept of psychological altruism and its associated five dimensions could incorporate valued aspects of empathy, while avoiding some of the conceptual and practice related problems that attend it. After describing Kitcher's concept of psychological altruism, and using it as the basis for an altruism theoretical framework, we investigated its implications for practice. In our view, the capacity of the psychological altruism concept to provide an ethical and theoretical framework for viewing correctional practice is encouraging. It reminds practitioners that work with sex offenders has a strong normative, as well as a scientific or empirical, dimension and that the concept of psychological altruism is much better positioned to provide this broader perspective than that of empathy.

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## Putting the “Community” Back in Community Risk Management of Persons Who Have Sexually Abused

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### Abstract

The actions and consequences of sexual offenders continue to be a topic of great discussion among researchers, clinicians, policymakers, and the community-at-large. Much of this discussion has centered on how offenders should be managed once released to the community. Legislatures have been quick to enact statutes identifying and limiting the community behaviors of offenders. However, many in the research community have questioned their efficacy, or have published research highlighting potential iatrogenic effects suggesting decreased offender stability and increased risk for new criminality (including sexual reoffending). This paper reviews current practices regarding sexual offender sentencing, statutory risk management, and measures of official control prior to suggesting a model of community engagement in providing both support and accountability frameworks to offenders demonstrating both high risk and need. The Circles of Support and Accountability model of professionally supported wraparound care is described, and research data supporting its effectiveness are provided. General comments are made regarding policy and practice issues in community-based sexual offender risk management. Overall, greater collaboration between researchers, policymakers, and the community-at-large is suggested as a means to increase offender reintegration potential while mitigating risks to vulnerable persons in the community.

### Keywords

sexual offenders, community, Circles of Support and Accountability, risk management, sexual offender treatment

Our communities continue to express significant concerns regarding the long-term risk posed to public safety by persons who sexually offend. Accordingly, governments have enacted legislation intended to mitigate those risks. Many of these legal responses (referred to as measures of “official” or “social” control throughout this review) have resulted in longer sentences, increased supervision upon release, sexual offender civil commitment procedures, and other measures intended to strengthen offender accountability in the community. Notwithstanding the fact that sexual offender risk management is a contentious issue, policymaker and community stakeholders are increasingly concerned about what to do regarding elevated risks posed by “sexual predators” and “sexually violent predators” (i.e., those offenders at the higher end of the risk continuum). Accordingly, specialized measures have been applied in an attempt to both manage risk and calm the fears of the community.

This review examines various strategies aimed at facilitating long-term management of the risk posed by persons who sexually offend. This includes discussion of:

1. Current sentencing practices and the effects of incarceration
  - a. Principles of effective correctional interventions
2. Post-incarceration risk management strategies for higher risk offenders
  - a. Long-term or lifetime probation/supervision
  - b. Sexual offender civil commitment
3. Innovative community reintegration models
  - a. Circles of Support and Accountability

In each section, pertinent issues are highlighted and areas for further attention and discussion are suggested. We conclude with a general summary of

the findings and suggest areas for continued focus, exploration, and discussion. Because the large majority of sexual offenders are male, this review uses masculine pronouns. This is not intended to suggest that problematic sexual behavior does not also occur among women, or that these behaviors do not also cause significant harm to those persons sexually abused by women. For those interested specifically in sexual offending committed by women, we suggest readers review Gannon and Cortoni (2010).

### ■ Sentencing Practices

Over time, sentences for sexual offenders have increased in terms of length, and in terms of the percentage of offenders receiving custodial sentences versus community supervision as the primary sanction. Further, the degree and length of post-incarceration risk management have also increased; many jurisdictions now have lengthy periods of sexual offender probation or even lifetime supervision. Twenty states and the federal government have also instituted post-sentence civil commitment of offenders adjudged to meet criteria for designation as sexually violent persons or predators (SVP).

### Effects of Incarceration

Sentences for sexual and other offenses are typically longer in the United States than in other parts of the developed world. This may be a consequence of the US tendency to aggregate sentences consecutively for separate offenses, whereas other jurisdictions (e.g., Canada) tend to sentence offenders concurrently for offenses occurring within the same general period. There are important considerations to be made regarding the cost implications of sentencing practices, as well as whether these efforts are having the anticipated or desired effects on reoffending.

In an influential meta-analysis of 117 studies involving 442,471 subjects from various jurisdictions,

Smith, Goggin, and Gendreau (2002) investigated correlations between recidivism and length of time incarcerated, type of sanction (institutional sentence vs. community-based monitoring and supervision), and imposition of an intermediate sanction (e.g., electronic monitoring, boot camps, drug testing). The following quote showcases this study’s findings regarding the possible difficulties associated with using “sanction alone” as a deterrent against reoffending:

*We are confident that, no matter how many studies are subsequently found, sanction studies will not produce results indicative of even modest suppression effects or results remotely approximating outcomes reported for certain types of treatment programs. (Smith et al. 2002, p.19)*

The overall results of Smith et al.’s meta-analysis were that type of sanction (incarceration vs. intermediate sanction vs. community-based placement) did not contribute to reductions in reoffense rates; that there were no differential effects of sanction type for juveniles, females, or minorities; and that there were tentative indications that longer sentences were associated with somewhat increased incidences of reoffending. Smith et al. (p. 6) concluded that:

1. *Prisons and intermediate sanctions should not be used with the expectation of reducing criminal behaviour (sic).*
2. *On the basis of (the Smith et al.) results, excessive use of incarceration may have substantial cost implications.*
3. *In order to determine who is being adversely affected by time in prison, it is incumbent upon prison officials to implement repeated, comprehensive assessments of offenders’ attitudes, values, and behaviours (sic) throughout the period of incarceration and correlate these changes with recidivism upon release into the community.*

A similar review was completed by researchers at the Washington State Institute for Public Policy (Aos, Miller, & Drake, 2006). Reviewing data from 291 program evaluations completed over a nearly 40-year period, these researchers obtained comparable results to Smith et al. (2002). Specifically, program options that included some aspect of rehabilitative work (i.e., treatment) were much more likely to decrease recidivism than were those that focused solely on sanction or supervision. In reviewing the effects of intermediate sanctions on criminal recidivism, Aos et al. concluded:

*The lesson from this research is that it is the treatment – not the intensive monitoring – that results in recidivism reduction. (p. 6)*

In a related research stream, Andrews and Bonta (2010; orig. 1994) responded to the “Nothing Works” perspective resulting from Martinson’s work in the mid-1970s (Martinson, 1974). In a meta-analytic review of the research investigating the effects of correctional interventions, Martinson concluded that there was little or no evidence to support a view this programming was reducing reoffending. However, Andrews and Bonta criticized these findings, noting that many studies included

results indicating positive effects for at least some types of offenders. In their answer to the “Nothing Works” contention, Andrews and Bonta conducted meta-analytic research as to what program components might contribute to greater positive outcomes. This research ultimately led to the formulation of a comprehensive general personality and social psychology of crime known as “The Psychology of Criminal Conduct” (PCC), with the Risk, Need, Responsivity (RNR) model embedded within it, as reported in their seminal volume *The Psychology of Criminal Conduct* (2010; orig. 1994). The PCC and its RNR model has significantly shaped modern correctional programming throughout the Western world, and is seen as one of the primary intervention philosophies and frameworks for providing evidence-based, best practice human service to offenders.

As part of their psychology of criminal conduct, the Andrews and Bonta RNR model asserts that effective interventions will match level of intensity of intervention to the level of assessed risk (Risk principle). Such programs also need to precisely target individualized criminogenic needs (personal traits, values, and attitudes known to contribute to reoffending – Need principle) in a manner that responds to client abilities, motivation, and other individualized variables (Responsivity principle). Andrews and Bonta demonstrated that significant decreases in reoffending were possible in offering rehabilitative interventions following these simple principles, as compared to supervision or criminal sanction alone (i.e., without interventions). In yet another, similarly oriented analysis, Lipsey and Cullen (2007) reviewed the various meta-analyses that have examined differential effects of supervision/sanction versus rehabilitation treatment. Their findings echo those of the others noted here – that supervision or sanction alone result in either no effect or a slightly negative effect on outcome (i.e., increased reoffending), while treatment results in positive and often large effects on outcome (i.e., decreased reoffending). In a cost-benefit analysis, the Correctional Service of Canada (2009) showed that every dollar spent on sexual offender treatment programming resulted in a savings of five dollars in costs not incurred due to decreased reoffending. Some have questioned the applicability of RNR constructs to the sexual offender population, presumably on the belief that these offenders are somehow different in their criminal and behavioral orientations and actions. However, in a meta-analysis of 23 studies (including 6,746 subjects), Hanson, Bourgon, Helmus, and Hodgson (2009) demonstrated that RNR principles apply to interventions with sexual offenders as much as they do with offenders in general. These principles have also been helpful in devising appropriate post-release risk management schemes (see Wilson, Cortoni, Picheca, Stirpe, & Nunes, 2009) in which evidence-based case management paired with community-based aftercare resulted in incremental reductions in post-release reoffending and other difficulties.

### Issues for Further Discussion

Contemporary American corrections policy has tended to emphasize sanction (e.g., retribution and

punishment) in addressing both general and specific deterrence. However, while exacting retribution and meting out punishments might make us feel better and satisfy our penchant for holding offenders accountable for their actions, the research reported above strongly suggests that offenders re-offend less (i.e., there are fewer victims) on release if they have had access to rehabilitation programming. Therefore, public safety-minded offender management policies must include a combination of both aspects – sanction and rehabilitation. In summary, the meta-analytic findings of the effects of correctional supervision/sanction and rehabilitative interventions suggest the following conclusions, which are applicable to persons who sexually offend:

1. Sentencing practices should take into consideration the level of risk posed by the offender, but should also appreciate the type and intensity of correctional programming required to assist the offender in increasing reintegration potential.
2. Comprehensive clinical interventions following evidence-based principles of effective correctional programming (i.e., RNR model) should be available to all sexual offenders during their incarceration.

Keeping the prescriptions of the RNR model in mind, it is important to ensure that the most restrictive and intensive measures are applied only to those offenders most in need of that level of supervision or intervention. Andrews and Bonta (2010) showed that sanction alone did little to address what they referred to as the “Big 4” predictors of criminal recidivism (antisocial values and attitudes, antisocial personality structure, antisocial behavior, and antisocial peer affiliations). They demonstrated that these core criminogenic need areas were best approached through programming that addresses inappropriate behavior by identifying antisocial values and attitudes developed over the offender’s life, and which contribute to continued offending (i.e., cognitive-behavioral interventions based in social learning principles). Finally, Andrews and Bonta further showed that, where feasible and safe, treatment programming is likely to have greater effect when offered in the community.

However, with respect to the findings noted above, many researchers have identified difficulties in the studies comprising this literature (see Hanson, Bourgon, et al., 2009). Issues have been noted regarding inconsistencies in regard to the degree of attention to empirical evidence, the use of rigorous program designs, and the degree to which implementation follows those designs. In their review of the sexual offender treatment programming literature, Hanson, Bourgon, et al. identified only a handful of studies that truly adhered to the prescriptions of the RNR model (i.e., a strong, evidence-based program design). Indeed, a general finding in the correctional treatment literature has been that those models most likely to reduce reoffending, or that are most likely to facilitate program evaluative research, are not often those employed (Lipsey & Cullen, 2007). For instance, random assignment designs are often seen as more highly

desirable for program evaluation; however, they are rarely employed and their feasibility has been questioned (Långström et al., 2013).

### ■ Post-Incarceration Risk Management for Higher Risk Offenders

Traditionally, persons convicted of sexual offenses have received determinate sentences; meaning that the greater majority of such offenders will at some point be released to the community. Beginning in the early 1990s, various levels of government started to consider their options in terms of the post-release management of sexual offenders. In Canada, high profile cases of sexual abuse and murder led to sweeping changes that established national policy and the development of specific community-based sexual offender management practices (see Correctional Service of Canada, 1996). In the United States, national SORs were established and many states either established or began investigating sexual offender civil commitment. In almost all cases, new practices were intended to increase the degree of scrutiny focused on released sexual offenders, in addition to generally increasing the length of time that scrutiny would endure, in some jurisdictions for the remainder of the offender’s life.

#### Long Term Sexual Offender Probation and Lifetime Supervision

Meta-analyses focusing on the predictors of sexual recidivism (e.g., Hanson & Morton-Bourgon, 2005) have greatly assisted both risk assessment and risk management personnel. Evaluators and treatment staff now have a range of tools available to increase accuracy in identifying offenders at risk, as well as increasing the effectiveness of interventions by more specifically targeting pertinent criminogenic needs. However, questions remain as to the length of time that sexual offenders remain at risk, or whether or for how long they need to be in rehabilitative programming.

Many US jurisdictions have statutes allowing for (up to) lifetime community-based supervision for sexual offenders, usually according to differential levels of risk. States like California have established “three strikes” provisions, in which offenders with three convictions meeting certain criteria are placed on lifetime supervision. With respect to managing risk in the community, many jurisdictions favor “containment” approaches (see English, Pullen, & Jones, 1996). This approach seeks to hold persons who sexually offend accountable through the coordinated use of the client’s internal controls, external criminal justice controls, and polygraph monitoring of client self-regulation and general compliance with external controls. English emphasizes further that treatment, supervision, and monitoring occur through a commitment to teamwork and collaborative efforts at increasing public safety. The containment strategy has five components (English, 1998):

1. A victim-centered philosophy
2. Multi-disciplinary collaboration
3. Specific management tools
4. Consistent multi-agency policies and protocols
5. Program quality-control mechanisms

One of the best examples of the containment approach is found in Colorado, where sexual offenders who commit certain types of offenses may be supervised for life after release. Ideally, the containment model is an initiative that assists in increasing offender accountability, resulting in decreased risk to the public. Colorado officials strongly support use of polygraph in their version of the containment model, asserting that it assists greatly in identifying problems before they become unmanageable or lead to reoffending (see Heil, Ahlmeyer, McCullar, & McKee, 2000). However, there continues to be a general lack of research regarding the effectiveness of polygraphy in reducing sexual recidivism (McGrath, Cumming, Hoke, & Bonn-Miller, 2007). Indeed, the McGrath et al. paper noted here is one of very few to study this issue, suggesting that there is, as yet, no conclusive evidence regarding the true value-added of polygraph evaluations in the community risk management of sexual offenders.

A variation on the containment model is found in the United Kingdom (UK). Known as Multi-Agency Public Protection Arrangements (MAPPA – see Wood & Kemshall, 2007), the intent of this framework is to ensure collaborative risk management of offenders after they are released from prison. MAPPA includes representation from statutory agencies (probation, law enforcement), non-government organizations (social service agencies that provide treatment and support – Quakers, Lucy Faithfull Foundation, Salvation Army), and community partners such as victims advocacy groups and Circles of Support and Accountability (CoSA – see below). As noted, MAPPA is similar to containment in its intent and implementation; however, the major difference between containment and MAPPA is the use of polygraph monitoring, not presently used by MAPPA. In their review of MAPPA, Wood and Kemshall (2007) reported that all partners indicated increased belief that offender risk and needs were being better managed. However, they also highlighted unresolved issues regarding availability of post-incarceration housing and treatment services, as well as a lack of key performance indicators for evaluating efficacy.

### Sexual Offender Civil Commitment

At present, 20 states and the US federal government have legislated sexual offender civil commitment (SOCC) procedures. SOCC is based on a belief that some offenders will be at continued high risk (in some cases, termed “more likely than not”) to commit a new sexual offense if they are not preventively detained and offered rehabilitation treatment. SOCC statutes typically require that a potential candidate has a history of criminal sexual behavior, as well as a “mental abnormality” that, without treatment, would preclude him from being able to manage his sexual behavior in the community. Persons committed as Sexually Violent Persons/Predators (SVPs) are usually held until the Court finds they no longer meet the criteria outlined above.

SOCC continues to be a source of controversy on many fronts, affecting such stakeholders as legislators, risk assessors, treatment providers, public policy analysts, offenders and their families, and the general public (see review in Prentky, Janus, Bar-

baree, Schwartz, & Kafka, 2006). Beyond issues of constitutionality, the majority of these issues center on the methods used to identify persons worthy of SOCC, the efficacy of sexual offender treatment, and the safety and utility of “less restrictive alternatives” or “step-down” programs used if and when SVPs might be released to the community. Furthermore, there has been a general lack of agreement as to what constitutes appropriate procedure in measuring of risk to reoffend (see Campbell & DeClue, 2010; Mann, Hanson, & Thornton, 2010). Specifically, issues of base-rates and appropriateness of comparison groups have been raised as issues for additional attention and study (see Wilson, Looman, Abracen, & Pake, 2012).

For their part, persons sent to civil commitment centers have expressed anger and frustration at being brought into the SOCC domain when they had been expecting to be going home to their families. This has significant implications for treatment readiness (Wilson, 2009), combating hopelessness and addressing issues of poor treatment responsiveness (Moulden & Marshall, 2009) – each of which is important in the development of the sort of balanced, self-determined lifestyles (Curtiss & Warren, 1973) required for lasting prosocial change and successful community re-entry. Indeed, such barriers to treatment success have required the use of considerable creativity on the part of professionals attempting to devise treatment models that will appropriately address the programming needs of SVPs as they prepare for possible release to the community.

On some level, it is reasonable to compare and contrast SOCC with lifetime supervision. At present, the number of persons being released from civil commitment centers following completion of intensive treatment is relatively low. One important consideration may be financial. According to the Center for Sex Offender Management (2000), there is a great disparity in costs associated with managing sexual offenders through incarceration versus community supervision:

*One year of intensive supervision and treatment in the community can range in cost between \$5,000 and \$15,000 per offender, depending on treatment modality. The average cost for incarcerating an offender is significantly higher, approximately \$22,000 per year, excluding treatment costs.*

Depending on the individual state, costs associated with civil commitment may be even higher than traditional prison placement. According to a 2005 survey (Washington State Institute for Public Policy, 2005), costs of SOCC vary from \$12,680 to \$109,000 per resident per year.

### Issues for Further Discussion

Long-term management of risk among released sexual offenders continues to present theoretical and practical difficulties. As a theoretical model of community risk management, the containment and MAPPA models make sense and are commendable for their collaborative focus. However, these models have been criticized for being susceptible to a breakdown of the collaborative element when clients experience problems. Specifically, detractors

have suggested that the law and order sector of the containment triad (probation/parole supervision, community treatment and, more often in the US, polygraph supported monitoring) assumes a predominant role when clients experience difficulties and that collaboration involving information and perspective from treatment providers may be then overlooked. As we move toward the future, we must learn from these experiences, meaning it will become important for all stakeholders to work together to maintain a truly collaborative approach to risk management, including some level of participation by members of the community.

In *The Death and Life of Great American Cities*, urban development theorist Jane Jacobs (1961) asserted that community involvement was crucial in establishing and maintaining public order:

*The first thing to understand is that the public peace – the sidewalk and street peace – is not kept primarily by the police, necessary as police are. It is kept primarily by an intricate, almost unconscious, network of voluntary controls and standards among the people themselves and enforced by the people themselves... No amount of police can enforce civilization where the normal causal enforcement of it has broken down. (p. 32)*

Research generally supports a view that sexual offenders in the community may continue to pose risk for reoffending for 10 years or more post-release (Hanson & Thornton, 2000; Helmus, 2009; Quinsey, Harris, Rice, & Cormier, 2005). Accordingly, there is support for extended supervision for certain offenders. However, it is the latter element that is most pertinent – for certain offenders. The distribution of risk for sexual offenders is positively skewed (i.e., low risk offenders outnumber high risk offenders), with the average rate of sexual reoffending over 5-6 years being approximately 15% (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005), although higher rates of reoffending are likely to be observed over longer follow-up periods (i.e., 24% over 15 years – see Harris & Hanson, 2004).

However, considerable debate continues in the scientific literature and popular media as to what are the true rates of reoffending in sexual offenders. There are several issues complicating the process of arriving at a reasonable estimate: (a) Due to under-reporting by victims of sexual offenses, underestimation is a continuing problem; (b) Not all groups of offenders reoffend at the same rate; and (c) The length of follow-up reported in recidivism studies can be misleading. On the last point, many believe that longer-term follow-up studies are preferable; however, there are limitations inherent even in studies with long periods of follow-up. Essentially, a study with a 15-year follow-up is a commentary on the effectiveness of interventions offered 15 years ago. Given that coordinated methods of sexual offender treatment and risk management are relatively recent (i.e., less than 30 years) and the importance of recent changes in these methods (e.g., migration from relapse prevention methods to self-regulation and Good Lives approaches), it may be more reasonable to consider shorter-term reviews of better practices.

Notwithstanding arguments for or against long-term follow-up studies, it is clear that there is a group of sexual offenders who pose a higher than average risk to reoffend. In keeping with the aforementioned Risk principle, more highly restrictive measures – like long-term or lifetime supervision or SOCC (offender civil commitment) – might be better and more appropriately applied to this group than to apply these measures *carte blanche* across the board to all sexual offenders. For instance, a group of “almost SVPs” identified by Milloy (2003) appears to be comprised of released offenders in need of more intensive supervision, given the strong potential for higher rates of recidivism in comparison to other groups of sexual offenders. For offenders at this level of risk, it would be better to employ less restrictive, step-down, graduated intensity release program options upon their re-entering the community (see Jackson, Travia, & Schneider, 2010). These options include halfway houses or other similar residential options, with almost three-quarters of such programs offering at least some state-based funding to support offender reintegration into the community.

Regardless, despite the existence of programs able to provide graduated intensity, organized community follow-up options, the majority of civil committees (and other detained sexual offenders, for that matter) are held in civil commitment for lengthy periods. This is often because the courts have difficulty ascertaining which offenders are most likely to reoffend. Anecdotal reports from professionals working in SOCC centers indicate the presence of higher than usual levels of apathy, hopelessness, and other treatment interfering factors in SOCC center residents (see also Levenson & Prescott, 2009). Additionally, there are concerns as to what options will be available for post-release aftercare for this higher risk/need group. These unresolved issues contribute to low rates of release, which makes completion of follow-up studies of this population difficult or impossible. One potential solution to this problem is to investigate whether a group of sufficiently high-risk sexual offenders (analogous to typically civilly committed sexual offenders) can be identified in a jurisdiction where no commitment laws have been enacted and where offenders are therefore routinely released to the community (see Wilson et al., 2012). Comparisons of these groups would provide insight as to the criminal trajectories of such groups post-release. Long-term follow up data on such a population would also provide helpful clarification as to whether such groups are actually “more likely than not” to reoffend sexually if released to the community. Additionally, information could be extrapolated regarding the potential mediating effect of successful completion of treatment and/or provision of coordinated post-release follow-up treatment and supervision.

### Innovative Models for Community Reintegration of Offenders

Although specifics regarding etiology are scarce, sexual offending as a behavioral condition likely results from a complex interaction of offender specific and environmental factors. Management

of this condition requires competent assessment, effective treatment, and subsequent monitoring (clinical and case management), perhaps, for long periods depending on the individual presentations of the offenders in question. Although offenders are certainly known to engage in further problematic behavior while in institutional settings (e.g., prison, hospital, civil detention), the community is where the rubber hits the road when it comes to risk management.

In many respects, when an offender returns to the community, an “us vs. them” scenario is often played out, in that the offender may be seen as being on one side of the coin while the remainder of the key stakeholder groups (e.g., victims, law enforcement, correctional and mental health personnel, the media, etc.) are on the other. Indeed, many of the measures enacted to control offender behavior once released are often aimed at separating these two sides. However, some (see Levenson & D’Amora, 2007; Huebner et al., 2013) have questioned whether mandating this separation is actually good for risk management.

Among the more popular measures of official control instituted by various levels of government are sexual offender registration and notification, residency restrictions, electronic and GPS monitoring, long-term (or lifetime) supervision orders, and sexual offender civil commitment (SOCC). The risk management literature contains various entries that either support or oppose such measures, dependent on the writers’ perspectives. However, for our part, we believe that each of these approaches has the potential to help manage the risk of certain offenders while likely being ineffective or potentially damaging to the risk management of others. The key, from our perspective, is staying true to RNR precepts and ensuring the individualization of cases based upon offender presenting problems. Clearly, there are some offenders for whom special attention is warranted and we would be wise to use stringent measures to maintain community safety – consistent with both the risk and need principles of RNR. However, all too often official control measures are applied to *all* identified sexual offenders without consideration of whether or not they are actually indicated. Such practices limit the efficacy of the measures in question in three main ways:

1. Because the distribution of sexual offender risk potential is positively skewed, many more lower risk offenders will be targeted than those who are truly at high risk.
2. Due to the reality of limited resources, community risk management personnel will be unable to appropriately supervise the high-risk offenders because they are spending too much time in over-supervising lower risk offenders.
3. Public education efforts may be compromised because the message given is one indicating that all sexual offenders are at the same level of risk and that these time-consuming and, sometimes, costly measures must be applied to everyone.

Let us use sexual offender registration (SOR) as a case in point: Generally speaking, SOR is intended to establish a list of all the sexual offenders in a given jurisdiction (state, province, country, etc.).

Community safety is theoretically increased because there is a “narrowing of the field” for law enforcement and other officials as they attempt to manage risk to the community. The rationale is that sexual offenders are “predatory prowlers” who are always at risk to commit another offense, and that reoffense rates are high – leading to the perspective that we need to know where offenders are at all times to reduce the likelihood that they will engage in further abuse of vulnerable citizens. This rationale exacerbates the issues we identified in the preceding paragraph. Specifically, we know that, as a group, sexual offenders demonstrate significant heterogeneity, including the degree to which static markers indicate heightened risk and/or the extent of lifestyle instability for each individual (i.e., dynamic factors) (Hanson et al., 2007) – meaning that not all sexual offenders are the same and approaches will need to be individualized to achieve greatest effect.

Current meta-analytic reviews suggest the average sexual reoffense rate for all known sexual offenders, post-criminal sanction, is approximately 13 to 15% over a follow-up period of approximately 5-6 years (see Hanson & Morton-Bourgon, 2005). However, it is also clear that when we subdivide the whole population of known sexual abusers according to risk levels and other grouping variables (e.g., sexual deviance, personality disorders, offense type; see Hanson et al., 2007; Helmus, 2009; Mann et al., 2010; Thornton, Hanson, & Helmus, 2009), rates of reoffending vary. Of greatest concern to the community should be those sexual abusers judged to be at highest risk to reoffend, and who also present high levels of criminogenic need (e.g., poor sexual self-management, dysfunctional or unstable lifestyle choices). Additionally, aftercare programs are often few and far between for high risk/need sexual offenders coming to the end of their supervision or conditional release periods. In some cases, the community has had to be creative in its attempts to manage risk in its midst (Silverman & Wilson, 2002).

### Circles of Support and Accountability

In the summer of 1994, Charlie Taylor – a repeat child molester with a long history of offending and a dire risk profile according to actuarial measures – was released at the end of his sentence (known as Warrant Expiry Date, or WED, in Canada and equivalent to the US phenomenon of “max-ing out”), to the city of Hamilton, a short distance southwest of Toronto, Ontario. Charlie was ineligible for the sorts of services typically offered to offenders under supervision. In desperation, Charlie’s institutional psychologist reached out to members of the Welcome Inn, an inner-city church with whom Charlie previously had contact.

Charlie’s process of re-entry was made all the more difficult by a media blitz notifying Hamiltonians that Charlie was in their midst, resulting in picketing of the Welcome Inn and expensive, around the clock police surveillance of Charlie. As well, many agencies well known for their work with released offenders declined to be involved with Charlie, given the negative attention he was attracting. This very first Circle of Support and Accountability

worked to establish some measure of stability for Charlie. Days went into weeks and then months, all without any renewed offending. The police eventually withdrew their surveillance after having spent many tens of thousands of dollars on overtime. The media attention also died down; the truth being that Charlie and his re-entry ceased to be newsworthy.

Based on these *ad hoc* methods employed in Hamilton several months earlier, another group of faith-based community members decided to apply the same approach with a similar high-risk offender, named Wray, who was released to Peterborough, Ontario. As this group began to offer its support, they encountered similar pushback and hostility from their community, through the media. The pressure became so intense, Wray was forced ultimately to flee Peterborough, and take up residence in the larger metropolis of Toronto. Again, the community reacted with hostility. However, like Charlie, with time, support and guidance from this second group of concerned citizens, the fear and hostility that surrounded also cooled and calmed. On the strength of these experiences, the Mennonite Central Committee of Ontario (MCCO) agreed to steward a pilot project, known as the Community Reintegration Project. Pilot-project funding was provided by the Government of Canada. Nearly 20 years later, the Community Reintegration Project is well known as Circles of Support and Accountability (CoSA).

The CoSA model has grown significantly since the initial circle was formed in Hamilton in 1994. Projects are established throughout Canada and in several American jurisdictions (most pertinently California, Minnesota, and Vermont). In the United Kingdom, *Circles-UK* has been established as a national charity, while projects are established in some European countries (e.g., the Netherlands) and interest continues to grow in other nations (e.g., New Zealand, Latvia, France, and Korea, among others).

In this unique, restorative justice-informed approach, professionally-supported community members volunteer to assist high-risk, high-need sexual offenders as they attempt to integrate with society after release from prison. The CoSA model has provided hope that communities can assist in risk management, the end result being greater safety for potential victims and increased accountability for released offenders. Peer-reviewed evaluative research has shown that involvement in a CoSA can result in statistically significant reductions in sexual recidivism of 70% or more over statistical/actuarial projections (such as the Static-99) or matched comparison subjects (Wilson, McWhinnie, & Wilson, 2008).

As shown in figure 1, the CoSA model consists of two concentric circles of participants. The inner circle is comprised of a released offender (known as a Core Member) and 4-6 community volunteers. These participants meet regularly to discuss risk and reintegration issues presented by the core member. Periodically, issues arise requiring expert assistance (e.g., probation/parole violations, indications of imminent risk to reoffend, mental health

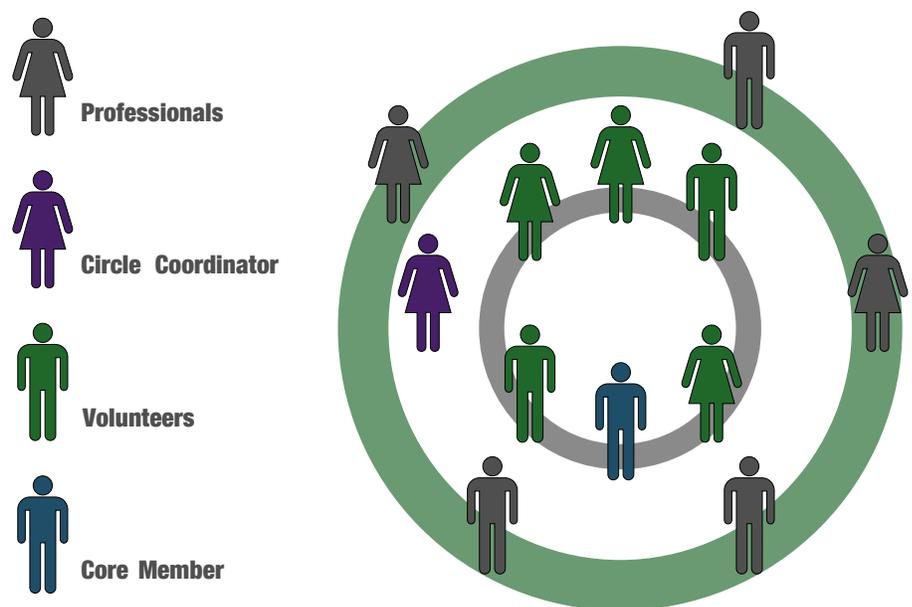


Figure 1. Graphic representation of CoSA model (adapted from Wilson & Picheca [2005], Netherlands Probation Service, 2012).

problems). This is when the outer circle – comprised of psychologists, probation and parole officers, social service workers, law enforcement personnel, etc. – becomes important. Essentially, while the inner circle provides support and accountability for the core member, the outer circle functions in a markedly similar fashion for the inner circle.

### The Efficacy of the CoSA Model

Two Canadian reviews have focused on the relative rates of reoffending between CoSA core members and matched comparison subjects who were released without benefit of a Circle (see Wilson, Picheca, & Prinzo, 2007b; Wilson, Cortoni, & McWhinnie, 2009). In the first study, 60 high risk sexual offenders involved in CoSAs (core members from the original pilot project in South-Central Ontario in Canada) were matched to 60 high risk sexual offenders who were not involved in CoSA (matched comparison subjects), with an average follow-up time of 4.5 years. Subjects were matched according to level of actuarial risk, type of release, date of release to the community, and prior involvement in sexual offender treatment. Results demonstrated a 70% reduction in *sexual* recidivism in the CoSA core members in contrast to the matched comparison group (5% vs. 16.7%), a 57% reduction in *all types of violent* recidivism (including sexual – 15% vs. 35%), and an overall reduction of 35% in *all types of recidivism* (including violent and sexual – 28.3% vs. 43.4%). In those three instances in which a core member committed a new sexual offense, a harm reduction (Marlatt, 1998) effect was observed, in that the new offenses were categorically less severe and invasive than the offenses for which the offenders had previously been convicted. A similar effect was not observed in the matched comparison group.

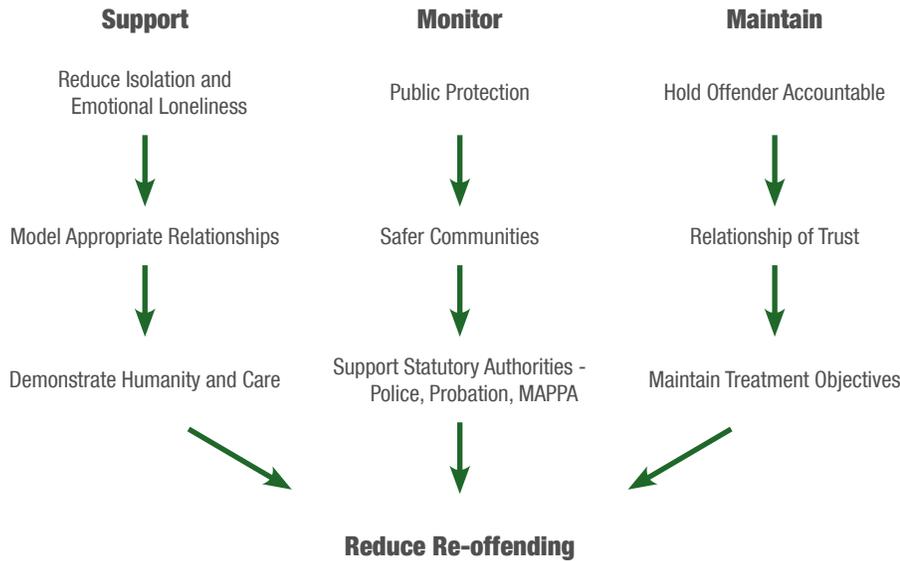
The second Canadian study consisted of a national replication of the Wilson et al. (2007b) pilot proj-

ect. Using the same basic methodology – comparing CoSA core members to matched comparison subjects – participants for this study were drawn from CoSA projects across Canada, but not including members of the pilot project. In total, the post-release behavior of 44 core members was compared to 44 matched comparison subjects, with an average follow-up time of approximately three years. Similar to the first study, dramatic reductions in rates of reoffending were observed. Specifically, there was an 83% reduction in *sexual* recidivism (2.3% vs. 13.7%), a 73% reduction in *all types of violent* recidivism (including sexual – 9.1% vs. 34.1%), and an overall reduction of 70% in *all types of recidivism* (including sexual and violent – 11.4% vs. 38.6%) in comparison to the matched offenders.

Recently, data were published as to the effectiveness of CoSA in international jurisdictions (Bates, Macrae, Wilson, & Wilson, 2013). The UK CoSA model is slightly modified from the Canadian original, in that most core members are still “under license” (British terminology for continuing to be supervised by Probation Services). As such, CoSAs in the UK are more formally situated within the statutory framework of criminal justice (i.e., Multi-Agency Public Protection Arrangements – MAPPA); whereas Canadian CoSAs have tended to focus on core members who are entirely post-sentence. Notwithstanding this difference, the unifying element between Canadian and UK iterations of the model remains with the voluntary sector, rendering the two models more similar than not. Key principles associated with the UK CoSA model are shown in Figure 2.

In a recent study, British CoSA researchers (Bates et al., 2013) followed 71 core members for an average period of 55 months, comparing them to a group of comparison subjects using a matching protocol similar to that used in the Wilson et al. (2007a, 2009a) studies, described above. Although several

## The Three Key Principles



**Figure 2.** The Three Key Principles (Saunders & Wilson, 2002)

core members experienced behavioral difficulties related to sexual offending, resulting in enhancements in their supervision schemes or a return to custody, only three of 71 core members (4.2%) were subsequently charged for sexual or violent re-offending. In contrast, among the members of the comparison group, 12 of 71 offenders (16.9%) were charged with new sexual or violent offenses. Overall, these findings are very much in line with those reported previously in Canada. As occurred in the Canadian studies, the UK project also observed a harm reduction effect – core members who reoffended did so by engaging in noncontact offenses (e.g., pornography or exposing).

At this point, there is a general lack of data regarding the effectiveness of the CoSA model in US jurisdictions. Currently, there are well-established CoSA projects in California, Minnesota, Pennsylvania, and Vermont, with additional projects in the development or early stages in Washington, North Carolina, and Colorado, among other states. Reports from the program based in Fresno, CA indicate no documented cases of sexual reoffending among the 25 CoSAs formed to date. However, there have been technical violations, some of which were related to risk for sexual reoffense. Minnesota has now run more than 30 CoSAs. A recently published evaluation of the effectiveness of the MnCoSA model (Duwe, 2013) employed random assignment of core members and comparison subjects, making it the most methodologically rigorous CoSA evaluation to date. However, due to short periods of follow-up, Duwe was not able to demonstrate differences in rates of sexual reoffending. However, comparative reductions were observed in the CoSA group regarding rearrests, reconvictions, and return to custody for other reasons. Last, the MnCoSA evaluation included a cost-benefit anal-

ysis, indicating an 82% return on investment (i.e., CBA = \$1.82).

### Issues for Further Discussion

The data regarding the potential effectiveness of the CoSA model reported above are certainly encouraging; however, it is important to note that these are but four studies with small sample sizes, short follow-up times, and no random assignment of participants to CoSA or no-CoSA groups outside of the MnCoSA evaluation. The use of a matched comparison design studies improves the strength of the findings but, ultimately, it would be very helpful if additional research meeting high standards of scientific rigor were to be completed. This will require more study in individual projects, such as the 5-year Process and Impact Evaluation of 16 Canadian CoSAs currently underway, sponsored by Public Safety Canada's National Crime Prevention Centre. Researchers from Pennsylvania State University are currently working with the Department of Justice's Office of Sex Offender Monitoring, Apprehending, Sentencing and Tracking (SMART) to develop an evaluation plan for several US CoSA sites in an effort to assess the utility of the CoSA model in US jurisdictions; however, no formal data are available as yet. Nonetheless, findings to date suggest that CoSA is likely to be just as effective in reducing risk in the USA as it has been in Canada and the UK.

Part of the difficulty associated with large-scale research on the CoSA model is attributable to the relatively few US jurisdictions in which the model is used. Implementation of a CoSA project requires a strategic engagement of quality community partners, resulting in both community buy-in (through volunteerism) and support from governmental agencies (e.g., corrections, police, etc.), which is a particularly novel and atypical way of managing

offender risk in the community. Collaboration between groups of stakeholders will require a degree of intention, such as that found in the MAP-PA scheme in the UK, as outlined above. Further, it would be of some benefit to the growth of the model if a process of “seeding” were implemented, in which existing projects could provide guidance and other assistance to jurisdictions interested in establishing their own project. Efforts in this regard are currently underway.

Additional problems in garnering support for re-entry innovations like CoSA come from potential misappraisals of the reasons for currently decreasing rates of reoffending (Finkelhor & Jones, 2006). Some in the United States have suggested that rates of sexual recidivism are low because identified offenders, by virtue of long periods of incarceration, are being removed from the “risk pool,” as it were, during the portion of their lives during which they pose the greatest risk. However, this is unlikely to be the sole reason, as similar trends towards lower recidivism rates have also been observed in countries without such sentencing practices.

In our view, the dramatic differences in rates of reoffending (e.g., between the 1990s and the 2010s) are due to a combination of factors, both technological and philosophical. First, intensified focus on implementing practices according to the RNR principles led to the first actuarial risk assessment instruments (e.g., Static-99R, VRAG, etc.), which started to become available to evaluators in the mid to late 1990s. ARAIs advanced the field immeasurably by providing a reliable and valid means of triaging offenders by risk level, so that attention could be better focused on higher risk offenders. Second, the last 10-15 years has also seen the development of a number of risk assessment tools focused on dynamic predictors (e.g., Stable-2007, SOTIPS, SRA-FV), which are also useful in focusing treatment and intervention strategies on those characterological and lifestyle issues most highly predictive of reintegration problems. Third, the turn of the millennium also saw a rethinking of traditional sexual offender treatment methods. Relapse prevention methods (see Laws, 1989) gave way to self-regulation and pathways approaches (see Yates, Prescott, & Ward, 2010), as well as strength-based models (see Marshall, Marshall, Serran, & O'Brien, 2011). These holistic models of intervention have refined treatment techniques while maintaining appropriate levels of attention on treatment responsiveness. Indeed, of the RNR principles, it would appear that the one most often getting short-shrift is responsibility, which we suggest is an offshoot of society's general distaste for and intolerance of sexual abuse and offenders. Indeed, promoters of CoSA programs around the globe are well familiar with the difficulties associated with finding community members willing to volunteer to spend time guiding and being friendly with a released sexual offender.

### General Comments

There is no doubt that communities continue to experience revulsion around the issues of sexual offending, and considerable fear and unrest about the presence of known sexual offenders in their

midst. Policymakers and legislators have struggled to implement effective measures to manage risk to the public and to address the fears of constituents. However, the current literature is mixed as to the utility of these measures (Levenson & D'Amora, 2007; Huebner et al., 2013), and recent results suggest these initiatives may be having unanticipated negative effects on offender stability, which in turn compromises safety by increasing risk of further victimization. Indeed, there is a considerable disconnect between empiricism and policymaking; however, regardless of this reality, it is unlikely that strict measures enacted to manage risk will be repealed simply because scientists say they do not work. Concerned professionals need to work collaboratively with policymakers to develop innovative approaches that make the best use of our increasing knowledge, while accounting for limited resources as we strive to ensure the highest degree of public safety.

An additional problem potentially confounding our efforts at risk management and reduction is the general tendency for practices to be uniformly applied to all sexual offenders, regardless of levels of risk and criminogenic need. The literature regarding sexual offenders is clear in showing that this population is heterogeneous as to the level of risk posed to the community, their needs, or the degree to which they require rehabilitative programming (Helmus, 2009). This suggests that supervision models and treatment programming must be designed in appreciation of and adherence to the tenets of the RNR model (Wilson & Yates, 2009). Further complicating the matter is that groups of offenders with similar actuarially determined risk levels are also heterogeneous (i.e., not all persons who achieve the same score on the Static-99R will present their "risk" in necessarily the same way, or have the same criminogenic needs (see Thornton et al., 2009), suggesting that the risk appraisal process is more complicated than our current technologies can accommodate. Future research will need to focus on the development of reliable and valid methods for comparing offenders to appropriate comparison groups.

In and of itself, each risk management measure enacted is likely to have a beneficial effect for some offenders. However, in order to maximize the value-added of these measures, it is important that they be differentially applied to those offenders who require them most (in keeping with both the Risk and Need principles). Wholesale application of a measure to all offenders likely "washes out" the particular benefit that might be observed in those offenders to whom the measure most apply. As such, it is advisable that the application of risk management measures be individualized according to the degree of risk a particular offender poses. Although this may be initially more time consuming for case managers who will need to collate risk and need data, there will ultimately be savings in regard to staff resources, as case managers will be able to direct more intensive supervision and services to those offenders at higher levels of risk and need.

It is also likely that the citizens of any jurisdiction will benefit from greater understanding of the dy-

namics of sexual offending in their communities, and of the processes involved in sexual offender risk management. Nevertheless, legislators and sexual offender specialists alike have done a generally poor job in meeting those needs. Future efforts in this vein will need to better educate members of the community as to what it means to have released sexual offenders in their midst, as well as what they can do to personally influence the risk management process. Although Circles of Support and Accountability provide one method for greater community participation in risk management, it is nonetheless unlikely that this will fully meet the public's needs in this regard. More, and better quality research, in addition to an evaluation of current practices, is required in order for us to know how best to meet the dual and inseparable goals of increased public safety and effective community reintegration for offenders. The cost-benefit analyses (e.g., Aos et al., 2006; Correctional Service of Canada, 2009; Duwe, 2013; Elliott & Beech, 2013) reported in this article are clear that, although evidence-based initiatives also promote fiscal responsibility, it is also a sad truth that some of the long-term risk management measures currently employed are neither cost effective nor would they withstand scientific scrutiny (at least in their current form).

In this article, we have noted that prolonged incarceration or increasingly punitive sanctions are unlikely to reduce reoffending, unless they are paired with human service programming attending to the principles of Risk, Need, and Responsivity. However, the public has little tolerance for the potential danger posed by offenders judged to be at higher risk, but, although public fear often leads to legislative action, there is an apparent disconnect between research and practice in terms of choosing measures that are likely to be effective (Levenson & D'Amora, 2007). This suggests that researchers need to be more proactive in making sure legislators are aware of and have at their disposal good research upon which to base their decision-making practices. Further, legislators will need to rise above political rhetoric in being diligent when considering research findings before enacting policy and law. In this regard, sentencing and parole decisions would be well advised to consider RNR principles. For example, the risk and need principles assert that more stringent risk management practices like community notification, electronic monitoring, or long/lifetime supervision should be applied only to those offenders presenting the greatest risk to reoffend and demonstrating the highest degrees of lifestyle instability.

It also appears that greater participation of and understanding by community members, including citizen legislators, both in recognizing the realities of sexual offending in their community and in the risk management processes, would lead to a fuller understanding of the issues faced by offenders returning to the community (Silverman & Wilson, 2002; Wilson, Picheca, & Prinzo, 2005). This should then influence legislative reform regarding long-term sexual offender management strategies and policies that are commensurate with risk and appropriately respond to identified criminogenic needs. Notwithstanding the emotional responses

typically evoked when discussing issues of sexual abuse (e.g., fear, rage, disgust, hatred), the simple truth is that most sexual offenders will at some point return to the community. As noted above, the literature regarding the effectiveness of various methods of official control (e.g., sexual offender registration, community notification, residency restrictions) does not support the perspective that these sorts of measures alone will sufficiently address sexual offender re-entry concerns (see Huebner et al., 2013). Indeed, it would appear that some of these measures might actually increase risk to the community by making it quite difficult for some offenders to establish stability (see Huebner et al., 2013; Willis & Grace, 2008, 2009).

If the laws we enact to increase community safety do not appear to be accomplishing their appointed tasks, what are we to do to ensure that vulnerable persons are safe and that offenders are able to establish themselves as law-abiding citizens? We have suggested herein that coordinated and collaborative approaches to re-entry, in which all stakeholder groups are represented (especially including the community-at-large) and considered, are most likely to achieve our shared goal of no more victims. Our perspective emphasizes the idea of ensuring community involvement in the process of community re-entry and risk management.

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## What were we thinking? Five erroneous assumptions that have fueled specialized interventions for adolescents who have sexually offended

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### Abstract

Since the early 1980s, five assumptions have influenced the assessment, treatment, and community supervision of adolescents who have offended sexually. In particular, interventions with this population have been informed by the assumptions that these youth are (i) deviant, (ii) delinquent, (iii) disordered, (iv) deficit-ridden, and (v) deceitful. There is very little research to support these beliefs, however, and some researchers and clinicians have long pointed out that adolescents who commit sexual crimes are heterogeneous and that there is no typical profile. Indeed, many adolescents who commit sexual crimes display healthy sexual interests, are prosocial in their orientation, are not psychiatrically disordered, can be described by many strengths and protective factors, and are open regarding past sexual crimes and their sexual interests. If the goal of intervention is to help adolescents to prevent future offenses, then it is essential for all involved in their care to be more critical of these erroneous assumptions that have influenced the field for the past several decades.

### Keywords

Adolescent sexual offending, sexually abusive behavior, , sexual offense assessment and treatment, juveniles who sexually offend

*Since the offending act is an exercise in power and control perpetrated by an anti-social, conduct-disordered, manipulative, deviant person, descriptors of the treatment of choice include confrontation, insistence on accountability for the offending behavior, a punitive rather than therapeutic orientation, and a focus on self-disclosure and the acquisition of strategies to prevent relapse" (Goocher, 1994, p. 244)*

With a description of treatment such as the one provided above by Goocher (1994), it would not be surprising to learn that, in some jurisdictions, adolescents who have committed sexual crimes have routinely been removed from their homes – regardless of the nature of their crimes – subjected to polygraph and penile plethysmograph (PPG) examinations, aggressively and repeatedly confronted regarding the details of their past sexual crimes, and asked to engage in punishment-based behavioral procedures – designed for adults – that are intended to alter their presumed deviant sexual arousal. In some parts of the world, such as the U.S., adolescents who offend sexually have also been subjected to registration and community notification laws in the hopes of protecting people from being victimized by these youth (Zimring, 2004).

This has not how professionals have always viewed adolescents who have committed sexual crimes, however. Indeed, in some of the earliest academic reports from the 20<sup>th</sup> century, it was pointed out that these youth are in fact heterogeneous with respect to many different variables and that there was no singular treatment goal or approach that would universally apply for youth who have engaged in this behavior (e.g., Atcheson & Williams, 1954; Doshay, 1943; North, 1956; Waggoner & Boyd,

1941). This view seemed to change fairly quickly in the early 1980s, however, when it was more widely recognized that many adults who offended sexually began offending sexually as adolescents (e.g. Abel, Mittelman, & Becker, 1985; Longo & Groth, 1983). Given that there were already well-established assessment and treatment procedures developed for adults who offended sexually, many of the early treatment programs for adolescents mimicked adult programs – with a particular focus on the assessment and punishment of deviant sexual arousal and confrontational approaches to extract details of past sexual offenses (Knopp, 1982). This blind application of the adult-based assessment and treatment approaches of the day was likely attributable to the fact that the sexual crimes committed by adolescents looked behaviorally similar in nature to the sexual crimes committed by adults, despite the fact that there are rather obvious and critical developmental differences regarding not only sexual functioning (e.g., Bancroft, 2006; Bukowski, Sippola, & Brender, 1993) but, more importantly, the cognitive process that impact social and emotional functioning (Steinberg, 2010).

It is argued herein that, since the early 1980s, five assumptions have fueled the assessment, treatment, and management of adolescents who have offended sexually. These assumptions are referred to herein as the “5 Ds”: (1) deviant, (2) delinquent, (3) disordered, (4) deficit-ridden, and (5) deceitful. Although there have been some shifts in thinking over the past three decades, and there are many locations in the world where youth who have offended sexually are not subjected to polygraphs and PPGs, placed on public registries, or asked to partake in untested, punishment-based procedures to alter

sexual interests, these beliefs unfortunately continue to inform clinical practices and laws in many jurisdictions. This is particularly unsettling, however, given that there is very little empirical support for these assumptions.

### ■ They Are All Sexually Deviant, Aren't They?

Perhaps the assumption that has had the most influence on the assessment and treatment of adolescents who offend sexually is the notion that they can all be characterized by deviant sexual interests: i.e., sexual interests in prepubescent children and/or sexual violence. A brief perusal of treatment manuals, textbooks, and journal articles written in the 1980s and 1990s would certainly lead one to believe that all adolescents who have offended sexually are sexually deviant. For example, Perry and Orchard (1992) stated that a goal for all adolescents who offend sexually is to “learn more appropriate sexual preferences” (p. 64). Lahey (1994) explained that “other important treatment issues involve changing deviant sexual fantasies and masturbatory practices” (p. 758). Similarly, in their description of treatment, Hunter and Santos (1990) concluded that “insight-oriented approaches for the treatment of these youth are of limited value... key components include the reduction of deviant arousal via satiation therapy and the use of covert sensitization” (p. 240).

Furthermore, in the 1993 National Task Force Report from the National Adolescent Perpetrator Network (National Task Force on Juvenile Sexual Offending), it was pointed out that every sexually abusive youth should understand the role of sexual arousal in their sexual offending and should reduce their deviant sexual arousal. The American Academy of Child and Adolescent Psychiatry (Shaw, 1999) also argued that decreasing deviant sexual arousal is an integral component of treatment for all youth who have offended sexually. It should not be surprising, therefore, that most specialized treatment programs for adolescents in the UK and the Republic of Ireland (Hackett, Masson, & Phillips, 2006), and in Canada and the U.S. (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010), address deviant sexual interests in some fashion.

It should be stressed, however, that there is very little evidence to support the assumption that most adolescents who offend sexually actually have deviant sexual interests. Looking at research where investigators have used the penile plethysmograph (PPG), a tool developed to assess adult male sexual interests (Freund, 1991), Seto, Lalumière, and Blanchard (2000) reported that only 25% of the adolescent males in their investigation demonstrated maximal sexual interest in prepubescent children. With an overlapping and augmented sample, Seto, Murphy, Page, and Ennis (2003) noted that just 30% of adolescent males who had offended sexually responded equally or more to child stimuli during PPG assessments.

In two investigations using clinician ratings, it was also found that a minority of adolescent males who offended sexually could be described as evidencing deviant sexual interests. In the first study (Worling, 2004), structured ratings from several clinicians who used the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR; Worling & Curwen, 2001) were examined, and it was found that only 36% of the participants were rated as having sexual interests in prepubescent children and/or sexual violence. A majority of the adolescents in that investigation were residents in a residential treatment center in the Northern U.S. designed to address the needs of high-risk youth. More recently, in a prospective validation study of the ERASOR (Worling, Bookalam, & Littelljohn, 2012) it was found that only 39% of adolescent males who had offended sexually were rated by a number of different clinicians as demonstrating sexual interest in prepubescent children and/or sexual violence.

There was one investigation in which the authors concluded that 60% of the adolescents studied had deviant sexual fantasies at the outset of the study and that this somehow increased to 90% after 3 months in treatment (Aylwin, Reddon, & Burke, 2005). It is critical to point out, however, that the authors considered it *deviant* if adolescents were fantasizing about the staff in the residence – regardless of the age of the staff and the nature of the sexual fantasy. As such, it is unclear what proportion of self-reported fantasies in that investigation actually involved prepubescent children or sexual violence.

Overall, therefore, the available research indicates that, depending on the sample studied, approximately 60-75% of adolescent males who have offended sexually are, in fact, maximally sexually interested in consensual activities with age-appropriate partners. Although deviant sexual arousal likely plays a role in the etiology and/or maintenance of adolescent sexual offending for *some* adolescents, there are obviously other factors to consider such as intimacy deficits, antisociality, and access and opportunity, for example. This is not to minimize the role of deviant sexual interests altogether, as it is clear that some adolescents who have offended sexually are clearly sexually interested in prepubescent children and/or sexual violence, and there is evidence to suggest that deviant sexual interest is a risk factor for adolescent sexual recidivism (Worling & Långström, 2006).

In their meta-analysis, Seto and Lalumière (2010) found that, relative to adolescents who committed nonsexual crimes, adolescents who offended sexually were more likely to be characterized by “atypical sexual interests.” It is important to point out, however, that there was significant heterogeneity in effect sizes in their analysis and that this factor was made up of several diverse variables, including prior sexually abusive behaviors, sexual preoccupation, and cross-dressing, for example. Furthermore, although the moderate effect size informs us

that adolescents who offend sexually are more likely to have “atypical sexual interests” relative to adolescents who offend nonsexually, it does not give us any indication of the absolute level of “atypical sexual interest” in either group.

### Do All Sexually Abusive Youth Demonstrate Deviant Interests?

During the second year of my career in this field, in the late 1980s, I had the good fortune to learn some valuable lessons from an adolescent client. In particular, I was working with an adolescent who had sexually abused two younger female siblings. After a number of months during which we had worked on goals such as awareness of the impact of sexual offending, repairing the sibling relationships, increasing his sense of responsibility/accountability, enhancing his interpersonal intimacy with peers, enhancing his relationship with his mother (his father was not involved in his life), and reducing the impact of his early childhood trauma, I unfortunately assumed that I should perhaps address his presumed deviant interest in children. I taught him the finer points of covert sensitization, as outlined in various contemporary texts (e.g., Carey & McGrath, 1989; Maletzky, 1991), and the youth managed to produce an audiorecording of a single session for our next meeting. In particular, his recording included a 3 minute sexual offense script, a 3 minute punishment script, and then a 3 minute reward/relaxation script. While listening to the audio recording, not only was I suddenly horrified to think that I had actually asked this 16-year-old to make a recording of his deviant sexual thoughts, but I started to wonder about potential problems related to privacy and security of the recording. I also wondered about the fact that this homework assignment could perhaps unwittingly reinforce deviant fantasies. Fortunately for both of us, I also noticed that the youth's recorded voice sounded quite inauthentic during the first few minutes. When I asked him about this during our next meeting, he informed me that he was actually inventing a sexual fantasy regarding a young child, as he has never been sexually aroused by young children. He added that he felt that we had a good working relationship, and he was afraid that I would terminate his therapy if he did not make up a deviant sexual interest in prepubescent children and told me that he actually never had such an interest.

I was very fortunate that this adolescent taught me three important lessons early on in my career: (a) the therapeutic alliance is incredibly important, (b) not all adolescents who have offended against young children are sexually aroused by young children, and (c) treatment techniques designed for adults have the potential for iatrogenic harm when applied to adolescents. I was also fortunate that the program that I have worked at for the past 25 years started out as a treatment program for adolescent survivors of sexual abuse – not as a treatment program for adult males who offended sexually.

As such, most of the assessment and treatment approaches that were utilized there – even in the 1980s and 1990s – were sensitive both to adolescent development and trauma.

### The Treatment of Adolescent Sexual “Deviancy”

In my recent review of the literature (Worling, 2012), I pointed out that punishment-based approaches are the most common treatment described in the literature for addressing deviant sexual arousal. The majority of these behavioral treatments were actually developed for use with adult males, and there are many questions regarding their use with adolescents. Take masturbatory satiation (Marshall, 1979), for example. With this procedure, an adult client is instructed first to masturbate to a nondeviant sexual fantasy. He or she is then instructed to immediately attempt to masturbate to one of his or her deviant sexual fantasies. The assumption underlying this approach is that the masturbatory behavior immediately following climax is going to be unpleasant and, as such, the individual will gradually associate his or her deviant sexual fantasy with a significantly diminished drive state (Maletzky, 1991). Given that the refractory period for adolescent males can be extremely short (Bancroft, 2009), it is possible that this procedure could actually serve to *strengthen* an adolescent's deviant fantasies. It is also crucial to point out that there are no controlled investigations of the effectiveness of this treatment for youth aged 12 to 18.

Another treatment approach designed to extinguish deviant sexual arousal among adult males is aversive behavioral rehearsal (Wickramasekera, 1976). This technique has also been called “shame aversion therapy” (Serber, 1970), and clients engaged in this treatment are taught to pair their deviant sexual fantasies with intense shame and/or anxiety. Presently, approximately 15% of treatment programs in the USA for adolescents who have offended sexually employ this technique (McGrath et al., 2010). Not only is there is no empirical support for this technique with adolescents, but there is a general consensus amongst professionals that shame actually *inhibits* treatment effectiveness for individuals who have offended sexually by increasing defensiveness and social withdrawal (e.g., Association for the Treatment of Sexual Abusers, 2001; Bumby, Marshall, & Langton, 1999; Jenkins, 2005; Proeve & Howells, 2002; Ward, Day, Howells, & Birgden, 2004; Worling, Josefowitz, & Maltar, 2011). Other punishment-based techniques designed for adult males who have offended sexually, such as covert sensitization (Cautela, 1967), minimal arousal conditioning (Jensen, 1994), and olfactory aversion (Colson, 1972), are also still utilized with adolescents to reduce their deviant sexual arousal (McGrath et al., 2010), despite the fact that there are no controlled investigations of their efficacy with this age group – or of their potential for iatrogenic harm.

In addition to techniques designed to punish deviant sexual interests, there are also some behavioral procedures that have been developed to enhance nondeviant sexual interests. Procedures such as orgasmic conditioning (Maletzky, 1991) or orgasmic reconditioning (Marquis, 1970), for example, require the individual to masturbate to nondeviant fantasies and/or imagery. As in the case of punishment-based procedures, however, there have been no controlled investigations of the positive (or negative) impact of these approaches with adolescents, despite the fact that some programs continue to utilize them (McGrath et al., 2010).

Of course, there are also a number of ethical concerns regarding the use of any behavioral techniques with adolescents to alter sexual interests. For example, is it ever appropriate to use masturbation in treatment for adolescents who have offended sexually? How can treatment materials and homework tasks be safeguarded during treatment? How can a therapist ensure compliance when a client is utilizing masturbatory procedures? At what age can a youth truly consent to these procedures? Given that adolescents are still developing and refining their sexual interest and identities (Bancroft, 2006), how can one safeguard against potential iatrogenic harm? What about the possibility that we might inadvertently be encouraging an adolescent to create and reinforce deviant sexual scripts?

Another popular approach in the treatment of deviant sexual is thought stopping, or urge suppression (e.g., Hunter, 2011; Kahn & Lafond, 1988). With this technique, the adolescent is taught procedures to push a deviant sexual thought out of conscious awareness by thinking of an aversive experience or by picturing a distractor such as a stop sign, for example. In their reviews of the literature regarding the effectiveness of thought stopping, Johnston, Ward, and Hudson (1997) and Shingler (2009) pointed out that there is often an ironic rebound effect such that thoughts that are consciously suppressed in psychological treatment approaches actually tend to intrude more frequently, and more intensely, than had the thought-suppression intervention not been used in the first place.

An alternative to teaching adolescents strategies to suppress deviant sexual thoughts and urges is to teach clients mindfulness-based approaches where they can learn simply to notice the thoughts and to let the thoughts pass without acting on them. Some may believe that this is a novel application of mindfulness-based cognitive therapy; however, this treatment approach was actually a component of some of the earliest specialized treatment programs (e.g., Steen & Monnette, 1989). Although there has not yet been any research regarding the effectiveness of this approach with adolescents who have offended sexually, there have been supporting findings using mindfulness-based cognitive therapy with adolescents to cope with stress (e.g., Biegel, Brown, Shapiro & Schubert, 2009) and impulsivity (e.g., Semple, Lee, Rosa, & Miller, 2010). Singh et

al. (2011) recently employed a multiple-baseline investigation with a small sample of adult males with an intellectual disability who had offended sexually against children, and they demonstrated that mindfulness-based approaches impacted significantly on deviant sexual arousal. Given that mindfulness-based approaches do not involve punishment, masturbation, or shame, and that there is no evidence to suggest that they would result in a rebound effect, they are likely to be more readily embraced by both clients and therapists relative to punishment and thought-stopping procedures, and particularly if they can be supported with empirical evidence.

Medication is also used by a number of treatment programs to reduce deviant sexual arousal for adolescents (McGrath et al., 2010); however, there has yet to be a double-blind trial of any medication for this purpose. In their review, Bradford and Federoff (2006) stressed that there may be undesirable side effects if adolescents are prescribed medications that have been used to control sexual behaviors in adults. They also pointed out that most regulatory bodies do not currently recognize the use of medication to reduce deviant sexual interests.

#### **Alternative Approaches to Treating Deviant Sexual Interests in Adolescents**

Given that (a) most adolescents who have offended sexually do not evidence deviant sexual interests, (b) there is no clear empirical support regarding treatment techniques aimed at reducing deviant sexual arousal for adolescents, and (c) there are significant ethical concerns regarding the use of thought-stopping procedures and behavioral approaches to shape sexual interests, an alternative approach to address deviant interests, if present, is to build skills for sexual health (Worling, 2012). In other words, given the relative plasticity of sexual arousal patterns during adolescence (Bancroft, 2006), there is a very real possibility that nondeviant sexual interests can be strengthened if adolescent clients see the possibility of forming emotionally and sexually intimate relationships in their future. Some of the elements that are necessary to achieve this goal include prosocial sexual attitudes, positive knowledge regarding human sexuality, self-regulation and decision-making skills, increased self-efficacy, and hope in a healthy future. It should be stressed that many of these elements have long been addressed in specialized treatment for adolescents who have offended sexually (e.g., Steen & Monnette, 1989). Some adolescents who display deviant sexual interests may also have significant barriers to achieving interpersonal intimacy, such as social anxiety, or dysfunctional beliefs regarding interpersonal relationships. In addition to skill building, therefore, it is also important to reduce barriers such as these.

In answer to our first question, then, it should be clear that adolescents who have offended sexually are not all sexually deviant. Indeed, from the extant

research, it would appear that most of these youth are most sexually interested in consenting activities with age-appropriate partners. Naturally, some adolescents will evidence deviant sexual interests, and this is a risk factor for continued sexual offending. Despite the fact that many treatment programs utilize behavioral techniques to alter sexual interests, there is no evidence that they are actually effective with adolescents. More importantly, there is a danger that these techniques could be harmful. For an adolescent who demonstrates sexual interest in young children and/or in sexual violence, it may be best to use mindfulness-based approaches while simultaneously building the skills necessary for a healthy sexual future.

#### **■ They Are All Just Delinquent, Aren't They?**

Is it not the case that adolescents who have offended sexually have broken the law and, therefore, that they should simply be viewed as delinquent or antisocial youth? Is there really a need for specialized assessment and treatment approaches? Do we not need simply to apply generic tools and approaches designed for antisocial youth? There are some (e.g., Letourneau & Miner, 2005; Milloy, 1998; Zimring, 2004) who argue that there is little that is unique to adolescents who have offended sexually and, thus, they question the wisdom of tailoring assessment or treatment specifically for youth who have committed sexual crimes. In support of this argument, it is often pointed out that there is research to suggest that there are few, if any, differences between youth who offend sexually and youth who offend nonsexually (e.g., Caldwell, Ziemke, & Vitacco, 2008). For example, Lewis, Shankok, and Pincus (1979) reported no significant differences on a host of variables and test scores when they compared a sample of 17 adolescents who had offended sexually with 61 adolescents who had offended violently. Similarly, McCraw and Pegg-McNab (1989) found no differences in personality scores when they compared 45 adolescents who offended sexually to 45 adolescents with nonsexual charges. Recidivism statistics (e.g., Caldwell, 2007) have also been used to point out that, when adolescents who have offended sexually are charged with new crimes following treatment, they are more often charged with nonsexual crimes. It is essential, however, to be mindful of the fact that most survivors of a sexual crime never report their victimization to authorities (e.g., Brennan & Taylor-Butts, 2008).

In an effort to determine if there is anything that differentiates adolescents who commit sexual crimes from those who commit nonsexual crimes, Seto and Lalumière (2010) conducted a meta-analysis with studies where investigators compared youth with sexual offenses to youth with nonsexual offenses. In support of the argument that adolescents who offend sexually are not particularly unique, there were certainly a number of variables where there were no significant differences be-

tween groups, such as antisocial attitudes, family relationship problems, heterosocial skills deficits, general psychopathology, and nonabusive sexual experiences. These findings would support the generalist argument that adolescent sexual offending is simply a product of some underlying antisocial process. However, Seto and Lalumière also found many important differences between the groups. For example, youth who offended sexually were significantly more likely than youth who offended nonsexually to be characterized by atypical sexual interests, socially isolation, increased exposure to sexual media, a lower self-esteem, elevated anxiety, and a history of sexual, physical, and emotional abuse. Furthermore, those youth with nonsexual offenses were more likely than those who offended sexually to associate with delinquent peers, use illegal drugs/alcohol, and have a more extensive criminal history. These aggregate findings certainly support the argument that adolescents who have sexually offended are significantly different from those who offend nonsexually on a number of important dimensions.

Of course, it is not argued here that all adolescents who offend sexually share the characteristics outlined by Seto and Lalumière in their meta-analysis. Some adolescents who offend sexually will share many markers of general delinquency, such as antisocial attitudes, diverse criminal history, substance use, academic underachievement, poor self-regulation, etc. However, there are many other adolescents who have offended sexually who show very few markers of antisociality – aside from their sexual offending behaviors. Indeed, researchers have found that there are distinct subgroups of adolescents who offend sexually where antisociality is one of the key variables that differentiates the groups (Smith, Monastersky, & Deisher, 1987; Richardson, Kelly, Graham, & Bhate, 2004; Worling, 2001). In these three investigations, it was found that there was one subgroup where an antisocial orientation was the predominant characteristic; however, there were several other subgroups where antisociality was not prevalent. Indeed, in each of these investigations where subgroups were formed on the basis of personality test data, researchers found that there were subgroups where a prosocial orientation was predominant.

Research regarding risk assessment is also supportive of the notion that there are key characteristics that differentiate adolescents who offend sexually from the more general population of adolescents in conflict with the legal system. Although a number of risk factors for sexual recidivism, such as impulsivity, antisociality, and social isolation, are also found in tools designed to predict general, adolescent criminal recidivism (e.g., Hoge & Andrews, 2011), there are several risk factors unique to continued sexual offending, such as deviant sexual interests, deviant sexual attitudes, and sexual preoccupation, for example (Worling & Långström, 2006). There have been a number of risk

assessment tools developed specifically to address the risk of sexual recidivism for adolescents, such as the ERASOR (Worling & Curwen, 2001), the Juvenile Sex Offender Assessment Protocol (J-SOAP-II; Prentky & Righthand, 2003), the Juvenile Risk Assessment Tool (J-RAT; Rich, 2007), and the Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (JSORRAT-II; Epperson, Ralston, Fowers, DeWitt, & Gore, 2006). It has been found that measures designed specifically to predict adolescent sexual recidivism perform better relative to more generic measures of criminal and/or violent behavior in youth (Viljoen, Mordell, & Beneteau, 2012).

It is not being argued here that adolescents who sexually offend are prosocial save their sexual crimes. Rather, there are simply no data to support the assumption that they are all antisocial, or even that most of them can be described as characteristically delinquent. As in the case of deviant sexual interests discussed above, it is important for those working with adolescents who have sexually offended to determine whether or not an antisocial orientation is present in each case. If an adolescent who has offended sexually does have many markers of delinquency (e.g., affiliation with delinquent peers, substance use, procriminal attitudes), then treatment and management efforts should obviously be aimed at addressing these issues. Otherwise, this would not be necessary, and there could possibly be iatrogenic harm if prosocial youth are required to participate in interventions designed to target criminogenic factors for antisocial youth.

### ■ They Are All Psychiatrically Disordered, Aren't They?

It must be a natural assumption for the layperson that a teenager who has committed a sexual crime must have a psychiatric disorder of some kind, and particularly if the youth has offended sexually against a young child. Why else would he or she have committed such a heinous act? Surely it is not the case that “normal” adolescent males and females would ever commit sexual crimes? There must be some mental disorder that leads a teen to commit a sexual crime.

Becker, Kaplan, Cunningham-Rathner, and Kavoussi (1986) reported on the psychiatric diagnoses given by one practitioner to 19 adolescent males referred to a state psychiatric institute as a result of incest offenses. It was found that 14 of the adolescents had some type of psychiatric diagnosis, with 12 of these youth qualifying for a diagnosis of Conduct Disorder. The next most common diagnosis was Attention Deficit Hyperactivity Disorder (ADHD), and this was identified for five (26%) of the participants. Galli et al. (1999) similarly reported on psychiatric diagnoses given to 22 adolescent males who had offended sexually and who had been recruited from residential treatment programs. As in Becker et al. (1986), Conduct Disorder was diagnosed for most of the participants (16 of 17). However, 100% of the participants in this

investigation were also diagnosed with Pedophilia, and 71% (12/22) were diagnosed with ADHD. This result contrasts sharply with Mazur and Michael (1992) in their follow-up investigation with 10 adolescents who had offended sexually, where they found that none of the participants met diagnostic criteria for a paraphilia. Likewise, in their review of adolescents seen at a psychiatric hospital in Canada, Saunders and Awad (1988) stressed that “the vast majority of adolescent sexual offenders do not fit the criteria of paraphilia” (p. 575).

The prevalence and nature of psychiatric diagnoses for this population appear to vary considerably depending on the sample that is selected and the diagnostic processes that are employed. Furthermore, very few, if any, authors have reported on the reliability/validity of the diagnostic tools that have been utilized, most investigations have relied on a single diagnostician, and samples of adolescents have been very small. It is also unclear in most of this research whether or not diagnosticians have been blind to the criminal status of the youth.

In the meta-analysis completed by Seto and Lalumière (2010), there was little evidence to suggest that adolescents who offend sexually can be described using specific psychiatric diagnoses, relative to other adolescents involved in the criminal justice system. Although the authors of the small studies cited above describe adolescents who offend sexually as highly conduct disordered, there was no evidence to suggest that those who offend sexually are any more antisocial than those adolescents who commit nonsexual crimes. Indeed, as noted above, Seto and Lalumière found that those adolescents who offended *nonsexually* were significantly more likely to have markers of antisociality, such as a more extensive criminal history, associations with delinquent peers, and drug/alcohol use. Furthermore, although adolescents who offended sexually are more likely to exhibit heightened anxiety (not necessarily an anxiety disorder, per se) and low self-esteem, there were no differences between groups with respect to general psychopathology.

Once again, as in the case of both deviant sexual interests and delinquency, there is no empirical support for the notion that adolescents who offend sexually are all psychiatrically disordered. Adolescent sexual offending is a behavior that reflects a choice that the youth has made; it is not a function of a disorder, a disease, a condition, or an illness. Of course, there may well be a psychiatric diagnosis for some youth who have offended sexually, and the ability to accurately describe a mental disorder should lead to more appropriate and effective treatment. For example, given the increased prevalence of sexual, physical, and emotional abuse relative to youth who have offended nonsexually, it would not be surprising to learn that some adolescents who have offended sexually experience Posttraumatic Stress Disorder. Likewise, given that there is a subgroup where a delinquent orientation is predominant, there will be some adolescents who offend

sexually where a diagnosis of Conduct Disorder is clearly evident, and particularly for those youth who end up in correctional settings.

### ■ They Are All Just Deficient-Ridden, Aren't They?

After reading many assessment reports prepared at various agencies throughout North America since the 1980s, one might certainly believe that adolescents who offend sexually can be described only by the long list of deficits that have been catalogued during an assessment. This is, perhaps, a result of a focus on risk, disorder, and deviance that has pervaded this work. Of course, this may also have been the result of the nature of the crime, as it may be particularly difficult for some evaluators to look for strengths and assets in individuals who have committed sexual crimes.

This focus on deficits has been prevalent in professional publications for several decades, and the most commonly cited characteristic of adolescents who offended sexually is that they have a deficit with respect to social skills. For example, in their treatment guidelines, Groth, Hobson, Lucey, & St. Pierre (1981) stated that “juvenile sexual offenders need instruction in regard to developing effective social skills and communication skills with age mates” (p. 266). Similarly, Stops and Mays (1991) pointed out “that adolescent sex offenders have at their core, deep-seated feelings of inferiority, inadequacy, a lack of self-confidence, and immaturity” (p. 101). Although the assumption that adolescents who offend sexually are deficient in their social skills was very often forwarded in the 1980s and 1990s (e.g., Bagley & King, 1990; Burnett & Rathbun, 1993; Graves, Openshaw, & Adams, 1992; Groth & Lored, 1981; Saunders, Awad, & Levene, 1984; Stenson & Anderson, 1987; Stevenson & Wimberley, 1990), a time when many treatment programs were being developed, there are still some authors who make this assumption (e.g., Hunter, 2011). Not surprisingly, treatment manuals have been replete with instructional exercises for ameliorating this supposed deficit in social skills. Of course, social skill deficits are no more prevalent in populations of adolescents who commit sexual crimes relative to adolescents who offend nonsexually (Seto & Lalumière, 2010), and there are subgroups of adolescents who have offended sexually who are actually quite skilled socially (Richardson et al., 2004; Smith et al., 1987; Worling, 2001).

Perhaps another reason that clinicians have focused so heavily on risks and deficits is a result of the fact that most of the research has been focused on these topics, at the expense of a focus on strengths, protective factors, and resiliency. This is not unique to the field of sexual offending, as research into general criminal behavior has been aimed almost exclusively on the identification of factors that predict risk rather than on the identification of protective factors that predict desistance from reoffending. This preoccupation with risk-only factors in risk

assessment tools, which also influenced my original efforts (Worling & Curwen, 2001), has likely resulted in inaccurate judgments by evaluators and therapists (e.g., Miller, 2006; Rogers, 2000). Farrington (2007) has stressed that researchers should enhance the accuracy of violence risk assessments by also identifying factors that are predictive of desistance.

Unfortunately, there have been very few investigations designed to identifying protective factors for adolescent sexual recidivism. In 1998, Bremer developed the Protective Factors Scale to assist with placement decisions for youth who had offended sexually; however, this tool has not been subjected to empirical scrutiny. There has, on the other hand, been some initial work regarding the identification of protective factors for general youth violence. Preliminary, multi-site research from the Centers for Disease Control and Prevention (Hall, Simon, Lee, & Mercy, 2012) suggests that factors such as academic achievement, prosocial peer relationships, positive family management, and attachment to school may operate to reduce the onset of general youth violence. These authors stress, however, that firm conclusions regarding protective factors cannot be drawn at this time given the paucity of research at this point.

The Structured Assessment of Violence Risk in Youth (SAVRY; Borum, Bartel, & Forth, 2006) is a widely-used, risk assessment tool that contains 24 risk and 6 protective factors. Although there is preliminary evidence from investigations with adolescents to suggest that these protective factors are related to desistance in general criminal recidivism (Rennie & Dolan, 2010) and violent recidivism (Lodewijks, Ruiter, & Doreleijers, 2010), the SAVRY protective factors are not related to desistance of adolescent sexual recidivism (Schmidt, Campbell, & Houlding, 2011; Spice, Viljoen, Latzman, Scalora, & Ullman, 2012). This suggests that there are unique protective factors that are predictive of desistance for adolescent sexual reoffending. This is not surprising given that there are unique risk factors for adolescent sexual recidivism (Worling & Långström, 2006). Possible protective factors for adolescent sexual recidivism include factors that are both sexual offense-specific (e.g., prosocial sexual interests, prosocial sexual attitudes, and prosocial sexual environment) and sexual offense-related (e.g., compassion for others, emotional intimacy with peers, and positive problem-solving skills) (Worling, 2013).

### A Shift in Focus: Strengths and Protective Factors

In addition to the recent empirical quest to identify protective factors for adolescent sexual recidivism (e.g., Spice et al., 2013; Worling & Langton, 2013), there has also been a more conscious shift towards strength-based approaches; in part, perhaps, as a result of the Good Lives Model (Ward, 2002; Ward & Stewart, 2003). According to this model, the goal of treatment is to provide the individual with the

means to achieve primary human goods, which are conditions that would allow one to achieve an enhanced sense of well-being and purpose, such as happiness, creativity, spirituality, and knowledge, for example. This model has recently been examined with specific reference to adolescents who have offended sexually (Chu, Hoh, Zeng, & Teoh, 2013); however, it is important to stress that a strength-based approach has been advocated for many years in work with this population.

More specifically, despite the unfortunate focus on deviance, disorder, deficit, and deceit that has plagued the field, many programs have also simultaneously stressed the need to build positive self-regulation skills (Lee & Olender, 1992), social skills (Margolin, 1983), positive sexual knowledge (Becker, 1990), and healthy family relationships (Steen & Monnette, 1989), for example. Indeed, Rich (2006) remarked that the need to enhance relationship skills, self-regulation, self-agency, and decision making has long been part of treatment programs that have taken a more holistic and integrated view of youth who have sexually offended in contrast to those programs that have had a more myopic focus on the sexual offending.

In sum, it is obviously not the case that adolescents who sexually offend can be described only by their deficits. It may be, once again, that the nature of the crime has propelled researchers and clinicians to focus almost exclusively on deficits rather than on assets and protective factors. Alternatively, this orientation may be more reflective of the assumption that these youth are inherently deviant, delinquent, disordered, and deceitful. Efta-Breitbach and Freeman (2004) remarked that, although some current treatment goals are consistent with a strength-based approach that would foster resilience in adolescents who have offended sexually, there is dire need to more methodically understand and promote resilience and competence and focus on strengths and positive behaviors.

### ■ They Are All Deceitful, Aren't They?

In speaking about treatment for adolescents who commit sexual offenses, Margolin (1983) remarked that “the need to control others pervades the offender’s every social interaction. The most prominent symptom of this compulsion to control is his [sic] proclivity to lie” (p. 3). In a similar vein, Perry and Orchard (1992) stated that “adolescent sex offender work is very demanding and stressful. Clinicians are working with clients who attempt to deny, minimize, or rationalize the extent of their problems” (p. 29). According to Barbaree and Cortoni (1993), “the first stage in treatment targets denial and minimization and successful completion of this stage is a prerequisite to successful treatment” (p. 255).

It should not be surprising, therefore, that there is typically a call for clinicians and probation officers to be diligent in their efforts to confront the denial and minimization of these adolescents to ensure

that they will come clean with the details of their past sexual crimes and/or their current sexual deviance (e.g., Bethea-Jackson & Brissett-Chapman, 1989; Ferrara & McDonald, 1996; Kahn & Lafond, 1988; Lakey, 1994; National Task Force on Juvenile Sexual Offending, 1993; Sermabeikian & Martinez, 1994; Shaw, 1999; Way & Balthazor, 1990). This demand for adolescents to acknowledge all details of their past sexual offending and current sexual deviance is likely based, at least in part, on the prevailing sentiment that one must first acknowledge a problem before it can be treated. Of course, it may also reflect the difficulty that some practitioners have separating the person from the behavior; the need to use aggressive confrontation, shame, and punitive approaches may simply reflect anger towards the youth for the criminal sexual behavior.

Without minimizing the significant harm that can result for the survivor and his or her family, it is important to note that a sexual crime is likely to lead to significant shame, embarrassment, and guilt for the adolescent who has offended – in addition to significant personal, family, legal, and social consequences. It would be unusual, therefore, to expect any individual to readily provide a detailed account of past sexually abusive behaviors and/or current deviant sexual thoughts and fantasies – especially at the outset of a relationship with another individual. As such, minimization and denial are likely a natural phenomenon connected to the nature of the crime, rather than a pathological characteristic of the adolescent who has offended sexually.

Given this push for adolescents who have offended sexually to confess all of the details of their past sexual crimes, it should not be surprising to find that many authors have advocated for therapists to use confrontational approaches in treatment to break through denial and minimization (e.g., Baird, 1991; Burnett & Rathbun, 1993; Goocher, 1994; Groth et al., 1981; Hird, 1997; National Task Force on Juvenile Sexual Offending, 1993; Perry & Orchard, 1990; Sermabeikian & Martinez, 1994; Smets & Cebula, 1987). In their review of the literature, however, Marshall et al. (2003) pointed out that a confrontational approach is actually likely to *increase* defensiveness and resistance for individuals who have offended sexually. Marshall et al. suggested instead that the best approach to address minimization and denial in treatment is to supportively challenge individuals when necessary rather than to use a confrontational approach. They also noted that research points to the fact that therapeutic interventions are actually more effective when the therapist is empathic, warm, genuine, and rewarding.

### Getting to the “Truth”

The view that adolescents who offend sexually lie and deceive is perhaps best exemplified in the U.S. where 50% of treatment programs presently use the polygraph (McGrath et al., 2010). McGrath et al. pointed out that this represents a marked increase

in the use of the polygraph in recent years, as only 22% of treatment programs for adolescents who offended sexually used the polygraph in the U.S. in 1996. Chaffin (2011) has stressed that the polygraph is seldom used with youth in the U.S. who commit nonsexual crimes, and that there are actually very few countries outside of the U.S. where the polygraph is utilized with any adolescents. Chaffin (2011) and Prescott (2012) have outlined a number of significant concerns regarding the use of the polygraph with adolescents who have offended sexually. In addition to the complete lack of empirical support for the reliability and validity of the approach, they also underscore the significant potential for harm to the adolescent including the coercive nature of a polygraph examination and the replication of an abusive experience, the increased likelihood of false confessions in an effort to satisfy program requirements, and the dubious ethics that result from the use of an interrogation procedure with youth in compulsory treatment.

The argument that is often forwarded in support of the utility of the polygraph is that this procedure will result in the identification of survivors of sexual abuse who have previously been unknown to authorities. There have been only two published studies with adolescents where this issue has been examined. In the first paper, Emerick and Dutton (1993) reported that adolescents disclosed an average of almost one ( $M=0.98$ ) new victimized individual as a result of a polygraph examination. In a similar investigation, Van Arsdale, Shaw, Miller, and Parent (2012) also found that adolescents who had offended sexually disclosed an average of almost one ( $M=0.73$ ) new survivor of sexual abuse based on a polygraph examination. Although some might argue that these data support the use of the polygraph with this population, this result should be contrasted with research supporting the fact that adolescents are more likely to disclose new information within the context of a trusting therapeutic relationship. For example, Baker, Tabacoff, Tornusciolo, and Eisenstadt (2001) found that adolescents in specialized treatment disclosed an average of 3.3 new victimized individuals during the course of discussions with their treatment providers. Prescott (2012) also emphasized the fact that survivors of sexual abuse should be free to disclose when and how they choose and that some may not wish to be identified via the results of a polygraph examination.

With this pressure for youth to acknowledge details of past sexual crimes, it is also important to highlight the fact that there is presently no empirical evidence to support the notion that it is necessary for future sexual health for adolescents to acknowledge all of the details of all past sexual crimes. This is not, of course, to suggest that adolescents need not take responsibility for their sexual offending behaviors. Most practitioners would agree that it is important for an adolescent to acknowledge that he or she has offended sexually and that it is ideal if

they can be open regarding the identity of the people whom they have abused and take responsibility for how they have harmed others. However, there is just no scientific rationale for impelling youth to confess all of the details of all of their sexual crimes.

Perhaps this focus on deception and denial has also somehow been related to the assumption that adolescents who are denying their past sexual offending are also at higher risk of reoffending sexually. A number of risk-assessment guidelines (e.g., Prentky & Righthand, 2001; Ross & Loss, 1988) list denial of sexually abusive behaviors as a risk factor; however, there is no research to support the notion that denial at the point of assessment is predictive of sexual recidivism for adolescents (Worling & Långström, 2006; but also see Rich, 2009). Indeed, there is actually some evidence to suggest that those adolescents who offend sexually and who are categorically denying past offenses may actually be at a reduced risk of reoffending sexually relative to those adolescents who are acknowledging their crimes (Kahn & Chambers, 1991; Långström & Grann, 2000; Worling, 2002).

### Honesty by Self-Report in Treatment

The notion that individuals who offend sexually are naturally prone to deception and dishonesty is perhaps best contradicted by the available research regarding the assessment of deviant sexual interests. A layperson would naturally assume that individuals who have offended sexually would be reluctant to be open regarding a sexual interest in prepubescent children and/or sexual violence; however, authors of the available research suggest otherwise. For example, with a sample of men who offended sexually against children, Laws, Hanson, Osborn, and Greenbaum (2000) found that self-reported sexual interests obtained via a card-sort procedure were more accurate than penile plethysmograph (PPG) data in identifying the gender of victimized individuals. In a similar study, Day, Miner, Sturgeon, and Murphy (1989) found that self-report data from a questionnaire regarding sexual thoughts, feelings, and behaviors could accurately classify men according to the gender of their children whom they abused.

Looking at research with adolescents, Seto et al. (2000) reported that the self-report of a majority of youth acknowledging a sexual interest in children during an interview was subsequently supported by objective PPG examination. Similarly, Worling (2006) found that self-report indices and procedures were able to identify those adolescents who sexually abused children. Using a self-report questionnaire, Daleiden, Kaufman, Hilliker, and O’Neil (1998) also reported that adolescents who offended sexually disclosed significantly more deviant sexual behaviors relative to both adolescents who offended nonsexually and adolescents with no criminal histories. These studies each lend support for the idea that adolescents in treatment for sexually abusive behavior are able to engage honestly and that

self-report is a valuable and viable means by which to learn about the sexual behaviors and interests of youth in treatment.

To answer to our final question, then, it is not always the case that adolescents who offend sexually lie and deny. Indeed, it would appear that many of these youth are able to identify previously undisclosed sexual crimes within the context of a trusting therapeutic relationship, and many are also forthcoming with respect to their sexual interests when evaluators use structured, self-report procedures. There is also no compelling evidence to suggest that it is necessary for adolescents to disclose all of the details of their past sexually abusive behaviors, or that denial is predictive of continued sexual offending. When adolescents are struggling to acknowledge information that is likely to lead to shame, embarrassment, and significant personal, legal, and familial consequences, it is important that professionals employ supportive rather than confrontational approaches.

## ■ Conclusion

Interventions with adolescents who have committed sexual crimes have been influenced for the past several decades by the belief that these youth are inherently sexually deviant, delinquent, disordered, deficit-ridden, and/or deceitful. This is likely related, in part, to the rather blind application of the adult-based techniques and approaches that were popular in the 1980s. It should be no surprise, therefore, that many of these adolescent have been removed unnecessarily from their homes, confronted aggressively regarding the details of their past sexual crimes, wired up to physiological measurement devices that have questionable scientific merit, and subjected to untested interventions designed to alter presumed deviant sexual interests.

There are likely some professionals who believe that the nature of the crime merits such an aggressive and punitive approach, that these youth have forfeited many of their human rights as a result of choosing to commit a sexual crime, and that we should not be particularly concerned about subjecting these youth to assessment and treatment techniques that have little to no scientific credibility. However, there is considerable danger if we let these assumptions persist and thereby influence our responses to adolescent sexual offending. Indeed, as outlined in this paper, these assumptions can lead to questionable interventions that may actually increase the risk of continued sexual offending. Take, for example, untested behavioral interventions designed to decrease deviant arousal that could inadvertently establish and strengthen novel, deviant sexual scripts; or consider a polygraph interrogation that could result in heightened fear, false confessions, and/or an unnecessarily protracted stay in a specialized residential program.

There will obviously be some adolescents who have offended sexually who display deviant sexual interests, and those who are also antisocial, deceitful,

disordered, and who have a number of significant deficits. However, it is clear from the available research that there are many adolescents who commit sexual crimes who have age-appropriate sexual interests and who are prosocial, forthcoming regarding past offending and current sexual interests, without psychiatric disorder, and who have many strengths and putative protective factors. As a result, it is critical that professionals examine the unique strengths, risks, and needs of each adolescent and tailor treatment and supervision, if necessary, accordingly (Worling & Langton, 2012). Furthermore, it is important that we choose assessment and treatment approaches that have been developed with sensitivity to adolescent cognitive, social, and emotional development. Of course, it is also essential that we select approaches that have an empirical basis and that do not risk iatrogenic harm.

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## Treatment of Sexual Offenders: Research, Best Practices, and Emerging Models

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### Abstract

Treatment of sexual offenders has evolved substantially over the years; various theoretical and practice models of treatment have been developed, modified, refined, and proposed over time. The predominant current recommended approach, supported by research, adheres to specific principles of effective correctional intervention, follows a cognitive-behavioral, skills-based orientation, and explicitly targets risk factors empirically associated with sexual offending and with recidivism, such that risk of re-offending may be reduced. Cognitive-behavioral treatment focuses on changing behavior, cognition, and affect, using a skills-based approach, with the aim of reducing risk of recidivism, and includes specific characteristics and methods on the part of treatment providers. Treatment is also guided by specific principles of intervention to maximize effectiveness. New models of treatment have been proposed with the aim of replacing and/or augmenting existing models. This article discusses existing and emerging models, their research basis, and recommendations for best practice in the treatment of sexual offenders.

### Keywords

Sexual offender treatment; adult sexual offenders; good lives model; risk, need, and responsivity, self-regulation

Sexual offending has long been recognized as a serious problem with significant impacts on victims, their families, and society at large. Coinciding with this recognition has been the development and implementation of treatment interventions designed to reduce the risk of recidivism, empirical research into treatment effectiveness, and an increase in the availability of treatment programs for sexual offenders (McGrath et al., 2010). Current best practice involves the application of cognitive-behavioral interventions that target risk and that adhere to the principles of effective correctional intervention (Andrews & Bonta, 2010; Hanson, Bourgon, Helmus, & Hodgson, 2009). In addition, meta-analytic research has found that cognitive-behavioral treatment is most effective in reducing recidivism in comparison to both other types of treatment and to criminal sanctions (Hanson et al., 2002; Lösel & Schmucker, 2005). Lastly, research indicates that effective therapists and therapeutic techniques are associated with improved outcomes (Beech & Fordham, 1997; Marshall, Anderson, & Fernandez, 1999; Marshall et al., 2002, 2003; Serran, Fernandez, Marshall, & Mann, 2003; Shingler & Mann, 2006; Yates et al., 2000). In this article, a review of sexual offender treatment is provided, with accompanying research support for specific approaches. This is followed by a review of emerging treatment models and their potential to inform the practice of sexual offender treatment.

Various models of sex offender treatment have been proposed and implemented over time, including general psychotherapy, neurosurgery, physical castration, pharmacological interventions, behavioral reconditioning, cognitive-behavioral intervention, and relapse prevention (for a review, see Laws 2003; Yates, 2002; Yates & Ward, 2007). Early treatment approaches assumed that sexual offending was caused by a single factor, such as anger or deviant sexual arousal (Becker & Murphy, 1998; Marshall, 1996). However, over time, the multidimension-

ality of sexual offending became evident, and treatment approaches incorporated multiple elements in order to address these multiple influences on behavior and sexual offending risk (Marshall et al., 1999; Marshall, Marshall, Serran, & Fernandez, 2006; Yates, et al., 2000).

Many early interventions, such as psychotherapy and neurosurgery, have been found to be ineffective (see Yates, 2002, 2003, for a review), while others, including pharmacological interventions, are potentially promising in some specific cases (Bradford, 1990; Grossman, Martis, & Fichtner, 1999; Meyer, Cole, & Emory, 1992). Still others, including relapse prevention, continue to be used in spite of an absence of research support for their effectiveness. Treatment models that have been shown to be effective, and emerging promising models, are the focus of this review.

### ■ Principles of Effective Correctional Intervention

In general, in correctional intervention with offenders, specific principles have been found to be essential in interventions designed to reduce recidivism, and specifically, the principles of *risk, need, and responsivity* (RNR model; Andrews & Bonta, 2010). While originally intended to be applied predominantly to criminal justice sanctions (i.e., sentencing, diversion, and supervision), in practice this model has additionally been applied to treatment, and perhaps more so to treatment than to sanctions.

**Risk Principle.** According to the *risk principle*, the intensity of correctional interventions must be matched to the level of risk posed by the offender. Treatment, as well as supervision, should be longer in duration, applied more frequently, and include more contact hours as assessed risk to reoffend increases (Andrews & Bonta, 2010; Bourgon & Armstrong, 2005; Hanson & Yates, 2013; Lowenkamp, & Latessa, 2002; Lowenkamp, Latessa, & Holsing-

er, 2006). Thus, the most intensive levels of service should be reserved for higher risk offenders, while lower levels of intervention (or no intervention) should be applied to lower risk offenders. In fact, low risk offenders likely do not require specialized treatment at all, and will benefit from routine supervision (Andrews & Bonta, 2010; Hanson & Yates, 2013).

Adherence to the risk principle, in addition to being the best use of limited resources, demonstrates that treatment is most effective when its level of intensity is matched to risk (Andrews & Bonta, 2010; Gendreau & Goggin, 1996, 1997; Gendreau, Little, & Goggin, 1996; Gordon & Nicholaichuk, 1996; Hanson et al., 2009; Nicholaichuk, 1996). That is, when higher risk offenders receive higher intensity treatment, and moderate risk offenders receive intervention at more moderate levels of intensity, the impact on reduced recidivism is greatest. Furthermore, research indicates that, when risk and treatment intensity are not appropriately matched, recidivism can increase as a function of treatment, as in the case of lower risk offenders who receive treatment at an intensity that is greater than required to address their needs (Andrews & Bonta, 2010; Lowenkamp, & Latessa, 2002; Lowenkamp, et al., 2006).

Among sexual offenders, specific static and dynamic risk factors have been associated with increased risk of recidivism. Static risk factors – those that cannot be changed through intervention – include younger age, previous sexual offenses, the commission of non-contact sexual offenses and non-sexual violent offenses, and offending against male victims, unrelated victims, and strangers (Hanson & Thornton, 1999). Dynamic risk factors are discussed below.

When considering treatment intensity, little research has been conducted regarding the most appropriate length of intervention, and practice varies substantially across jurisdictions (McGrath, et al., 2010). Some programs recommend between 80 (Beech & Mann, 2002) and 120 contact hours (e.g., Marshall, et al., 2006), while others recommend between 160 to 195 contact hours for moderate risk sexual offenders and approximately 300 hours of treatment contact for high risk offenders (Correctional Service Canada, 2000). In a comprehensive evaluation, Bourgon and Armstrong (2005) examined treatment intensity as a function of both risk and criminogenic needs (see below). They found that 100 contact hours was sufficient to reduce recidivism for general offenders presenting with moderate risk and few criminogenic needs, 200 hours was more effective when offenders were *either* high risk *or* had multiple criminogenic needs, and that 300 contact hours or more was required to reduce recidivism among offenders who were *both* higher risk *and* who had multiple criminogenic needs. Based on research pertaining to general offenders, as well as results from accredited sexual offender programs, Hanson & Yates (2013) recommend no specialized treatment for low risk sexual offenders (the bottom 10% to 20% of the risk distribution; Hanson, Lloyd, Helmus, & Thornton, 2012), 100 to 200 contact hours for moderate risk sexual

offenders, and a minimum of 300 hours for sexual offenders presenting with high risk and high needs (the top 10% to 20% of the risk distribution; Hanson et al., 2012).

**Need principle.** The second principle of effective correctional intervention, the *need principle*, states that treatment and interventions such as supervision should explicitly target the criminogenic needs of offenders – that is, the specific risk factors that can be changed through intervention (i.e., dynamic risk factors) and that are empirically associated with recidivism risk (Andrews & Bonta, 2010). Targeting these risk factors for change leads to reduced re-offending.

Research indicates that, among sexual offenders, criminogenic needs include such risk factors as sexual deviance and antisocial lifestyle, the two strongest predictors of recidivism among sexual offenders (Hanson & Morton-Bourgon, 2004, 2005). It is important to note here that research has consistently found that sexual offenders are more likely to reoffend with offenses that are non-sexual in nature than to commit new sexual offenses (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005; Nicholaichuk et al., 2000). In addition, research indicates that the predictors of recidivism are different for different types of re-offending. That is, while the strongest predictors of sexual recidivism among sexual offenders include deviant sexual interest and antisocial orientation/lifestyle (antisocial personality, antisocial traits, a history of rule violation, and self-regulation problems such as impulsivity, lifestyle instability, and a history of non-sexual criminal offending), sexual deviance has been found to be unrelated to violent non-sexual offending (Hanson & Morton-Bourgon, 2005). Therefore, when determining criminogenic needs to be targeted during treatment, it is important to attend to the type of recidivism that is likely to occur, and to tailor treatment accordingly.

Recent research has additionally demonstrated specific dynamic risk factors that are associated with recidivism among sexual offenders. These include deviant sexual preferences, a lack of positive social influences, intimacy deficits, problems with sexual self-regulation, problems with general self-regulation, attitudes supportive of sexual assault, and problems with cooperation with supervision (Hanson, Harris, Scott, & Helmus, 2007). In treatment, it is recommended that these be assessed *a priori*, and included as appropriate in individualised treatment plans (Yates, Prescott, & Ward, 2010), along with assessment of static risk in order to determine treatment intensity by these factors in combination (Hanson, et al., 2007; Yates et al., 2010).

In addition to ensuring that factors empirically-related to risk of recidivism are addressed, the need principle also specifies that treatment should not focus on *non-criminogenic needs* -- factors not found to be associated with recidivism -- as this expends resources on addressing factors that are unlikely to result in reduced re-offending (Andrews & Bonta, 2010). Non-criminogenic factors include such areas as self-esteem, personal distress, victim

empathy, and denial (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005; Yates, 2009a), none of which has been found to be reliably linked to recidivism in research. While it is common practice in treatment to address such factors, these are not empirically supported and are unlikely to be the best use of limited resources that aim to reduce reoffending.

**Responsivity Principle.** The third principle of effective correctional intervention, the *responsivity principle*, concerns the interaction between the individual and treatment. Specifically, this principle indicates that treatment, in addition to being cognitive-behavioral in orientation (see Andrews & Bonta, 2010), should be delivered in a manner that is responsive to various characteristics of the individual, such as language, culture, personality style, intelligence, anxiety levels, learning styles, and cognitive abilities, in order to increase their engagement and participation in treatment to ensure maximal effectiveness (Andrews & Bonta, 2010). These factors can affect clients' engagement with treatment, their motivation, their ability to understand and apply information presented in treatment to their own personal circumstances, and their manner of processing information presented in treatment. Therefore, treatment implementation should be varied and adapted to individual styles and abilities in order to maximize effectiveness, which involves significant skill on the part of clinicians.

Research support is strong for the application of the RNR model and its principles, and indicates that treatment that complies with these principles is superior to treatment that does not adhere to these principles and to criminal sanctions alone. Specifically, meta-analytic research clearly indicates that adherence to this model is effective for intervention with offenders in general, young offenders, violent offenders, and female offenders (Andrews, et al., 1990; Dowden & Andrews, 1999a, 1999b, 2000, 2003). Importantly, adherence to these principles also applies to the treatment of sexual offenders. Specifically, meta-analytic research indicates that, when treatment adheres to these principles, it is associated with reduced sexual re-offending. The most significant treatment effect has been found among treatment programs that adhered to all three principles (Hanson et al., 2009), and treatment effectiveness increases as a function of adherence to principles (odds ratios of 1.17, .64, .63, and .21, respectively for adherence to all three principles, only two, only one, and no adherence). The odds ratio is the likelihood of an event occurring or not occurring, and in this case indicates that treatment was most effective when it adhered to all three principles, and decreased progressively in effectiveness when treatment adhered to fewer principles.

Lastly, program integrity, organizational adherence to treatment standards, and staff selection, also improve treatment outcomes (Andrews & Dowden, 2005; Dowden & Andrews, 2004; Gendreau & Goggin, 1996; 1997; Gendreau et al., 1996; Hanson et al., 2009; Hanson & Yates, 2004).

## ■ Cognitive-Behavioral Treatment

Although there is some debate regarding whether treatment with sexual offenders is effective, cognitive-behavioral treatment remains the most widely accepted and empirically supported model of sexual offender treatment with respect to reducing recidivism (e.g., Hanson et al., 2002; Lösel, & Schmucker, 2005). Based on behavioral, cognitive, and social learning theory and models (e.g., Bandura, 1986; Beck, 1964, 1967, 1976; Yates et al., 2000, 2010), sexual offending is conceptualized as behavioral and cognitive patterns that are developed and maintained as a result of modeling, observational learning, and reinforcement of behavior, attitudes, and cognition. The focus of treatment is on altering patterns of behavioral, cognitive, and affective responding associated with sexual offending, such that such problematic, deviant, and/or criminal behavioral patterns and responses are replaced with adaptive, non-deviant, pro-social responding. In doing so, treatment targets such responses as these are related to the specific dynamic risk factors known to be linked to risk for re-offending, as described above.

In practical application, cognitive-behavioral treatment involves changing attitudes, challenging cognitive distortions, addressing general self-regulation skills such as problem-solving, improving sexual, intimate, and social relationships, managing affective states, developing adaptive cognitive processes, and addressing sexual self-regulation, such as reducing deviant sexual arousal (Barbaree & Marshall, 1998; Marshall et al., 1999, 2006; Yates, 2002, 2003; Yates et al., 2000, 2010). Appropriately applied, treatment should, therefore, explicitly target the development of client skills matched to these dynamic risk factors, in addition to risk factors for offending that is not sexual in nature, such as general criminal attitudes. Cognitive-behavioral treatment also includes extensive rehearsal and practice of the adaptive and self-regulatory skills that are being learned by the client, as such skills require repetition in order to become well-entrenched in the individual's behavioral repertoire (Hanson, 1999; Hanson & Yates, 2004).

Common components of cognitive-behavioral intervention include general and sexual self-regulation, addressing relationship and intimacy deficits, developing empathy for victims of offending, challenging cognitive distortions, delineating the offense process and circumstances that trigger offending, inculcating responsibility for behavior in the offender, and developing relapse prevention plans. Some of these targets, such as victim empathy and taking responsibility, have received little research support for their contribution to reducing recidivism (e.g., Hanson & Morton-Bourgon, 2005; Yates, 2009a), and so are questionable treatment targets. In addition, much has been written in recent years regarding targeting cognitive distortions versus addressing cognitive schema in treatment. Targeting cognitive distortions (Abel, Becker, & Cunningham-Rathner, 1984; Barbaree, 1991) has historically been a common component

of sexual offender treatment. However, it has come to be recognized that cognitive schema represent individuals' underlying views and attitudes, while cognitive distortions are the *products* of these underlying schema (Mann & Beech, 2003). In cognitive theory (e.g., Beck, Freeman, & Davis, 2004), schema are cognitive structures that function to process, organize, and evaluate incoming information, direct cognitive activity, and influence information processing. Schema are based on individuals' previous experiences, contain attitudes, beliefs, and assumptions about the self, the world, and others, and provoke affective and behavioral responses. Schema have specific content and are activated by situational cues, particularly in ambiguous or threatening situations (Mann & Shingler, 2006). Among sexual offenders, specific schema, such as sexual entitlement, a general view that the world is a hostile place, or the belief that children can consent to sexual activity, have been found to be implicated in sexual offending (e.g., Mann & Beech, 2003; Ward & Keenan, 1999). It is suggested, therefore, that treatment should focus more on identifying and altering schema, rather than focusing solely on cognitive distortions (Gannon, 2009). Lastly, Fernandez, Shingler, & Marshall (2006) and others (e.g., Yates et al., 2000, 2010) have observed that treatment for sexual offenders has, in recent years, over focused on cognitive aspects, with insufficient reliance on the rehearsal and practice that is essential for behavioral change, and recommend that treatment approaches explicitly place greater emphasis on skills development and practice, including *in situ*.

### ■ Relapse Prevention

The relapse prevention (RP) approach has long been the predominant approach to sexual offender treatment (e.g., Laws, 1989, 2003; Pithers, 1990; Pithers, Kashima, Cumming, & Beal, 1988; Pithers, Marques, Gibat, & Marlatt, 1983) and this continues to be the case (McGrath et al., 2010), in spite of a lack of evidence supporting its effectiveness with sexual offenders (Laws, 2003; Laws & Ward, 2006; Yates, 2005, 2007; Yates & Ward, 2007). In some respects, RP has become synonymous with cognitive-behavioral treatment; however, this is an inaccurate conceptualization.

Relapse prevention was initially developed as a post-treatment follow-up intervention for motivated alcoholic patients who had successfully ceased alcohol use but who demonstrated difficulty maintaining abstinence following treatment (Marlatt, 1982, 1985). RP had an intuitive appeal to clinicians delivering sexual offender treatment and was applied to the treatment of this group following revisions to adapt the model to this population (Laws, 1989; Marlatt & Gordon, 1985; Marques, Day, & Nelson, 1992; Pithers, 1990; Pithers et al., 1988). It is noted that, at the time, there was a dearth of research pertaining to static and dynamic risk and the processes of sexual offending generally.

The goal of RP as initially conceptualized was to assist patients to identify, anticipate, and prevent high risk situations that could lead to *lapses*, defined in

the original RP model as a temporary return to the alcohol use, as well as to avoid *relapse*, defined as a return to chronic alcohol abuse (Marlatt, 1982). In doing so, treatment involved teaching patients to cope with problems and high risk situations when these arose, and to address skill deficits in patients' abilities to do so. Applied to sexual offenders, this model did not fit and required adaptation (Laws & Ward, 2006; Marques et al., 1992; Pithers, 1990). For example, RP as applied to sexual offenders represents a "one size fits all" approach and does not adequately address the multiple treatment needs with which offenders present or the pathways to offending they follow, and it incorrectly regards sexual offending behavior as an addictive process, and presents such conceptual difficulties as defining what constitutes a lapse (Laws, 2003; Laws & Ward, 2006; Yates, 2005; Yates & Kingston, 2005; Yates & Ward, 2007). For example, although illegal and potentially signaling an increase in risk, a single use of child pornography would be considered as a simple lapse within the RP framework. As such, many core constructs of the RP approach are not applicable to the sexual offending process.

The RP model also presents a narrow view of sexual offending behavior, not acknowledging multiple pathways to offending, and assumes that sexual offending results from negative affective states and a lack of coping skills. As such, this approach ignores processes of gratification and does not fit with offenders who explicitly plan their offending behavior (Laws, 2003; Laws & Ward, 2006; Yates, 2005; Yates & Kingston, 2005; Yates & Ward, 2007).

Nonetheless, this model was adopted in the treatment of sexual offenders, and continues to be an accepted approach to treatment, in spite of a lack of empirical research supporting its application to intervention with sexual offenders (Hanson, 1996, 2000; Laws, 2003; Laws, Hudson, & Ward, 2000; Laws & Ward, 2006; Yates, 2003, 2005; Yates & Kingston, 2005; Yates & Ward, 2007).

### ■ Importance of Therapeutic Process in Treatment

While not a model of sexual offender treatment *per se*, the characteristics of therapists and the approaches they use in treatment, have been found in research to be associated with improved treatment outcomes (Beech & Fordham, 1997; Fernandez et al., 2006; Hanson et al., 2009; Marshall et al., 1999, 2002; Shingler & Mann, 2006; Yates, 2002; Yates et al., 2000). For example, research indicates that establishing a positive therapeutic relationship with the client accounts for a significant proportion of the variance in treatment outcome (Fernandez et al., 2006; Hanson, 2009; Witte, Gu, Nicholaichuck, & Wong, 2001; Mann, Webster, Schofield, & Marshall, 2004; Marshall et al., 1999, 2003).

Specific therapist characteristics that have been shown to maximize treatment gains include demonstrating empathy, respect, warmth, friendliness, sincerity, genuineness, directness, confidence, and interest in the client. In addition, being a pro-social model, communicating clearly,

listening actively, being "firm but fair," reinforcing and encouraging clients without being collusive, creating opportunities for success, dealing appropriately with frustration and other client difficulties, being appropriately challenging without being aggressively confrontational, and creating a secure treatment atmosphere, all contribute to treatment outcome (Fernandez, 2006; Marshall et al., 1999, 2002). Relatedly, using specific techniques of motivational enhancement is also viewed as essential to sexual offender treatment (Prescott, 2009). Importantly, creating a positive treatment environment leads to improved cooperation and compliance with treatment, treatment progress, enhanced motivation, and prevents termination or dropout from treatment (Beech & Fordham, 1997; Kear-Colwell & Pollack, 1997; Marshall et al., 1999; Miller, 1995). As research clearly indicates that offenders who do not complete treatment re-offend at significantly higher rates than offenders who complete treatment (Hanson & Bussière, 1998; Hanson et al., 2002), it is essential that treatment is delivered in a positive manner that is motivating to clients.

### ■ Self-Regulation Model

The self-regulation model (SRM; Ward & Hudson, 1998; Ward et al., 1995) is an emerging approach to sexual offender treatment that was developed as a result of shortcomings, such as those described above, with the RP approach to treatment. Originally a nine-phase model of the offense process, the model was developed specifically for sexual offenders based on self-regulation principles of behavior (Baumeister & Heatherton, 1996; Karoly, 1993; Thompson, 1994). The SRM explicitly takes into account variability in offense-related goals and the manner by which individuals regulate their behavior in order to achieve these goals. Offense-related goals include both inhibitory or avoidance goals (i.e., directed toward avoidance of undesired states or outcomes) and appetitive or approach goals (i.e., directed toward the attainment of desired states and outcomes). Offenders with avoidant goals desire or attempt to refrain from offending, while offenders with approach goals more actively seek out opportunities to offend. Achieving goals is based on individuals' self-regulation capacity, with some offenders failing to control behavior (*under-regulation/disinhibition*), others attempting to actively control their behavior using strategies that are ultimately counterproductive and ineffective (*mis-regulation*), and others having intact self-regulation abilities and an absence of self-regulation deficits (Ward et al., 1995, 2004, 2006; Yates, 2007; Yates & Kingston, 2005).

Therefore, according to the SRM, offenders may follow one of four pathways to offending, as follows: The *avoidant-passive pathway* is associated with the desire to refrain from sexual offending (avoidance goal), but a lack of the required awareness and skills to effectively control behavior in order to achieve this goal. Thus, although individuals following this pathway desire to avoid offending, they do not implement strategies to do so, resulting in failure to achieve the avoidance goal and, ultimately, of-

fending. Self-regulation is under-regulated, and when confronted with the possibility of offending, disinhibition of behavior, loss of control, impulsivity, and anxiety occur, alongside goal failure. The *avoidant-active pathway* is a mis-regulation pathway along which individuals actively implement strategies to cope with the desire and opportunities to offend in order to meet an avoidance goal. However, the strategies selected are ineffective and, in some instances, result in the iatrogenic effect of increasing the likelihood of offending. For example, individuals may masturbate to deviant images in an attempt to avoid committing a hands-on offense, or may use substances to regulate mood. However, such strategies may function to disinhibit the individual or to further entrench deviant arousal, thus increasing risk to offend. A key difference with this pathway is that the individual is aware that there is a problem and that action is required and actively implements strategies to prevent offending. The *approach-automatic pathway* is associated with approach-motivated goals with respect to offending and is characterized by *under-regulation*. Individuals following this pathway do not desire to prevent offending, nor do they attempt to refrain from pursuing offense-related goals. Offending occurs as a response to situational cues in the immediate environment, and cognitive schema that support offending are activated by these cues. In addition, offending may appear impulsive. Lastly, the *approach-explicit pathway* is associated with intact self-regulation and an approach goal with respect to offending. Sexual offenses are explicitly and overtly planned in order to achieve a desired objective, such as sexual gratification, and offending is associated with attitudes and core beliefs that support sexual aggression as an appropriate means by which to achieve these goals.

From this brief overview, it is evident that the SRM is a more comprehensive approach to the sexual offending process than other models, such as RP, which posits a single pathway to offending, and is more consistent with the risk/need/responsivity (RNR) model described above. Furthermore, the SRM allows for a more comprehensive and individualized approach to treatment that better addresses individual dynamic risk factors and motivations for sexual offending and that is tailored to offense pathway (Yates & Kingston, 2005; Ward et al., 2005, 2006; Yates & Ward, 2008; Yates et al., 2010).

Research supports the validity of the SRM and its applicability to the assessment and treatment of sexual offenders. Specifically, there is support for the validity of the model, including the existence of multiple pathways to sexual offending, offense characteristics such as offense planning and victim type, variability in pathways across different types of offenders, and treatment participation, compliance, motivation, progress, and outcome (Bickley & Beech, 2002, 2003; Kingston, Yates, & Firestone, 2012; Proulx, Perreault, & Ouimet, 1999; Simons, McCullar, & Tyler, 2008; Simons, Yates, Kingston, & Tyler, 2009; Ward et al., 1995; Yates & Kingston, 2006). In addition, the four pathways have been found to be differentially associated

with actuarially-measured static and dynamic risk (Kingston et al., 2012; Kingston, Yates, Simons, & Tyler, 2009; Leguizamo, Harris, & Lambine, 2010; Simons et al., 2008; Stotler-Turner, Guyton, Gotch, & Carter, 2008; Yates & Kingston, 2006), offense specialization (Leguizamo et al., 2010), and psychopathy (Doren & Yates, 2008; Gotch, Carter, & Stotler-Turner, 2007). Importantly, SRM offense pathways have been found to be differentially associated with recidivism (Kingston, 2010; Kingston et al., 2012; Kingston, Yates, & Olver, in press; Webster, 2005). Taken together, research support is considerable for the application of the SRM in the treatment of sexual offenders.

### ■ The Good Lives Model

The good lives model (GLM) is another emerging approach to sexual offender treatment, and was developed as a result of shortcomings identified with the RNR approach to intervention (Ward & Brown, 2004; Ward & Gannon, 2006; Ward, Melsner, & Yates, 2007; Ward & Stewart, 2003). For example, while essential, the focus of the RNR approach on risk and criminogenic needs, was criticized as insufficient for treatment effectiveness due to its focus on deficits, risk management, and avoidance goals, as well as its inability to sufficiently motivate clients to change (Mann et al., 2007; Ward & Gannon, 2006; Ward et al., 2007). This is important given that sexual offenders tend not to be particularly motivated to participate in treatment (Thornnton, 1997), resulting in the need for motivational approaches to treatment (Prescott, 2009; Yates, 2009b).

Briefly, the GLM proposes that, like other human beings, sexual offenders are goal-directed and seek to acquire fundamental primary human goods, defined as actions, experiences, and activities that are intrinsically beneficial to individual well-being and that are sought for their own sake (Ward & Gannon, 2006; Ward & Stewart, 2003). Examples of primary human goods, also termed common life goals (Yates & Prescott, 2011, 2012), include relationships and friendships, happiness and sexual pleasure, being independent, and attaining peace of mind or emotional equilibrium. The GLM posits that sexual offending results from maladaptive strategies (termed *secondary* or *instrumental* goods) that individuals use to attain these life goals. For example, an offender may desire intimacy, but as a result of factors such as emotional identification with children, turns to children to meet this need. Similarly, an individual may utilize substances to regulate mood and attain peace of mind, or utilize aggression and violence to achieve the goal of independence and autonomy. In the GLM framework, the problem does not lie in the life goals of each individual but in the ways they attempt to achieve these goals, which lead to life problems and to sexual and other offending.

In treatment using the GLM approach, there is an explicit focus on assisting individuals to attain important and valued life goals in pro-social, non-harmful ways (Ward et al., 2004, 2006; Yates et al., 2010; Yates & Prescott, 2011). This model, unlike

the RNR and RP, also explicitly utilizes *approach* rather than avoidance goals in treatment. That is, rather than focus solely on those activities and behaviors in which clients cannot engage, treatment includes actively working toward and attaining important life goals. Thus, for example, treatment actively assists clients to attain independence and autonomy without abusing others, to achieve intimacy without engaging in sexual activity with children, to experience sexual pleasure in non-harmful and healthy ways, and so forth. This is an important element, given that approach goals are more easily attainable and sustainable over the long-term than are avoidance goals (Mann et al., 2004). Using the GLM approach, it is hypothesized that will not only offenders be assisted to attain greater well-being but also that dynamic risk factors will be mitigated, thereby reducing risk to reoffend (Ward & Stewart, 2003), responsivity will be better addressed in treatment, and offenders will be more motivated to change and to participate in treatment. Importantly, the GLM cannot be implemented in the absence of risk management approaches and explicitly targeting criminogenic needs in treatment – to do so runs the risk of ignoring important risk factors and potentially increasing recidivism (Ward et al., 2006; Yates et al., 2010). In order to ensure the inclusion of risk factors and risk management, the GLM has been integrated with the self-regulation model in a comprehensive approach to assessment and treatment (Ward, et al., 2006; Yates, Kingston, & Ward, 2009; Yates & Ward, 2008; Yates, in press; Yates et al., 2010; Yates & Prescott, 2011) that is consistent with the principles of effective correctional intervention, and that employs practices and techniques from demonstrated effective interventions.

Research into the GLM as an approach to sexual offender treatment is in its infancy, although does provide some preliminary support. For example, good lives constructs have been found to be differentially associated with offense characteristics (Yates, Simons, Kingston, & Tyler, 2009), as well as static risk to re-offend, dynamic risk factors, and sexual offense pathway (Kingston et al., 2009), thus suggesting the potential utility of the GLM with sexual offenders with respect to risk, need, and self-regulation. In one of the first empirical investigations of the model, Simons, McCullar, and Tyler (2006) found that, compared to an RP approach, offenders participating in GLM-based treatment were more likely to complete treatment, remained in treatment longer, and were rated by therapists as more motivated to participate in treatment. In addition, pre-/post-treatment comparisons indicated that offenders participating in either program improved similarly on social skills, victim empathy, and problem-solving ability. However, those who participated in the GLM approach demonstrated significantly greater improvements compared to clients who received the RP approach, and demonstrated significantly better coping skills post-treatment. Importantly, offenders participating in the GLM program were found to drop out from treatment at much lower rates (Yates et al., 2009). Conversely, Harkins, Flak, Beech, and Woodhams

(2012) found no differences in attrition rates between and their RP and GLM programs, although qualitative data suggested that both therapists and clients perceived the program as more positive and future-oriented than RP.

## ■ Conclusions and Future Directions

This article provides a necessarily brief overview of current and emerging approaches to the treatment of sexual offenders. Research clearly supports the application of an approach in which treatment intensity varies on the basis of the risk for recidivism posed by offenders, with treatment being more effective when it is applied to higher risk cases, when it targets known dynamic risk factors for recidivism, and when it is responsive to the characteristics of individual offenders. Research further demonstrates that targeting specific known risk factors using cognitive-behavioral methods, is most effective in reducing recidivism among sexual offenders. An explicit skills-based approach is recommended in order to enable treatment participants to change cognition, affect, and behavior such that these become entrenched their behavioral repertoire. Emerging research suggests that the traditional relapse prevention approach, not demonstrated to be effective to date, is overly simplistic in its conceptualization of pathways to offending, and the self-regulation approach, with its broader conceptualization of offense process, dynamics, and motivations, is gaining substantial support for its application to the sexual offender treatment. Research also indicates that there are essential characteristics of the intervention itself and of therapists, that are associated with improved outcomes. In a related vein, the good lives model, has been found to have some validity and, importantly, to be associated with increased motivation and reduced treatment attrition, although additional research into this model is required. It is suggested that treatment of sexual offenders can be most effective when it is based in empirically-demonstrated models and methods and in a manner integrates various approaches (Yates, in press), and that such an approach shows the greatest promise of reducing recidivism, improving offenders' lives, and contributing to community safety and growth.

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