

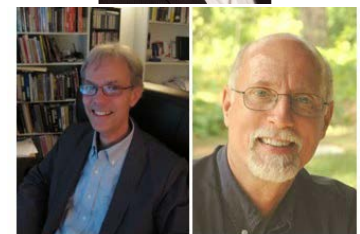
FRIDAY, SEPTEMBER 16, 2016

Returning to What's Real

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The elephant in the closet in the treatment and supervision of people who have sexually abused is the voice of the clients themselves. The service user (or in this instance the person who has sexually abused) is at the center of the work that we do, but these perspectives and views of the services that they are subject to are not always present. We need to hear the views, attitudes and perspectives of the service user regarding the work that they are part of (that is listening to the service user voice); we do it in health, business, marketing and other areas of life, but why not sex offender treatment and management? There is an inherent view in some sectors of our field that people who have sexually abused are manipulative, deceptive, and therefore not trustworthy; which means that their views of the service they are part of is unreliable at best and suspect at worst. This is a real issue when one considers that people who have sexually abused are the users of multiple services including counseling, psychology, health, social services, and the criminal justice system. Other users of these services often have mechanisms through which to have their voices heard and participate in the processes that have an impact on their lives. This might take the form of client advisory councils, satisfaction surveys, or *feedback-informed treatment*.

One has to wonder why a lack of a coherent client/service-user voice is uncommon for one population (e.g., people who have abused) and not another (e.g., people in substance abuse treatment). Perhaps more importantly, do professionals all too often come to think of treatment of people who have sexually abused as something we do *to* and *on* our clients rather than *with* and *for* them (Miller & Rollnick, 2013)? Do we dictate that treatment must take place in the fashion that we want or one that is most effective for the client? How do we know when we are meeting both the need and responsibility principles in a way that is meaningful for the client? Or is it that we are just as susceptible to bias, misperception, stereotypes and misunderstandings as the public and politicians? Do you “fall in line” with biases that we argue against? This is an international dilemma, as this problematic approach to the person who has abused as a disenfranchised and unrecognized service user is not just a western problem. Let's explore this further.



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 at 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.

A discussion of the role of Volunteer Probation Officers (VPOs) recently took place at the United Nations Asia and Far East Institute in Tokyo. VPO's are typically older and well-established citizens who mentor young offenders, from around Japan. The role of the VPO's is to assist the young offenders with their behavior, actions, and plans for the future. It is a system designed to provide support and bring about hope and accountability, even as the young offenders can be at risk for disengaging and participating minimally. During the panel discussion, one attendee asked what regrets the VPOs had about their work. The answers were as heart-rending as they were similar; each participant described a time when they had listened more effectively, worked harder to understand the young person, or helped them to achieve the goals that were meaningful to them and not just the legal system.

On their own, these responses are unsurprising, and resemble other human situations where desired outcomes aren't achieved, such as parents whose children haven't lived to their full potential or whose lives have ended early. What was striking among the VPOs was what was not said. Reflecting on their failures, no VPO regretted that their young charges had not gotten the diagnostic clarity, effective medication regimes, or the correct empirically supported protocols they needed. In further discussion of this fact, the VPOs acknowledged, as do all professionals, that diagnostic and treatment considerations are vital to success, but that the prevention of failure can reside in the moment-by-moment interactions that all professionals have with their clients.

Likewise, as we go to press with this blog, the Australian Psychological Society has just issued an [apology](#) to the indigenous peoples of that country. They state:

To demonstrate our genuine commitment to this apology, we intend to pursue a different way of working with Aboriginal and Torres Strait Islander people that will be characterized by diligently:

- Listening more and talking less
- Following more and steering less
- Advocating more and complying less
- Including more and ignoring less
- Collaborating more and commanding less

This sounds like good, old-fashioned therapy to us.

Underneath all of our clinical practices – indeed all helpful interactions – lies a particular kind of conversation. Our field is replete with examples of how professionals should speak with and be with clients. This can be a source of great fascination, from the earliest authors, through Carl Rogers' core conditions, Berg and de Shazer's focus on the seemingly simple search for solutions, and beyond. Wampold and Imel (2015) referred to the conversation as "perhaps the ultimate in low technology" (p. ix).

Obviously, not all conversations are helpful, even as they are central to all bona fide forms of psychotherapy (Wampold & Imel, 2015). Indeed, Liliensfeld (2007) has highlighted how some treatments can cause harm. What was central to the Japanese VPOs' assessment of their failures reflects what has been found in research into the therapeutic alliance (Hubble, Duncan, & Miller, 1999; Duncan, Miller, Wampold, & Hubble, 2010). That is, that the most helpful clinical practice takes place when there is agreement, from the client's perspective, on the nature of their relationship, the goals of their work, and the means by which they go about it. This view of the *working alliance* dates back decades (Bordin, 1979), although research has also emphasized the importance of delivering treatment in accordance with strong client values and preferences (e.g., Norcross, 2010). Indeed, importance of the alliance has long been recognized (Orlinsky & Rønnestad, 2005).

These points seem worthwhile in the wake of recent discussions on ATSA's listserv regarding whether treatment "works" and with whom it is most likely to be effective. It often seems odd that professionals in our field rarely ask their clients about their beliefs as to whether the services they receive are helpful. Perhaps this is due to many professional's beliefs that asking about what does and doesn't work in treatment would open the door to discord or attempts at manipulation. Perhaps it's because many of us couldn't handle what our clients really think.

Likewise, as professionals we seem hesitant to get into debates about the service user voice evidence-based practices. In a recent conversation on the ATSA listserv a member noted the differences between the American Psychological Association's definition ("the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences") and the more stringent standards for empirically supported protocols such as EMDR and DBT. In the end, understanding the treatment experience from the perspective of the client and working to ensure agreement on the goals and tasks of treatment as well as the nature of the working relationship may have as strong an evidence base as any other approach in the helping professions.

The need to understand, process and reflect upon the service user raises the important question - what is an appropriate evidence base? We spend a lot of time discussing the merits of psychometrics, clinical trials, Randomized Control Trails and downplay the importance of qualitative research. The common narrative in the field is about levels of significance and outcome measures, not necessarily about what was said in and about the treatment. Maybe the first think that we need to do, before listening to and acting, is to recognize the service user voice.

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