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**Things We Think We Know: Ten Interesting Ideas and The Exercise of Critical Thinking in Our
Work With Sexually Abusive Youth**

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Things We Think We Know: Ten Interesting Ideas and The Exercise of Critical Thinking in Our Work With Sexually Abusive Youth

Multidimensional Reality

“The history of psychology is littered with the broken hopes of those who mistakenly assumed that a single measure permitted a confident conclusion about a psychological process”
(Kagan, 2006, p. 81)

Multidimensional Reality: More Than One Correct Answer

- From my point of view, the idea that a single theory or single model and single application of that model can drive things is a strange and simplistic, and even naive, idea.
- It always appears to me, and is usually proven in action, even if only over time, that there is more than a single way to approach, understand and, sometimes, to solve, a problem.
- Further, the idea that cognitions, emotional experiences, and behaviors can be understood as the result of single processes is equally simplistic and error-prone.

- We extend thinking beyond single measures of the world to single ideas about the world when we come to believe that a single idea or a single truth, or a single view of the world, permits a confident conclusion about psychological processes and human interactions and behaviors.
- This is a unidimensional method which can only lead to a unidimensional model of a world which, in actuality, is multidimensional.
- One of the strange and beautiful things that emerges from a multidimensional approach and view is, not only that there is no single answer, but there is more than one correct answer and answers that are right at some point and under some circumstances are wrong at other times.

The Opposite of Great Truth

- In fact, the process of dialectic argument is built upon the premise that every idea has an opposite idea and that new ideas result from resolving the difference between the two ideas, not eliminating differences.
- Of this, Niels Bohr, the Danish physicist, is reputed to have said, “The opposite of a great truth is also true.”

Acquiring Information and the New Conventional Wisdom

- People in our field understandably have a need to know.
- I understand the need for answers and direction, and that professionals and practitioners, and even teachers, in our field don't have the time, and in many cases the inclination, to go out themselves and collect the information, not simply by generating research but by *reading* all the research.
- Understandably, many, if not most, professionals depend upon a group of academics, whether clinically or research driven in orientation, to provide information, direction, and answers.
- However, in reviewing and thinking about those ideas that we receive, which are, after all, the ideas of others, I hope we will exercise incisive and critical thinking before we fully accept those ideas and ourselves begin to pass on to others the new “conventional wisdom.”

What We Used to Think...

- In July 2007, the cover story of the New York Times magazine (Jones, 2007) was a story outlining our changing perspectives about juvenile sexual offenders and work with sexually abusive youth.
- In it, Rob Longo described sexual offender treatment for juveniles as a new field in the 1980s.
- He described, like other therapists at that time, basing his practices on what he knew about: treatment for adult sexual offenders:
- “It's where the literature was... It's what we'd been doing.” As it turns out, he went on to say, “much of it was wrong.”

20 Years On?

- More to the point, having learned the lesson that “much of what were doing was wrong,” I wonder if we believe we’ve now got it “right.”
- How much of our practice of today and of what we believe today, informed by our ideas of today, might we reflect back on in twenty years and say...
... “It’s what we were doing. As it turns out, much of it was wrong”?

Thinking Critically

- Regardless of what approach to treatment we adopt or interventions we apply, underlying each method is a belief system about what works best in the assessment and treatment of juvenile sexual offenders.
- But instead of simply adopting such methods and ideas at face value, as “received wisdom,” we can be most effective when we apply a critical eye even to the most accepted methods and practices of our field.
- And, by understanding the thinking that lies behind our beliefs and practice, we are most able to engage in informed treatment and are therefore placed in the best position to decide which treatment methods and approaches to adopt.
- The willingness to challenge the status quo of treatment is an important tool in the development of inspired, informed, and original thinking.

Idea 1.
Research Provides the Answers.

Do We Too Quickly and Uncritically Accept Ideas?

- One of the developments in our field over the past decade and more has been the deepening and broadening of our research base, as well as movement towards the discovery and application of evidence-based models of assessment and treatment.
- However, Anita Schlank (2009) has described “pendulum swings” in terms of both research findings and attitudes about sexual offender treatment.
- She wrote of “instant excitement” about new ideas that have led to “knee-jerk reactions, with individuals wanting to abandon all previously held beliefs” (p. 27).
- Besides abandoning ideas that actually have merit and adopting new ideas that lack time tested and well researched support, the risk in any pendulum-like application of ideas is that we become reactive rather than proactive, because pendulum thinking is limited in its flexibility and responsiveness.

The Quality of Research

- Further, research into juvenile and adult sexual offending is significantly flawed, often fails to produce meaningful or consistent data, and is often not replicated by others or cannot be replicated.
- In the natural sciences, experiments can be replicated with relative ease. Not so in the social sciences, however. In fact, it’s difficult to imagine running the *same* experiment with the same subjects and getting exactly the same results, let alone using *different* subjects and under different circumstances.
- That’s why we use inferential statistics in the social sciences, why we require random samples that we believe represent the general population under study, why we replicate studies, why we use independent research teams, and why we require large sample sizes so we can be relatively sure that our data have true meaning.
- Nonetheless, research into sexual offending often do not meet these standards, for many practical and ethical reasons. In fact, many research studies are too limited in size or design to be of any significant value, other than pointing us in a particular direction.
- In fact, it is enormously difficult, if not ethically impossible, to create experimental and control groups for study, subjects selected for study are often not selected randomly, and it is virtually impossible to replicate experimental research designs.

The Shape of Research

- Marshall and Marshall (2007) have highlighted some of the difficulties inherent in conducting human research, with sexual offenders in particular, pointing to the great difficulty in applying highly experimental designs, such as randomized control trials.
- Even though the RCT design is often considered the “gold standard” in human research, Marshall and Marshall noted the practical issues of design and logistics inherent in such studies.
- They also suggested that for a number of reasons, and by virtue of the actual design of the model, the outcomes of RCT studies may be inaccurate.
- They also assert that RCT studies raise ethical concerns regarding the provision of treatment, which must be controlled, and even manipulated, for the sake of the study design.
- Their conclusion was that there are better and more appropriate designs to use in conducting research of this type, but also that there are problems with all methods for evaluating the process and outcomes of sexual offender treatment.

The Correct Shape of Research?

- Marshall and Marshall’s perspective was hotly refuted by Seto et al. (2008). In turn, Marshall and Marshall refuted the perspective of Seto and colleagues, and stuck firmly to their position.
- However, the point here is clear. There is no single or “correct” perspective that is accepted by all, including those who conduct research for a living.

Research Duels, Bias, and Allegiance

- Besides this, when we read research that tells us one thing, we can often cite research that tells us just the opposite.
- Nevertheless, those who support a particular perspective sometimes present research that strengthens and justifies their position, sometimes ignoring or minimizing research that negates or refutes their point - a practice sometimes referred to as *confirmation bias*.
- We should be particularly aware of research that supports a particular idea or model when it has been conducted by parties who have a stake in the model or idea that is being studied, reflecting the possibility, or even likelihood, of an *allegiance effect* (Blair, Marcus, & Boccaccini, 2008),
- The tendency for researchers and others to select and interpret outcome data in a manner that supports a favored perspective.

What we Thought Then...

- In addition to “dueling” studies in which one study directly, indirectly, or partially, refutes another, we also know that research may tell us something at one point in time but is refuted by later research.
- One example involves the study of Michael Seto and Howard Barbaree (1999), which concluded that adult sexual offenders with high psychopathy scores who also scored well on treatment participation were the most likely to sexually recidivate, a conclusion later retracted by Barbaree (2005).
- He subsequently wrote that “there is no evidence that offenders who are high in psychopathy and good in treatment behavior reoffend at a greater rate than other offenders” (p. 1129).
- He additionally concluded that “interpretation of studies... should be done with caution and patience, and firm conclusions should await an accumulation of evidence over a number of similar studies” (p.1129).

... And What We Know Now.

- Consequently, although always of great importance, statistical human research is not always relevant, is certainly not always correct, can sometimes mislead, is sometimes poorly designed or conducted, is sometimes biased by the allegiances of the researchers, and is often flawed and limited, and can thus just as easily hold treatment back as promote it.

Think Critically

- Our best counter-measure, in order to help ensure the quality, accuracy, and value of research, is to recognize the strengths and weaknesses of research as a whole, as well as individual studies.
- And, as Schlank (2009) cautions, exercise critical thinking in our appraisal and application of research.

Single Solutions?

- In seeking parsimonious answers, and sometimes global answers, and in trying to understand causation and correlation, Jerome Kagan (2006) describes the necessary coming together of multiple conditions that produce outcomes that result from the interaction and collaboration of many independent conditions.
- “There is no single cause. A coherence of several factors is necessary to produce a particular phenomenon” (pp. 94-95).

“Who, then, is right? Everyone. They all are.”
(Shephard, 2002, p. 27)

Idea 2
Group Treatment has Iatrogenic Effects.

Deviancy Training in Group Treatment?

- In a much cited study, Dishion, McCord, and Poulin (1999) described “iatrogenic” effects in the treatment of antisocial youths.
- They concluded that under some circumstances aggregating antisocial youths into treatment facilities and groups can be counter-productive, possibly contributing to an increase in problem behaviors among these youth rather than decreasing these behaviors.
- These conclusions have been supported in other studies also, including ongoing studies conducted by Dishion, Poulin, and colleagues.

- Other studies include:
 - Dishion & Andrews, 1995; Dishion & Dodge, 2005; Dishion, McCord, & Poulin, 1999; Dishion, Piehler, & Myers, 2008; Dodge, Lansford, & Dishion, 2006; Gifford-Smith, Dodge, Dishion, & McCord, 2005; Poulin, Dishion, & Burraston, 2001; Prinstein & Dodge, 2008), and...
 - Gatti, Tremblay, and Vitaro (2009).
- Note the potential allegiance effect or confirmation bias among the group of colleagues producing or confirming almost all of the research that supports position held by this very group of researchers

Group Treatment is Effective?

- On the other hand, in partial response to these conclusions, in their studies Handwerk, Field, and Friman (2000) and Huefner, Handwerk, Ringle, and Field (2009) report substantial reductions of antisocial behavior among youths treated in group care.
- They conclude that group treatment of antisocial youth in groups is both feasible and effective in reducing delinquent behavior.

- This finding is also reported by Mager, Milich, Harris, and Howard (2005), and Weiss, Caron, Ball, Tapp, et al. (2005).
- Mager et al. assert that, although Dishion and colleagues’ deviancy training/iatrogenic effects hypothesis has intuitive appeal and is popular among researchers and clinicians, “strong empirical support for this hypothesis is lacking” (p. 359).
- Weiss et al. (2005) concur that the iatrogenic, or deviancy training, model lacks support, additionally reporting that 17 of 18 meta-analyses failed to support an iatrogenic/deviancy training effect in group treatment.
- Accordingly, Weiss et al. conclude that the risk of iatrogenic effects in group treatment is overstated.
- Mager et al. support the use of the group treatment model for antisocial youths, concluding that “aggregation of at-risk adolescents in group treatment is not necessarily a condition that triggers negative effects” (p. 362).

- In their study, Leve and Chamberlain (2005) found some support for the idea that mixing highly delinquent adolescents with other delinquent youth increases on-going interaction between antisocial youth after treatment completion.
- However, they also found that delinquent peer association following treatment declined after treatment, even if antisocial youths were mixed together in treatment.
- They concluded that “among youth with chronic delinquency... increases in delinquent peer association following intervention were not present” (p. 345).

Deviancy Training or Poor Treatment?

- Could both sets of conclusions be correct?
- That group treatment can be ineffective, and even counter-productive, *and* effective?
- Sure...
 - partly because not all group treatment is equal in design
 - partly because not all group treatment is equal in skilled leadership or delivery,
 - partly because not all antisocial youths are the same, and
 - partly because these studies themselves focus only on particular hypotheses or research questions and can therefore easily miss, or avoid, broader issues which remain invisible.

The Final Word on Group Treatment and Deviancy Training?

- In fact, in their 1999 article, Dishion, McCord, and Poulin themselves note that “not all interventions using peer groups with difficult children have had iatrogenic effects”(p. 763)
- In their article, Weiss et al. (2005) similarly report that it is possible that deviancy training might occur in some group treatment contexts other those tested in their study.

Idea 3.
It's About Trauma:
Trauma-Informed Treatment.

Rich New Ideas

- Recent and developing themes that have appeared consistently in the literature include attachment-focused, psycho-neurological, and trauma-informed models.
- These ideas and models promote an openness, richness, and sophistication in our thinking, and they allow us to see children, adolescents, and adults as complex beings.
- They allow us to recognize and take into consideration the natural power of the social environment in which children are raised and the developmental process through they pass while in these social environments.
- The downside is that these ideas may become buzz words, or the “soup de jour,” and begin to lack real meaning, blinding us to larger and still more complex factors and issues and potentially simplifying, rather than furthering, our thinking.

Treatment Fads?

- Chaffin et al. (2006) note that “mental health and related fields have a long history of diagnostic fads, when rare or esoteric diagnoses become fashionable and spread rapidly through the practice world, support groups, and the popular press.
- Rarely have these fads resulted in real clinical or scientific progress, and occasionally they have resulted in demonstrable harm” (p. 82).

Is All Adverse Developmental Experience Traumatic?

- It has become common to hear “trauma” described as a significant factor in the histories of both juvenile and adult sexual offenders, and the impact of such trauma on the development of their relationships and sexually abusive behavior.
- However, the use of the term “trauma” now seems to be often used to capture all aspects of adverse childhood and early developmental experiences.
- This model supposes that all adverse developmental experiences are “traumatic,” thus diluting the meaning of the concept to a rather nebulous and somewhat meaningless term.

What About Resiliency?

- Adopting a trauma-based model by which to understand our clients assumes them to be mere products of their earlier developmental experience, and assumes that all adverse developmental experience is traumatic.
- The trauma-based model ceases to recognize children and adolescents as individuals capable of experiencing and responding to life differently.
- Instead, it concludes that these youths have been traumatized by earlier adverse experiences rather than, for instance, becoming more resilient in some cases, or being *shaped* by the experience but not traumatized by it.

Reductionism at Work?

- The trauma model not only diminishes the complexity of trauma, but also the individualized experience of trauma, assuming that all developmental insults are experienced as traumatic by the child.
- The “trauma-informed treatment” perspective represents a narrow lens through which to see developmental problems that may obscure other developmental views.

Does One Size Fits All?

- Ben Shephard (2002) has written the concept of “trauma” has been “vectored into society” (p. 24)
- Allan Young (1995) notes that the concept and its accompanying trauma does not possess an “intrinsic unity...”
- “Rather it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources” (p.5).

The New Wisdom?

- Is the term "trauma-informed" becoming part of a new dogma/conventional wisdom?
- Is it a new, single-theory “one-size-fits-all” model of understanding behavioral, emotional, and social disturbance?
- Susan Clancy (2009) has recently written that “the dominant conceptualization of trauma “ is simply not a good characterization of the reality...
- “You cannot challenge the trauma conceptualization... because of a deep-seated dogma that has prevailed in the mental health and policy circles since the late 1970s” (pp. 180-183.)

Coming of Age or the Age of Invention?

- Heather MacIntosh and Valerie Whiffen (2005) found that a PsycInfo search for articles published in 1984 listed only four articles with the keywords *PTSD*, *psychological trauma*, or *dissociation*, compared with 1,868 in 2003.
- Derek Summerfield (2001) noted that by 1999 the National Center for PTSD listed more than 16,000 articles addressing PTSD.
- MacIntosh and Whiffen write, “the field has come of age” (p. 488).
- On the other hand, Summerfield writes that the story of PTSD is an example of the role of society and politics in the process of invention rather than discovery.
- “Originally framed as applying only to extreme experiences that people would not normally expect to encounter every day, (trauma) has come to be associated with a growing list of relatively commonplace events” (Summerfield, 2001, p. 96).

Do Adverse Events Always Produce Trauma?

- Margaret Hagan (2003) writes that the trauma conceptualization of sexual abuse has shown itself to be “utterly resistant” to facts revealed over twenty years of research.
- “A review of the last 20 years of research... does not support the view that the majority of children known to have been sexually abused exhibit signs or symptoms of trauma” (p. 344).
- George Bonanno (2004) asserts that available research on loss and life-threatening events indicates that the vast majority of individuals exposed to such events do not exhibit chronic symptom profiles
- “Many, and in some cases the majority, show the type of healthy functioning suggestive of the resiliency trajectory” (p. 22).
- In describing differences between “recovery” and “resiliency,” Bonanno notes that resiliency is common among children growing up under disadvantaged conditions.

Traumatology: Broad Brush?

- The traumatology model asserts a level of sameness for all sexually abusive youth.
- It implies that the commonalities in adverse environmental conditions always give rise to “trauma,” rather than recognizing individual differences and differential responses in different children, including the development of resilience in response to adversity.
- Although we say that everybody is different, in applying a trauma model to all of our youthful clients, are we actually saying that they are all actually the same?

Idea 4.
**Denial Is Not Predictive of Sexual
Recidivism.**

Absence of Evidence Equals Evidence of Absence

- In Worling and Långström's (2003, 2006) typology of empirically supported risk factors, they describe denial of sexual offending as an unlikely risk factor.
- They write that, despite its obvious appeal, there is no empirical evidence to support denial as a predictor or indicator of risk.
- However, Worling and Långström are not describing evidence that disproves denial as a risk factor; they are simply discussing a failure to find a significant statistical correlation between denial and sexual recidivism.

Denial Is Not a Risk Factor?

- The conjecture that denial is not a risk factor is largely drawn from the literature of adult sexual offending.
- In particular, it is derived from the meta-analyses of Hanson and Bussière (1998) and, later, Hanson and Morton-Bourgon (2005) which found no significant correlation between denial and sexual offense recidivism.
- However, the role of denial is neither resolved nor closed to further enquiry, and the lack of support for denial as a risk factor in the Hanson meta-analyses is questionable, and was challenged by Lund (2000).
- Further, there now exists empirical evidence that denial is or may be a risk factor.

Denial Is a Risk Factor?

- In contrast to studies that fail to show evidence of correlation (absence of proof), several studies provide evidence that denial is linked, in some cases, to sexual recidivism, and may therefore be a risk factor.
- Nunes et al. (2007), with Hanson as second author, described two studies that included 1000 adult sexual offenders in which, "contrary to expectations," denial was associated with increased sexual recidivism among both low-risk offenders and incest offenders, and replicated in two independent samples.
- The authors conclude that "denial merits further consideration for researchers as well as those involved in applied risk assessment of sexual offenders" (p. 92).
- They now concur with Lund's (2000) speculation that "denial could be a real... risk factor" (p. 102).
- Langton et al. (2008) described both minimization and denial in adult sexual offenders as significant predictors of sexual recidivism, with minimization as a significant predictor among high risk offenders (in contrast to the finding of Nunes et al.).
- In their study of 436 sexual offenders, they report that denial was associated with serious (including sexual) recidivism.
- They conclude that is reasonable to postulate that the presence of denial and minimization, specifically during and at the conclusion of treatment, represents "an increased risk among higher risk offenders for sexual recidivism" (p. 91).

- Lund (2000) challenged Hanson and Bussière's (1998) conclusion that denial was not a risk factor through a careful analysis of the seven studies included in the meta-analysis that addressed the relationship between denial and treatment.
- He noted a broad range in the definition of denial and how and when it was measured in assessment and treatment. We'll return to this point.
- He also noted that those who completely denied offending were frequently excluded from treatment and were therefore absent in the meta-analysis.
- Further he speculated that heterogeneity among sexual offenders may result in differences in strength of denial as a risk factor for different offenders.
- Lund thereby foreshadowed the suggestion of Nunes et al. (2007) that denial might have a differential effect on recidivism for low and high-risk offenders, and also that the influence of denial on higher risk offenders might be made invisible by the presence of other high risk factors.

Absence of Proof Does Not Equal Proof of Absence

- Overall, Lund concluded that the Hanson and Bussière meta-analysis did not clarify the relevance of denial in predicting recidivism.
- He wrote that “the failure of meta-analysis to clarify the relevance of denial should not be construed as indicating support for the opposite conclusion that denial is not a risk factor” (p 285).
- This mirrors the admonishment of Altman and Bland (1995) that “absence of proof is not proof of absence.”

Denial, Engagement in Treatment, and Risk for Re-Offense

- There is further support that denial has relevance to risk prediction and sexual recidivism.
- In their study of adult sexual offenders, Levenson and Macgowan (2004) found that treatment progress was correlated with lower levels of denial, and that engagement in treatment and denial were negatively associated with one other. That is, people engaged in treatment did not engage in denial, and vice versa.
- In their work on stable and acute risk factors, Hanson and Harris (2000) similarly observed that failure to engage in treatment and the presence of denial (in this case of future risk to re-offend) was a significant predictor of sexual recidivism.

Logical Inferences?

- As completion of treatment supports reduced risk for recidivism (Marques et al., 2005; Seager, Jellicoe, & Dhaliwal, 2004; Worling & Curwen, 2000), or conversely failure to complete treatment is a risk factor for sexual recidivism (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005; Worling & Långström, 2006), it is reasonable to conclude that denial is also linked to treatment outcome, or recidivism rates.
- That is, if low denial is related to engagement in treatment which, in turn, is related to lowered recidivism, then level of denial must also be related to treatment outcome (i.e., the presence or absence of recidivism).
- This represents a logical inference drawn from information which has empirical support.
- On the basis of its relationship with treatment engagement, even without direct empirical evidence we can conclude that denial must be a risk factor if failure to complete treatment presents risk for recidivism.

The Problem of “Denial”

- Yates (2009) concludes that the research does not convincingly demonstrate denial as a risk factor for sexual re-offense, nor that targeting denial in treatment is associated with improved treatment outcomes.
- However, she notes that denial nevertheless continues to be regarded as a risk factor for re-offending.
- One of the problems she points to is the lack of definition for the meaning of denial
- Yates notes it has been widely and variably defined in the literature, with definitions ranging from narrow to broad, covering complete denial of an offense to minimization of the impact of sexually abusive behavior, holding others responsible, denial of sexual deviance, and denial of planning, among other forms of denial.

What is Denial and When is It Measured?

- This lack of clear definition, as well as a lack of clarity in terms of at what point in the treatment process is denial measured, and whether denial is treated as a static construct or a dynamic factors that changes over time, is highlighted in a recent article (Harkins, Beech, & Goodwill, 2010).
- This study examined the influence of denial, motivation, and risk on sexual recidivism.
- In their study, the “denial index” measured several features, and not denial alone, and measured denial before treatment started.
- Denial was also measured as a “static” measure, regardless of any changes in the denial index, brought about by the treatment process.
- In fact, the “post-treatment denial index was predictive of reduced recidivism” (personal communication, February 22, 2010).

The Final Word (For Now)

- Let's give David Thornton (personal communication, November 27, 28, 2008) the last word.
- He describes a new wave of research on denial and recidivism, but also the importance of understanding the complexity of the emerging findings.
- "First, results continue to support the idea that there is no general, overall, unqualified relationship between sexual recidivism and denial... However, results vary across different studies..."
- "The Langton et al. (2008) study found that minimization was associated with higher recidivism for high risk adult sexual offenders; on the other hand, Nunes et al. (2007) found the opposite result in which denial was only related to recidivism for adult offenders assessed at low risk who scored lower on the same actuarial risk assessment instrument..."
- "We have a hint that the role of denial may increase risk for sexual re-offense, or even lower it... but we can't presently specify the conditions under which it reduces risk or the conditions under which it increases risk."
- "What does this mean for theory and research? More nuanced theories that can explain both protective and risky aspects of denial need to be developed further and tested."

Idea 5.
**Actuarial Risk Assessment is a Stronger Model than
Clinical Risk Assessment.**

The Two Contenders

- Despite a move towards the center and the development of more comprehensive assessment processes, two distinct camps remain.
- The “clinical versus actuarial prediction debate” is described by Douglas, Cox, and Webster (1999) as one of the “persisting controversies in the risk assessment field” (p. 154).

In One Corner...

- In the actuarial camp, writers such as Quinsey, Harris, Rice, and Cormier (2006) advocate for a strictly actuarial approach, supporting the complete elimination of clinical practice in forensic risk assessment.
- “What we are advising is not the addition of actuarial methods to existing practice, but rather the replacement of existing practice with actuarial methods” (p. 197).
- Built significantly on the work of Paul Meehl, advocates of actuarial assessment argue that there is no true hybrid of clinical and statistical methods of prediction, and the two methods are incompatible (Grove & Lloyd, 2006; Harris & Rice, 2007).
- Harris and Rice describe the idea of blending actuarial and clinical assessment as an illogicality, asserting that forensic decision makers must inevitably choose between the two methods, and that “empiricism should replace clinical judgment wherever possible” (pp. 1652-1653).

- However, not all actuarial specialists share this view. This position is characterized by Sjöstedt and Grann (2002) as “extreme,” who describe “the implications of the pure actuarial stand taken by Quinsey et al. (as) extremely problematic” (p. 182).
- Further, Monahan et al. (2001) describe their belief that actuarial instruments should be used as tools for clinical assessment, used to “support, rather than replace, the exercise of clinical judgment” (p. 134).

And in the Other Corner

- Squarely in the clinical camp, Litwack (2001) argues that actuarial assessments of risk have not been proven superior to clinical assessment.
- The picture emerging from research is complex with little empirical support for the greater effectiveness of actuarial assessment of risk.
- He concludes that “it is premature to substitute actuarial for clinical assessments of dangerousness” (p. 410).
- Advocating for the use of clinical assessment, Boer et al. (1997) write that actuarial assessment instruments are passive tools that disengage professionals from the evaluation process because, by design, they require minimal professional intervention and judgment.

The Two Encampments

- Daniel Kahneman and Gary Klein (2009) write that the two camps of clinical judgment and statistically-derived judgment “are set in competition.”
- The idea of statistically-developed algorithms that outdo human judges is a source of pride and joy for members of the statistical, or scientific, camp, but usually distrusted by the clinical judgment community.
- Boer (2006) describes the risk prediction literature as fragmented and oppositional, in which neither the authors of actuarial or structured clinical instruments acknowledge the effectiveness of instruments in the opposing camp.
- Douglas, Cox, and Webster (1999) concluded that both actuarial and clinical assessments have clearly identified but different strengths. They are critical of the “gap” between the practitioners of actuarial and clinical evaluation in which neither method could be said to be intrinsically more effective than the other.

Criticism of the Actuarial Model

- Grove, Zald, Lebow, Snitz, and Nelson (2000) contended that actuarial assessment proved to be superior than clinical assessment in the 136 studies included in their meta-analysis.
- They also noted that actuarial assessment were only substantially more accurate in about 10% of the studies they reviewed and that clinical predictions were “often as accurate as mechanical predictions” (p. 19).
- They also noted that many of the studies included in their meta analysis were “methodologically unsound” (p. 25).
- In their review of the Grove et al. meta-analysis, Hart et al. (2003) asserted that in about 40% of the cases the two approaches to prediction were equal, and in about 20% of the studies the clinical method was more effective.
- They concluded that “although it is correct to conclude from this that the actuarial approach was equal or superior 80% of the time, it is equally correct to conclude that the clinical approach was equal or superior 60% of the time” (p. 11).

Can Actuarial Assessment Deliver?

- Further, Boer et al. (1997) assert that there are no well-validated actuarial scales of risk for sexual violence.
- Melton, Petrila, Poythress, and Slobogin (1997) write that “the bottom line is that the research has not delivered an actuarial equation suitable for clinical application in the area of violence prediction” (p. 285).
- Similarly, Doren (2002) has written that no actuarial instrument can assess true re-offending risk because current actuarial instruments do not yet “include enough of the relevant considerations to maximize our predictive effectiveness” (p. 113).
- Summarizing this position, Hart et al. (2003) write that no methods currently exist for making precise estimates of future risk with any degree of certainty.
- The “superiority of actuarial decision-making is an article of faith. Any claim of actuarial superiority is an inference” based on questionable evidence” (p. 11).

Well-Developed Science?

- Grisso (2000) notes that many of the present actuarial assessment instruments require some degree of clinical judgment
- Addressing ethical issues in adult sexual offender risk assessment, Grisso expressed concern that the results of actuarial assessment instruments are given far more weight than the instruments can actually support, and concluded that the process of actuarial assessment in predicting sexual offense recidivism is in its infancy.
- Karen Franklin (2009) writes “with its modest accuracy... its complex statistical language and, now, its injection of clinical judgment, ... the Static-99 also has the potential to create confusion and lend an aura of scientific certitude above and beyond what the state of the science merits.”
- Questions about construction, standardization, inter-rater reliability, and ambiguous base rates raise questions about the capacity of such instruments to meet legal standards for scientific evidence.

Pseudo-Precision?

- Just as Hart et al. (2003) describe “pseudo-precision” in actuarial assessments, Grisso (2000) pointed out that the base rates upon which actuarial assessments are necessarily built are not really known with respect to the various populations with whom the instruments may be applied, and highlighted other difficulties and concerns about the psychometric validity of the instruments.
- On this very note, Boccaccini, Murrie, Caperton, & Hawes (2009) examined the predictive validity the Static-99 and MnSOST-R, on a sample size of 1,928 offenders. They concluded “relatively weak performance” in the “real world.”
- Boccaccini et al. concluded that actuarial assessment of sexual offenders “cannot be assumed to perform similarly across all contexts,” and that “evaluators cannot claim that a particular actuarial score for an offender corresponds to the same likelihood of recidivism that it did in the original test-development sample” (p. 306).
- In short, they wrote, “a measure’s ‘field validity’... may differ from the measure’s performance in controlled research studies.”
- Their study “suggests that two popular actuarial risk assessment instruments tend to work less well, and overestimate reoffense risk” (p. 311)

Scientific Rigor?

- Campbell (2004) similarly argues that current instruments create an appearance of precision that exceeds their actual accuracy, and when subjected to scrutiny current actuarial assessments fail to pass scientific muster.
- Both Grisso (2000) and Hart et al. (2003) note the absence of published manuals by which to ensure the correct administration, scoring, or interpretation of current actuarial assessment instruments.
- Like Campbell, they assert that such tools have not yet achieved the level of psychometric rigor to meet publication standards.

Actuarial Assessment is Objective?

- Based on a sample of 72 case of adult sexual offenders referred for civil commitment, Murrie et al. (2009) found that assessed risk levels on the STATIC-99, MnSOST-R, and Hare PCL-R, supported the party that retained the evaluator, in which the "evaluator's adversarial allegiance could influence some assessment instrument scores in forensic evaluation" (p. 19).
- "Results of the study strongly suggest that scores on some popular measures widely used in legal proceedings may be influenced by adversarial allegiance" (p. 48).

The Flaws of Both Methods

- Campbell (2004) argues that both clinical and actuarial risk assessment instruments are significantly flawed.
- He argues that the "elasticity of clinical judgment allows stretching it to conform with the *a priori* expectations of an evaluator" (p. 35), and that actuarial assessments are "systematically biased in the direction of ruling-in recidivism risk" (p. 67).
- He further asserts that neither method stands up to rigorous scientific scrutiny, characterizing all current actuarial and clinical risk assessment processes as inadequate.
- He asserts that all current evaluation instruments are insufficiently standardized, lack inter-rater reliability, are absent of adequate operational manuals, and generally fail to satisfy significant scientific standards.

The Failings of Both Methods

- Hart et al. (2003) write that all forms of risk assessment share problems and deficiencies, including their focus on risk factors, rather than those associated with strengths, resources, and protective factors.
- They describe a second problem as the failure of risk assessment instruments to address intervention strategies, and yet a third as a lack of quality assurance, in which they recognize that it is naive to assume that all professionals will function similarly in their work.

Do the Goals of Risk Assessment Determine its Value

- Douglas, Cox, Webster (1999) take the approach that both assessment approaches have clear strengths but are both flawed, perhaps less by their intrinsic operational methods than the global manner in which they are carried into practice by evaluators.
- They hold the view that actuarial prediction is generally superior to clinical prediction in terms of predictive validity, but nevertheless inapplicable and inappropriately used when the goals of risk assessment include management, prevention, and treatment.
- Their view is that risk assessments should "reach into the future," and specify the level of risk as a function of various possible conditions so that treatment and management can be organized to reduce risk for recidivism.
- Their position is that "something more than mere prediction is normally needed," and that actuarial instruments are appropriate and important only as part of a larger assessment process (p. 157).

Proceed with Care

- Sjöstedt and Grann (2002) assert that both actuarial and clinical risk assessment processes have strengths and weaknesses.
- In their study, actuarial assessment instruments worked well only under certain conditions, but were less accurate in discriminating among types of sexual re-offenses, and of little value in distinguishing between types of sexual offenders.
- Hence, they are in agreement with Douglas et al. (1999), as well as Hart (1998), in conceptualizing the scope of risk assessment as the management, treatment, and prevention of sexually abusive behavior and not simply prediction.
- They write that prediction alone provides so narrow a focus as to become meaningless. They relegate the role of actuarial assessment, therefore, to “rough screening and pre-treatment assessments” (p.312).
- This is in keeping with Hanson and Thornton’s (2000) observation that when used in isolation, actuarial assessment cannot be used to plan for or implement treatment, recognize or assess change, or predict when or under what circumstances sexual recidivism is most likely to occur.
- Sjöstedt and Grann recommend that actuarial instruments be used cautiously, knowing that whereas they may predict well under some circumstances they may go “far off target” in other cases (p. 183).

Mixed Support

- Viljoen and colleagues (2009) conclude from their study, which reviewed predictive validity, that structured clinical assessment tools for adolescents provided “some support” for clinical assessment.
- They also recognized that the “relative merits of structured professional judgment and actuarial models are heavily debated” (p. 996), pointing also to contrasting research studies that provide support for one method over the other.

Recognizing Both Assessment Mechanisms and Processes

- In fact, even though actuarial methods of judgment are objective and require no clinical interpretation, this does not mean that they consistently outperform human judgment or that human interpretation cannot do as well, or arrive at the same conclusions.
- In describing the conditions under which clinical judgment may be most effective, Kahneman and Klein (2009) write that there is compelling evidence that under certain conditions, arithmetic judgment outperforms human judgment.
- However, they write that concluding clinical/human judgment to be inferior to that of simple algorithms is unwarranted.
- In describing the conditions under which clinical judgment may be most effective, Kahneman and Klein (2009) write that although there is compelling evidence that under certain conditions, arithmetic judgment outperforms human judgment, concluding the performance of human judges as inferior to that of simple algorithms is unwarranted.
- The correct conclusion, they write, is that people perform significantly more poorly than algorithms in uncertain and unstable environments but not in a “stable” informational environment, in which a great deal of information is available to human decision makers and thus provides adequate and meaningful information upon which to base judgment.
- According to Kahneman and Klein, statistical algorithms achieve only limited accuracy and outperform human judgment in weak and limited informational environments because of their advantage of consistency.

- Likewise, Karelaia and Hogarth (2008) write that people are capable of achieving high levels of judgmental performance in well-known and predictable informational environments, whereas statistical models have the clear advantage of consistency under a range of circumstances.
- Westen and Weinberger (2004) agree that statistical methods outperform the ability of individuals to consolidate large amounts of information, and thus provide analysis and assessment based on aggregated data.
- But they also conclude that deficiencies of clinical judgment have been over-estimated and that clinical judgment can be highly reliable and valid and especially when focused and quantified through the use of structured instruments.

The Role of Clinical Expertise

- The American Psychological Association Presidential Task Force on Evidence-Based Practice (2006) describes and supports the significance of clinical expertise.
- This includes the ability of clinicians to recognize meaningful patterns of information and disregard irrelevant information, acquire extensive knowledge and organize it in ways that reflect a deep understanding of the case, and organize knowledge using functional rather than descriptive features.
- The APA task force describes clinicians as able to use their expertise to conduct assessments, formulate clear and theoretically coherent case conceptualizations, and form accurate diagnostic judgments.
- Clinical expertise, they write, is used to integrate the best research evidence with clinical data, while also understanding the influence of individual, cultural, and contextual differences in cases.
- The Task Force highlights a best practice and evidence-based model in which research driven findings are combined with elements and values associated with individual cases, and the application and synthesizing power of professional clinical judgment, or expertise.

Idea 6.
**Juvenile Sexual Offending Is Just
Another Strain of Juvenile Delinquency.**

Is There a Difference Between Sexually Abusive Youth and Juvenile Delinquents?

- It's widely reported that recidivism for adult and juvenile sexual offenders is significantly higher for non-sexual offenses than criminal offenses.
- Although varying from study to study, the rate of various forms of non-sexual criminal recidivism for adult sexual offenders always falls higher than their rate of sexual recidivism (for instance, Hanson & Morton-Bourgon, 2007; Hanson & Bussière, 1998; Proulx et al., 1997).

Juvenile Sexual Offenders Engage in Delinquent Behaviors

- Similarly, the idea that juvenile sexual offenders are at greater risk for re-engaging in non-sexual criminal behavior than a sexual offense is commonly noted (Caldwell, 2002, 2007; Fortune & Lambie, 2006; Reitzel & Carbonell, 2006).
- Letourneau and Miner (2005) report that this finding reported is consistent across nearly all studies of juvenile sexual offender recidivism.
- For instance, in his study of recidivism in 249 juvenile sexual offenders and 1,780 non-sexual juvenile offenders, Caldwell (2007) noted that the juvenile sexual offenders were nearly ten times more likely to recidivate non-sexually than sexually, although that number increases widely in different studies (including Caldwell, 2010, who reported a rate of general arrests six times higher than sexual arrests).

Are Juvenile Sexual Offenders Generally Delinquent?

- These findings, among others, including similar histories and shared characteristics, have led some to believe and espouse that juvenile sexual offenders are very much like, and perhaps essentially not distinct from, juvenile delinquents.
- They can therefore benefit from the same form of treatment, rather than receiving treatment especially designed for sexually abusive behavior.
- From this perspective, most juvenile sexual offenders simply "appear to be little more than juvenile delinquents with a sexual offense" (DiCataldo, 2009, p. 48).

Juvenile Sexual Offenders Are General Delinquents

- This point of view in effect argues that sexually abusive youth are conduct disordered.
- To some degree, this is proven by a higher rate of non-sexual recidivism than sexual recidivism, as well as historical, psychological, and behavioral aspects shared in common with non-sexual juvenile offenders.
- This leads to the position that juvenile sexual offenders should be more-or-less understood and treated in much the same way as other juvenile delinquents, even if as a subset.
- Letourneau and Miner (2005), for instance, conclude that "juvenile sex offenders are similar to other juvenile delinquents, and most would benefit from similar legal and clinical interventions" (p. 307).

- In comparing juvenile sexual offenders to both non-sexual juvenile offenders and juvenile non-offenders, Ronis and Borduin (2007) reported few differences between juvenile sexual and non-sexual offenders, or between types of juvenile sexual offenders (i.e., those with child victims and those with peer/adult victims).
- Hence, their study did not support distinguishing between sexually abusive youth and juvenile delinquents, asserting that "the reality is that juvenile sexual offending is often part of a broader pattern of serious antisocial behavior" (p. 161).
- The authors ask whether the developmental pathways for sexual offending are identical to those for non-sexual offending.
- Their position is essentially that the same treatment model can be applied to sexually abusive youth and juvenile delinquents, namely multisystemic therapy (their own treatment model).

- Milloy (1998) argues that as most juvenile sexual offenders do not sexually recidivate and many are at greater risk for non-sexual recidivism they should be considered as “generalists” (in effect, criminally versatile) and treated as delinquents and not “sexual offenders,” per se.
- Lewis, Shankok, and Pincus (1979, 1981) also concluded that juvenile sexual offenders are similar to non-sexual juvenile offenders, and experience the same psychological, neurological, and behavioral problems.
- Based on a small study sample, they argued that juvenile sexual offenders are similar to non-sexual *violent* offenders, and that the development of sexually abusive behavior and generally violent behavior has the same etiology.
- In their study, Jacobs, Kennedy, and Meyer (1997) similarly concluded that sexually abusive behavior by the subjects in their study was “likely to be but one expression of antisocial, violent behavior” (p. 201).
- Nevertheless, Jacobs and colleagues also provided support for the position that sexually abusive youths are not merely a variant of general delinquents.
- They noted that the sexual offenders in their study were a less chronic, less versatile, and in some ways a more benign group than the non-sexual offenders.

Do Juvenile Sexual Offenders Represent a Special Variant of Delinquency?

- Despite reporting that high levels of non-sexual recidivism make juvenile sexual offenders appear similar to non-sexual juvenile delinquents, Calder (2002) takes the position that juvenile sexual offenders represent a different group
- Even within the population, juvenile sexual offenders may be further sub-typed in terms of inter-group differences.
- And, despite noting high rates of non-sexual recidivism among juvenile sexual offenders, Caldwell (2007) also found the sexual offenders were significantly less likely to be charged with a non-sexual offense than the non-sexual juvenile delinquents.
- This suggests that the nature of non-sexual offenses by juvenile sexual offenders may be different than non-sexual offenses committed by non-sexual juvenile offenders, a point to be further explored as we think about sexually abusive youth.

Juvenile Sexual Offenders are Different

- This represents a second and more finely grained position that recognizes, as do Seto and Lalumière (2006), that although sexually abusive youth engage in juvenile delinquency by definition, their antisocial behaviors are often different than those of non-sexual juvenile delinquents.
- Indeed, drawn from their literature review, Varker, Devilly, Ward, and Beech (2008) assert that “adolescent sexual offenders are a distinct group from juvenile delinquents” (p. 258)
- Based on their literature review, van Wijk, Vermeiren, Loeber, Hart-kerkhoffs, and Bullens (2006) reach a similar conclusion, writing that “it is likely that sex offenders are different from non-sex offenders in specific ways” (p. 237).

- Those taking this second position clearly recognize heterogeneity among types of juvenile sexual offenders and between sexual and non-sexual juvenile offenders.
- In recognizing sub-groups within the population of juvenile sexual offenders, such as those with child victims and those with peer/adult victims, it is also implicitly implied that sexually abusive youth are a special subset of the larger population of juvenile delinquents.

Adult Sexual Offenders: Generalists and Specialists

- This dichotomy among adult sexual offenders and non-sexual criminals was highlighted by Harris, Mazerolle, and Knight (2009). They point to two distinct trajectories of offending among adult sexual offenders:
 - (i) Those along which “versatile” sexual offenders engage in sexual offenses as part of a broader pattern of criminal activity;
 - (ii) Those along which “specialist” sexual offenders commit sexual offenses but “seldom, if ever, engage in any other rule breaking behavior” (p.1064).
- Harris et al. recognize differences *among* sexual offenders and also *between* sexual offenders and non-sexual criminals, in which many adult sexual offenders do not resemble criminologically “typical” criminal offenders.

The Etiology, Dynamics, and Risk Factors of Juvenile Sexual Offending

- Returning to juvenile sexual offenders, from this perspective sexually abusive youth are not seen as simply “garden variety” juvenile delinquents.
- Instead, the etiology, dynamics, social skills, and social orientation of sexually abusive youth, not to mention their sexually abusive behaviors, are recognized as a unique and special strain of juvenile delinquency that is significantly different in many respects and driven by different risk factors and motivations.

- In their study of general and sexual risk assessment instruments, Viljoen et al. (2008) recognized differences between the development and dynamics of sexually abusive behavior and those of non-sexual conduct disordered behavior.
- They concluded that among sexually abusive youth a different set of risk factors may be relevant to their sexual and non-sexual offending behaviors.
- Further, Viljoen and colleagues (2009) describe research that significantly distinguishes between risk factors for sexual recidivism and risk factors for general, non-sexual recidivism.
- This lends further support for the idea that juvenile sexual offenders and juvenile delinquents represent different strains of troubled behavior, in which one “type” of offender (i.e., sexual or non-sexual) is not merely a variant of the other.

Conduct Disorder or Disordered Conduct?

- From France and Hudson’s (1993) assertion that approximately 50% of juvenile sexual offenders may be diagnosed with a conduct disorder, it may also be implied that approximately 50% may not be conduct disordered.
- Seto and Lalumière (2006) give far more thought to the question of conduct disorder in juvenile sexual offenders than most who have written on the subject.
- Recognizing a high incidence of conduct disordered behaviors in sexually abusive youth, like Harris et al (2009), they note the possibility that it is only among a *subset* of juvenile sexual offenders that highly antisocial behavior is found.
- They describe the additional possibility that a further subset of sexually abusive youth may not be broadly criminal or antisocial but instead restrict their antisocial conduct to sexually abusive behavior.

- From their meta-analysis of 24 studies that included over 1,600 juvenile sexual offenders and 8,000 non-sexual juvenile delinquents, Seto and Lalumière concluded that although many juvenile sexual offenders engage in conduct disordered behaviors, they generally score lower in conduct disordered behavioral problems than non-sexual juvenile delinquents.
- “As a group they had less extensive criminal history than non-sex -offenders... Many juvenile sexual offenders showed evidence of conduct problems, but juvenile non-sex offenders had even more conduct problems” (p. 181).
- This was especially true of juvenile sexual offenders who abused children (who appear to represent the majority of sexually abusive youth), and who demonstrated less conduct problems relative to both non-sexual juvenile offenders and juvenile sexual offenders who offended peers or adults.

A Special Pathway

- Seto and Lalumière suggest that it is in the lack or reduced level of conduct disordered behavior that we see a substantial difference between juvenile sexual offenders and non-sexual juvenile delinquents.
- Their conclusion is that factors relevant to the development of juvenile delinquency have relevance to understanding the development of sexually abusive behavior in juveniles.
- However, because juvenile sexual offenders score lower in conduct problems than non-sexual juvenile offenders they are, as a group, quite different in some respects, and Seto and Lalumière accordingly suggest that juvenile sexual offending may have unique causes.
- From their meta-analysis of 59 studies, comparing 3,855 male adolescent sexual offender to 13,393 male adolescent non-sexual offenders, Seto and Lalumière (in press) concluded that a general delinquency model is not a sufficient explanation of understand adolescent sexual offenders, noting a number of significant differences that distinguish between the two groups despite similarities.

Do Sexually Abusive Youth Have Special Treatment Needs?

- In practical terms, despite its diagnostic simplicity and utility, conduct disorder is not a unitary or categorical construct in which behavior is either categorized as conduct disordered or not.
- It is instead better understood and applied as a dimensional construct that takes variation into account in the nature, quantity, intensity, shape, and context of the behavior.
- This is what Seto and Lalumière are addressing in their work.
- And, without recognizing conduct disordered behaviors as multidimensional, we risk having the label mislead us into homogenizing sexually abusive youth into a single group, rather than recognizing subtleties and variations in the social experiences, behaviors, skill sets, and motivations, and, above all, the underlying dynamics of sexually abusive behavior in juveniles.

Remember Heterogeneity

- In our search for commonalities among juvenile sexual offenders, it is important that we avoid simplifications and do not mistake all behaviors that look alike as the same behavior.
- We must instead seek the nuances that will help us to distinguish juvenile sexual offenders from one another and thus allow greater depth in our insight and capacity to understand the children and adolescents we are assessing and treating.

Idea 7.
Empirically-based Research Is the Imperative.

“The scientific point of view has wiped out every other view to a point where they all seem primitive.”
Robert Pirsig, Zen and the Art of Motorcycle Maintenance

Evidence of Effectiveness

- The evidence-based treatment model pulls all treatment, including the treatment of juvenile sexual offenders, toward treatments that have been empirically proven.
- The goal, reasonably, is to discover what treatments are most effective for different ailments, based on empirically established evidence of their efficacy.

Not Without Controversy

- In many ways paving the way for both stronger and more effective treatment, evidence-based treatment requires that we *account* for the treatment models we develop and apply, provide support for their value, and demonstrate their effectiveness.
- The empirically-based treatment model stresses the importance of independently gathered and concrete (empirical) evidence of efficacy.
- It also represents a movement that de-emphasizes and curtails clinical judgment and practice.
- Although the model has been widely accepted and adopted by many professional organizations, it has nonetheless led to great controversy in the field, and is once again evidence of the split between a research-driven, scientific perspective and a clinical point of view.

- Norcross, Beutler, and Levant (2005) point out that there is initially universal agreement that we should use evidence as a guide in determining what works. They ask asking whether anyone would seriously advocate the reverse.
- But they point out that it is neither as simple nor as consensual as that.
- Defining and deciding what qualifies as evidence and applying those ideas are complicated matters with deep philosophical and huge practical consequences.
- For instance, once empirically proven, treatments are standardized so that they are always practiced that way, and other non-validated treatments are no longer used or recommended.
- This approach both offers a seal of approval to certain treatments that meet the criteria but also, in effect, designates all others as non-proven and perhaps not to be used.

Criticisms of Evidence-Based Treatment

- The EBT model is driven by a particular philosophy that provides useful information but also risks stifling treatment, limiting and potentially ignoring innovation and other ideas outside of its framework.
- Duncan (2001) has described the “certain seductive appeal to the idea of having a specific psychological intervention for any given type of problem” (p. 31), but also describes the whole notion of validated treatment as critically flawed.
- Reed (2005) has argued that Americans have been offered the idea that the essential problem with the health care system is uninformed practice, which would be resolved if health care professionals practiced in ways consistent with research findings. He asserts that this the basic premise of the EBP model.

Criticisms of Evidence-Based Treatment

- Garfield (1996) has criticized empirically-based treatment because it overlooks limitations in research methods, as well as the variations in each case and the importance of the therapeutic relationship.
- Indeed, Norcross (2002) asserts that empirically-based models validate the efficacy of *treatments*, or technical interventions, rather than the therapeutic relationship or the interpersonal skills of the clinician.
- It additionally, reduces clients to a static problem to be worked on rather than an individual in a therapeutic relationship, with much to offer and bring to the relationship.

The Application of the Scientific or Method

- Asay and Lambert (1999) have written that no matter how well intended, not only do findings not support the empirically-validated approach, but they “scream of scientific or theoretical arrogance” (p. 23).
- Silverman (1996) has called the movement towards validated treatment “methodolatry.”
- These writers assert that treatment manuals oversimplify treatment and provide a cookbook, paint-by-numbers approach to treatment.
- Indeed, by design evidence-based models reduce or eliminate clinical interpretation.

Good Science?

- One risk related to the role and nature of research and its application to practice involves the adoption of a perspective that denies the value or relevance of any form of evidence other than that derived through the scientific method.
- However, to consider scientific method the only source of our knowledge is to accept the idea that the methods of quantitative science are applicable to all spheres of life and experience, and consider that which cannot be measured through the scientific method to lack legitimacy (Hayek, 1952).
- From this perspective, any knowledge obtained by any means other than that of the scientific tradition is “at once ruled out of court” (Feyerabend, 1993, p. 11).
- We therefore risk becoming “hamstrung by arbitrary (even if widely agreed on) definitions of what counts as good science” (Marshall & Marshall, 2007, p. 259).
- “There is not one entity ‘science’ with clearly defined principles... science contains a great variety of (high level theoretical, phenomenological, experimental) approaches...” (Feyerabend, 1993, p. x).

The Range of Science

- Jeffrey Jensen Arnett (2009) writes that “restricting research to falsifiable hypotheses alone is far too narrow a view of psychology as a human science” (p. 573).
- His perspective is that such a focus restricts psychology’s “intellectual and scientific scope” to laboratory originated experimental situations that can be carefully controlled but not replicated in real life, are ecologically invalid, and have little in common with how people actually live and experience life.
- He writes of the many aspects of human development, behavior, and experience that are worth investigation even if they cannot be reduced to the falsifiable theories required by the scientific method.
- Recall also the objections of Marshall and Marshall (2007) to the application of highly experimental designs, such as randomized control trials which, although the “gold standard” in the application of scientific method, they describe as flawed and, in some cases, even unethical.
- Arnett (2009) encourages the application of diverse methods of science, beyond experimental design.
- “Many diverse methods (of science) are welcome, and all contribute valuable pieces to the mosaic that makes up a full understanding of humanity” (p. 574).

Physics Envy?

- Arnett concludes that “psychology needs to get over its ‘physics envy’ and adapt its methods and theoretical approaches to its uniquely human topic, in all its cultural complexity and diversity, rather than endlessly and fruitlessly aping the natural sciences.” (P. 574).
- Jerome Kagan (2006) similarly writes: “Physics is the beloved firstborn in the scientific academy; psychology is the envious toddler aping the elders. “Many psychologists would love to write equations with the power of Isaac Newton’s terse statement that force is the product of mass and acceleration...” “Psychologists lust for equally simple, rigorous, profound laws that explain the behavior of living things” (p. 11).

The Dominance of The Scientific Method

- Nevertheless, we work in a field increasingly dominated by the scientific method, which has added a tremendous amount to our work and strengthened our understanding, but has also in many significant ways overwhelmed the work we do as clinicians.
- In this respect, clinical work and judgment is sometimes swept to one side by research, and research thus becomes the tail that wags the dog.

Clinician or Technician

- Under these circumstances, our experiences as clinicians are driven, and sometimes defined, by research and appear of value only when they can be empirically substantiated.
- The risk of empirically-validated treatment in this context, and particularly manualized treatment, is that it may strip treatment of clinical experience, perspective, judgment, and skill.
- In so doing, evidence-based treatment and its counterpart, manualized treatment, risks reducing therapy to the level of the *technician*, rather than that of *clinician*.
- 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.

Absence of Proof Is Proof of Absence

- Despite Altman and Bland’s (1995) warning that absence of evidence does not prove that a relationship does not exist, Greenberg and Watson (2005) write that the dominant view in psychology at the moment is that only quantifiable evidence counts.
- They assert “the fallacy” that absence of evidence does mean “evidence of absence is currently dominating psychotherapy funding, practice, and education” (p.113).

Who’s Wagging Who?

- Smith and Pell (2003) assert that the “quest for the holy grail of exclusively evidence based” practice (p.1460) may create dependency on research alone, precluding clinical expertise and judgment.
- It is important, then, that we remain alert to the possibility that research will become the tail that wags the dog, in which “the dog,” is the practice of treatment.

Dependence on One Model?

- Martin Seligman (1995), a former president of the APA, has written that evidence-based studies are not the only way, or the best way, of learning which treatments work.
- He has noted that the conditions under which treatment is actually practiced in the field themselves yield important validation of psychotherapy not accounted for by empirically-based models.
- On a similar note, Henry (1998) has written that the validated treatment model ignores the empirical results generated by decades of psychotherapy research, serving only to entrench a particular model of experimental research.

- A dependence upon empirically-based treatment research, then, potentially weakens, and even devalues, professional judgment and clinical practice rather than strengthening it.
- In adopting a purely empirically-based treatment model, In so doing, several assumptions are made:
 - The only proof of efficacy is empirical.
 - Empirical proof can only be legitimately gathered through quantitative, classic design research methods.
 - Empirically proven treatments actually work, and are the best treatment.
 - Empirically-validated treatments work because of the single theory behind the treatment model and the associated treatment techniques rather than other explanations for its effectiveness.
 - Lack of proof is a tacit assumption that a treatment is not effective.

Coming Together

- As we learn how to use this instrument of evidence-based practiced, we must also recognize that it is presently, and may remain for some time to come, a clumsy instrument that is as capable of great harm as it is great good.
- We must therefore think about what models of evidence-based treatment currently exist, how to develop new models, how such models are empirically-validated and upon what evidence they are built, how we conceptualize and measure the variables that we define as evidence, and how we can best apply such models.
- It's important that we recognize that our ideas about and approach to statistical research and empirically-validated treatment frame how such research is used, and have clear implications for the "rest" of our work – that is, clinical practice.
- An equal partnership is required between research and practice, recognizing that the imperative of research is not simply to increase knowledge and drive practice, but also to serve practice and learn from it.

Optimism Without Evidence?

- Ironically, the effectiveness of sexual offense specific treatment itself is not well validated, if validated at all.
- Most of the research into the effectiveness of treatment fo adult sexual offenders has been inconsistent or weak in its conclusions and/or study designs (Brooks-Gordon & Bilby, 2006; Collaborative Outcome Data Committee, 2007; Kenworthy, Adams, Bilby, Brooks-Gordon., & Fenton, 2003; Rice & Harris, 2003)
- One significant study showed that a major cognitive-behavioral treatment program had no effect (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005).
- Despite this, there is support for the idea that treatment for both adult and juvenile sexual offenders works, and much optimism that it can work.
- Marshall, Anderson, and Fernandez (1999) noted that they were optimistic about the future development of sexual offender treatment, with "encouraging, if not methodologically purely based, evidence" of the benefits of treatment (p. 163).

Idea 8.
Empirically-Based Treatment Should Be Manualized.

The Removal of Clinical Judgment in Clinical Work?

- There has been an increasing movement towards accepting and using only treatments that through empirical means have been demonstrated to work.
- Unlike treatment practices based on clinical evidence only, or the opinion of the clinical community in absence of other empirical proof, evidence-based treatments are ostensibly held to a higher and more rigorous standard of scientific proof.

Treatment Manuals

- Validated treatment requires the development and use of treatment manuals that are single theory in design, and involve a clearly defined set of steps to be followed and techniques to be used in the treatment of a specifically defined disorder.
- In this manner, treatment validation not only supports particular treatments, but also standardizes the treatment so that it must be practiced only in the manner prescribed by the model and described in the treatment manual.
- In effect, manuals serve as guided workbooks for clinicians to ensure consistency and adherence to the treatment model.
- It is generally only possible to manualize treatments that can be concretely defined and operationalized, including expected technique, progress, response, and outcomes.

The Validation of Technique and Model

- A “manualized” approach to treatment emphasizes treatment technique over treatment approach, and treatment content over treatment process, and hence approaches treatment as technical.
- Validated treatment manuals are based on the belief that specific therapeutic models and defined techniques are largely responsible for the success of therapy, rather than either unique or common factors (Ogles, Anderson, & Lunnen, 1999).
- In fact, one of the criticisms of the manualized approach to treatment is that it is technique dependent, incapable of innovation or flexibility, and unable to integrate clinical judgment.
- Further, Greenberg and Watson (2005) assert that once an empirically-derived treatment manual has been written, then “only manual-driven treatment is acceptable” (p. 113).

- Norcross (2000) has asserted that this 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) notes that empirically-based models validate the efficacy of *treatments*, or technical interventions, but ignore the therapeutic relationship or the interpersonal skills of the clinician.
- He describes the clinician in manualized treatment as invisible.

Take One Therapy Pill After Dinner

- Perhaps at the extreme end of the spectrum, it is proposed that treatment methods are so sufficiently well specified that they can be taught to “intelligent laypeople” who can then presumably provide the treatment without clinicians (Quinsey, Harris, Rice, & Cormier, 2006, p. 92).
- Therapy is reduced to a technical, rather than a clinical, process.
- “Clients are reduced to a diagnosis and psychotherapists to technicians, while psychotherapy is administered like a pill” (Duncan & Miller, 2005, p. 152).

Manualized Treatment Restricts Clinical Work

- Although authors such as Mann (2009) continue to support the manualization of treatment for adult sexual offenders, manualized treatment is now under increasing scrutiny by others who question its value and effectiveness (Hollins, 2009).
- For instance, Marshall (2006, 2009) writes that manualized treatment in work with adult sexual offenders doesn't allow for necessary flexibility in clinical style or the development of the therapeutic alliance.
- He notes that rigid adherence to a manual reduces, if not eliminates, clinical flexibility.
- Manuals restrict the expression of therapist features that he writes have repeatedly been shown to be central to treatment in both general clinical treatment and sexual offender specific treatment literature.
- Similarly, Marques et al. (2005) recognize that 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.
- In recognizing the severe limitations of manual-driven treatment, the field is increasingly pulled towards treatment driven by individual case formulation, the skill of the clinician, and the therapeutic relationship.
- The Good Lives model is but the most recent example of this shift in thinking and practice (Ward, Gannon, & Mann, 2007; Wilson & Yates, 2009; Yates & Ward, 2008).

Manualized Treatment and Technique Versus the Treatment Experience

- In fact, regardless of theoretical focus or technique, all forms of therapy take place within the context of the therapeutic relationship (Castonguay et al., 1996).
- Regarding treatment outcome, Norcross (2000) and Lambert (1992, 2005) have written that the clinician-client relationship accounts for more than particular treatment techniques.
- Kazdin and Bass (1989) have written that techniques either do not play a powerful role or, if they do, research methods are not powerful enough to detect them.

What Makes Treatment Work?

- Regarding what makes therapy work, regardless of theory, technique, or manual, Holmes and Bateman (2002) have written that "common factors such as the therapeutic relationship, the creation of hope, explanations, a pathway to recovery, and opportunities for emotional release remain important explanatory variables for the similar outcomes of different therapies in the same conditions" (p. 8).
- The essential elements in these common factors, accounting for 70% of treatment outcome (Lambert, 1992, 2005), are the highly interpersonal factors introduced by the therapist and the client together, embodied in the therapeutic alliance that forms between them and in which the work of treatment is accomplished.

The Violation of the Treatment Manual

- Addressing the manualized approach to treatment, Beutler (2000a) has written that the most effective clinicians violate manualized treatments.
 - "The tasks facing the modern clinician are often incompatible with selecting a specific structured manual that is built around a specific diagnosis..."
 - "The art of psychotherapy is taking simple principles of relationship and interpersonal influence and applying them in creative ways to fit the endless permutations and complexities that characterize the people who seek our services..."
- "If a clinician is just a technician, that clinician will never cope with the complex problems that are presented in clinical practice" (Beutler, 2000b, p.47).

The Value of Manuals in Clinical Work

- Even proponents of manualized treatment, Addis and Cardemil (2005) write that function of a treatment manual is not to replace the sensitive, creative, and flexible clinician but to assist in the dissemination and implementation of evidence-based treatment" (p.135).
- Similarly, Woody and Sanderson (1998) write that treatment manuals describe validated treatments in enough detail to allow a trained clinician to replicate the treatment, but add that no treatment manual is adequate in the absence of solid theoretical grounding and training.

On Manuals, Technique, and Treatment

- Beutler (2000a) has written that effective manuals must resolve single theory models in the face of multi-theory practice, and the idea and widely held belief that all treatments are more-or-less equivalent in treatment effect.
- In this model, treatment effectiveness is based on underlying common factors that make them effective, rather than technique.
- Beutler writes that “procedures that enhance the quality of healing relationships are immanently more powerful than the theory-based techniques to which contemporary manuals are addressed....
“ Indeed, the power of any set of techniques may well be to enhance the quality of the therapeutic relationship” (p. 1006).

Empirical Evidence of Clinical Effectiveness

- The idea that the therapeutic relationship, including the behavior and attributes of the clinician, is central has been the subject of empirical research by Norcross (2000, 2002), Lambert (1992, 2005), Castonguay and Beutler (2006), and others.
- They have written that the clinician-client relationship contributes more to treatment outcome than treatment techniques.
- Lambert (1992, 2005) and associates (Asay & Lambert, 1999; Lambert & Bergin, 1993) have written that *most* of what happens in successful treatment is unrelated to treatment model or technique, related instead to factors that are common to all therapy.
- According to Lambert, of the four elements most commonly associated with treatment efficacy, model and technique accounts for only 15% of the variance in treatment outcome, with 85% of treatment success resulting from human interactional factors: client factors (40%), therapeutic alliance (30%), and the expectancy effects of placebo and hope (15%).
- These ideas, and the idea that there are common factors found in all forms of effective treatment, are supported by the findings of the American Psychological Association’s Divisions 12 and 29 Task Force on Empirically Based Principles of Therapeutic Change (Castonguay & Beutler, 2006; Norcross, Beutler, & Levant, 2005).

Is Sexual Offender Treatment Different?

- Does the treatment of adult sexual offenders follow a different path than treatment in general?
- Do treatment manuals play a different role in sexual offender specific treatment, because sexual offender specific treatment is different?
- Is the treatment of juvenile sexual offenders different than the treatment of other children and adolescents?

Idea 9.
Psychopathy Can be Detected in Adolescents.

Conduct Disorder and Psychopathy in Juveniles

- One well-established construct in the assessment of risk for sexual recidivism in adult sexual offenders is that psychopathy counts (Hanson & Morton-Bourgon, 2007; Olver & Wong, 2006).
- Is this true also in the assessment of risk of sexual recidivism in juveniles also?

- More than simply troubling and disturbed behavior, seriously conduct disordered attitudes and behaviors in children and adolescents involves the hallmark features of callousness, lack of empathy, social disconnection, and lack of regard for others.
- These are clearly linked to concerns we have for sociopathic behavior that continues into adulthood.
- But, is the construct of psychopathy in children and adolescents legitimate?
- Can juveniles be considered psychopaths if they display symptoms relevant to the diagnosis of psychopathy in adults?

Are Psychopaths Made or Born?

- Salekin and Lochman (2008) note that considerable work lies ahead in recognizing protective factors that guard against psychopathy in youth, and by inference suggest that psychopathy is a developmental process, and that psychopaths are made, not born.
- On the other hand, the failure of Lynam, Loeber, and Stouthamer-Loeber (2008) to find protective factors that reduce the appearance of later psychopathy in at-risk adolescents provides evidence that psychopathic traits are already present in some juveniles, and perhaps evidence that people are genetically predisposed to psychopathy.
- Is it therefore legitimate to consider some juveniles as psychopaths, even if we choose to not use that label?

Assessing for Psychopathy

- Although assessing for conduct disorder and antisocial behavior, none of the most commonly used instruments to assess risk for sexual re-offense in adolescents assess for psychopathy.
- However, this is not the case for the SAVRY (Structured Assessment for Violence Risk in Youth), which specifically assesses for the presence of psychopathic traits in adolescents.
- The SAVRY, therefore, to some degree at least, gives credence to the idea that psychopathy is a relevant construct in our capacity to understand adolescent antisocial behavior and its persistence and trajectory in adulthood.

- The SAVRY uses the youth version of the Hare Psychopathy Checklist to assess for the presence of psychopathic traits in adolescents.
- Like its adult counterparts, the PCL-YV is assessing for the presence of psychopathic traits within the adolescent being assessed.
- Of special note, the authors of the PCL-YV (Forth, Kosson, & Hare, 2003), specifically note that although used to assess the presence of psychopathic traits in adolescents, adolescents may not be assessed as psychopathic.
- Nevertheless, this seems to be hair splitting as the instrument itself is named the "Psychopathy" Checklist, and is clearly built on the premise that psychopathy exists in adolescence (and in childhood), even if cautious about using the term to define such adolescents.
- In effect, both the SAVRY and PCL-YV accept and build upon the idea that adult psychopathy can be recognized in adolescence, and, in effect, that it already exists in adolescents whose psychopathic trait scores are high enough.
- This may not be surprising as Adele Forth, the lead author of the PCL-YV, is also co-author of the SAVRY.

Psychopathic Traits in Children?

- Whereas the PCL-YV is used to assess psychopathic traits in adolescents aged 12-18, the Antisocial Process Screening Device (ASPD) can be used to assess for psychopathic traits in children aged 6-13.
- The again points to the idea that even very young children may exhibit psychopathic traits, and perhaps may be considered psychopaths in development.
- Indeed, the ASPD was formerly known as the Psychopathy Screening Device.

Can Psychopathy be Assessed in Children and Adolescents?

- We recognize that adult behavior doesn't pop into existence full blown at age 18.
- In keeping with the idea that adult sociopathic behavior is necessarily linked to adolescent, and even childhood, behavior, Robert Hare and others point to adolescent and childhood predictors or indicators of adult psychopathy (Frick, 2002; Hare, 1999; Lynam, 2002).
- Forth, Kosson, and Hare (2003) describe psychopathy as a stable personality disorder that is first evident in childhood, and conclude that psychopathic traits are observable in adolescents and children, likely the result of genetic transmission.
- Careful not to use the PCL-YV to actually diagnose psychopathy in adolescents, the authors nevertheless conclude that psychopathic traits are observable in adolescents (and children) and may be effectively and accurately measured.

- Forth et al. recognize that personality can change both during adolescence and between adolescence and adulthood.
- They also acknowledge the lack of prospective studies of personality traits conducted in adolescents later diagnosed with psychopathy, noting also that none of the psychological mechanisms proposed to explain adult psychopathy have been thoroughly examined in children or adolescents.

Psychopathic Youth are Different

- Nevertheless and quite distinctly, the proponents of psychopathy in juveniles clearly describe a definite subset of children and adolescents as less moral, less empathic, and less connected than their peers, even when compared to other conduct disordered youth (Forth et al., 2003; Frick et al., 2003b).
- Both Forth and Frick consider these juveniles to potentially be constitutionally different than their peers, reflected in part through the early onset of their severe behaviors.
- If Frick and Forth are correct, then these are children whose affect and behavior is driven by psychopathic processes that make them "similar to adults with psychopathy" (Frick et al., 2003b, p. 256).
- Indeed, although they appear reluctant to say it, and are cautious and equivocal in their descriptions, these theoreticians clearly support the idea that psychopathy does appear in childhood, and the children described are, in effect, young psychopaths.
- In fact, if psychopathy is innate and not developmental, then it must be dispositional in children and adolescents, long before emerging as adult psychopathy.

Conceptual Controversy

- However, although the presence of serious antisocial behavior is recognized in children and adolescents, there is controversy about defining children and adolescents in such terms (Vincent, 2006; Vitacco, Rogers, & Neumann, 2003).
- Additionally, questions continue to exist regarding the application and transportability of ideas about psychopathy in adults to juveniles, as well as the stability of psychopathic traits from adolescence into adulthood (Salekin, 2008; Skeem & Petrila, 2004; Vincent, 2006).
- Others argue that disruptive behavioral and impulsive behaviors in children and adolescents cannot reliably identify "fledgling" psychopaths (Vincent, Vitacco, Grisso, & Corrado, 2003).

Conceptual Controversy

- Seagrave and Grisso (2002) urge against assessing juveniles as psychopaths, and describe the risks and possible mistakes inherent in diagnosing adolescents in this manner.
- Hart, Watt, and Vincent (2002) echo this perspective and express their concerns about the implications of diagnosing psychopathy in children and adolescents, writing that “the assessment of juvenile psychopathy is like an Impressionist painting: fine from a distance; but the closer you get, the messier it looks” (p. 241).

The Developmental Path to Psychopathy: Biological or Home Grown?

- Forth and colleagues link attachment deficits to the development of psychopathy in some cases, by asserting that the maladaptive and hostile interpersonal style characteristic of psychopathy is likely to be found in children with an insecure and dismissive attachment style.
- They report that psychopathy is linked to adverse family histories, such as those common to both insecurely attached children and juvenile sexual offenders, and suggest that such histories are developmental antecedents to psychopathy.
- They conclude that “children characterized by a lack of attachment to others are expected to display impulsive, dominant, and nonanxious interpersonal behavior and, eventually, to develop a coercive interpersonal style that is associated with psychopathy” (2003, p. 6).
- However, attachment theory tells us that detached, and indeed all, attachment styles are developmental and contextual in nature, and develop in response to the social and family environment in which the child is raised.
- From the perspective of attachment theory, all attachment styles are adaptive to the environment. In the development of troubled attachments, it is the environment that is pathological and not the child.
- In fact, from the perspective of attachment theory, rather than describing behavior reflective of psychopathy, the lack of attachment described by Forth and colleagues is exactly that behavior expected in insecure avoidant attachment, rather than evidence of a lack of attachment or the presence of psychopathy.

From Troubled Attachment to Psychopathy: Made, Not Born?

- Although describing early psychopathic traits, Frick and Forth are also describing children affected by early attachment difficulties and on-going life experiences, as partly suggested by Forth herself.
- In this case, the behavioral and emotional traits that Frick and others consider to represent callousness and lack of emotionality may actually distinguish these children from others because they reflect more severe attachment difficulties, rather than psychopathy.
- That is, the troubled personal attributes, social behaviors, interpersonal difficulties, and social disconnection displayed by these children may be developmental responses to early experience rather than manifestations of innate psychopathy.
- If unchecked, these developmental (rather than dispositional) traits may yet lead to the callous unemotionality that mark adult psychopaths, as these children harden through adolescence and into adulthood.
- In this scenario, psychopathy may be a developmental phenomena, in which adult psychopaths are made, rather than born.

Psychopathy in Juveniles : Dispositional or Developmental?

- On the one hand, if the source of psychopathy is biological, even if influenced by environmental conditions, then it is dispositional in the child. It is therefore not a result of attachment and other early developmental experiences, even if they aggravate the condition.
- In this case, the unattached personality that characterizes psychopathy is the product of biology, rather than developmental experience.
- Here, it is predispositional genetic traits that set the course for both attachment deficits and psychopathy, neither of which in this case are experiences truly shaped by development.
- On the other hand, if the psychopathy is linked to and emerges from early history and on-going adverse childhood experiences, then it is developmental rather than biological/temperamental, and sociopathic traits and behaviors develop over time and through adverse and difficult life experiences.

Psychopathy in Juveniles : Dispositional or Developmental

- Perhaps the better question is not whether, as I have asked, can psychopathy be diagnosed in juveniles, but is the development of psychopathy in adults a genetic or a developmental process, or both?
- The issue is of course likely to involve both biological temperament and social development, or nature and nurture, but is one predominant over the other?
- If genetics is the key, psychopathy may rightly be recognized in children and adolescents, and a trajectory that quite likely cannot be significantly altered.
- If development is the key, though, although we may see psychopathic like traits, trajectory remains open to change and further development.

The Position We Assume

- It is clear that we see in some juveniles far more social, emotional, and psychological disturbances than in others, and in some children and adolescents behaviors are far more deeply entrenched.
- It is equally clear, and quite obvious, that adult psychopathy must develop during childhood and adolescence, and its precursors or early form must be evident before adulthood.
- And despite questions and concerns, there is little doubt that traits of psychopathy, even if not fully formed, appear in both adolescents and children, and there is convincing evidence that in these youths psychopathic traits are enduring and stable into adulthood (Barry, Barry, Deming, & Lochman, 2008; Edens, Campbell, & Weir, 2007; Gretton, Catchpole, McBride, Hare, & Regan, 2005; Lynam et al., 2007, 2008, 2009; Salekin, 2008).

- However, by restricting concepts of psychopathy to adults, we do not risk unnecessarily labeling children and adolescents with a diagnosis of personality organization and psychosocial functioning that is among the most frightening to the public.
- We also perhaps best ensure that we ourselves do not treat these youths differently or imagine that treatment for these children and adolescents likely to be ineffective due to the enduring and pervasive effects of psychopathy.

The Best of Our Knowledge

- In any case, the genetic *psychopathy-as-latent* versus the developmental *psychopathy-is-created* perspective again reminds us that there are few unequivocally correct or universally accepted ideas, perspectives, or answers in our field.
- Like every idea we have thus far discussed, it is not one or the other (in this case, genetics or developmental).
- There is more than one correct perspective, more than correct answer, and more than a single set of etiological factors.
- "There is no single cause. A coherence of several factors is necessary to produce a particular phenomenon" (Kagan, 2006, pp. 94-95).

Idea 10.
Research is Free of Allegiance Effect and Confirmation Bias.

Peer Review, Substantiation, and Replication

- I would like to produce research that shows that my ideas and the work I'm doing are effective and efficacious.
- However, rather than reading my evaluations of work I have written or produced, I suspect that most people would want to see the quality and outcomes of my ideas and work evaluated and confirmed by researchers who are independent and free of allegiances towards me or my model.
- And not only one piece of research at that, but the replication of that research, at least two times and better still three times or more.

- Only in this way, through the work of independent researchers, and researchers who are independent of one another, in multiple studies, can we begin to eliminate the possibility of confirmation bias, publication bias, and allegiance effects, poor study designs, and other influences that skew, misinterpret, or otherwise weaken research or shape its outcomes, and thus move towards more transparent and more valid empirically-supported treatment ideas and practices.

The Depth and Breadth of Research

- We should not only be aware of studies that present contradictory conclusions, but also bodies of single-minded data that are produced largely by the same teams of researchers.
- This may be especially true when studies have not been replicated by teams of independent researchers and/or researchers not involved in the development of models under examination. This body of research may have depth, but lacks breadth.
- We should thus be aware of the breadth of research literature that addresses any particular subject area, and not simply depth.

The Presentation and Interpretation of Research: Confirmation Bias and Allegiance Effect

- Some of the focus on how research is presented and the outcomes it supports, in terms of effectiveness and efficacy, may be explained by the understandable allegiance of theory and model developers to their own theories and models.
- Luborsky, Diguier, Seligman, Rosenthal, et al. (1999) examined the association between the treatment allegiances of researchers and the outcomes of studies that compared different psychosocial treatments.
- They concluded that, when the authors of treatment models were also the authors of studies that researched the efficacy of those models, the effects of "treatment allegiance" explained 69% of the variance among different study results.
- They concluded that such associations can distort reported treatment results.
- "There are no articles in the entire literature published by a first author who is a founder of a treatment, where the results are counter to that author's allegiance!" (p. 102).

- In their study of the possible relationship between allegiance and the study of risk assessment instrument, Blair, Marcus, and Boccaccini (2008) similarly reported allegiance effects and a pattern of allegiance when the author of a study is also the author of an instrument under study
- Similarly, Littell (2008) concludes that published studies are vulnerable to allegiance effects that appear when interventions are studied by their advocates, or a form of "experimenter expectancy effect."
- She notes that allegiance effect, confirmation bias, and publication bias, each contribute to research findings being less valid and reliable than they might appear.

Confirmation Bias and Allegiance Effect? MST as Case Example.

- One significant example of both limited authorship and possible treatment allegiance is the large body of work that has been accumulated on the development and application of multisystemic therapy (MST).
- There is a great deal of data supporting the theory and model and its efficacy, and MST has justly come to be considered a premier example of an evidence-based model of treatment.
- Indeed, the model has received strong support and is a well-constructed, well-informed, robust, and well-considered model used throughout North America and internationally.
- However, the strangest thing about research into the effects of multisystemic therapy is that, with one exception, every study citing the efficacy and effectiveness of MST has been designed, implemented, and authored by or under the direct guidance of the developers, proponents, or affiliates of the model itself.
- This, potentially provides a very strong example of both confirmation bias and treatment allegiance at work.

Lack of Independent Studies

- To date, among the entire body of work that supports and shows the efficacy of the MST model, only one efficacy study has been completed by researchers who are independent of the MST developers.
- Timmons-Mitchell, Bender, Kishna, and Mitchell (2006) report that their study is the first and only randomized clinical trial of MST in the U.S. conducted without direct oversight by the developers of the MST model.

- In fact, there are barely any independent research studies of MST, despite calls for such independent studies (for instance, Harpell and Andrews, 2006, and Littell, 2005).
- Other than Timmons-Mitchell (2006) study, of the few independent studies that have looked at either the efficacy or the quality of the MST research literature, none have provided any clear support for MST as significantly more effective, or more effective at all, than other “usual treatment” models, or its research methods.

Lack of Independent Confirmation

- In a study comparing MST to two other community-based intensive “wraparound” services, Stambaugh et al. (2007) provided *some* support for MST compared to other services, but concluded that youths in all three treatment groups improved over the study period and that there were no significant outcome differences in generalized psychosocial functioning between the MST treatment group and the other two groups.
- In an independently researched study of MST in Sweden, Sundell et al. (2008) reported that the results of a randomized clinical effectiveness trial did not support the effectiveness of MST relative to the usual treatment for conduct disordered youths.
- In a four-year independent study of MST in Canada, applied over four different regions of Ontario, outcomes did not support MST as more effective than the usual treatments.
- The study instead essentially concluded that the treatment effects of MST were either too small to be statistically detected or that MST treatment effects are no greater than those of usual treatment services (Leschied & Cunningham, 2002).
- The authors noted that the MST and Treatment-as-Usual groups were not distinguishable on any outcome measure, suggesting that MST showed no treatment effect.

Study Designs

- In terms of protocols and design, MST research has been criticized on several grounds, and the same is true for empirically-based research in more general terms (Littell, 2008; Westen, Novotny, & Thompson-Brenner, 2004).
- In reviewing MST research, Littell (2005) describes inconsistent and incomplete reports on primary outcome studies, important variations in the implementation and integrity of randomized experiments, errors of omission and interpretation in reviews, and findings that differ from those of prior, published reviews.
- She additionally points out that most of the MST research has been conducted by its developers, and that this creates confirmation bias in terms of conflicts of interest
- “Authors are less likely to be critical of their own programs and studies than independent reviewers, particularly when additional funding for services and research is at stake” (Littell, 2005, p.459).

More Independent Scrutiny Required?

- Littell, Harpell and Andrews (2006) also clearly noted the direct links between the majority of MST researchers and the developers of the model, the lack of quality assurance measures in MST studies, and what they described as the over-interpretation of findings from correlational studies
- They recommend further empirical scrutiny of MST efficacy, despite the fact that the model continues to expand nationally and internationally.
- They note that more independent researchers must conduct efficacy studies before MST can be claimed as a viable, or better, alternative to usual services
- They note that, to date, the results of independent researchers do not sufficiently replicate the results reports by studies conducted by the developers of the MST model.

Anti Empirically-Based Treatment?

- In response to Littell's 2005 review, Henggeler, Schoenwald, Swenson, and Borduin (2006), the designers of the MST model, pointed out that the conclusions of Littell's review was at odds with conclusions drawn by reviews of MST research conducted by reviewers and federal entities entirely independent of MST developers and researchers.
- They described Littell's 2005 paper, as well as a paper by Westen, Novotny, and Thompson-Brenner (2004) that was also critical of the design, assumptions, and practices of empirically-supported treatment research, as part of an "insidious strategy" designed to denigrate evidence-based research, camouflaging a commitment to treatment protocols that are not based in empirical research and thus maintain the treatment status quo (p. 455).
- In their conclusion, Henggeler et al. contended that Littell's meta-analysis was a "trojan horse" of "questionable value in debates among reasonable people regarding the promise and challenges of identifying and implementing empirically supported treatments to improve the nation's mental health care for youth" (p. 455).

Open to Scrutiny and Evaluation?

- In *her* response to the Henggeler et al. article, Littell (2006) asked whether multisystemic therapy is a model built on scientific evidence free of allegiance bias.
- She also asked whether the evidence-based practice movement will become a new "orthodoxy," founded on selective use of evidence and premature closure of inquiry, and whether it remains open to critical assessments of evidence.
- She recommended that before transporting "off-the-shelf programs like MST, funders and consumers should insist on independent evaluations of their effectiveness" (p. 470).
- Independent of Littell's work, Harpell et al.(2006) reached similar conclusions, describing the over-interpretation of findings in studies conducted by the MST researchers, and recommending further empirical scrutiny of MST efficacy and the need for independent research.
- Like Littell, they concluded that to date there is no independent research establishing MST as a treatment model that is better than treatment-as-usual.

Are the Research Results All we Need to Know?

- This description and debate again illustrates that research is neither straightforward nor free of complications.
- We must understand the design, method, approach, underlying assumption, and application of research within a larger context, including the biases and allegiances that influence design and interpretation, and even underlying ideology.
- Not all research is created equal, and research itself is subject to research.

Allegiance Effect? Good Lives Model as Case Example.

- The currently developing Good Lives model (GLM) offers another example of both theory and research that demonstrates a focused perspective, but also possibly confirmation bias, in which the most significant and articulate proponents and researchers of GLM, as with the MST model, are its designers or affiliates.

The Good Lives Model in Design

- Like the MST model, Good Lives is a strong theoretical model, and I, and increasingly many others, find the model both well-developed and clinically satisfying in its philosophy of approach to treatment.
- The Good Lives model has been amply described by its developers and others (Thakker, Ward, & Tidmarsh, 2006; Ward, Gannon, & Mann, 2007; Ward, Polaschek, & Beech, 2006; Ward & Stewart, 2003).
- Good Lives aims to be a fully developed and integrated model, and continues in its development, most recently blending with the self-regulation model, also developed by Ward and colleagues (Ward et al., 2004; Yates, Kingston, & Ward, 2008).

Allegiance Effect/Confirmation Bias?

- However, despite the proliferation of literature describing the Good Lives and the Self-regulation models, and their recent integration, virtually all of this material has been produced by the very developers and close associates of the model itself.
- This includes optimistic evaluations that the a model such as combined Good Lives/Self-regulation model “is most likely to be effective in achieving the goals of reduced recidivism, risk reduction, and reduced rates of sexual victimization ” (Yates & Ward, 2008; p. 3).

- One important and persistent element in the literature describing both the individual Good Lives and Self-regulation models, and now the integrated GL/SR model, is the comparison to other models for the assessment, treatment, and/or management of adult sexual offenders.
- This includes the well-informed and well-defined critique of other, pre-existing models, including their limitations and weaknesses.
- However, in critiquing the currently popular Risk, Need, and Responsivity model, for instance, Yates and Ward (2008) not only point to strong empirical support for the RNR model, but also note that the RNR model has been subjected to a number of critiques aimed at its underlying theoretical assumptions and the model’s lack of scope.
- However, the critiques cited by Yates and Ward cited are authored by Ward and Gannon (2006), Ward and Maruna, 2007, and Ward, Melsner, and Yates (2007), the very authors and affiliates of the GL/SR model itself, rather than independent researchers who have no potential allegiance to either the RNR or the GL/SR model.

- Even the “recent debate in the literature, as to whether RNR and GLM might be at odds,” described by Wilson and Yates (2009, p. 160) refers to papers written, again not by independent researchers, but the authors of the Good Lives model, citing the sources of these debates as Ward (2006) and Ward, Melsner, and Yates (2007).

Exercising Caution

- Hence, in the delivery, and even “marketing” of research ideas and models, we must exercise caution in our review of the literature and our application of those ideas, even if we agree with those ideas in theory and in practice, and those ideas and the models they support are intuitively and professionally attractive to us.
- For the record, as I do not want to appear opposed to or evidence-based treatment, nor opposed to the ideas and models described, or rejecting the hard, well-developed, and excellent work of their authors, I am a strong supporter of both the MST and Good Lives model, and fully support their ideas, methods, and underlying philosophies.
- To be clear, both MST and GLM are the sort of theoretical and practice models that I think are exactly right for the kind of work we do, at least with juveniles.
- However, that isn’t the point here. The point, instead, is that if we are going to use empirically-based treatment models, they must be based on far more than just our sensibilities, preferences, opinions, and allegiances.
- They must instead be promoted, validated, and replicated through multiple independent research studies, and research studies that are both independent of the model developers and independent of other similar independent research studies.

Epilogue
Who, Then, is Right? Everyone. They All Are

Changes and Development Across the Field

- Beyond the ideas discussed today, we've seen other changes and evolution in our field.
- We've come to recognize, both a multi-factorial pathway to the development of sexually abusive behavior and that multiple factors are also at play in sexual recidivism, clearly reflected in the work of Tony Ward and colleagues in the development of their self-regulation model of offense and relapse (Ward, Bickley, Webster, Fisher, et al., 2004; Yates, Kingston, & Ward, 2008).

- In turn, this has led us to our reconsider our view and use of the relapse prevention plan as the only and best means for combating and managing sexual relapse, which has been increasingly critically scrutinized by some (Carich, Dobkowski, & Delehanty, 2008; Wheeler, George, & Stoner, 2005), rejected by others (Laws, 2003; Thakker, Ward, & Tidmarsh, 2006; Yates, 2007; Ward, Polaschek, & Beech, 2006), and subject to recent spirited debate (Carich, Dobkowski, & Delehanty, 2009; Yates & Ward, 2009).
- This new thinking has helped shift the balance from what Laws (2001) described as the uncritical acceptance by the treatment community of the relapse prevention model to a more critical and sophisticated mindset.
- It has added to our expanded understanding and conceptualization of both what drives recidivism and the individuals who recidivate.

The Ecology of Sexually Abusive Behavior

- Another emerging perspective in our field, clearly related to the multi-faceted nature and heterogeneity of the youths with whom we work, is our recognition that sexually abusive behavior neither develops in a vacuum nor follows a simple, one-size-fits-all pathway driven by factors common to every sexually reactive child or sexually abusive adolescent.
- Accordingly, we now more clearly understand and describe a *multi-factorial* pathway to the sexually troubled and abusive behavior of children and adolescents, along which different individuals develop differently.
- Put another way, the root of juvenile sexual offending is multi-determined, involving individual, family, peer, school, and community variables (Letourneau, Schoenwald, & Sheidow, 2004), as well as biology (O'Connor & Rutter, 1996), temperament (Kagan & Snidman 2004), and socio-economics (Lipsey & Derzon, 1998).
- Thus, despite the many developmental commonalities and shared features in the lives of sexually troubled youth, the development and enactment of sexually troubled behavior sexual behavior is a complex phenomenon and develops under conditions and through circumstances that are different for each person.

The Complexity of Individual Pathway

- Even though the pathway for many sexually abusive youth often starts at a common point, we have learned that we cannot predict the eventual outcome of the pathway because the pathway is influenced by many subtle factors, many of which we are unaware or cannot predict.
- There are no pre-determined pathways that inevitably set into motion any particular behavior, including sexually troubled behavior.
- Individual pathways are so complex and influenced by so many factors, both subtle and obvious, that it is unlikely we will be able to define a single pathway, or set of factors or events, that leads to the same behavioral outcome for every individual first stepping along a similar path.

The Heterogeneity of Sexually Abusive Youth

- And we've also come to clearly recognize the heterogeneity of sexually abusive youth, described by Caldwell (2002) as "one of the most resilient findings in the research on juvenile sexual offenders" (p. 296).
- He notes the importance of distinguishing between types of juvenile sexual offenders, lending support to the idea that not only are sexually abusive youth different from one another but they are not simply cut from the same cloth of juvenile delinquency, even if a special variant.

Is the World Just Waiting to Be Discovered?

- Beyond this, in terms of how we think about and approach the work, the work doesn't just exist, waiting for us to come along and pick up the reins.
- The ideas that shape, define, drive the work we do, and by which we evaluate our work, aren't just "there," waiting to be discovered. Rather, to a great degree the work is what we make of it, in which our view as researchers and practitioners is key.
- Moreover, the ideas that we develop, and sometimes hold onto, are neither set in stone nor necessarily correct.
- It's important that we let these ideas lead us to new understandings, that we understand the basis for our ideas and think about them in a critical manner, recognizing that there's usually more than one way to think about and find solutions for the same problem, and also that we don't hold on to our ideas too tightly.

The New Boss

"Some particular body of doctrine in time rallies the majority round it, organizes social institutions and modes of action conformably to itself, education impresses this new creed upon the new generations without the mental processes that have led to it, and by degrees it acquires the very same power of compression, so long exercised by the creeds of which it had taken the place"

(John Stuart Mill, 1961, p. 149).

It's the Clients

"A saving grace for any medical theory or practice--the thing that spares it perpetual thralldom to the gusty winds of fashion-- is the patients. They are real, they are around, and a knowledge of their distressing symptoms guards against oversimplification"

(McHugh, 1992, p. 501).

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