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**Contemporary Thinking and Approaches to
Work with Sexually Abusive Youth**


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Introduction

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Emerging Ideas, Themes, and Models

- An expanding and evolving literature over the past decade has created a "new age" in the development and advancement of our thinking and practice...
... in which we increasingly recognize troubled young people as "whole" people.
- We also increasingly recognize the need for a multifaceted and multidimensional approach to treatment.



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Emerging Ideas, Themes, and Models

- We recognize also that healthy people emerge from healthy communities.
- In turn, healthy people, in healthy families, in healthy communities, engage in healthy behavior.
- In an ecological environment, healthy behavior fosters the development of healthy communities, healthy families, and healthy people.



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Emerging Ideas, Themes, and Models

- When we consider juveniles from this perspective...
... it provides a rich contextual nature to how we understand their behavior, the foundation of their behavior, and the future of their behavior.
- It means that we understand risk factors in light of developmental considerations regarding the biological and psychological growth, and the emergence of adolescence from childhood.



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Emerging Ideas, Themes, and Models

- It also means that we recognize that risk factors for sexually abusive and other forms of antisocial behavior emerge from...
... and are embedded within, the deeply contextual and interwoven systems of the social environment.



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The Environment is Active


- The social environment in which the child is raised is not just an important, but passive backdrop to the development of social connection, self-regulation, and moral behavior.
- The social environment itself is an active ingredient in social development.
- This is not only true in the development of sexually abusive behavior...
... but also in the treatment of sexually abusive behavior.



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Treatment is Developmentally and Contextually Sensitive

- Treatment in the developmental context isn't only about cognitive behavioral therapy and psychoeducational treatments.
- Of great importance is the manner in which we approach and see our clients, and the way in which we help them to think about themselves and others.
- We recognize the power of developmental experience and social context. In...
 - ✓ The formation of personality
 - ✓ Neurological development
 - ✓ Social connectedness
 - ✓ Social competence
 - ✓ Current behavior



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Glued Together by Life

- "People don't come preassembled, but are glued together by life."
-LeDoux, 2002
- As we think about children and adolescents, in every aspect of their lives, including assessment of risk...
... we must remember that any research on stress and risk, as well as protection against risk and the development of resilience...
... makes sense only when seen from a developmental point of view in which a central feature of juvenile experience and behavior is "the dynamic background of developmental change."
- Pless & Stein, 1996



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Working with Sexually Abusive Youth

- Working with sexually abusive youth is a substantially different proposition than work with adult offenders.
- This is primarily because sexually abusive behavior in both children and adolescents appears far more tied to developmental issues than sexual deviance, including:
 - The emergence of personality, psychological development
 - Response to the social environment and social messages and
 - The myriad of forces that shape and define the emotions, cognitions, relationships, and behavior of children and adolescents



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Behavior in the Developmental Context

- Adolescent behavior, including sexually abusive behavior...
... is far more influenced by developing biological, emotional, cognitive, and social systems, and the social environment in general, than adult behavior.
- This view distinguishes adolescents from adults, not just by physical size or life experience...
... but also by developmental stage and resulting differences in experiences of and responses to the social environment in which children and adolescents live, learn, and develop.



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Behavior in the Developmental Context

- The contexts and circumstances under which adolescent behavior emerges are usually quite different than those that surround adult behavior.
- Adolescent behavior is far more sensitive to the background contexts and circumstances from which they emerge.



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Behavior in the Developmental Context

Consequently, juvenile sexually abusive behavior must also be understood in a manner that is sensitive to:

- i. Physical (including neurological) and psychological development
- ii. Circumstances present in the social environment that partially give rise to adolescent behavior, **and**
- iii. The meaning of behavior in the context of the social environment.



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“Less Guilty by Reason of Adolescence”

- Highlighting these differences in understanding, evaluating, and making decisions about adolescent antisocial behavior...
... Steinberg and Scott (2003) describe young offenders as “less guilty by reason of adolescence.”
- They write that, even when the cognitive capacities of adolescents are close to those of adults, their judgment lags behind due to their psychosocial immaturity.



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“Less Guilty by Reason of Adolescence”

In understanding differences between adult and adolescent decision making, in adolescents Steinberg and Scott point to:

- ✓ Greater susceptibility to peer influence
- ✓ Immature attitudes toward and perceptions of risk
- ✓ A different and unformed orientation to the future **and**
- ✓ A more limited capacity for self-management



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Developmental Immaturity

In describing the conceptual skills of adolescents, Steinberg (2005) writes:
... it is though "one is starting an engine without yet having a skilled driver behind the wheel."



Development and Personal Responsibility in Troubled Adolescents

- Understanding children and adolescents partly as a product of physical development and partly the social environment is a statement...
... that we cannot reasonably or fully understand juveniles and their behavioral choices without understanding the larger contexts out of which behavior develops.



Development and Personal Responsibility in Troubled Adolescents

- It is not a way of saying that juveniles:
- ✓ are not responsible for their choices,
 - ✓ have no free will,
 - ✓ do not understand or have no capacity to recognize the consequences of their behaviors,
- or
- ✓ are merely the products of physical and social developmental forces.



Development and Personal Responsibility in Troubled Adolescents

- Adolescents are capable of making choices.
- In many respects adolescents are as capable as adults, informed by accurate perceptions of right and wrong.
- Epstein, 2007
- Although we recognize juvenile behavior in the contexts of physical, psychological, social development, and the socio-cultural environment...
...we also recognize that juveniles are not passive beings and do make volitional behavioral choices for which, to varying degrees, they are responsible.



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Juvenile Behavior and Responsibility

- In most cases, children and adolescents, to varying degrees based in part upon their age, cognitive development, and cognitive skill, are responsible for their behavioral choices.
- We recognize intentionality in children and adolescents...
... even as we recognize that juveniles may not fully comprehend the nature and consequences of their behavior to self and others.



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Juvenile Behavior and Responsibility

- Regardless of differences in development, the teen brain neither "causes" adolescent behavior...
... nor renders the adolescent incapable of significant cognitive and emotional decisions or accomplishment.
- "The teen years need to be what they used to be: a time not just of learning... but learning to be responsible."
-Epstein, 2007
- Nevertheless...



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A Balanced View of Juvenile Behavior

- Steinberg (2003) emphasizes that differences in adolescent reasoning play out in action because adolescents differ from adults in...
 - ✓ Brain development
 - ✓ Psycho-social development
 - ✓ Capacity to consider the consequences of behavior
 - ✓ The manner in which they weigh rewards and risks
 - ✓ Their ability to plan aheadand
 - ✓ Their ability to control their impulses



Maintaining a Balanced View of Juveniles

- These ideas illuminate a balance between recognizing the adolescent as a "person-in-development" ...
... and acknowledging the need to also recognize that adolescents make choices and are capable of accepting responsibility for their choices.
- It is the balance that is so critical in how we understand adolescent behavior and how we treat the outcome of such behavior.



Maintaining a Balanced View of Juveniles

Ideas about child and adolescent development help us to consider differences in...

1. How we recognize the course and meaning of sexually abusive behavior.
2. How we recognize, understand, and evaluate risk for future sexually abusive behavior.
3. How we treat sexually abusive behavior.



Treatment in the Ecological Environment

- As in mainstream psychotherapy, we have come to see children and adolescents in context...
... engaging with, influenced by, and contributing to an interacting set of social forces and systems.
- Here, the attitudes, beliefs, social interactions, and behaviors of our children can only be more fully understood in the context of the ecological environment.
- Bronfenbrenner, 1979; Elliot, Williams, & Hamburg, 1998



Treatment in the Ecological Environment

- In the ecological environment, there is a constant interaction between individuals and other individuals...
... between individuals and the systems within they live and function...
... and between systems.
- Just as in a physical ecology, all aspects of the environment are linked, mutually interactive and influential.




Treatment in the Ecological Environment

- In adopting a developmental and ecological perspective, we can more easily see the "fit" between the sexually troubled behaviors of children and adolescents...
... and the social environments in which they live, learn, and function and with which they constantly interact.
- This view has helped to promote treatment models such as multisystemic therapy, which work with delinquent and sexually troubled youths in and within their families and communities.



Our Changing Sensibility


- It is not that we have concluded that our former approach to the treatment of young people with sexual behavior problems was ineffective.
- In fact, there is no evidence that our former treatment methods did not work...
 ... at least based on well known and widely described statistics regarding juvenile sexual recidivism, which are our best and most obvious indicator of treatment effectiveness.



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Our Changing Sensibility


- On the contrary, although different studies have reported different rates of recidivism...
 ... the most commonly reported statistics have consistently illustrated relatively low rates of sexual re-offense among juvenile sexual offenders, which are not likely to get much lower.



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Our Changing Sensibility

- Thus, changes and developments in our field reflect a change in our perspective about and sense of treatment...
 ... and a shift in our thinking about what it is that makes treatment effective or ineffective, as well as the manner in which we think about our clients.





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Our Thinking Shapes Our Treatment

In any model of treatment, our view as clinicians influences our work in three broad interacting categories, each of which build upon one another:

1. The way we think about and understand the young people who we study and with whom we work, and what they need in treatment.
2. Our ability to think about and plan our treatment interventions.
3. The way that we interact with and relate to the people we are seeking to help.





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Our Thinking Shapes Our Treatment

It is also, and perhaps more critically, reflective of:


1. The manner in which we think about and understand adult and juvenile sexual offenders.
2. The way we interact with and relate to our clients.
3. The way in which we come to conceptualize what sexual offenders need in treatment.




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The Application of Insight and the Exercise of Critical Thinking in Treatment


- For the individual sexually abusive youth, the treatment questions are what happened, how, why...
... and what can we do to ensure it doesn't happen again?
- However, the larger and more looming questions ask why do so many children sexually abuse other children...
... and how did this situation come about?
- What social forces have led to the development of so many children and adolescents who engage in sexually abusive behavior or behavior that is sexually troubled, or, at least, sexually precocious?



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The Application of Insight and the Exercise of Critical Thinking in Treatment


- Although we cannot possibly answer such complex issues...
... we nevertheless can approach these questions, asserting the importance of developing well-informed practitioners who consider and struggle with such questions...
... and think originally while engaging in the practice of assessment and treatment.



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The Application of Insight and the Exercise of Critical Thinking in Treatment


- Having strong and well-informed opinions can both shape our practice at the level of the individual youth...
... and the way we think about juvenile sexual offenders and execute our practice at the broadest level.



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The Application of Insight and the Exercise of Critical Thinking in Treatment


- From this point of view...
... insight into the motivation, the mind, and the behavior of the sexually abusive youth is critical to effective practice.
- In each individual case, clinicians must understand how and why the juvenile sexually offended...
... and demonstrate this insight through clinical formulations that demonstrate knowledge into the case.



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The Application of Insight and the Exercise of Critical Thinking in Treatment


In addition, they must be able to visualize and describe the youth's pathway to sexual offending, causation and motivation, psychological development...
 ... and the goal of or need filled by the offense.



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The Application of Insight and the Exercise of Critical Thinking in Treatment


This is very different from the model found in many programs today in which, despite changes in our field in thinking and practice...
 ... treatment is still conceived primarily as a cognitive process, largely delivered through the teaching of concepts and techniques to juvenile offenders.



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The Application of Insight and the Exercise of Critical Thinking in Treatment

This model typically requires clinicians to teach such concepts and test for their acquisition and retention...
 ... but requires little clinical insight into motivation, the development of behavior, or the underlying psychology of the individual.



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The Application of Insight and the Exercise of Critical Thinking in Treatment


Concerns about:

- ✓ attachment and social connection
- ✓ empathy
- ✓ moral development and remorse
- ✓ personal responsibility
- ✓ sexual arousal

and

- ✓ other factors central to the treatment of juvenile sexual offenders...

... are often addressed through treatment methods that require little insight in either the juvenile or the clinician, and often do not involve the family system.



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What Makes Treatment Work? A Relational Approach

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Whole Treatment for Whole People


- We not only see our clients as multifaceted and multidimensional, and far more than just their sexually abusive behaviors...
... but we also see treatment itself as equally complex and far-reaching, and more than simply the sum of its parts.
- We also see an increasing recognition that treatment is not simply technique and the delivery of information...
... but that the therapeutic relationship itself lies at the heart of treatment.



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What Makes Treatment Work?


- In a meta analysis of almost 3,000 juvenile sexual offenders, Reitzel and Carbonell (2006) concluded that treatment is effective in reducing the recurrence of sexually abusive behavior in juveniles.
- However, despite the focus on cognitive behavioral therapy in the treatment of sexually abusive juveniles and adults...
 - ... with respect to what actually works in treatment sexually abusive youth...
 - ... Reitzel and Carbonell concluded we do not know.



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What Makes Treatment Work?


- Despite many claims and the conventional wisdom that it is the CB aspect of sexual offender treatment that makes it effective...
 - ...Reitzel and Carbonell concluded there is little to no clear evidence that this is true.
- The idea that CBT is effective...
 - ... has been "extended down to the (treatment of juvenile sexual offenders) with little direct empirical support."
 - "There remain more questions than answers about 'what works' for juvenile sexual offenders."



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What Makes Treatment Work?


- Similarly, and more recently, Långström et al. (2013) write...
 - ... "The scientific evidence (is) insufficient to determine if cognitive behavioral therapy... reduces sexual reoffending."
- They write that there is no evidence available to determine the effect of CBT on sexual re-offending among adult sexual offenders or sexually abusive youth...
 - ... or the effectiveness of any treatment method aimed at preventing sexual re-offense among adolescent or pre-adolescent sexual offenders.



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What Makes Treatment Work?

- Långström and colleagues found insufficient evidence to determine whether CBT is more effective than standard treatment in preventing sexual offending.
- They concluded...
... "There is insufficient evidence regarding benefits and risks of cognitive behavioral treatment for adults and adolescents who sexually abuse children and for children with sexual behavior problems."



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What Makes Treatment Work?

- Nevertheless, despite the conclusions of Långström et al. (2013) and Reitzel and Carbonell's (2006) conclusion that we don't truly understand exactly what it is that makes the treatment of sexually abusive youth effective....
... we do have clues!
- Years of both practice and empirical research into the practice of psychotherapy in general yields important information about what does make treatment effective.
- This research base yields important information for us, not only about treatment in general, but also treatment for sexually abusive youth and adult sexual offenders.



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What Makes Treatment Work?


- In describing standards of care for work with adult sexual offenders, McNeill, Batchelor, Burnett, and Knox (2005) write that...
Research on therapist and therapy factors has reminded clinicians about the utility of seeking to establish a strong **treatment alliance** with offenders.
- They describe key skills for supporting change in adult sexual offenders, which include "building relationships that support change."
"It is clear from the psychotherapy and counseling literature that the relationship between the worker and the client is a critical factor in effective interventions."



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What Makes Treatment Work?

- This includes the practitioner's ability to:
 - ✓ convey empathy, respect, warmth and genuineness
 - ✓ establish a working alliance based on mutual understanding and agreement
 - ✓ develop an approach that is person-centered and collaborative.
- McNeill et al. write that sexual offenders respond well to clinicians who are genuinely interested and concerned.



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What Makes Treatment Work?


- "This emerging (if belated) focus on the relational and interpersonal aspects of effective practice with offenders is strongly supported by research evidence from psychotherapy...
 - ... which suggests that specific methods of intervention have a relatively minor role in determining success and that...
 - ...common (treatment) factors are responsible for bringing about change."



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Principles of Effective Treatment: A Common Factors Model

- Studies designed to identify the relationship of treatment elements to treatment outcome generally conclude that elements common to all forms of effective treatment are most responsible for efficacy in treatment...
 - ... rather than technique or orientation.
- Technique has the least relevance in the provision of effective treatment.



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**Principles of Effective Treatment:
A Common Factors Model**

Common factors such as the *therapeutic relationship*, the *creation of hope, clarification and explanation*, a *pathway to improved mental health*, and opportunities for *emotional release*...
...remain important explanatory variables for the similar outcomes of different therapies.
-Holmes & Bateman, 2002



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Common Treatment Factors in Effective Treatment


- Most of what happens in successful treatment is unrelated to treatment model or technique, and effective treatment outcomes...
... are instead related to factors common to all forms of effective therapy.
-Duncan, Miller, Wampold & Hubble, 2010; Kelly, Bickman, & Norwood, 2010; Lambert, 1992, 2005; Asay & Lambert, 1999; Lambert & Barley, 2002; Lambert & Bergin, 1993; Norcross & Lambert, 2011



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Common Treatment Factors in Effective Treatment

- In describing treatment in general (the principles of which are no different in work with sexual offenders)...
... Lambert (1992, 2005) notes that 85% of treatment outcome involves the highly interpersonal factors introduced by the therapist and the client together...
... embodied in the therapeutic alliance that forms between them and through which the work of treatment is accomplished.



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Common Treatment Factors in Effective Treatment

- According to Lambert, of the four elements most commonly associated with treatment efficacy, technique accounts for only 15% of the variance in treatment outcome.
- Lambert describes 85% of treatment success resulting from:
 - ✓ Client factors (40%)
 - ✓ Therapeutic alliance (30%)
 - ✓ The expectancy effects of placebo and hope (15%)
 - ✓ Technique (15%)



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Common Treatment Factors in Effective Treatment

- Norcross (2000) similarly asserts that treatment technique accounts for only 12% to 15% of the variance across therapies.
- In 1989, Kazdin and Bass wrote that techniques either do not play a powerful role or, if they do, research methods are not powerful enough to detect them.



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Common Treatment Factors in Effective Treatment

- Hubble, Duncan, Miller, and Wampold (2010) write, "these shared curative factors drive the engine of therapy."
- Factors related to the client and the therapeutic relationship appear to be the operating variables common to effective treatment, rather than the specific ideas and techniques of treatment associated with a particular therapeutic model.
- "These common factors are indeed the 'heart and soul' of therapy, a conjecture supported by the research evidence"
-Wampold, 2010



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Common Treatment Factors in Effective Treatment

"We wish that more psychotherapists would acknowledge the inseparable context and practical interdependence of the relationship and the treatment."
"That can prove a crucial step in... improving the effectiveness of psychotherapy."
-Norcross & Lambert, 2011



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Therapeutic Model and Technique

- If we accept the idea that technique has the least bearing on treatment outcome, then we recognize that in sex offense specific treatment...
... the primary application of a specific treatment model or technique is far less important than the manner in which they are used.



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Therapeutic Model and Technique

- Technique in the treatment of sexually abusive youth is a way of:
 - ✓ teaching and re-framing ideas
 - ✓ developing awareness
 - ✓ delivering instruction and information
 - ✓ providing corrective experiences with respect to patterns of thinking, social interactions, and behavior
- Alone, however, no technique is likely to produce effective results without being coupled to the larger framework of common factors that produce favorable treatment outcomes.
- Technique is very important, as is method and structure in treatment.



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Therapeutic Model and Technique


- However, when technique defines treatment, we risk having treatment become technique.
- Hubble, Duncan, Miller, & Wampold (2010) write...
 “Bluntly put, the existence of specific psychological treatments for specific disorders is a myth.”



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Therapeutic Model and Technique


“If the therapist becomes wedded to technique, remaining a craftsman...
 ... contact with patients will be objective, detached, and clean, but also superficial, manipulative... and ultimately not highly effective.
 “Training... should therefore be a way of teaching technique whose essence is mastered then forgotten....
 “... Only a person who has mastered technique and then contrived to forget it can become an expert therapist.”
 -Minuchin & Fishman, 1981



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Therapeutic Model and Technique


“If a person is just a technician, he or she will never transcend the use of techniques...
 “Only an artist can apply these scientific principles to the complexity of lives and find creative and new ways of making them relevant and workable in complex environments.”
 -Beutler, 2000



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The Application of Technique Restricts Clinical Relatedness


- Manualized treatment in work with adult sexual offenders doesn't allow for necessary flexibility in clinical style or the development of the therapeutic alliance.
- Rigid adherence to a manual reduces, if not eliminates, clinical flexibility.
-Marshall, 2006, 2009
- Manuals restrict the expression of therapist features that Marshall writes have repeatedly been shown to be central to treatment in both general clinical treatment and sexual offender specific treatment literature.
- Manualized treatments limit the ability to plan or implement treatment interventions based on individual case formulations, as well as limiting the creativity and freedom of the clinician.
-Marques et al., 2005



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The Treatment Relationship and Technique Driven Treatment


- Norcross (2000) asserts that the shift towards empiricized and standardized treatment is not only unrealistic and untenable...
... but also contains an effort to eliminate the individual therapist as a variable in effective treatment.



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The Treatment Relationship and Technique Driven Treatment

- Norcross (2002) asserts that the empirically-based model depicts a "disembodied" clinician performing standardized procedures...
... standing in marked contrast to the clinician's experience of treatment as an intensely interpersonal experience.
Empirically-based models validate the efficacy of treatments, or technical interventions, rather than the therapeutic relationship or the interpersonal skills of the clinician (Norcross, 2002).
- In so doing, evidence-based treatment risks reducing therapy to the level of technician, rather than clinician.



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The Treatment Relationship and Technique Driven Treatment

- In this model, therapy may be reduced to a technical, rather than a clinical, process, in which...
"Clients are reduced to a diagnosis and psychotherapists to technicians, while psychotherapy is administered like a pill."
-Duncan & Miller, 2005



The Treatment Relationship and Technique Driven Treatment

- Bohart and Tallman (2010) go further, advocating for the "abandonment" of empirically supported treatments...
... instead embracing the American Psychological Association's definition of evidence-based practice (2006).



The Treatment Relationship and Technique Driven Treatment

- In 2006, the APA Presidential Task Force on Evidence-Based Practice described and supported the significance of clinical expertise.
- They wrote that clinical expertise integrates the best research evidence with clinical data, while also understanding the influence of individual, cultural, and contextual differences in individual cases.
- Treatment "in the context of patient characteristics, culture, and preferences."



The Treatment Process

- Thus, with respect to our view about what makes treatment work...
 - ... we've recently come to believe that it's the treatment process, rather than treatment method or technique, that is most effective, or at least central, in the application of method.
- It is the treatment process that drives effective outcomes in treatment rather than the techniques of treatment or the materials we use.

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The Treatment Process

- These ideas fit with those found in the general literature of psychotherapy...
 - ... in which we are increasingly recognizing that what the clinician brings into treatment, in terms of attitude and characteristics, has a great deal of effect upon the outcomes of therapy.

-Baldwin, Wampold, & Imel, 2007; Elliott, Bohart, Watson, & Greenberg, 2011; Horvath, Del Re, Flückiger, & Symonds, 2011; Kolden, Klein, Wang, & Austin, 2011; Kramer, de Roten, Beretta, Michel, et al., 2008; Marmarosh, Gelsso, Markin, Mallery, et al. 2009; Norcross, & Lambert, 2011; Shirk, Karver, & Brown, 2011

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The Treatment Process

- There is an increasing recognition in our work with adolescent and adult offenders that the techniques and content of treatment are inadequate on their own.
- Treatment ideas and tasks are most effectively delivered and worked on through:
 - ✓ the therapeutic interaction between clinician and client,
 - ✓ the environment in which treatment and rehabilitation occurs, and
 - ✓ the investment of the client him/herself.

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Empirically Validated Elements of Effective Psychotherapeutic Treatment

- The APA Interdivisional Task Force on Evidence-Based Therapy Relationships produced 61 empirically validated principles of therapeutic change.
 - Castonguay & Beutler, 2006; Norcross, Beutler, & Levant, 2005
- These included the importance of client investment and participation in treatment, noting that effective treatments do not induce resistance in the client, and...
 - ... treatment outcome is enhanced if the client is willing to engage in the treatment process.



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Empirically Validated Elements of Effective Psychotherapeutic Treatment

Treatment is more likely to be beneficial if...

- ✓ The therapist is able to facilitate a high degree of collaboration with the client
- ✓ A therapeutic alliance is established and maintained in which clinicians both experience empathy for their clients and...
- ✓ Are experienced by their clients as authentic in the relationship.



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Empirically Validated Elements of Effective Psychotherapeutic Treatment

With respect to the clinician in the therapeutic relationship, treatment effectiveness is likely to be enhanced if the therapist:

- ✓ demonstrates open-mindedness and flexibility,
- ✓ is patient and able to tolerate any negative feelings he or she may experience about the client, and
- ✓ is comfortable with an emotionally connected treatment relationship.

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Treatment Process Versus Treatment Method

- Indeed, Beech and Hamilton-Giachritsis (2005) describe a change in the treatment of adult sexual offenders...
... from a direct and confrontational style to a model built on supportive and emotionally responsive treatment relationships.
- Similarly, Marshall (2005) recommends that clinicians adopt a relationally-based approach to treatment, in which...
... the attributes and behaviors of the therapist more greatly influence behavioral change than the techniques and methods of treatment manuals.



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Treatment Process Versus Treatment Method

- In work with sexually abusive youth, Longo and Prescott (2006) similarly emphasize the use of a warm, empathic, and rewarding approach over a hostile, confrontational, and harsh treatment style...
... which they conclude is ineffective with sexually abusive youth.
- Similarly, Ward and Salmon (2011) write that an emphasis on relationships in the treatment of adult sexual offenders "helps to create a powerful medium for change."



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Treatment Process Versus Treatment Method

- In our work with juveniles, this relationship includes:
- ✓ the fit between the emotional experiences of both clinician and youth,
 - ✓ the effect of the clinician's attitudes on the client,
and
 - ✓ the youth's investment of trust, safety, and faith in the therapist as an agent of hope and change.
- Dryden, 1989



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The Therapeutic Alliance

- Although cognitive-behavioral work is important in sex offender specific, and will remain central to any sex offender specific treatment program...
... the therapist uses interactional techniques imparted through the therapeutic alliance.
- It is through this relationship, as well as other techniques and practices of treatment...
... that a treatment environment and relationship is established that can help re-build attachment, connection to others, and social belongingness.



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The Therapeutic Alliance


Ultimately, the emphasis in a attachment-oriented therapy is on the development of an understanding, supportive, and caring relationship, marked by attunement between the therapist and the client.



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The Therapeutic Interaction

- Whatever its form, individual therapy is administered through the relationship between the clinician and the client.
- In addition, effective therapy always requires the active participation of the client and many have suggested that, more than any other factor, such participation is the primary key to therapeutic success.
- Indeed, many, if not most, believe that a critical and essential factor in therapy is the client-clinician relationship, or the therapeutic alliance.



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The Facilitative Role of the Therapeutic Alliance

Allen (1995) writes that when working with clients who have experienced difficult childhood relationships with parents and/or other adverse experiences...

... the clinician must overcome three obstacles to the development of the therapeutic relationship:

1. Distrust of authority figures.
2. The possibility of dependency upon the clinician, which he points out is an especially difficult area because psychotherapy requires a degree of dependency.
3. Difficulties with boundary development, and especially in work with clients who have previously experienced behavioral difficulties and faced difficult relationships with parents and other caregivers.



The Facilitative Role of the Therapeutic Alliance

- Nevertheless, it is through the special relationship embodied in the therapeutic alliance, and the safe boundaries within that relationship, that client growth is sparked and enhanced.
- This idea is echoed by O'Brien, Pilowsky, and Lewis (1992) : "Children conceive of the therapist as a real object in their lives, one who offers a viewpoint different from others and, above all, who allows the testing of new ideas and new ways of feeling and behaving in a supporting and supportive environment...."

"...Thus, therapy allows the children to experience and experiment."

- The therapeutic relationship is thus facilitative.



The Facilitative Role of the Therapeutic Alliance

However, for client development to occur in what he calls the facilitative treatment environment, Rogers (1980) describes three necessary elements.



The Facilitative Role of the Therapeutic Alliance:
1. Congruence and Authenticity

- Rogers' first condition involves the authenticity of the clinician, or "congruence."
 The therapist is genuine, transparent, and honest in the therapeutic relationship, "putting up no professional front or personal facade... (in which) the client can see right through what the therapist is in the relationship."
- In other words, the therapist is real and present, and fully engaged in the therapeutic relationship.




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The Facilitative Role of the Therapeutic Alliance:
1. Congruence and Authenticity


- Kolden, Klein, Wang, and Austin (2011) describe congruence or genuineness as a highly valued relational quality in the therapist.
 - ✓ Therapists must embrace the idea of striving for genuineness with their clients.
 - ✓ Therapists can develop the quality of congruence.
 - ✓ Therapists can model congruence.
 - ✓ Congruent responses are honest.
 - ✓ Congruent responses are not disrespectful, overly intellectualized, or insincere. They are authentic and consistent with the therapist as a real person.
 - ✓ The maintenance of congruence requires that therapists be aware of instances when congruence falters.



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The Facilitative Role of the Therapeutic Alliance:
1. Congruence and Authenticity

- ✓ Effective therapists modify and tailor their congruence style according to client presentation.
- ✓ Congruence may be especially important with younger, less educated, and perhaps less sophisticated clients, such as adolescents and young adults.
- ✓ The congruent therapist communicates acceptance and the possibility of engaging in an authentic relationship.
- ✓ Congruence appears to be especially apparent in psychotherapy with more experienced clinicians.
- ✓ Experienced therapists may recognize and more carefully discern a client's need for relational congruence.



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**The Facilitative Role of the Therapeutic Alliance:
2. Unconditional Positive Regard**

- Rogers' second condition for facilitative growth involves creating in the client a sense of feeling accepted, cared for, and prized, a condition he termed "unconditional positive regard."
The therapist is recognized and experienced by the client as present and honest, who in turn experiences a sense of being recognized, understood, and valued by the therapist.



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**The Facilitative Role of the Therapeutic Alliance:
2. Unconditional Positive Regard**

- Unconditional positive regard allows clients to feel recognized, valued, cared for, and accepted.
- These are the very qualities that we wish to instill, develop, or unlock in the treatment of sexually abusive youth.
- They are also the same qualities that sexually abusive youth must experience from others in their environment, whether in their own homes, the community, or in the therapeutic relationship.
- Accordingly, we recognize that being valued and cared for is the first step in the development of the capacity to value and care for others.



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**The Facilitative Role of the Therapeutic Alliance:
3. Therapeutic Empathy**

- Rogers' third facilitative aspect of the therapeutic relationship is empathic understanding, in which:
"The therapist senses accurately the feelings and personal meanings that the client is experiencing and communicates this understanding to the client."
Rogers describes the ideal therapist as, "first of all, empathic," in which empathic understanding is provided freely, and not drawn from, the therapist.



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The Facilitative Role of the Therapeutic Alliance: 3. Therapeutic Empathy

- Rogers describes empathy in therapy as the ability of the therapist to enter the world of the client, understanding and demonstrating sensitivity to the personal experiences of the client.
- Therapeutic empathy must be authentic.
- Rogers warns that brilliance and diagnostic skills are unrelated to empathy, and that...
"Clients are better judges of the degree of empathy than are therapists."

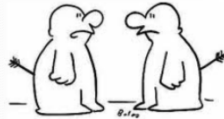


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On Therapeutic Empathy

- In building a therapeutic relationship a central task for the clinician is to become a source of security for the client.
- -Bowlby, 1988
- Bowlby (1980) writes unless a therapist can enable the client to feel secure, therapy cannot begin....
"The therapist strives to be reliable, attentive, and sympathetically responsive... and, so far as he can, to see and feel the world through his [or her] patient's eyes, namely to be empathic."



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On Therapeutic Empathy

- This aspect of therapeutic empathy is central to the therapeutic relationship, described by Rogers as essential to the facilitative treatment environment...
.... through which individuals are able to recognize and modify their attitudes, behaviors, and self-concepts.
- Part of the therapist's job in individual therapy is to provide the conditions under which self-healing, personal growth, and rehabilitation can best take place, thus creating the facilitative treatment environment described by Rogers.




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The Empathic Clinician

- Elliott, Bohart, Watson, and Greenberg (2011) describe therapeutic empathy as an essential goal for all clinicians, regardless of theoretical orientation, treatment model, and severity of client psychopathology.
 - ✓ Clinicians must understand their clients and demonstrate this understanding through their behaviors to the client.
 - ✓ The empathic therapist's primary task is to understand experiences rather than words.
 - ✓ Empathic therapists do not parrot clients' words back or reflect only the content of those words.
 - ✓ Empathic therapists assist clients to express their experience in words so that clients can deepen their experience and become more self-reflective.




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The Empathic Clinician

- ✓ Empathy entails individualizing responses to particular clients.
- ✓ Therapists need to know when, and when not, to respond empathically.
- ✓ Therapists should assume neither that they are mind readers nor that their experience of understanding the client will be matched by the client feeling understood.
- ✓ Empathy should always be offered with humility and held lightly, ready to be corrected.
- ✓ Because research has shown empathy to be inseparable from other relational conditions, clinicians should seek to offer empathy in the context of positive regard and genuineness.


Empathy will not be effective unless it is grounded in authentic caring for the client.



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The Empathic Clinician

"We encourage psychotherapists to value empathy as both an 'ingredient' of a healthy therapeutic relationship as well as a specific, effective response that promotes strengthening of the self and deeper exploration."
 -Elliott, Bohart, Watson, and Greenberg (2011)



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Facilitative Therapy and the Treatment Alliance

- In the facilitative treatment climate, established through the therapeutic relationship...
... sexually abusive youth are not coerced, confronted, or even educated, into improved attitudes, increased self-awareness and awareness and concern for others, greater emotional and behavioral control, and prosocial behavior.
- It is, instead, through the therapeutic alliance that treatment becomes a joint venture into which the client willingly enters and engages in treatment.



Facilitative Therapy and the Treatment Alliance

Horvath and colleagues (2011) describe central elements of this aspect of the treatment relationship, based on their meta-analysis of over 200 research reports covering more than 14,000 treatments.

- ✓ The development and fostering of the alliance is not separate from the interventions clinicians implement to help their clients. It is influenced by and an essential and inseparable part of everything that happens in therapy. Its distinguishing feature is the focus on therapy as a collaborative enterprise.
- ✓ The development of a therapeutic alliance early in therapy is vital for therapy success.
- ✓ In the early phases of therapy, modulating the methods and tasks of therapy to suit the specific client's needs, expectations, and capacities is important in building the alliance.



Facilitative Therapy and the Treatment Alliance

- ✓ The strength of the alliance, within and between sessions, often fluctuates. These "normal" variations – as long as they are attended to and resolved – are associated with good treatment outcomes.
- ✓ Therapists' non-defensive responses to client negativity or hostility are critical for maintaining a good alliance.
- ✓ Therapists have to develop the ability to neither internalize nor ignore clients' negative responses.
- ✓ Therapists who are good at building a strong alliance tend to have better alliances with most of their clients.
- ✓ The reverse is also true.
- ✓ Alliance development is a skill and/or capacity that therapist can and should be trained to develop, just as they are trained to attend to other aspects of their practice.



The Treatment Alliance in Work With Juveniles

- Shirk, Karver, and Brown (2011) describe additional elements of the therapy relationship in work with children and adolescents.
- They write that the treatment alliance is an important predictor of effective therapy with juveniles, and may very well be an essential ingredient in successful treatment, and that alliances with both youth and their parents are predictive of positive treatment outcomes.
- Consequently, clinicians need to attend to the development of alliances with parents as well.



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The Treatment Alliance in Work With Juveniles

- Shirk et al. write that the formation of a therapeutic alliance with both youth and parent requires the therapist to attend to multiple perspectives and to develop a treatment plan that accommodates both youth and parent perspectives...
... and that the development and maintenance of a positive alliance over time predicts successful outcomes with youth.
- Kelly, Bickman, & Norwood (2010) similarly write that caregivers and family obviously play an important role in work with children and adolescents...
... family involvement and participation are key factors influencing and shaping youth engagement in treatment and effective outcomes.



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The Treatment Alliance in Work With Juveniles

- Shirk et al. also advise clinicians to monitor the treatment alliance over the course of treatment...
... not simply as an early treatment task but also as a recurrent and on-going task.
- They write that youth are likely to have a limited understanding of therapy.
- The early development of a therapy alliance requires the therapist to balance actively listening to the youth and providing an explicit framework for understanding therapy processes.
- Over-emphasizing framework without actively listening to the client interferes with alliance building, at least with adolescents.




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Understanding the Therapeutic Process


- Norcross and Wampold (2011) write that the therapeutic relationship accounts for why clients improve in treatment, at least as much as the particular treatment method...
... and develops and acts in sync with treatment methods, client characteristics, and the qualities that the clinician brings to treatment.
- They recommend that clinicians make the therapeutic relationship a primary goal in treatment, and routinely monitor the responses of their clients to the relationship, as well as ongoing treatment.



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Understanding the Therapeutic Process


- Lambert (2010) concurs that it is essential for clinicians to actively monitor and seek feedback from clients about the therapeutic relationship and treatment alliance.
- Such monitoring leads to increased opportunities to reestablish collaboration, improve the relationship, and modify treatment strategies.
- Norcross and Wampold (2011) also note that effective clinicians are responsive to the different needs of different clients...
... providing varying levels of relationship elements in different cases, and within the same case at different moments.



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Understanding the Therapeutic Process


- Norcross and also address what does not work in effective treatment.



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Understanding the Therapeutic Process


- ✓ Confrontation.
- ✓ Negative processes, such as comments or behaviors that are hostile, pejorative, critical, rejecting, or blaming.
- ✓ Assumptions. Clinicians who assume their client's perceptions of relationship satisfaction and treatment success are frequently inaccurate.
- ✓ Therapist-centricity. The client's observational perspective on the therapy relationship best predicts outcome, rather than the clinician's perspective. Clinical practice that relies on the therapist's perspective does not predict outcome as well.
- ✓ Rigidity.



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Understanding the Therapeutic Process

- ✓ Ostrich behavior, in which Norcross (2010) describes research showing that treatment alliance ruptures are common and frequently result in poor treatment outcomes and/or treatment termination...
 .. but are rarely addressed by clinicians.
 "Many psychotherapists apparently prefer... ostrich behavior: burying their heads in the sand and hoping (against hope) that early signs of a rupture do not materialize into negative outcome."
- ✓ Conformity and standardized treatment applied to all clients...
 ... which Norcross and Wampold refer to as the "procrustean bed" in which the client must "fit" the treatment rather than flexing the treatment to fit the client.



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Guidelines and Tips for Relational Therapy


- The practice of individual therapy is too far ranging in goals, scope, and orientation to apply a simple formula.
- However, there are some basic guidelines that underlie all applications and uses of individual therapy that can both instruct and keep the therapist on track, and ensure that the therapy is individualized.



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Nineteen Tips for Relational Therapy


1. Formulate the case
 Learn about the client and his or her developmental pathway, and the factors that have contributed to who the child is today and what motivated or led to his or her behaviors, including sexually abusive behavior.
 Develop a theory about what makes your client tick, and under what circumstances.
2. Recognize wholeness
 Your clients are more than simply, or only, sexually abusive youth. Recognize the totality, or the wholeness of your clients...
 ... and make sure that they recognize that you see and value them.
3. Build relationships
 Most of the work is about relationships and rehabilitation, not teaching concepts about sexually abusive behavior, although this is an essential part of the work.



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Nineteen Tips for Relational Therapy


4. Work from strengths
 Discover for yourself and help your clients find their strengths, and work to build upon these.
5. Be respectful
 Disrespect is unlikely to meet the goals of a positive therapeutic relationship or the rehabilitation of the juvenile, and is antithetical to the treatment alliance.
6. Use appropriate techniques
 Apply the correct technique to each client and each treatment situation. The technique should fit the client, rather than squeezing the client to fit the approach.
 Failure may otherwise be seen as client failure, rather than the failure of the technique, and this cannot serve the outcome of helping the child.



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Nineteen Tips for Relational Therapy

7. Like your clients
 It is not only important to not judge, dismiss, and disrespect clients, but more to the point it is important to actively *like* them.
8. Authenticity
 Be genuine in your relationships with your clients.
9. Demonstrate genuine interest
 Therapists not really interested in their clients, and especially when the clients are kids who can almost sense authenticity in adults, are not likely to do well with their clients.
10. Unlock and demonstrate empathy
 Experience the world that your client lives within, and the way that he or she experiences that world.
 Therapeutic attunement may help your client learn to recognize the experiences of and experience empathy for others.




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Nineteen Tips for Relational Therapy

11. [See the world through the eyes of the client](#)
 This is about the phenomenology of the juvenile, and also about empathy and connection. Clinicians must be able to understand the world of the client in the way that each client experiences it.

12. [Start where the client is at](#)
 Recognize the developmental, cognitive, and emotional capacities and individual needs of each client, and start treatment at that point. This means designing and employing interventions that match each client's current level.


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Nineteen Tips for Relational Therapy

13. [Maintain the right emotional distance](#)
 Recognize and respond to each client's attachment needs and style. Some clients need to get closer to you, some need to remain more distant. Maintaining your own appropriate boundaries will help you to set the "right" emotional distance, based on the individual needs and styles of each client.


14. [Pace treatment](#)
 Some things happen later in treatment rather than earlier. Don't expect too much too soon, and think about a logical progression in treatment for each client.


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Nineteen Tips for Relational Therapy

15. [Push clients further](#)
 Pacing is essential, beginning with guideline number 12, in which the clinician works at the client's level. Nevertheless, clinicians must continue to assess clients throughout treatment and take them further, ensuring not only that they learn new ideas, acquire new information, develop new language, and experience insight and retain these things...
 ... but go deeper and further until the point that treatment is considered to be over.



16. [Take clients where they don't want to go](#)
 Clients are often uncomfortable with the behaviors that brought them into treatment – that is, their sexually abusive behavior. However, building on the therapeutic relationship and treatment alliance, and the pacing of treatment, taking clients to uncomfortable emotional places is key.


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Nineteen Tips for Relational Therapy

17. Help clients be uncomfortable
 Encourage clients to go to emotionally charged places they'd rather avoid, and usually do avoid through some form of emotional numbing or distraction.
 Support juveniles when they get to those affectively laden places, helping them recognize that they can tolerate the discomfort and thus face and eventually overcome the emotional problem.



18. Expect regression
 At different times and under different circumstances, clients will move forward and then appear to fall back in treatment. They usually haven't really fallen back, but have just stepped off to one side or taken a dead end road. They may not be able to move forward, but they almost certainly haven't lost all of the gains previously made.

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Nineteen Tips for Relational Therapy

19. Recognize that change comes slowly
 Recognize that changing means giving up prior ways of behaving that were, more likely than not, adaptive in some way. Change not only means finding new ways to adapt, but comes slowly.

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Implications for Practice

Finally, Bohart and Tallman (2010) recommend that:

- ✓ Therapists enlist and promote client strengths, resources, and personal agency.
- ✓ Therapists believe their clients are motivated and capable of proactive change.
- ✓ Therapists promote client involvement: Psychotherapy is a collaborative endeavor.
- ✓ Therapists listen to clients and privilege their experience and ideas.
- ✓ Therapists are trained to value clients: their strengths, ideas, and propensities for self-healing.
- ✓ Therapists are trained to listen, emphasizing that "listening is an art."
- ✓ We abandon empirically supported treatment, instead embracing evidence-based practice.
- ✓ We renew our interest in person-centered care.



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The Facilitative Treatment Environment

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The Developmentally Sensitive Treatment Environment

- Treatment that is sensitive to developmental needs, or a developmentally sensitive model...
... recognizes the impact of the social environment on child and adolescent development.
- It is aimed at multiple goals that connect the young person to the larger social community, including...
 - ✓ Attachment
 - ✓ Competency in social skills
 - ✓ The resolution of trauma and other developmental injuries and
 - ✓ Self-regulation

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The Developmentally Sensitive Treatment Environment

- In operation, the model is aimed at changing behavior and relationships by rehabilitating ideas, attitudes, and beliefs about the world...
... and through the development of a stronger sense of self-confidence, confidence in others, and a confident sense of social belonging and relatedness.

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The Developmentally Sensitive Treatment Environment

- A developmentally sensitive model recognizes and treats youths as “whole” children...
 - ... whose sexually troubled behaviors are one part of a much larger complex of emotional, cognitive, behavioral, and social problems...
 - ... many of which are the outgrowth of earlier adverse childhood experiences, attachment difficulties, and insecure and troubled attachments to others.

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The Facilitative Treatment Environment

- The treatment environment is simultaneously the medium through which treatment occurs...
 - ... and itself a mirror of the treatment that is provided.
- Additionally this environment does not simply define and shape treatment...
 - ... but is also the channel through which attachments and connections are fermented and form.
- The treatment environment is the environment in which treatment relationships develop and thrive...
 - ... and which serves as the unspoken marker of the safe, supportive, attuned, and trusted treatment relationship.

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The Facilitative Treatment Environment

- Beyond what we say in words, embedded within the treatment environment are the hidden dynamics and regulators of attachment – not what we say, but how we say it and how we behave.
- The treatment environment sits in the background, but is always active, not merely dormant.
- In the treatment environment, care givers are “agents of change,” through whom children and adolescents are helped to change, develop prosocial skills and healthy relationships, and thrive in their development.

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Adding a Developmentally-Sensitive Layer

A treatment environment that is sensitive to developmental and social needs recognizes that skills develop and are acquired, not in a vacuum...
.. and not as a pure result of the individual's efforts...
... but in, through, and in concert with the social environment.

Adding a Developmentally-Sensitive Layer

However, a treatment model attuned to and sensitive to developmental needs not only recognizes the impact of the environment in contributing to, creating, or maintaining difficulties in psychosocial functioning...
... but also recognizes the role of the environment in treating problems in real time, in the here and now.

Adding a Developmentally-Sensitive Layer

If we wish to build treatment environments that foster attachments and connections, and a sense of social relatedness in our clients...
... they must take into account at least nine elements.

Nine Elements of the Facilitative Treatment Environment

- 1. The treatment environment must be safe.**
The environment, people, and social situations in the environment must be experienced as physically and emotionally safe.
- 2. The treatment environment must be structured, predictable, and well-defined.**
Personal security is first and foremost about physical and emotional safety.
This calls for clients to experience the treatment environment as organized, consistent, non-chaotic, and stable, and thus predictable.
For many sexually abusive youth, this may be the first time they've had such an experience.

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Nine Elements of the Facilitative Treatment Environment

- 3. The treatment environment must be understanding, supportive, respectful, and attuned.**
Supportive and facilitative environments are dependent on the ability of caregivers to provide positive and prosocial support to its developing children...
... in which desired behaviors and attitudes are most effectively taught through role modeling.
- 4. The treatment environment must be therapeutic, designed to heal, care for, and restore to health...**
... rather than simply controlling and managing behavior.

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Nine Elements of the Facilitative Treatment Environment

- 5. The treatment environment must be strength-based.**
It recognizes and builds upon strengths, provides opportunities for strength building and skill development.
It works to help clients identify with their strengths, rather than their deficits.
- 6. The treatment environment is encouraging and focused on recognition and praise.**
It uses praise to support, teach, reinforce, and encourage strengths, and assist clients to recognize and build on their strengths.
It uses praise freely, but not lightly.
Praise will otherwise be inauthentic, and recognized as such by clients.



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Nine Elements of the Facilitative Treatment Environment

7. The treatment environment favors and emphasizes collaboration...
 ... between treatment staff and clients and, in group care and family treatment settings, among clients.
 The message?
We are working on this together!

8. The treatment environment has clear and predictable boundaries...
 ... which provide for safety, define roles, and establish some level of directionality (clinician-client, for instance).
 Boundaries are not only about safety.
 They are also instructive, rich in invisible information about roles and relationships, social expectations and what is inappropriate...
 ... and how far we may travel in different relationships.

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Nine Elements of the Facilitative Treatment Environment

9. The treatment environment is relationship-based and attachment friendly.
 It recognizes the importance and power of relationships, relationships are promoted and supported, and opportunities are provided for connection to others.
 It is not a sterile environment, devoid of genuine interpersonal relationships...
 ... even if appropriate and relevant limitations and boundaries are necessarily placed on the nature of those relationships in treatment environments.

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The Power of the Environment: The "Snowball Effect"


- Physical, emotional, and social environments that do not support, allow for, or provide opportunities for growth are not likely to help children and adolescents change.
- Treatment environments that are ineffective:
 - ✓ Fail to understand the problems that reside beneath the surface
 - ✓ Do not provide elements necessary for change and
 - ✓ May even fuel and amplify existing problems, in some cases making the problem bigger and more entrenched



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The Power of the Environment: The "Snowball Effect"

- Under these circumstances, problem attitudes, behaviors, and relationships may "snowball" and grow larger...
... becoming more fixed rather than moving towards change.
- Conversely, effective treatment environments recognize, understand, and provide the elements and relationships that support, promote, and provide opportunities for change...
... as well as understanding that change comes slowly.




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And, Finally...

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Treatment is Brain-Based

- Back to where we started...
"People don't come preassembled, but are glued together by life."
-LeDoux, 2002
- Regardless of temperament or other biological predispositions, the central idea here is that nature works with nurture to produce the people we become.
- We recognize that the developing brain is both shaped internally by biology and externally via experience and interactions in the social world...
... and that biological markers work with environmental factors.



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Treatment is Brain-Based

- In this respect, a developmentally-sensitive model of treatment is a brain-based model.
- It recognizes that attachment and other childhood experiences profoundly affect neurological development in children...
... and also that neural development continues through adolescence and into young adulthood.
- That is, the experience, and not simply the content, of therapy influences the rehabilitative changes we seek in our clients.

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Treatment is Brain-Based

- It is brain-based because, beyond what treatment is saying to our clients in words, in workbooks, or in cognitive behavioral and psychoeducational instruction...
... it is what treatment is saying at the experiential and relational level that is of central importance.
- As such, non-verbal learning and the unspoken messages of treatment are certainly among the most important elements of treatment.

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The Therapeutic Relationship and the Brain

- The quality of content is important in the treatment of sexually abusive youth...
... but the quality of contact is even more important in a facilitative model of treatment.
- With respect to the goal of attunement, Siegel (1999) describes the experience of "feeling felt" by another person, and asserts that attunement provides the non-verbal, brain-based basis for collaborative and engaged communication.

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The Therapeutic Relationship and the Brain

- Accordingly, Schore (1994) describes a key task for the therapist as getting in tune with the client, providing a mirroring and reflective function...
... in which the clinician becomes psychobiologically attuned to the client's emotional and mental state.
- Social attachments shape and re-shape, organize and re-organize neural structure, and physiologically regulate and modify neurobiological processes
-Amini et al., 1996; Schore, 2001; Siegel, 2001

The Therapeutic Relationship and the Brain

- In fact, Schore (2001) sees attachment theory as a regulatory theory, with implications for emotional and self-regulation capacities throughout life.
- Emphasizing the neurobiology of attachment and its effects upon brain development, Schore very much sees the therapeutic relationship as an attachment relationship.
- He asserts that for many clients the therapeutic relationship creates, for the first time, an optimal environment for the development of neural structures that can efficiently regulate affect.

The Therapeutic Relationship and the Brain

- Diana Fosha (2003) describes in similar terms the clinician's ability to access and engage in an unspoken emotional connection with the client, in which...
... "therapeutic discourse (is) conducted in a language that the right hemisphere speaks."
- Not only do therapeutic relationships clearly reflect many qualities of an attachment relationship (Parish & Eagle, 2003), but Amini et al. (1996) write that therapy works...
... because it is an attachment relationship," capable of regulating neurophysiology and altering underlying neural structure."

**What Makes Treatment Work?
A Therapy of Engagement**

Psychotherapy is:
 "At root a human relationship... Both parties bring themselves – their origins, culture, personalities, psychopathology, expectations, biases, defenses, and strengths – to the human relationship....
 "Some will judge that relationship a precondition of change and others a process of change, but all agree that it is a relational enterprise."
 -Norcross & Wampold, 2011



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**What Makes Treatment Work?
A Therapy of Engagement**


These relatively new ideas in sexual offender treatment...
 ... that we need to build therapeutic alliances with our clients, help instill hope in them, and help them grow...
 ... bring the treatment of juvenile (and adult) sexual offenders closer to therapeutic principles and processes already found in mainstream psychotherapy.



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**What Makes Treatment Work?
A Therapy of Engagement**


This is a therapy of engagement, in which the clinician is a significant conduit for self-realization and change in the client...
 ... and in which the therapeutic relationship becomes a crucible in which growth is fermented and from which change emerges.



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Treating Deficits in Social Skills

- The goal of teaching sexually abusive youth psychoeducational concepts...
... such as dysfunctional behavioral cycles and thinking errors that contribute or lead to sexually abusive behavior...
... has been and remains an important element in sex offender specific treatment.
- However, this work must be embedded into a larger and more complete treatment that also, and perhaps more significantly addresses deficits in attachment, social relatedness, and social skills.



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Treating Deficits in Social Skills

Such deficits include a limited ability to:

- ✓ Form meaningful and satisfying relationships
- ✓ Experience empathy and concern for others
- ✓ Engage in the behaviors, interactions, and relationships that are the backbone of appropriate social connection



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Summary/Final Words

- Treatment for both sexually abusive youth and adult sexual offenders has shifted during the past few years, and continues to do so, embracing ideas about the nature of the therapeutic process...
... rather than focused solely upon the delivery of psychoeducational and cognitive behavioral concepts related to sexually abusive behavior.

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Summary/Final Words

- Treatment for sexually abusive behavior has become more sophisticated.
- It recognizes and embraces elements common to all effective forms of treatment, rather than cognitive behavioral concepts alone...
... in which treatment is, perhaps above all, about relationships, social connection, and engagement in a healthy and safe community.

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Summary/Final Words

- In this more holistic model of rehabilitation, not only is treatment significantly about attachment and connection...
... but treatment must itself be delivered in a manner that is connective and relational.
- In this contemporary approach, the role of the clinician, the clinician's engagement in the treatment process, and the therapeutic relationship are each central and critical.

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The Facilitation of Change Through the Treatment Experience


- Through the warmth, concern, support, safety, and structure provided in the empathic and attuned treatment environment...
... sexually abusive youth are experienced as children and young people with many complex needs.
- This includes the need to be recognized and understood by others.



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The Facilitation of Change Through the Treatment Experience

- Perhaps more to the point, they must experience themselves as being seen and understood by others.
- Through this experience, they are enabled to see and explore themselves in a different light.
- In turn, they are able to see and experience other people in a different light.



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The Facilitation of Change Through the Treatment Experience

However, the qualities that we wish to develop in sexually abusive youth...

....not only of behavioral restraint, appropriate social and sexual boundaries, and belongingness...

... but also empathy and concern for and the valuing of others...

... are exactly those qualities that juvenile sexual offenders must themselves experience from others in their environment, including...

... and perhaps, especially, those who provide treatment.



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The Forensic Mental Health Association of California
The 39th Annual Conference
Monterey, CA

Contemporary Thinking and Approaches to Work with Sexually Abusive Youth

Friday March 21, 2014

Presented by

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Workshop Description

Workshop Outline

This workshop will discuss contemporary thinking regarding treatment for sexually abusive youth, and will review recent empirical and clinical/theoretical literature that helps establish current directions in and approaches to treatment. This includes a shift to a developmentally-sensitive and relational approach to treatment and treatment that is holistic, multidimensional, and collaborative, aimed at rehabilitation and personal change. The workshop will also include case examples as a means for better understanding the actual application of ideas in treatment.

Workshop Objectives

At the conclusion of this ws, participants will...

1. Understand the elements of a relational model to the treatment of sexually abusive youth.
2. Understand the elements of attachment-informed and developmentally-sensitive treatment environment.
3. Be able to describe the importance of individualized variables in the treatment of each individual client.

Emerging Ideas, Themes, and Models

- An expanding and evolving literature over the past decade has created a “new age” in the development and advancement of our thinking and practice, in which we increasingly recognize troubled young people as “whole” people.
- We also increasingly recognize the need for a multifaceted and multidimensional approach to treatment.
- We recognize also that healthy people emerge from healthy communities. In turn, healthy people, in healthy families, in healthy communities, engage in healthy behavior.
- In an ecological environment, healthy behavior fosters the development of healthy communities, healthy families, and healthy people.
- When we consider juveniles from this perspective, it provides a rich contextual nature to how we understand their behavior, the foundation of their behavior, and the future of their behavior.
- It means that we understand risk factors in light of developmental considerations regarding the biological and psychological growth and the emergence of adolescence from childhood.
- It also means that we recognize that risk factors for sexually abusive and other forms of antisocial behavior emerge from, and are embedded within, the deeply contextual and interwoven systems of the social environment.

The Environment is Active

- The social environment in which the child is raised is not just an important, but passive backdrop to the development of social connection, self-regulation, and moral behavior.
- The social environment itself is an active ingredient in social development.
- This is not only true in the development of sexually abusive behavior, but also in the treatment of sexually abusive behavior.

Treatment is Developmentally and Contextually Sensitive

- Treatment in the developmental context isn't only about cognitive-behavioral therapy and psychoeducational treatments.
- Of great importance is the manner in which we approach and see our clients, and the way in which we help them to think about themselves and others.

Treatment in the Developmental Context

We recognize the power of developmental experience and social context:

- The formation of personality
- Neurological development
- Social connectedness
- Social competence
- Current behavior

Glued Together by Life

- “People don't come preassembled, but are glued together by life” (LeDoux, 2002).
- Pless and Stein (1996) write that much of the research on stress, risk, protection against risk, and the development of resilience in children and adolescents makes sense only when seen from a developmental point of view, in which a central feature of juvenile experience and behavior is “the dynamic background of developmental change.”
- Our current thinking is that children and adolescents are still being glued together by life and, in reality, are very much in that process.

Working with Sexually Abusive Youth

- Working with sexually abusive youth is a substantially different proposition than work with adult offenders.
- This is primarily because sexually abusive behavior in both children and adolescents appears far more tied to developmental issues than sexual deviance, including:
 - i. The emergence of personality, psychological development,
 - ii. Response to the social environment and social messages, and
 - iii. the myriad of forces that shape and define the emotions, cognitions, relationships, and behavior of children and adolescents.

Behavior in the Developmental Context

- Adolescent behavior, including sexually abusive behavior, is far more influenced by developing biological, motional, cognitive, and social systems, and the social environment in general, than adult behavior.
- This view distinguishes adolescents from adults, not just by physical size or life experience, but also by developmental stage and resulting differences in experiences of and responses to the social environment in which children and adolescents live, learn, and develop.
- The contexts and circumstances under which adolescent behavior emerges are usually quite different than those that surround adult behavior.
- Adolescent behavior is far more sensitive to the background contexts and circumstances from which they emerge.
- Consequently, juvenile sexually abusive behavior must also be understood in a manner that is sensitive to:
 - Physical (including neurological) and psychological development
 - Circumstances present in the social environment that partially give rise to adolescent behavior, and
 - The meaning of behavior in the context of the social environment.

“Less Guilty by Reason of Adolescence”

- Highlighting these differences in understanding, evaluating, and making decisions about adolescent antisocial behavior, Steinberg and Scott (2003) describe young offenders as “less guilty by reason of adolescence.”
- They write that, even when the cognitive capacities of adolescents are close to those of adults, their judgment lags behind due to their psychosocial immaturity. ”
- In understanding differences between adult and adolescent decision making, in adolescents Steinberg and Scott point to:
 - Greater susceptibility to peer influence,
 - Immature attitudes toward and perceptions of risk,
 - A different and unformed orientation to the future, and
 - A more limited capacity for self-management.
- In describing the conceptual skills of adolescents, Steinberg (2005) writes it is though “one is starting an engine without yet having a skilled driver behind the wheel.”

Development and Personal Responsibility in Troubled Adolescents

- Understanding children and adolescents partly as a product of physical development and partly the social environment is a statement that we cannot reasonably or fully understand juveniles and their behavioral choices without understanding the larger contexts out of which behavior develops.
- It is not a way of saying that juveniles:
 - are not responsible for their choices,
 - have no free will,
 - do not understand or have no capacity to recognize the consequences of their behaviors, or
 - are merely the products of physical and social developmental forces.
- Adolescents are capable of making choices.
- In many respects adolescents are as capable as adults, informed by accurate perceptions of right and wrong (Epstein, 2007)
- Although we recognize juvenile behavior in the contexts of physical, psychological, social development, and the socio-cultural environment, we also recognize that juveniles are not passive beings and do make volitional behavioral choices for which, to varying degrees, they are responsible.

Juvenile Behavior and Responsibility

- In most cases, children and adolescents, to varying degrees based in part upon their age, cognitive development, and cognitive skill, are responsible for their behavioral choices.
- We recognize intentionality in children and adolescents, even as we recognize that juveniles may not fully comprehend the nature and consequences of their behavior to self and others.
- Regardless of differences in development, the teen brain neither “causes” adolescent behavior, nor renders the adolescent incapable of significant cognitive and emotional decisions or accomplishment.
- “The teen years need to be what they used to be: a time not just of learning, but learning to be responsible” (Epstein, 2007).

A Balanced View of Juvenile Behavior

- Nevertheless, Steinberg (2003) emphasizes that differences in adolescent reasoning play out in action because adolescents differ from adults in:
 - Brain development
 - Psycho-social development
 - Capacity to consider the consequences of behavior
 - The manner in which they weigh rewards and risks
 - Their ability to plan ahead, and
 - Their ability to control their impulses

Maintaining a Balanced View of Juveniles

- These ideas illuminate a balance between recognizing the adolescent as a “person-in-development” and acknowledging the need to also recognize that adolescents make choices and are capable of accepting responsibility for their choices.
- It is the balance that is so critical in how we understand adolescent behavior and how we treat the outcome of such behavior.
- Ideas about child and adolescent development help us to consider differences in:
 1. How we recognize the course and meaning of sexually abusive behavior, .
 2. How we recognize, understand, and evaluate risk for future sexually abusive behavior, and
 3. How we treat sexually abusive behavior.

Treatment in the Ecological Environment

- As in mainstream psychotherapy, we have come to see children and adolescents in context, engaging with, influenced by, and contributing to an interacting set of social forces and systems.
- Here, the attitudes, beliefs, social interactions, and behaviors of our children can only be more fully understood in the context of the ecological environment (Bronfenbrenner, 1979; Elliot, Williams, & Hamburg, 1998).
- In the ecological environment, there is a constant interaction between individuals and other individuals, between individuals and the systems within they live and function, and between systems.
- Just as in a physical ecology, all aspects of the environment are linked, mutually interactive and influential.
- In adopting a developmental and ecological perspective, we can more easily see the “fit” between the sexually troubled behaviors of children and adolescents and the social environments in which they live, learn, and function and with which they constantly interact.
- This view has helped to promote treatment models such as multisystemic therapy, which work with delinquent and sexually troubled youths in and within their families and communities.

Our Changing Sensibility

- It is not that we have concluded that our former approach to the treatment of young people with sexual behavior problems was ineffective.
- In fact, there is no evidence that our former treatment methods did *not* work, at least based on well known and widely described statistics regarding juvenile sexual recidivism, which are our best and most obvious indicator of treatment effectiveness.

Our Changing Sensibility

- On the contrary, although different studies have reported different rates of recidivism, the most commonly reported statistics have consistently illustrated relatively low rates of sexual re-offense among juvenile sexual offenders, which are not likely to get much lower.
- Thus, changes and developments in our field reflect a change in our *perspective* about and *sense* of treatment, and a shift in our thinking about what it is that makes treatment effective or ineffective, as well as the manner in which we think about our clients.

Our Thinking Shapes Our Treatment

- In any model of treatment, our view as clinicians influences our work in three broad interacting categories, each of which build upon one another:
 1. The way we think about and understand the young people who we study and with whom we work, and what they need in treatment.
 2. Our ability to think about and plan our treatment interventions.
 3. The way that we interact with and relate to the people we are seeking to help.
- It is also, and perhaps more critically, reflective of:
 1. The manner in which we think about and understand adult and juvenile sexual offenders.
 2. The way we interact with and relate to our clients.
 3. The way in which we come to conceptualize what sexual offenders need in treatment.

The Application of Insight and the Exercise of Critical Thinking in Treatment

- For the individual sexually abusive youth, the treatment questions are what happened, how, why, and what can we do to ensure it doesn't happen again?
- However, the larger and more looming questions ask why do so many children sexually abuse other children, and how did this situation come about?
- What social forces have led to the development of so many children and adolescents who engage in sexually abusive behavior or behavior that is sexually troubled, or, at least, sexually precocious?
- Although we cannot possibly answer such complex issues, we can nevertheless approach these questions, asserting the importance of developing well-informed practitioners who consider and struggle with such questions, and think originally while engaging in the practice of assessment and treatment.
- Having strong and well-informed opinions can both shape our practice at the level of the individual youth and the way we think about juvenile sexual offenders and execute our practice at the broadest level.
- From this point of view, insight into the motivation, the mind, and the behavior of the sexually abusive youth is *critical* to effective practice.
- In each individual case, clinicians must understand how and why the juvenile sexually offended, and demonstrate this insight through clinical formulations that demonstrate knowledge into the case.
- In addition, they must be able to visualize and describe the youth's pathway to sexual offending, causation and motivation, psychological development, and the goal of or need filled for the youth by the offense.

The Application of Insight and the Exercise of Critical Thinking in Treatment

- This is very different from the model found in many programs today in which, despite changes in our field in thinking and practice, treatment is still conceived primarily as a cognitive process, largely delivered through the teaching of concepts and techniques to juvenile offenders.
- This model typically requires clinicians to teach such concepts and test for their acquisition and retention, but requires little clinical insight into motivation, the development of behavior, or the underlying psychology of the individual.
- Concerns about attachment and social connection, empathy, moral development and remorse, personal responsibility, sexual arousal, and other factors central to the treatment of juvenile sexual offenders are often addressed through treatment methods that require little insight in either the juvenile or the clinician, and often do not involve the family system.

Whole Treatment for Whole People

- We not only see our clients as multifaceted and multidimensional, and far more than just their sexually abusive behaviors, but we also see treatment itself as equally complex and far-reaching, and more than simply the sum of its parts.
- We also see an increasing recognition that treatment is not simply technique and the delivery of information, but that the therapeutic relationship itself lies at the heart of treatment.

What Makes Treatment Work?

- In a meta analysis of almost 3,000 juvenile sexual offenders, Reitzel and Carbonell (2006) concluded that treatment is effective in reducing the recurrence of sexually abusive behavior in juveniles.
- However, despite the focus on cognitive behavioral therapy in the treatment of sexually abusive juveniles and adults, with respect to what actually works in treatment sexually abusive youth Reitzel and Carbonell concluded we do not know.
- Despite many claims and the conventional wisdom that it is the CB aspect of sexual offender treatment that makes it effective, Reitzel and Carbonell concluded there is little to no clear evidence that this is true.
- The idea that CBT is effective has been “extended down to the (treatment of juvenile sexual offenders) with little direct empirical support” (p. 415).
- “There remain more questions than answers about ‘what works’ for juvenile sexual offenders” (p. 418).
- Similarly, and more recently, Långström et al. (2013) write “the scientific evidence (is) insufficient to determine if cognitive behavioral therapy... reduces sexual reoffending” (p. 3).
- They write that there is no evidence available to determine the effect of CBT on sexual re-offending among adult sexual offenders or sexually abusive youth, or the effectiveness of any treatment method aimed at preventing sexual re-offense among adolescent or pre-adolescent sexual offenders.
- They found insufficient evidence to determine whether CBT is more effective than standard treatment in preventing sexual offending, and concluded “there is insufficient evidence regarding benefits and risks of cognitive behavioral treatment for adults and adolescents who sexually abuse children and for children with sexual behavior problems” (p. 5).

What Makes Treatment Work?

- Nevertheless, despite the conclusions of Långström et al. (2013) and Reitzel and Carbonell's (2006) conclusion that we don't truly understand exactly what it is that makes the treatment of sexually abusive youth effective, we do have clues!
- Years of both practice and empirical research into the practice of psychotherapy in general yields important information about what does make treatment effective.
- This research base yields important information for us, not only about treatment in general, but also treatment for sexually abusive youth and adult sexual offenders.

What Makes Treatment Work?

- In describing standards of care for work with adult sexual offenders, McNeill, Batchelor, Burnett, and Knox (2005) write that research on therapist and therapy factors has reminded clinicians about the utility of seeking to establish a strong treatment alliance with offenders.
- They describe key skills for supporting change in adult sexual offenders, which include “building relationships that support change.”
- “It is clear from the psychotherapy and counseling literature that the relationship between the worker and the client is a critical factor in effective interventions.”
- This includes the practitioner's ability to:
 1. convey empathy, respect, warmth and genuineness
 2. establish a working alliance based on mutual understanding and agreement
 3. develop an approach that is person-centered and collaborative.
- McNeill et al. write that sexual offenders respond well to clinicians who are genuinely interested and concerned.
- “This emerging (if belated) focus on the relational and interpersonal aspects of effective practice with offenders is strongly supported by research evidence from psychotherapy which suggests that specific methods of intervention have a relatively minor role in determining success and that common (treatment) factors are responsible for bringing about change.”

Principles of Effective Treatment: A Common Factors Model

- Studies designed to identify the relationship of treatment elements to treatment outcome generally conclude that elements common to all forms of effective treatment are most responsible for efficacy in treatment, rather than technique or orientation.
- Technique has the least relevance in the provision of effective treatment.
- Common factors such as the therapeutic relationship, the creation of hope, clarification and explanation, a pathway to improved mental health, and opportunities for emotional release remain important explanatory variables for the similar outcomes of different therapies (Holmes & Bateman, 2002).

Common Treatment Factors in Effective Treatment

- Most of what happens in successful treatment is unrelated to treatment model or technique, and effective treatment outcomes are instead related to factors common to all forms of effective therapy (Duncan, Miller, Wampold, & Hubble, 2010; Kelly, Bickman, & Norwood, 2010; Lambert, 1992, 2005; Asay & Lambert, 1999; Lambert & Barley, 2002; Lambert & Bergin, 1993; Norcross & Lambert, 2011).
- In describing treatment in general (the principles of which are no different in work with sexual offenders), Lambert (1992, 2005) notes that 85% of treatment outcome involves the highly interpersonal factors introduced by the therapist and the client together embodied in the therapeutic alliance that forms between them and through which the work of treatment is accomplished.
- According to Lambert, of the four elements most commonly associated with treatment efficacy, technique accounts for only 15% of the variance in treatment outcome.
- He describes 85% of treatment success resulting from:
 - 1 Client factors (40%)
 - 2 Therapeutic alliance (30%)
 - 3 The expectancy effects of placebo and hope (15%)
 - 4 Technique (15%)
- Norcross (2000) similarly asserts that treatment technique accounts for only 12% to 15% of the variance across therapies.
- In 1989, Kazdin and Bass wrote that techniques either do not play a powerful role or, if they do, research methods are not powerful enough to detect them.
- Hubble, Duncan, Miller, and Wampold (2010) write, "these shared curative factors drive the engine of therapy" (p. 28).
- Factors related to the client and the therapeutic relationship appear to be the operating variables common to effective treatment, rather than the specific ideas and techniques of treatment associated with a particular therapeutic model.
- "These common factors are indeed the 'heart and soul' of therapy, a conjecture supported by the research evidence" (Wampold, (2010, p. 54).

Therapeutic Model and Technique

- Norcross and Lambert (2011) write, "We wish that more psychotherapists would acknowledge the inseparable context and practical interdependence of the relationship and the treatment... That can prove a crucial step in... improving the effectiveness of psychotherapy."
- If we accept the idea that technique has the least bearing on treatment outcome, then we recognize that in sex offense specific treatment the primary application of a specific treatment model or technique is far less important than the manner in which they are used.
- Technique in the treatment of sexually abusive youth is a way of:
 - teaching and re-framing ideas
 - developing awareness
 - delivering instruction and information
 - providing corrective experiences with respect to patterns of thinking, social interactions, and behavior
- Alone, however, no technique is likely to produce effective results without being coupled to the larger framework of common factors that produce favorable treatment outcomes.
- Technique is very important, as is method and structure in treatment.
- However, when technique defines treatment, we risk having treatment *become* technique.
- Hubble, Duncan, Miller, & Wampold (2010) write: "Bluntly put, the existence of specific psychological treatments for specific disorders is a myth" (p. 28).

Therapeutic Model and Technique

-Minuchin & Fishman, 1981

"If the therapist becomes wedded to technique, remaining a craftsman... contact with patients will be objective, detached, and clean, but also superficial, manipulative... and ultimately not highly effective.

"Training...should therefore be a way of teaching technique whose essence is mastered then forgotten....

" Only a person who has mastered technique and then contrived to forget it can become an expert therapist."

-Beutler, 2000

"If a person is just a technician, he or she will never transcend the use of techniques... Only an artist can apply these scientific principles to the complexity of lives and find creative and new ways of making them relevant and workable in complex environments."

The Application of Technique Restricts Clinical Relatedness

- Manualized treatment in work with adult sexual offenders doesn't allow for necessary flexibility in clinical style or the development of the therapeutic alliance.
- Rigid adherence to a manual reduces, if not eliminates, clinical flexibility (Marshall, 2006, 2009).
- Manuals restrict the expression of therapist features that Marshall writes have repeatedly been shown to be central to treatment in both general clinical treatment and sexual offender specific treatment literature.
- Manualized treatments limit the ability to plan or implement treatment interventions based on individual case formulations, as well as limiting the creativity and freedom of the clinician (Marques et al., 2005).

The Treatment Relationship and Technique Driven Treatment

- Norcross (2000) asserts that the shift towards empiricized and standardized treatment is not only unrealistic and untenable, but also contains an effort to eliminate the individual therapist as a variable in effective treatment.
- Norcross (2002) asserts that the empirically-based model depicts a "disembodied" clinician performing standardized procedures, standing in marked contrast to the clinician's experience of treatment as an intensely interpersonal experience.
- Norcross (2002) argues that empirically-based models validate the efficacy of *treatments*, or technical interventions, rather than the therapeutic relationship or the interpersonal skills of the clinician. In so doing, evidence-based treatment risks reducing therapy to the level of *technician*, rather than *clinician*.
- In this model, therapy may be reduced to a technical, rather than a clinical, process, in which "Clients are reduced to a diagnosis and psychotherapists to technicians, while psychotherapy is administered like a pill" (Duncan & Miller, 2005).
- Bohart and Tallman (2010) go further, advocating for the "abandonment" of empirically supported treatments, instead embracing the American Psychological Association's definition of evidence-based practice.
- In 2006, the APA Presidential Task Force on Evidence-Based Practice described and supported the significance of clinical expertise, writing that clinical expertise integrates the best research evidence with clinical data, while also understanding the influence of individual, cultural, and contextual differences in individual cases. Treatment "in the context of patient characteristics, culture, and preferences" (p. 273).

The Treatment Process

- Thus, with respect to our view about what makes treatment work, we've recently come to believe that it's the treatment process, rather than treatment method or technique, that is most effective, or at least central, in the application of method.
- It is the treatment process that drives effective outcomes in treatment rather than the techniques of treatment or the materials we use.
- These ideas, regarding the tx process rather than the techniques or contents of treatment, fit with those found in the general literature of psychotherapy, in which we are increasingly recognizing that what the clinician brings into treatment, in terms of attitude and characteristics, has a great deal of effect upon the outcomes of therapy (Baldwin, Wampold, & Imel, 2007; Elliott, Bohart, Watson, & Greenberg, 2011; Horvath, Del Re, Flückiger, & Symonds, 2011; Kolden, Klein, Wang, & Austin, 2011; Kramer, de Roten, Beretta, Michel, et al., 2008; Marmarosh, Gelso, Markin, Mallery, et al. 2009; Norcross, & Lambert, 2011; Shirk, Karver, & Brown, 2011).

The Treatment Process

- There is an increasing recognition in our work with adolescent and adult offenders that the techniques and content of treatment are inadequate on their own.
- Treatment ideas and tasks are most effectively delivered and worked on through:
 - The therapeutic interaction between clinician and client
 - The environment in which treatment and rehabilitation occurs
 - The investment of the client him/herself

Empirically Validated Elements of Effective Psychotherapeutic Treatment

- The APA Interdivisional Task Force on Evidence-Based Therapy Relationships produced 61 empirically validated principles of therapeutic change (Castonguay & Beutler, 2006; Norcross, Beutler, & Levant, 2005).
- These included the importance of client investment and participation in treatment, noting that effective treatments do not induce resistance in the client, and... treatment outcome is enhanced if the client is willing to engage in the treatment process.
- Treatment is more likely to be beneficial if:
 - The therapist is able to facilitate a high degree of collaboration with the client.
 - A therapeutic alliance is established and maintained in which clinicians both experience empathy for their clients, and are experienced by their clients as authentic in the relationship.
- With respect to the clinician in the therapeutic relationship, treatment effectiveness is likely to be enhanced if the therapist:
 - Demonstrates open-mindedness and flexibility
 - Is patient and able to tolerate any negative feelings he or she may experience about the client,
 - Is comfortable with an emotionally connected treatment relationship.

Treatment Process Versus Treatment Method

- Indeed, Beech and Hamilton-Giachritsis (2005) describe a change in the treatment of adult sexual offenders, from a direct and confrontational style to a model built on supportive and emotionally responsive treatment relationships.
- Similarly, Marshall (2005) recommends that clinicians adopt a relationally-based approach to treatment, in which the attributes and behaviors of the therapist more greatly influence behavioral change than the techniques and methods of treatment manuals.
- In work with sexually abusive youth, Longo and Prescott (2006) similarly emphasize the use of a warm, empathic, and rewarding approach over a hostile, confrontational, and harsh treatment style, which they conclude is ineffective with sexually abusive youth.
- Ward and Salmon (2011) also write that an emphasis on relationships in the treatment of adult sexual offenders “helps to create a powerful medium for change” (p. 411).
- In our work with juveniles, this relationship includes:
 - the fit between the emotional experiences of both clinician and youth,
 - the effect of the clinician’s attitudes on the client, and
 - and the youth’s investment of trust, safety, and faith in the therapist as an agent of hope and change (Dryden, 1989).

The Therapeutic Alliance

- Although cognitive-behavioral work is important in sex offender specific, and will remain central to any sex offender specific treatment program, the therapist uses interactional techniques imparted through the therapeutic alliance.
- It is through this relationship, as well as other techniques and practices of treatment, that a treatment environment and relationship is established that can help re-build attachment, connection to others, and social belongingness. Ultimately, the emphasis in an attachment-oriented therapy is on the development of an understanding, supportive, and caring relationship, marked by attunement between the therapist and the client.
- Whatever its form, individual therapy is administered through the relationship between the clinician and the client.
- In addition, effective therapy always requires the active participation of the client and many have suggested that, more than any other factor, such participation is the primary key to therapeutic success.
- Indeed, many, if not most, believe that a critical and essential factor in therapy is the client-clinician relationship, or the therapeutic alliance.

The Facilitative Role of the Therapeutic Alliance

- Allen (1995) writes that when working with clients who have experienced difficult childhood relationships with parents and/or other adverse experiences, the clinician must overcome three obstacles to the development of the therapeutic relationship:
 - Distrust of authority figures.
 - The possibility of dependency upon the clinician, which he points out is an especially difficult area because psychotherapy requires a degree of dependency.
 - Difficulties with boundary development, and especially in work with clients who have previously experienced behavioral difficulties and faced difficult relationships with parents and other caregivers.
- Nevertheless, it is through the special relationship embodied in the therapeutic alliance, and the safe boundaries within that relationship, that client growth is sparked and enhanced.
- This idea is echoed by O'Brien, Pilowsky, and Lewis (1992): "Children conceive of the therapist as a real object in their lives, one who offers a viewpoint different from others and, above all, who allows the testing of new ideas and new ways of feeling and behaving in a supporting and supportive environment....
"...Thus, therapy allows the children to experience and experiment."
- The therapeutic relationship is thus facilitative.
- However, for client development to occur in what he calls the facilitative treatment environment, Rogers (1980) describes three necessary elements.

The Facilitative Role of the Therapeutic Alliance: 1. Congruence and Authenticity

- Rogers' first condition involves the authenticity of the clinician, or "congruence."
- The therapist is genuine, transparent, and honest in the therapeutic relationship, "putting up no professional front or personal facade... (in which) the client can see right through what the therapist is in the relationship." In other words, the therapist is real and present, and fully engaged in the therapeutic relationship.
- Kolden, Klein, Wang, and Austin (2011) describe congruence or genuineness as a highly valued relational quality in the therapist.
 - Therapists must embrace the idea of striving for genuineness with their clients.
 - Therapists can develop the quality of congruence.
 - Therapists can model congruence. Congruent responses are honest. Congruent responses are not disrespectful, overly intellectualized, or insincere. They are authentic and consistent with the therapist as a real person.
 - The maintenance of congruence requires that therapists be aware of instances when congruence falters.
 - Effective therapists modify and tailor their congruence style according to client presentation.
 - Congruence may be especially important with younger, less educated, and perhaps less sophisticated clients, such as adolescents and young adults.
 - The congruent therapist communicates acceptance and the possibility of engaging in an authentic relationship.
 - Congruence appears to be especially apparent in psychotherapy with more experienced clinicians. Experienced therapists may recognize and more carefully discern a client's need for relational congruence.

The Facilitative Role of the Therapeutic Alliance: 2. Unconditional Positive Regard

- Rogers' second condition for facilitative growth involves creating in the client a sense of feeling accepted, cared for, and prized, a condition he termed "unconditional positive regard."
- The therapist is recognized and experienced by the client as present and honest, who in turn experiences a sense of being recognized, understood, and valued by the therapist.
- Unconditional positive regard allows clients to feel recognized, valued, cared for, and accepted.
- These are the very qualities that we wish to instill, develop, or unlock in the treatment of sexually abusive youth.
- They are also the same qualities that sexually abusive youth must experience from others in their environment, whether in their own homes, the community, or in the therapeutic relationship.
- Accordingly, we recognize that being valued and cared for is the first step in the development of the capacity to value and care for others.

The Facilitative Role of the Therapeutic Alliance: 3. Therapeutic Empathy

- Rogers' third facilitative aspect of the therapeutic relationship is empathic understanding, in which, "The therapist senses accurately the feelings and personal meanings that the client is experiencing and communicates this understanding to the client."
- Rogers describes the ideal therapist as, "first of all, empathic," in which empathic understanding is provided freely, and not drawn from, the therapist.
- Rogers describes empathy in therapy as the ability of the therapist to enter the world of the client, understanding and demonstrating sensitivity to the personal experiences of the client.
- Therapeutic empathy must be authentic. Rogers warns that brilliance and diagnostic skills are unrelated to empathy, and that "clients are better judges of the degree of empathy than are therapists."

On Therapeutic Empathy

- In building a therapeutic relationship a central task for the clinician is to become a source of security for the client (Bowlby, 1988).
- Bowlby (1980) writes unless a therapist can enable the client to feel secure, therapy cannot begin: "The therapist strives to be reliable, attentive, and sympathetically responsive... and, so far as he can, to see and feel the world through his [or her] patient's eyes, namely to be empathic" (p. 140).
- This aspect of therapeutic empathy is central to the therapeutic relationship, described by Rogers as essential to the facilitative treatment environment, through which individuals are able to recognize and modify their attitudes, behaviors, and self-concepts.
- Part of the therapist's job in individual therapy is to provide the conditions under which self-healing, personal growth, and rehabilitation can best take place, thus creating the facilitative treatment environment described by Rogers.

The Empathic Clinician

- Elliott, Bohart, Watson, and Greenberg (2011) describe therapeutic empathy as an essential goal for all clinicians, regardless of theoretical orientation, treatment model, and severity of client psychopathology.
 - Clinicians must understand their clients and demonstrate this understanding through their behaviors to the client.
 - The empathic therapist's primary task is to understand experiences rather than words.
 - Empathic therapists do not parrot clients' words back or reflect only the content of those words.
 - Empathic therapists assist clients to express their experience in words so that clients can deepen their experience and become more self-reflective.
 - Empathy entails individualizing responses to particular clients .
 - Therapists need to know when, and when not, to respond empathically.
 - Therapists should assume neither that they are mind readers nor that their experience of understanding the client will be matched by the client feeling understood.
 - Empathy should always be offered with humility and held lightly, ready to be corrected.
 - Because research has shown empathy to be inseparable from other relational conditions, clinicians should seek to offer empathy in the context of positive regard and genuineness. Empathy will not be effective unless it is grounded in authentic caring for the client.
- "We encourage psychotherapists to value empathy as both an 'ingredient' of a healthy therapeutic relationship as well as a specific, effective response that promotes strengthening of the self and deeper exploration."

Facilitative Therapy and the Treatment Alliance

- In the facilitative treatment climate, established through the therapeutic relationship, sexually abusive youth are not coerced, confronted, or even educated, into improved attitudes, increased self-awareness and awareness and concern for others, greater emotional and behavioral control, and prosocial behavior.
- It is, instead, through the therapeutic alliance that treatment becomes a joint venture into which the client willingly enters and engages in treatment.
- Horvath and colleagues (2011) describe central elements of this aspect of the treatment relationship, based on their meta-analysis of over 200 research reports covering more than 14,000 treatments.

Facilitative Therapy and the Treatment Alliance

- Horvath et al (2011)

- The development and fostering of the alliance is not separate from the interventions clinicians implement to help their clients. It is influenced by and an essential and inseparable part of everything that happens in therapy. Its distinguishing feature is the focus on therapy as a collaborative enterprise.
- The development of a therapeutic alliance early in therapy is vital for therapy success.
- In the early phases of therapy, modulating the methods and tasks of therapy to suit the specific client's needs, expectations, and capacities is important in building the alliance.
- The strength of the alliance, within and between sessions, often fluctuates. These "normal" variations – as long as they are attended to and resolved – are associated with good treatment outcomes.
- Therapists' non-defensive responses to client negativity or hostility are critical for maintaining a good alliance. Therapists have to develop the ability to neither internalize nor ignore clients' negative responses.
- Therapists who are good at building a strong alliance tend to have better alliances with most of their clients.
- The reverse is also true.
- Alliance development is a skill and/or capacity that therapist can and should be trained to develop just as they are trained to attend to other aspects of their practice.

The Treatment Alliance in Work With Juveniles

- Shirk, Karver, and Brown (2011) describe additional elements of the therapy relationship in work with children and adolescents.
- They write that the treatment alliance is an important predictor of effective therapy with juveniles, and may very well be an essential ingredient in successful treatment, and that alliances with both youth and their parents are predictive of positive treatment outcomes.
- Consequently, clinicians need to attend to the development of alliances with parents as well.
- Shirk et al. write that the formation of a therapeutic alliance with both youth and parent requires the therapist to attend to multiple perspectives and to develop a treatment plan that accommodates both youth and parent perspectives, and that the development and maintenance of a positive alliance over time predicts successful outcomes with youth.
- Kelly, Bickman, & Norwood (2010) similarly write that caregivers and family obviously play an important role in work with children and adolescents, and that family involvement and participation are key factors influencing and shaping youth engagement in treatment and effective outcomes.
- Shirk et al. also advise clinicians to monitor the treatment alliance over the course of treatment, not simply as an early treatment task but also as a recurrent and on-going task.
- They write that youth are likely to have a limited understanding of therapy.
- The early development of a therapy alliance requires the therapist to balance actively listening to the youth and providing an explicit framework for understanding therapy processes. Over-emphasizing framework without actively listening to the client interferes with alliance building, at least with adolescents.

Understanding the Therapeutic Process

- Norcross and Wampold (2011) write that the therapeutic relationship accounts for why clients improve in treatment, at least as much as the particular treatment method and develops and acts in sync with treatment methods, client characteristics, and the qualities that the clinician brings to treatment.
- They recommend that clinicians make the therapeutic relationship a primary goal in treatment, and routinely monitor the responses of their clients to the relationship, as well as ongoing treatment.
- Lambert (2010) concurs that is essential for clinicians to actively monitor and seek feedback from clients about the therapeutic relationship and treatment alliance.
- Such monitoring leads to increased opportunities to reestablish collaboration, improve the relationship, and modify treatment strategies.
- Norcross and Wampold also note that effective clinicians are responsive to the different needs of different clients, providing varying levels of relationship elements in different cases, and within the same case at different moments.

Understanding the Therapeutic Process

Norcross and Wampold (2011) also address what does not work in effective treatment.

- Confrontation.
- Negative processes, such as comments or behaviors that are hostile, pejorative, critical, rejecting, or blaming.
- Assumptions. Clinicians who assume their client's perceptions of relationship satisfaction and treatment success are frequently inaccurate.
- Therapist-centricity. The client's observational perspective on the therapy relationship best predicts outcome, rather than the clinician's perspective. Clinical practice that relies on the therapist's perspective does not predict outcome as well.
- Rigidity.
- Ostrich behavior, in which Norcross (2010) describes research showing that treatment alliance ruptures are common and frequently result in poor treatment outcomes and/or treatment termination, but are rarely addressed by clinicians. "Many psychotherapists apparently prefer... ostrich behavior: burying their heads in the sand and hoping (against hope) that early signs of a rupture do not materialize into negative outcome" (p. 131).
- Conformity and standardized treatment applied to all clients, which Norcross and Wampold refer to as the "procrustean bed" in which the client must "fit" the treatment rather than flexing the treatment to fit the client.

Guidelines and Tips for a Facilitative Therapy

- The practice of individual therapy is too far ranging in goals, scope, and orientation to apply a simple formula.
- However, there are some basic guidelines that underlie all applications and uses of individual therapy that can both instruct and keep the therapist on track, and ensure that the therapy is individualized.

Nineteen Tips for Facilitative Therapy

- 1 Formulate the case. Learn about the client and his or her developmental pathway, and the factors that have contributed to who the child is today and what motivated or led to his or her behaviors, including sexually abusive behavior. Develop a theory about what makes your client tick, and under what circumstances.
- 2 Recognize wholeness. Your clients are more than simply, or only, sexually abusive youth. Recognize the totality, or the wholeness of your clients and make sure that they recognize you see and value them.
- 3 Build relationships. Most of the work is about relationships and rehabilitation, not teaching concepts about sexually abusive behavior, although this is an essential part of the work.
- 4 Work from strengths. Discover for yourself and help your clients find their strengths, and work to build upon these.
- 5 Be respectful. Disrespect is unlikely to meet the goals of a positive therapeutic relationship or the rehabilitation or the juvenile, and is antithetical to the treatment alliance.
- 6 Use appropriate techniques. Apply the correct technique to each client and each treatment situation. The technique should fit the client, rather than squeezing the client to fit the approach. Failure may otherwise be seen as client failure, rather than the failure of the technique, and this cannot serve the outcome of helping the child.
- 7 Like your clients. It is not only important to not judge, dismiss, and disrespect clients, but more to the point it is important to actively *like* them.
- 8 Authenticity. Be genuine in your relationships with your clients.
- 9 Demonstrate genuine interest. Therapists not really interested in their clients are not likely to do well with their clients, and especially when the clients are kids who can almost sense authenticity in adults,
- 10 Unlock and demonstrate empathy. Experience the world that your client lives within, and the way that he or she experiences that world. Therapeutic attunement may help your client learn to recognize the experiences of and experience empathy for others.
- 11 See the world through the eyes of the client. This is about the phenomenology of the juvenile, and also about empathy and connection. Clinicians must be able to understand the world of the client in the way that each client experiences it.

continued

Nineteen Tips for Facilitative Therapy

continued

- 12 Start where the client is at. Recognize the developmental, cognitive, and emotional capacities and individual needs of each client, and start treatment at that point. This means designing and employing interventions that match each client's current level.
- 13 Maintain the right emotional distance. Recognize and respond to each client's attachment needs and style. Some clients need to get closer to you, some need to remain more distant. Maintaining your own appropriate boundaries will help you to set the "right" emotional distance, based on the individual needs and styles of each client.
- 14 Pace treatment. Some things happen later in treatment rather than earlier. Don't expect too much too soon, and think about a logical progression in treatment for each client.
- 15 Push clients further. Pacing is essential, beginning with guideline number 14, in which the clinician works at the client's level. Nevertheless, clinicians must continue to assess clients throughout treatment and take them further, ensuring not only that they learn new ideas, acquire new information, develop new language, and experience insight and retain these things, but go deeper and further until the point that treatment is considered to be over.
- 16 Take clients where they don't want to go. Clients are often uncomfortable with the behaviors that brought them into treatment – that is, their sexually abusive behavior. In many cases, they will also be uncomfortable with other aspects of their lives: their families, their relationships, their social skills, and their sense of who they are and how others experience them. However, building on the therapeutic relationship and treatment alliance, and the pacing of treatment, taking clients to uncomfortable emotional places is key.
- 17 Help clients be uncomfortable. The first part of this guideline is to encourage clients to go to emotionally charged places they'd rather avoid, and usually do avoid through some form of emotional numbing or distraction, such as oppositional behavior, substance abuse, aggression, dissociation, and even sexual aggression itself. The second part of the guideline is supporting juveniles when they get to those affectively laden places, helping them recognize that they can tolerate the discomfort and thus face and eventually overcome the emotional problem.
- 18 Expect regression. At different times and under different circumstances, clients will move forward and then appear to fall back in treatment. They usually haven't really fallen back, but have just stepped off to one side or taken a dead end road. They may not be able to move forward, but they almost certainly haven't lost all of the gains previously made.
- 19 Recognize that change comes slowly. Recognize that changing means giving up prior ways of behaving that were, more likely than not, adaptive in some way. Change not only means finding new ways to adapt, but comes slowly.

Implications for Practice

Finally, Bohart and Tallman (2010) recommend that:

- Therapists enlist and promote client strengths, resources, and personal agency.
- Therapists believe their clients are motivated and capable of proactive change.
- Therapists promote client involvement: Psychotherapy is a collaborative endeavor.
- Therapists listen to clients and privilege their experience and ideas.
- Therapists are trained to value clients: their strengths, ideas, and propensities for self-healing.
- Therapists are trained to listen, emphasizing that "listening is an art."
- We abandon empirically supported treatment, instead embracing evidence-based practice.
- We renew our interest in person-centered care.

The Facilitative Treatment Environment

The Developmentally Sensitive Treatment Environment

- Treatment that is sensitive to developmental needs, or a developmentally sensitive model, recognizes the impact of the social environment on child and adolescent development.
- It is aimed at multiple goals that connect the young person to the larger social community, including attachment, competency in social skills, the resolution of trauma and other developmental injuries, and self-regulation.

The Developmentally Sensitive Treatment Environment

- In operation, this model of tx is aimed at changing behavior and relationships by rehabilitating ideas, attitudes, and beliefs about the world, and through the development of a stronger sense of self-confidence, confidence in others, and a confident sense of social belonging and relatedness.
- A developmentally sensitive model recognizes and treats youths as “whole” children whose sexually troubled behaviors are one part of a much larger complex of emotional, cognitive, behavioral, and social problems, many of which are the outgrowth of earlier adverse childhood experiences, attachment difficulties, and insecure and troubled attachments to others.

The Facilitative Treatment Environment

- The treatment environment is simultaneously the *medium* through which treatment occurs and itself a *mirror* of the treatment that is provided.
- Additionally this environment does not simply define and shape treatment, but is also the channel through which attachments and connections are fermented and form.
- The treatment environment is the environment in which treatment relationships develop and thrive, and which serves as the unspoken marker of the safe, supportive, attuned, and trusted treatment relationship.
- Beyond what we say in words, embedded within the treatment environment are the hidden dynamics and regulators of attachment – not what we say, but *how* we say it and how we *behave*.
- The treatment environment sits in the background, but is always active, not merely dormant.
- In the treatment environment, care givers are “agents of change,” through whom children and adolescents are helped to change, develop prosocial skills and healthy relationships, and thrive in their development.

Adding a Developmentally-Sensitive Layer

- A treatment environment that is sensitive to developmental and social needs recognizes that skills develop and are acquired, not in a vacuum, and not as a pure result of the individual’s efforts, but in, through, and in concert with the social environment.
- However, a treatment model attuned to and sensitive to developmental needs not only recognizes the impact of the environment in contributing to, creating, or maintaining difficulties in psychosocial functioning, but also recognizes the role of the environment in *treating* problems in real time, in the here and now.
- If we wish to build treatment environments that foster attachments and connections, and a sense of social relatedness in our clients, they must take into account at least nine elements:

Nine Elements of the Facilitative Treatment Environment

1. The treatment environment must be safe. The environment, people, and social situations in the environment must be experienced as physically and emotionally safe.
2. The treatment environment must be structured, predictable, and well-defined. Personal security is first and foremost about physical and emotional safety. This calls for clients to experience the treatment environment as organized, consistent, non-chaotic, and stable, and thus predictable. For many sexually abusive youth, this may be the first time they’ve had such an experience.
3. The treatment environment must be understanding, supportive, respectful, and attuned. Supportive and facilitative environments are dependent on the ability of caregivers to provide positive and prosocial support to its developing children, in which desired behaviors and attitudes are most effectively taught through role modeling.
4. The treatment environment must be therapeutic, designed to heal, care for, and restore to health, rather than simply controlling and managing behavior.
5. The treatment environment must be strength-based. It recognizes and builds upon strengths, provides opportunities for strength building and skill development, and works to help clients identify with their strengths rather than their deficits.
6. The treatment environment is encouraging and focused on recognition and praise. It uses praise to support, teach, reinforce, and encourage strengths, and assist clients to recognize and build on their strengths. It uses praise freely, but not lightly. Praise will otherwise be inauthentic, and recognized as such by clients.
7. The treatment environment favors and emphasizes collaboration between treatment staff and clients and, in group care and family treatment settings, among clients. The message? *We are working on this together!*

continued

Nine Elements of the Facilitative Treatment Environment

continued

8. The treatment environment has clear and predictable boundaries, which provide for safety, define roles, and establish some level of directionality (clinician-client, for instance). Boundaries are not only about safety, of course. They are also instructive, rich in invisible information about roles and relationships, social expectations and what is inappropriate, and how far we may travel in different relationships.
9. The treatment environment is relationship-based and attachment friendly. It recognizes the importance and power of relationships, relationships are promoted and supported, and opportunities are provided for connection to others. It is not a sterile environment, devoid of genuine interpersonal relationships, even if appropriate and relevant limitations and boundaries are necessarily placed on the nature of those relationships in treatment environments.

The Power of the Environment: The “Snowball Effect”

- Physical, emotional, and social environments that do not support, allow for, or provide opportunities for growth are not likely to help children and adolescents change.
- Treatment environments that are ineffective fail to understand the problems that reside beneath the surface, do not provide elements necessary for change, and may even fuel and amplify existing problems, in some cases making the problem bigger and more entrenched.
- Under these circumstances, problem attitudes, behaviors, and relationships may “snowball” and grow larger, becoming more fixed rather than moving towards change.
- Conversely, effective treatment environments recognize, understand, and provide the elements and relationships that support, promote, and provide opportunities for change, as well as understanding that change comes slowly.

And, Finally...

Treatment is Brain-Based

- Back to where we started today: “People don’t come preassembled, but are glued together by life” (LeDoux, 2002, p. 3).
- Regardless of temperament or other biological predispositions, the central idea here is that nature works *with* nurture to produce the people we become.
- We recognize that the developing brain is both shaped internally by biology and externally via experience and interactions in the social world, and that biological markers work *with* environmental factors.
- In this respect, a developmentally-sensitive model of treatment is a brain-based model; it recognizes that attachment and other childhood experiences profoundly affect neurological development in children, and also that neural development continues through adolescence and into young adulthood.
- That is, the *experience*, and not simply the content, of therapy influences the rehabilitative changes we seek in our clients.
- Treatment is brain-based because, beyond what treatment is saying to our clients in words, in workbooks, or in cognitive behavioral and psychoeducational instruction, it is what treatment is saying at the *experiential* and *relational* level that is of central importance.
- As such, non-verbal learning and the unspoken messages of treatment, as described here, are certainly among the most important elements of treatment.

The Therapeutic Relationship and the Brain

- The quality of content is important in the treatment of sexually abusive youth, but the quality of *contact* is even more important in a facilitative model of treatment.
- With respect to the goal of attunement, Siegel (1999) describes the experience of “feeling felt” by another person, and asserts that attunement provides the non-verbal, brain-based basis for collaborative and engaged communication.
- Accordingly, Schore (1994) describes a key task for the therapist as getting in tune with the client, providing a mirroring and reflective function in which the clinician becomes *psychobiologically* attuned to the client’s emotional and mental state.
- Social attachments shape and re-shape, organize and re-organize neural structure, and physiologically regulate and modify neurobiological processes (Amini et al., 1996; Schore, 2001; Siegel, 2001).

The Therapeutic Relationship and the Brain

- In fact, Schore (2001) sees attachment theory as a regulatory theory, with implications for emotional and self-regulation capacities throughout life.
- Emphasizing the neurobiology of attachment and its effects upon brain development, Schore very much sees the therapeutic relationship as an attachment relationship, and asserts that for many clients the therapeutic relationship creates, for the first time, an optimal environment for the development of neural structures that can efficiently regulate affect.
- Diana Fosha (2003) describes in similar terms the clinician's ability to access and engage in an unspoken emotional connection with the client, in which "therapeutic discourse (is) conducted in a language that the right hemisphere speaks" (p. 229).
- Not only do therapeutic relationships clearly reflect many qualities of an attachment relationship (Parish & Eagle, 2003), but Amini et al. (1996) write that therapy works because it *is* an attachment relationship, "capable of regulating neurophysiology and altering underlying neural structure" (p. 232).

What Makes Treatment Work? A Therapy of Engagement

- Psychotherapy is, "at root a human relationship... Both parties bring themselves – their origins, culture, personalities, psychopathology, expectations, biases, defenses, and strengths – to the human relationship.... "Some will judge that relationship a precondition of change and others a process of change, but all agree that it is a relational enterprise" (Orcross & Wampold, 2011)
- These relatively new ideas in sexual offender treatment - that we need to build therapeutic alliances with our clients, help instill hope in them, and help them grow - bring the treatment of juvenile (and adult) sexual offenders closer to therapeutic principles and processes already found in mainstream psychotherapy.
- This is a therapy of engagement, in which the clinician is a significant conduit for self-realization and change in the client, in which the therapeutic relationship becomes a crucible in which growth is fermented and from which change emerges.

Treating Deficits in Social Skills

- The goal of teaching sexually abusive youth psychoeducational concepts, such as dysfunctional behavioral cycles and thinking errors that contribute or lead to sexually abusive behavior has been and remains an important element in sex offender specific treatment.
- However, this work must be embedded into a larger and more complete treatment that also, and perhaps more significantly addresses deficits in attachment, social relatedness, and social skills.
- Such deficits include a limited ability to:
 - Form meaningful and satisfying relationships
 - Experience empathy and concern for others
 - Engage in the behaviors, interactions, and relationships that are the backbone of appropriate social connection.

Summary/Final Words

- Treatment for both sexually abusive youth and adult sexual offenders has shifted during the past few years, and continues to do so, embracing ideas about the nature of the therapeutic process rather than focused solely upon the delivery of psychoeducational and cognitive behavioral concepts related to sexually abusive behavior.
- Treatment for sexually abusive behavior has become more sophisticated, recognizing and embracing elements common to all effective forms of treatment rather than cognitive behavioral concepts alone, and in which treatment is, perhaps above all, about relationships, social connection, and engagement in a healthy and safe community.
- In this more holistic model of rehabilitation, not only is treatment significantly about attachment and connection but treatment must itself be delivered in a manner that is connective and relational.
- In this contemporary approach, the role of the clinician, the clinician's engagement in the treatment process, and the therapeutic relationship are each central and critical.

The Facilitation of Change Through the Treatment Experience

- Through the warmth, concern, support, safety, and structure provided in the empathic and attuned treatment environment, sexually abusive youth are experienced as children and young people with many complex needs.
- This includes the need to be recognized and understood by others.
- Perhaps more to the point, they must experience themselves as being seen and understood by others.
- Through this experience, they are enabled to see and explore themselves in a different light.
- In turn, they are able to see and experience other people in a different light.
- However, the qualities that we wish to develop in sexually abusive youth, not only of behavioral restraint, appropriate social and sexual boundaries, and belongingness, but also empathy and concern for and the valuing of others, are exactly those qualities that juvenile sexual offenders must themselves experience from others in their environment, including, and perhaps, especially, those who provide treatment.

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