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DATE: JUNE 1, 2014
TO: DAVID PRESCOTT
FROM: LORI JACOBS

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Chapter 20

Improving Outcomes One Client at a Time—Feedback Informed Treatment With Adolescents Who Have Sexually Abused

by David S. Prescott and Scott D. Miller

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OVERVIEW

In 1960, when almost nothing had been written on the treatment of people who sexually abuse, a law student named Alan Swanson wrote an essay on what were then referred to as “sexual psychopath” laws. After reviewing the often confusing ways in which these laws were implemented, he recommended the following: “The end result of such proceedings must always be ‘effective treatment’ and not ‘effective punishment.’” He went on to predict that “It may take many decades before the idea of ‘mental treatment’ supplants that of punishment” (pp. 226–227). Subsequent decades of criminological research would find that punishment-only approaches to crime did not reduce reoffense (Smith, Goggin, & Gendreau, 2002).

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Fast-forward to the present, and at this writing the web site of the Texas Department of State Health Services (2010) states, “Sex offender treatment is different than traditional psychotherapy in that treatment is mandated, structured, victim





centered, and the treatment provider imposes values and limits. Providers cannot remain neutral because of the risk of colluding with, adding to, and/or contributing to the offender's denial" (p. xx). The implicit belief in this statement is that people who have sexually abused are either unable or unwilling to change on their own, and that imposing interventions on them is essential. It further assumes that the client's perspective on his or her own treatment is so distorted that evidence of disagreement with the therapist may constitute denial or pathology.

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This chapter proposes that, in fact, actively engaging clients in treatment is critical to success. Ultimately, decades of research have shown that meaningful change cannot be imposed on a client any more than teachers can force education into the brains of elementary school students. As one practitioner from Texas describes that state's definition of treatment, "If I follow the State's expectations, I may be engaging outside the ethical codes of my professional counseling license; yet if I don't impose values and limits I could be found in violation of my sex-offender treatment certification" (Mark Asteris, personal communication, June 2, 2013).

INTRODUCTION

Early texts on treating people who have sexually abused emphasized overtly directive approaches to treatment. For example, in a highly influential 1988 book, Anna Salter stated that "[T]he process of treating child sex offenders is heavily weighted in the direction of confrontation. Treatment requires continual confrontations" (p. 93). Examples include the following statements:

- No, I do not trust you and you would be pretty foolish to trust yourself.
- Give me a break. What do you mean one drink can't do any harm? Drinking is a parole violation, and you seem to be making a serious attempt at getting yourself back in jail.

Salter points out, however, that "Confrontation does not have to involve hostility and it must not if it is to be therapeutic . . . the task in treatment is not only to confront, it is to hold the offender with one through the confrontation, and to come out the other side with the message clear but the rapport intact" (pp. 93–94). Where the line appears between confrontation and hostility is not entirely clear. What is clear, however, is that subsequent findings have cast confrontational approaches into a much less favorable light (Marshall, 2005; Parhar, Wormith, Derkzen, & Beauregard, 2008). In fact, in an influential article regarding addictive behavior, White and Miller (2007) stated:

There are now numerous evidence-based alternatives to confrontational counseling, and clinical studies show that more effective substance abuse counselors are those who practice with an empathic, supportive style. It is time to accept that the harsh confrontational practices of the past are generally ineffective, potentially harmful, and professionally inappropriate. (pp. xx–xx)

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Of course, the ultimate proof of any effectiveness in the treatment of sexual



aggression is in reoffense rates. A 1998 meta-analysis found that sexual offenders who drop out or otherwise fail to complete treatment are at elevated risk for reoffense (Hanson & Bussière, 1998). A decade later, meta-analytic study found that programs adhering to sound correctional practices produce better outcomes (Hanson, Bourgon, Helmus, & Hodgins, 2009). Still, researchers question whether results say more about the clients completing programming or the effects of treatment (Hanson et al., 2002). Further, given the questionable condition of the comparison groups, only limited conclusions are possible.

Most recently, investigators have emphasized the need for high-quality research in this area—in particular, randomized clinical trials (e.g., Långström et al., 2013). One such study that has helped influence the field was a long-awaited randomized clinical trial (RCT) led by Janice Marques (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005). Interestingly, it found no difference between those who completed the treatment program and those in the control group. However, the authors concluded that those treatment participants who “got it” and meaningfully completed their treatment goals really did reoffend at lower rates.

The Marques et al. study sparked considerable debate, serving as a source of optimism for some, but leading others to question the efficacy of treatment for sexual aggression. Marshall and Marshall (2007) argued that RCTs are not the final word in scientific evidence. A host of others (e.g., Seto et al., 2008) disagreed, with a net effect that it can be easy to forget that clients who complete programs do in fact reoffend at lower rates, but that the highest-quality studies are unable to find a treatment effect or identify what the active ingredients in treatment actually are, except that those who “get it” and achieve their goals do better than those who simply show up.

The most recent sexual offender treatment outcome meta-analysis (Hanson, Bourgon, Helmus, & Hodgins, 2009) found that programs adhering to the effective correctional principles (i.e., those of risk, need, and responsivity) have the greatest effect on sexual reoffense. Also known as the risk-need-responsivity model, these principles, summarized by Andrews and Bonta (2010), have explained the success and failure of numerous criminological interventions. Simply put, the risk principle holds that the majority of treatment resources should be allocated to those who pose the highest risk. The need principle holds that interventions should focus on treatment goals demonstrated to be related to criminal reoffense. The responsivity principle holds that interventions should be tailored to the individual characteristics of each client. This last principle can sometimes be the most confusing and challenging for programs to achieve. At its most basic level, the responsivity principle includes efforts to ensure that the client is capable of responding to an intervention (e.g., matching treatment to cognitive abilities). At a more challenging level, responsivity involves efforts at understanding motivation to change and what problems may constitute barriers to meaningful engagement in treatment.

The question remains: What about those people who do complete treatment programs? Should our research and practice efforts be focused on creating what Marques and colleagues referred to as those who “got it”? Elsewhere, Prescott and Levenson (2009) have asked whether our field is actually asking the right questions. For example, beyond “does treatment work?” there are concerns regarding with whom it works, under what conditions, with what kinds of providers, and so on. More recently,



Prescott (2011) suggested shifting the focus of clinical and research efforts to understanding what transforms reluctant clients into willing partners in treatment programs. That is, what can professionals do to create programs for clients who may be at risk for refusing treatment or dropping out to “get it” and make meaningful changes? Whatever the case, it’s important to remember that treatment attrition is a serious problem in all of criminology. Olver, Stockdale, and Wormith (2011) found an overall attrition rate of 27.1% and concluded that “the clients who stand to benefit the most from treatment (i.e., high-risk, high-needs) are the least likely to complete it. Offender treatment attrition can be managed and clients can be retained through an awareness of, and attention to, key predictors of attrition and adherence to responsivity considerations” (p. 6).

This should come as no surprise and recalls other important findings that have attracted little attention. For example, Parhar, Wormith, Derkzen, and Beauregard (2008) found that coercive methods of correctional treatment are less successful than voluntary, invested participation. This may be at least partially explained by self-determination theory, which holds in part that many change efforts begin with extrinsic motivation (e.g., being mandated into treatment) and evolve into clients discovering their own intrinsic motivations for building and maintaining change.

To summarize to this point, early approaches to treating sexual aggression were frequently of a harsh, confrontational nature despite any supporting research evidence. Research has focused more on the qualities of effective treatment programs (e.g., Hanson et al., 2009) but far less on the qualities of effective professionals (Marshall, 2005). Further, it seems that we know more about how programs can improve (e.g., through the use of measures such as the Corrections Program Assessment Inventory; Gendreau & Andrews, 2001) than about how professionals can improve their own effectiveness at helping their clients become successful.

People convicted for sex crimes very frequently present with barriers to immediate treatment engagement (Mann, 2009). The very nature of the material covered in these programs increases the likelihood of attrition, especially among those who would benefit from treatment the most. However, those who are able to establish meaningful and relevant treatment goals are more likely to complete treatment programs and reduce their risk for reoffense. Ultimately, the challenge for treatment providers is to create an environment in which change is possible; where treatment is tailored to each client’s abilities; and where there is agreement on the nature of the relationship, the goals and tasks of treatment, and accommodation of strong client preferences (Bordin, 1979; Duncan, Miller, Wampold, & Hubble, 2010; Norcross, 2011).

FEEDBACK INFORMED TREATMENT

Professionals treating people who have sexually abused need expertise at understanding their clientele, and global knowledge of how to establish empirically supported treatment goals. These professionals also need expertise in providing treatment and helping clients navigate change processes. Where the daily challenge lies, however, is in developing expertise at building responsivity in each of their clients.

An emerging body of research indicates that incorporating formal feedback regarding progress and engagement into treatment services builds responsivity while





simultaneously improving outcome and retention (Lambert, 2010). Briefly, feedback informed treatment (FIT) has been successfully integrated into both mental health and substance abuse services, serving both voluntary and mandated clients, in agencies and systems of care around the world (Bertolino & Miller, 2012). Multiple, randomized clinical trials demonstrate that adding FIT to existing treatment services as much as doubles the effectiveness of the care provided and reduces attrition and deterioration rates by 50% and 33%, respectively (Miller, Hubble, Chow, & Seidel (2013).

In practice, FIT involves administering two scales over the course of treatment; one measuring the quality of the therapeutic relationship, the other assessing progress or outcome. Over 1,100 studies have made clear the importance of the therapeutic relationship to treatment outcome (Duncan, Miller, Wampold, & Hubble, 2010). Indeed, in an era that emphasizes evidence-based practice, the therapeutic relationship is the most evidence-based concept in psychotherapy research (Miller & Bargmann, 2011). Understanding changes in the relationship can help ensure that clients are meaningfully engaged in change efforts, assist treatment providers in adjusting their strategies to meet each client's needs (thereby adhering to the responsivity principle), and act as an early warning system for treatment deterioration and failure. At the same time, research has demonstrated that changes in a person's individual, relational, and social functioning are strong predictors of successful therapeutic work (Miller & Bargmann, 2011; Miller, Duncan, & Hubble, 2004).

To date, research shows that access to real-time feedback regarding progress and engagement provides clinicians with an opportunity to adjust services in a way that enhances individual client responsivity and achievement of treatment goals (e.g., decreased reoffending). The same body of evidence documents that FIT promotes professional development, resulting in measurable improvements in individual provider responsivity and effectiveness (Miller et al., 2013). In 2013, FIT was deemed an evidence-based practice by the Substance Abuse and Mental Health Service Administration (SAMHSA) and listed on the National Registry of Evidence Based Practices and Programs (see www.nrepp.samhsa.gov/ViewIntervention.aspx?id=249).

WHAT ARE THE BARRIERS TO SEEKING FEEDBACK?

Treatment providers are under enormous pressure to produce results under difficult circumstances (e.g., Oaks, 2008). Shrinking budgets, difficulties maintaining contact with other overburdened professionals and outside stakeholders (e.g., program administrators, supervising agents, and victims' advocates), and a clientele that would frequently prefer to be anywhere else are the everyday realities of the sexual offender treatment provider. Add to this the inherent ethical challenges (such as balancing client beneficence and community safety) and it is not surprising that many professionals can lose their focus on the client's experience of treatment. In many regions, providers and/or supervising agents implicitly believe that participation in treatment is a privilege and must take place to their complete satisfaction. The unspoken expectation is that the client must change according to a process and timetable set by the treatment provider or supervising agent. Under these conditions, it shouldn't come as a surprise that attrition rates are high, and that—in many instances—little effort takes place to prevent it.

Another barrier to collecting feedback is that many treatment providers believe



they already do it. In our experience, many treatment providers have expressed that they can tell by the client's expressions and mannerisms how treatment is progressing. Others have felt that because they ask questions such as "how was group today?" they are soliciting feedback. Unfortunately, such vague information gathering amounts to little more than a polite nicety similar to the easily ignored feedback surveys offered in some restaurants. Clients need to know that someone is genuinely interested in their thoughts or it is highly likely they will say only what will meet their momentary needs for the situation.

WHAT KINDS OF FEEDBACK SYSTEMS EXIST?

Within the field of treating sexual aggression, the available measures for assessing treatment progress examine change in dynamic risk factors but do not examine factors related to engagement or predictive of treatment response (e.g., the therapeutic relationship and client functioning). Finding the right measure can be a daunting process. In 1996, Ogles, Lambert, and Masters reviewed available tools and found that more than 1,400 measures had been used to measure the effectiveness of psychotherapy. For the most part, the vast majority of these measures have been designed for the purpose of research or as part of a comprehensive evaluation.

Selecting a Method

A key consideration in selecting a method for gathering feedback is for it to be user-friendly and to provide real-time results. Until recently, many of the available measures have involved more than forty questions and have required specialized software and outside consultation. The client and/or his or her family would take time during a clinical session to fill this form out, and the results would not come back to the treatment provider for several days to weeks. Consider this case example from David Prescott's experience.

Jackie is a clinician providing in-home services for adolescents who have sexually abused. The Department of Human Services (DHS) for her state has taken the research on measuring clinical outcomes very seriously and has mandated that all therapists providing in-home services use a standardized measure for tracking clinical outcomes. The position of the DHS administration is praiseworthy. As one senior administrator put it, "We have an awesome obligation to the taxpayers and public at large. It is essential that we make sure that the services we provide are working and that if they are not that the providers have some idea of what they can do to reach our state's most vulnerable citizens." At a meeting of DHS administrators and their treatment providers, however, the mood was not so optimistic. Many treatment providers whispered amongst themselves that the information gleaned from this measure would be used against them by a governmental agency that is more adept at creating attractive spreadsheets than at understanding the complex needs of the families it serves. "My clients have real problems. They often complain that things are getting worse just before they're actually get-



ting better,” one treatment provider said. “Now the state wants information for a spreadsheet that they can put before the governor. Well, I’m not ‘spreadsheet guy.’”

Attempting to mandate a feedback structure such as this without gaining meaningful buy-in placed every professional, including the DHS administration, its stakeholders, and its clientele, into a difficult position. It was Jackie, however, who observed how this approach played out at the front lines of treatment:

The first thing to remember is that I already have to justify everything I do, via funding reviews, progress reviews, progress notes, and treatment plans for which I can find no evidence that they actually make things better. That’s okay, and I understand accountability. Don’t forget, though, that all this usually follows discussing other things like assessment results and diagnoses. It’s not always pleasant.

What I think the state administration forgets, though, is what an honor it is to actually work with these clients. I’m entering their homes, and entering their lives. I’m sharing assessment results. Like others have observed, I have to do a special kind of dance with them, always matching their steps, dancing backward, and in high heels. Now I have to bring a laptop and have them fill this thing out so that their data—their lives—go to another state for analysis. At the end of the day, these people are in pain and one of the greatest things I can do is listen. And on the days when we fill out this measure, that can’t happen. So this is one more meaningless dance we do to get to the real issues. By the time I get to the feedback and the consult calls, everything’s changed.

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This example highlights many of the ways in which the best-intentioned attempts of large groups of people to improve services can fail. Brown, Dreis, and Nace (1999) report that “any measure or combination of measures that [take] more than five minutes to complete, score, and interpret [are] not considered feasible by the majority of clinicians” (pp. xx–xx). Measures that are user-friendly and provide real-time feedback are therefore all the more important when one considers the often urgent circumstances in which clients and treatment providers exist.

Useful Measures

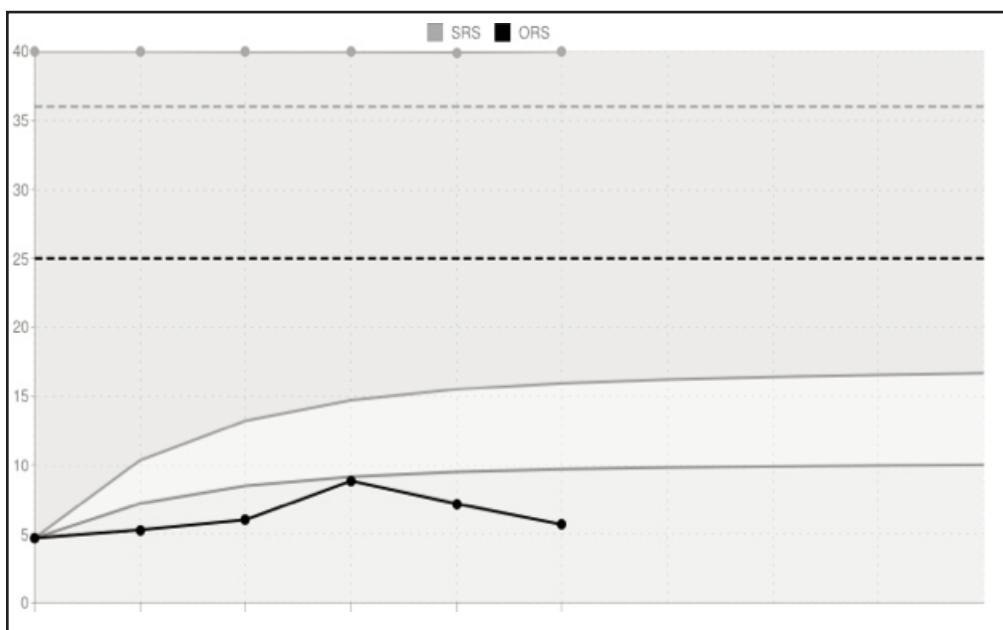
Although any measures may be used in FIT, two scales that have proven useful for monitoring the status of the relationship and progress in care are the Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2000), and the Outcome Rating Scale (ORS; Miller, & Duncan, 2000). The SRS and ORS measure alliance and outcome, respectively. Both scales are brief, self-reports instrument that have been tested in numerous studies and shown to have solid reliability and validity (Miller & Schuckard, 2013). Most important, perhaps, available evidence indicates that routine use of the ORS and SRS is high compared to other, longer measures (99% vs. 25% at one year) (Miller, Duncan, Brown, Sparks, & Claud, 2003).

Administering and scoring the measures are simple and straightforward. The ORS



is administered at the beginning of the session. The scale asks consumers of therapeutic services to think back over the prior week (or since the last visit) and place a hash mark (or “x”) on four different lines, each representing a different area of functioning (e.g., individual, interpersonal, social, and overall well-being). The SRS, by contrast, is completed at the end of each visit. Here again, the consumer places a hash mark on four different lines, each corresponding to a different and important quality of the therapeutic alliance (e.g., relationship, goals and tasks, approach and method, and overall). On both measures, the lines are ten centimeters in length. Scoring is a simple matter of determining the distance in centimeters (to the nearest millimeter) between the left pole and the client’s hash mark on each individual item and then adding the four numbers together to obtain the total score (the scales are available in numerous languages at <http://scottdmiller.com/performance-metrics/>).

In addition to hand scoring, a growing number of computer-based applications are available which can simplify and expedite the process of administering, scoring, interpreting, and aggregating data from the ORS and SRS. Such programs are especially useful in large and busy group practices and agencies. They have the added advantage of providing a real-time computation of provider and program outcomes as well as a normative comparison for judging individual client progress and determining risk. Figure 20.1 illustrates the progress of an individual client over the course of six treatment sessions. The light gray and gray zones show how unsuccessfully and success-



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Figure 20.1: The gray area at the top represents successful outcomes; the lighter gray area at the bottom represents unsuccessful outcomes. The solid black line connecting the dots represents the actual ORS score, plotted session by session from left to right.

Source: Screenshot courtesy of fit-outcomes.com.





fully treated clients respond based on a large normative sample, including 427,744 administrations of the ORS and 95,478 episodes of care delivered by 2,354 providers. As can be seen, the client is not responding like people who end services successfully, enabling providers to make adjustments aimed at improving outcomes in real time.

Detailed descriptions of these applications can be found online at <http://scottdmiller.com/performance-metrics/>.

Creating an Appropriate Atmosphere for the Chosen Method

Of course, soliciting clinically meaningful feedback from consumers of therapeutic services requires more than administering two scales. Clinicians must work at creating an atmosphere where clients feel free to rate their experience of the process and outcome of services: (1) without fear of retribution and (2) with a hope of having an impact on the nature and quality of services delivered.

Interestingly, empirical evidence from both business and health care demonstrates that consumers who are happy with the way failures in service delivery are handled are generally more satisfied at the end of the process than those who experience no problems along the way (Fleming & Asplund, 2007). In one study of the ORS and SRS involving several thousand “at risk” adolescents, for example, effectiveness rates at termination were 50% higher in treatments where alliances “improved” rather than were rated consistently “good” over time. The most effective clinicians, it turns out, consistently achieve lower scores on standardized alliance measures at the outset of therapy thereby providing an opportunity to discuss and address problems in the working relationship—a finding that has now been confirmed in a number of independent samples of real-world clinical samples (Miller, Hubble, & Duncan, 2007).

Beyond displaying an attitude of openness and receptivity, creating a “culture of feedback” involves taking time to introduce the measures in a thoughtful and thorough manner. Providing a rationale for using the tools is critical, as is including a description of how the feedback will be used to guide service delivery (enabling the therapist to catch and repair alliance breaches, prevent dropout, correct deviations from optimal treatment experiences, etc). Additionally, it is important that the client understands that the therapist is not going to be offended or become defensive in response to feedback given. Instead, therapists must take clients’ concerns regarding the treatment process seriously and avoid the temptation to interpret feedback clinically. When introducing the measures at the beginning of a therapy, the therapist might say:

“(I/We) work a little differently at this (agency/practice). (My/Our) first priority is making sure that you get the results you want. For this reason, it is very important that you are involved in monitoring our progress throughout therapy. (I/We) like to do this formally by using a short paper and pencil measure called the Outcome Rating Scale. It takes about a minute. Basically, you fill it out at the beginning of each session and then we talk about the results. A fair amount of research shows that if we are going to be successful in our work together, we should see signs of improvement earlier rather than later. If what we’re doing works, then we’ll continue. If not, however, then I’ll try



to change or modify the treatment. If things still don't improve, then I'll work with you to find someone or someplace else for you to get the help you want. Does this make sense to you?" (Miller & Duncan, 2004; Miller & Bargmann, 2011).

At the end of each session, the therapist administers the SRS, emphasizing the importance of the relationship in successful treatment and encouraging negative feedback:

"I'd like to ask you to fill out one additional form. This is called the Session Rating Scale. Basically, this is a tool that you and I will use at each session to adjust and improve the way we work together. A great deal of research shows that your experience of our work together—did you feel understood, did we focus on what was important to you, did the approach I'm taking make sense and feel right—is a good predictor of whether we'll be successful. I want to emphasize that I'm not aiming for a perfect score—a 10 out of 10. Life isn't perfect and neither am I. What I'm aiming for is your feedback about even the smallest things—even if it seems unimportant—so we can adjust our work and make sure we don't steer off course. Whatever it might be, I promise I won't take it personally. I'm always learning, and am curious about what I can learn from getting this feedback from you that will in time help me improve my skills. Does this make sense?" (Miller & Bargmann, 2011)

CASE EXAMPLE

To show how those concepts work in practice, this section presents a case example.

Eric was 19 when he came into treatment. He had accepted a plea agreement of numerous fourth-degree charges for simple assault following allegations that he had molested an 11-year-old girl, the daughter of some family friends. It was an unusual plea agreement that involved uncertain evidence, but one that ensured that he would receive treatment and long-term community supervision. The agency providing treatment in this case had seen a rising number of plea agreements involving lesser charges.

"I didn't do it," Eric said bluntly. "I know that's probably what everyone tells you, but it's true. Believe me, it would have been easier just to come out and admit it if I had done it. I took the plea because I couldn't stand jail, and didn't want to risk going to prison, even if the evidence wasn't any good."

This situation presented the therapist, Jason, with a number of dilemmas. Clearly, a more traditional structure for treatment (involving disclosure of the events leading up to the abuse and the abuse itself) was not going to work; Eric would lie, become completely uninformed, or both. Using the template mentioned earlier in this chapter, Jason introduced the ORS. Eric quickly filled it out, and Jason used a ten-centimeter ruler to tally the score, 29 of a possible 40. This concerned Jason, as it placed Eric over the cutoff score, placing him in the range associated with people who do not seek treatment. In this case, Jason interpreted this as an indication that Eric was at high risk



for dropping out of, or at the very least, avoiding treatment rather than actively seeking to benefit from it.

Jason: 29 is quite high. In fact, people who score in this range typically either don't enter treatment or else they enter and drop out. What do you think about that?

Eric: I don't know. I guess that thing works, because I don't need treatment.

Jason: The only reason you're here is because other people are breathing down your neck.

Eric: That's right. It's because I used to get into trouble when I was younger, and now the cops in this town are all targeting me. What I really need is to leave this town.

Jason: So the way things have been going, it often seems like it would be better for you to get a fresh start somewhere else.

Eric: Yes.

Jason: And yet you haven't left . . .

Eric: Yeah, I have my family here, and I'd been planning to go to community college. I can get the right financial aid here, but that's the only thing. What I need is to go back to school, but I don't know if that's even an option.

Jason: So you've got these really important things going on, and being in a therapist's office is just getting in the way.

Eric: Yeah. No offense, but that's true. What I really need is to get people off my back.

Jason: I really get we're from different worlds in a lot of ways. What I haven't gotten until now is just how hard this has been for you.

Eric: Yeah. (*elbows on knees, leaning forward, facing down, and sighing*)

Jason: I don't know how helpful I can be in the long run, but I'm committed to understanding you right now. A quick question if you don't mind: With everything you've got going on with your family, your friends, school, and the law, do you think you might have scored these areas a bit high? Maybe you'd like another look?

Eric: Okay, what the heck.

Under these conditions, Eric's score went down to 15, well within the range of people who are distressed enough to seek therapy. Over time in the session, Jason and Eric discussed his situation further. Eric was adamant that he had done nothing wrong, and Jason suggested that while Eric was the expert on his own life, perhaps he (Jason) could be helpful in working with Eric in areas that would demonstrate to others that he was becoming a better and more respectable young man, not the person he had once been. In Jason's view, this would address some of the broader risk factors for





sexual reoffense (e.g., self-management and interpersonal competence), if in fact it had occurred.

At the end of the session, Jason introduced the SRS with the template used above. Eric provided scores that totaled to 39. This is above the cutoff and suggestive of a positive alliance. Eric had scored him lower on the question related to goals:

Jason: I see you scored the “goals” question a little lower. What part of your goals am I not understanding?

Eric: Nothing, man, it’s all good.

Jason: Maybe I’m not asking the right question. Is there a different way I can be helpful with your goals? It’s your life (smiling).

Eric: No really, it’s all good. I didn’t think I’d be saying this, but . . . see you next week. (*shakes hands and leaves*)

Under these circumstances, most therapists would likely feel as though they had just snatched victory from the jaws of defeat. Eric’s was a difficult case at best, given that the circumstances were murky and Eric’s motivation for change was tenuous at this point. Jason, however, felt he had not done his best work because he had been unable to find out more about Eric’s goals. He felt fortunate that Eric had committed to returning but was aware that Eric was mandated to do so.

Eric indeed returned the next week. His ORS score was virtually unchanged at 16. Jason took the opportunity to summarize their work from the previous week.

Jason: Last week we talked about working so that others can see you differently, as a young man who is competent and responsible now, whatever his past mistakes might have been. How does that sit with you? What else would be meaningful?

Eric: I guess that’s just it. If I’m really going to do this, I want it to mean something. I want this to be about being a better person. I mean, I want to be able to have a family someday. It’s good to get other people off my back, but I want to be somebody for real.

Jason: You want to stand up for yourself and be able to provide for others. Live the dream, as they say, but for real. Am I getting it?

Eric: Yeah. (*slight hesitation in voice*)

Jason: And it’s a little weird this conversation, since standing up for yourself is usually something you do alone, not in an office like this.

Eric: Yeah, I think that’s about it. I hadn’t thought about it that way. (*folding forward, arms crossed, thinking*)

Jason: And why not. We hear lots of stories of military commanders making big decisions really quickly and by themselves. At the same time, every President has trusted advisors. I guess it’s the kind of thing we each have to figure out for ourselves.



Eric: Yeah.

Jason: Can I offer an idea?

Eric: Sure.

Jason: One thing you can consider is that we can work together on having you prove you're not the person you used to be. We talked about that last week. The other is a longer-term goal about being the best person you can be and having a great life. That's something you'll be thinking about for a long time. If you like, I can work with you some on that as well, more like a personal consultant, unless things change and you want to take another look at how you want to do that. How does that sound? My main thinking is that I can't and don't want to tell you what kind of life to have. But I might help you make some decisions along the way. I can do that by asking questions and sharing any ideas I might have if you like.

Eric: I can do that. That sounds good. I like that.

Jason: Great! Let's try that for a few sessions and then we can decide what's right for you.

In this dialog, Jason balanced his emerging knowledge of Eric with his knowledge of what's important to young men in general. He did not force his agenda onto Eric, instead working on developing an alliance to which Eric can respond. Jason and Eric talked further and by the end of the session Jason had him score the SRS.

AQ: We can only use black and white figures, so is this ok as changed, and is the change to text ok? If not, please supply an appropriate piece of artwork.
Thx



Figure 20.2: A plot of Eric's treatment progress. The gray area at the top represents successful outcomes; the lighter gray area at the bottom represents unsuccessful outcomes. The solid black line represents the actual ORS score plotted session by session from left to right, while the gray line indicates the actual SRS scores

Source: Screenshot courtesy of fit-outcomes.com.





Jason: I see you rated this session all the way up at 40. That's higher than last week.

Eric: Yeah, I think keeping these sessions meaningful is what makes the difference. Sorry I didn't say that last week when you asked. I just didn't yet really know what I was thinking.

Jason: No worries at all. It's why I ask. I hope you don't mind if I keep asking just to make sure this is all on track.

Eric: Thanks.

For the next twelve weeks, Eric's SRS score stayed steadily above the cutoff. Slight variations were noted when discussions went in one direction and Eric realized he hadn't been able to mention some other things that he thought were important. Pursuing a course of deliberate practice (described more fully in the next section), Jason responded by redoubling his effort to negotiate the session's agenda at the start of each session. Jason further worked to ensure that he explicitly stated the goals they were working on with one another, either at the start of each session or interspersed during the course of discussion. He did this in a casual way so as not to appear pedantic or robotic, but rather as a display of commitment to Eric.

Eric's ORS scores rose over twelve weeks to 30. At twelve weeks, he disclosed that he had in fact molested the girl and felt it would be important to address this at a deeper and more meaningful level. Jason and Eric worked together to place him in group treatment with others. This group also used the ORS and the Group SRS.

This case example shows how the measures can work in improving outcomes. However, Eric's case also shows how they can be used to detect cases at risk of dropout or noninvestment. Had Eric's numbers fallen, the measures may further have provided an early warning that Eric's situation was getting worse. This would be particularly helpful in Eric's case when one considers that Eric, like many other clients, was not always forthcoming with concerns and responded better to therapeutic elicitation of concerns.

NOW THAT WE HAVE FEEDBACK, WHAT NEXT?

As effective as feedback has proven to be in improving engagement and outcome, it is not enough for development of expertise. Consistent with the literature on superior performance, the evidence shows that clinicians do not necessarily learn from the information provided. De Jong, van Sluis, Nugter, Heiser, and Spinhoven (2012) found, for instance, that not all therapists benefit from feedback. In addition, Lambert reports that practitioners do not get better at detecting when they are off track or their cases are at risk for dropout or deterioration, despite being exposed to "feedback on half their cases for over three years" (Miller et al., 2004, p. 16). In effect, feedback functions like a GPS, pointing out when the driver is off track and even suggesting alternate routes, while not necessarily improving overall navigation skills or knowledge of the territory and, at times, being completely ignored.

Learning from feedback requires an additional step: engaging in "deliberate practice" (Ericcson, Charness, Feltovich, & Hoffman, 2006). Deliberate practice, as the term implies, means setting time aside for reflecting on feedback received, iden-



Figure 20.3: Therapists grouped into thirds based on their adjusted scores as a function of their accumulative time spent on solitary practice in the first eight years of clinical practice.

tifying where one's performance falls short, seeking guidance from recognized experts, and then developing, rehearsing, executing, and evaluating a plan for improvement. Research indicates that elite performers across many different domains devote the same amount of time to this process, on average, every day, including weekends. In a study of violinists, for example, Ericsson and colleagues found that the top performers devoted two times as many hours (10,000) to deliberate practice as the next best players and ten times as many as the average musician. In addition to helping refine and extend specific skills, engaging in prolonged periods of reflection, planning, and practice engender the development of mechanisms enabling top performers to use their knowledge in more efficient, nuanced, and novel ways than their more average counterparts (Ericsson & Stasewski, 1989).

Results from psychotherapy outcome psychotherapy research are in line with findings on factors that account for the development of expertise. For example, Chow, Miller, Kane, and Thornton (n.d.) examined the relationship between outcome and practitioner demographic variables, work practices, participation in professional development activities, beliefs regarding learning, and personal appraisals of therapeutic effectiveness. Consistent with previous findings (cf. Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Wampold & Brown (2005), they found that therapist gender, qualifications, professional discipline, years of experience, and time spent conducting therapy were unrelated to outcome or therapist effectiveness. Furthermore, similar to findings reported by Walfish, McAlister, O'Donnell, and Lambert (2012), therapist self-appraisal was not a reliable measure of effectiveness. Instead, as illustrated in the *Figure 20.2*, the amount of time therapists spent engaged in solitary activities intended to improve their skills predicted differences in outcome.

Such findings provide important support for the key role deliberate practice plays in the development of expertise.

AQ: Do
you mean
fig. 20.3?



CONCLUSION

Therapists have long desired to make interventions more meaningful to clients and community alike. Addressing risk factors, acquiring and enacting skills, balancing client beneficence and community safety, and many other components of current sexual offender treatment programs are vital to long-term change. FIT is not a replacement for other forms of treatment but, rather, offers new ways to reach clients, improve one's performance, reduce variability between therapists within agencies, and detect cases at risk for dropping out or participating at a superficial level. Ultimately, it also offers clinicians new structures for reaching beyond their current therapeutic limitations.

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