

Thursday, December 10, 2015

The “Who Works” Doctrine

David Prescott, LICSW & Gwenda M. Willis, PhD

In 1974, Robert Martinson published a now-classic text concluding that he was unable to find evidence of the effectiveness of rehabilitative efforts for people involved in the criminal-justice system. Although a section of his essay was titled, “Does nothing work?” it became known as the “nothing works” doctrine. Despite the fact that Martinson himself essentially admitted he had been wrong (Martinson, 1979), the nothing works doctrine held sway for many years until Canadian criminologists such as Paul Gendreau introduced the “something works” doctrine (meaning that it was clear that rehabilitative efforts could work, even if the exact mechanisms remained unclear), and eventually the “what works” doctrine that followed (e.g., Gendreau & Ross, 1987).

What works in treatment seems clear enough, but is it really? The principles of effective correctional rehabilitation (i.e. risk, need, and responsivity) state that we should provide more intensive treatments to those who pose the highest risk, focus on empirically supported treatment goals, and use empirically supported techniques (e.g., CBT). The responsivity principle further states that we should match treatment to the individual characteristics of each client (e.g., cognitive ability, culture, mental health needs, motivation).

From such simple principles many controversies can emerge and great minds can disagree. For example, one client who has sexually offended against children might benefit from treatment addressing interpersonal skills in such a way that sex with children is unnecessary and undesirable because of the client's ability to form intimate relationships with adults. Another client might reap minimal benefits from such treatment, because it is the combination of sexual interest in children and a suite of beliefs supporting abuse that contributes more to his risk. As Tony Ward recently pointed out (Yates, Prescott, & Ward, 2010), absent an explanatory means for



SAJRT Bloggers' Profile
Chief Blogger Kieran McCartan, Ph.D. and Associate Bloggers David S. Prescott, LICSW and Jon Brandt, MSW, LICSW are longtime members of ATSA. We are dedicated to furthering the causes of evidenced-based practice, understanding, and prevention in the field of sexual abuse.

The Association for the Treatment of Sexual Abusers is an international, multi-disciplinary organization dedicated to preventing sexual abuse. Through research, education, and shared learning ATSA promotes evidence based practice, public policy and community strategies that lead to the effective assessment, treatment and management of individuals who have sexually abused or are risk to abuse.

The views expressed on this blog are of the bloggers and are not necessarily those of the Association for the Treatment of Sexual Abusers, Sexual Abuse: A Journal of Research & Treatment, or Sage Journals.

understanding risk factors, they may simply be markers for further investigation and understanding in programs that seek to reduce risk and build capacities.

There is no question that the principles of risk, need, and responsivity are vital contributors to “what works” in treatment. However, a robust research literature both inside and outside our field points to the fact that who the professional is can be a vital contributor to building responsivity and beyond. As a result, we are proposing a “who works doctrine” alongside the what works doctrine. The name is intended to be provocative and only slightly tongue-in-cheek, and intended as a homage to those brilliant researchers who came before us. To illustrate the importance of thinking in terms of “who works” in addition to what works, it may be helpful to review influential developments of the past.

In 1979, Edward Bordin proposed a model of the therapeutic alliance that involved agreement on the nature of the therapeutic relationship, and agreement on the goals and tasks of treatment. Subsequent research by Jon Norcross and others would also highlight the importance of having therapy take place in the context of strong client preferences (Norcross, 2011). These four areas: agreement on the nature of the relationship, goals, tasks, and values form the basis of a critical element of treatment. Over a thousand studies have pointed to the contribution of the alliance to successful therapy outcomes. Recent research has highlighted the importance of clinicians getting feedback from their clients in these areas (e.g., Lambert, 2010; Prescott & Miller, 2015). In fact, one can argue that attention to the alliance is amongst the most evidence-based therapeutic activities there is. Without it, targeting criminogenic needs is useless, and a greater waste of resources for those at highest risk (since they presumably receive the most treatment).

Likewise, Bill Marshall’s classic 2005 summary of research that he conducted with others points to the qualities of the most effective professionals (Marshall, 2005). They are warm, empathic, rewarding, and directive (in the sense of being able to guide people and processes. However, much of our field remains influenced by early texts and professionals who advocated a more overtly confrontational approach (e.g., Salter, 1988). Indeed, a 2008 meta-analysis by Karen Parhar and her colleagues found that the more coercive the treatment experience, the less likely it is to be effective (Parhar, Wormith, Derzken, & Beauregard, 2008). Most recently, Theresa Gannon and Tony Ward published an important paper titled, “Where has all the psychology gone?” that illustrated how far correctional programs can stray from what – and who – works in helping people in the legal system to rebuild their lives (Gannon & Ward, 2014).

Elsewhere in the psychotherapy literature, there is evidence that there is a greater difference in success between therapists practicing within a model than there is between models themselves (Wampold & Imel, 2015). Likewise, there is considerable evidence that the most effective practitioners in any endeavor tend to spend more time engaging in activities meant to improve their skills and outcomes (Ericsson, 2006). It is important to separate deliberate practice aimed at improvement from simply practicing a lot. More hours doing the same thing can be just that – doing more of the same. This is particularly crucial when one considers research finding that therapists often overestimate their effectiveness (e.g., Beech & Fordham, 1997; Walfish, McAlister, O’Donnell, & Lambert, 2012).

However, in some quarters, our field is paying less attention to therapeutic variables and focusing on cutting costs by engaging in a very high level of manualization at the expense of a deeper and more meaningful treatment experience (Albright, 2015). There is no reason to believe this will work. For example, Janice Marques and her colleagues found in a randomized clinical trial that there was no difference in re-offense rates between those who did and didn’t

complete abuse-specific treatment, although those who “got it” and meaningfully completed their treatment goals really did re-offend at lower rates, although these individuals received no further study. It is therefore not difficult to see how over-manualization (e.g., highly scripted rather than individualized) can easily result in problems adhering to the responsivity principle.

What works in treatment? We propose it is time for a return to a greater attention to factors related to *specific* responsivity and to draw on the existing psychotherapy research. Areas of focus can include:

- A return to thinking of our programs as delivering therapy and not simply treatment
- Greater attention to the professional self-development of therapists
- Increased recognition that society’s attempts to use punishment-only approaches are almost entirely ineffective, while the right therapy and right supervision can make an impact on re-offense rates, community safety, and client well-being.
- A greater awareness of the role of adverse experiences in the lives of clients and a greater fine-tuning of therapy in order to help clients understand how adverse events have shaped their lives and provide avenues for growing beyond the effects of these experiences.
- Greater attention to what is important in clients’ lives (e.g., drawing on the Good Lives Model; Yates, Prescott, & Ward, 2010).

In many environments, this will involve a return to viewing therapists as the professionals and experts that they are. After all, the very definition of evidence-based practice includes clinical expertise as well as best available research and in accordance with client characteristics.

References

Beech, A. R. & Fordham, A. S. 1997. Therapeutic climate of sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment* 9: 219–237.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 16, 252-260.

Ericsson, K.A, Charness, N., Feltovich, P., & Hoffman, R. (eds.) (2006). *The Cambridge handbook of expertise and expert performance*. New York: Cambridge University Press.

Gannon, T. A., & Ward, T. (2014). Where has all the psychology gone? A critical review of evidence-based psychological practice in correctional settings. *Aggression And Violent Behavior*, 19, 435-446.

Gendreau, P., & Ross, R.R. (1987). Revivification of rehabilitation: Evidence from the 1980s, *Justice Quarterly*, 4(3), 349-407.

Lipton, D.S., Martinson, R., & Wilks, J. (1975). *The effectiveness of correctional treatment: A survey of treatment valuation studies*. New York: Praeger Press.

Marshall, W. L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: Journal of Research and Treatment*, 17, 109-116. doi: 10.1177/107906320501700202

Martinson, R. (1974). "What Works? - Questions and Answers About Prison Reform," *The Public Interest*, 35, 22-45.

Martinson, R. (1979). "New Findings, New Views: A Note of Caution Regarding Sentencing Reform". *Hofstra Law Review*, 7, 242-258.

Norcross, J. (2011). *Psychotherapy relationships that work*, 2nd ed. New York: Oxford University Press.

Parhar, K. K., Wormith, J. S., Derkzen, D. M., & Beauregard, A. M. (2008). Offender coercion in treatment: A meta-analysis of effectiveness. *Criminal Justice and Behavior*, 35, 1109 – 1135.

Prescott, D.S., & Miller, S.D. (2015). Feedback-Informed Treatment (FIT) with people who have sexually abused. In B. Schwartz (Ed.), *The sex offender, volume 8* (pp. 17-1 – 17-xxx). Kingston, NJ: Civic Research Press.

Salter, A. (1988). *Treating child sex offenders and victims*. Thousand Oaks, CA: Sage Publishing.

Walfish, S., McAlister, B., O'Donnell, P., & Lambert, M. J. (2012). An investigation of self-assessment bias in mental health providers. *Psychological Reports*, 110, 639–644.

Yates, P.M., Prescott, D.S., & Ward, T. (2010). *Applying the good lives and self-regulation models to sex offender treatment: A practical guide for clinicians*. Brandon, VT: Safer Society Press.