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## Fidelity to the Model or Fidelity to the Client? Reflections on Treatment

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I have had the very great privilege this year of training in many locations around the world. Again and again, it seems that the people in our field want nothing more than to end abuse by helping those who have abused. As others have often said, many of the people who benefit from this work will not know to say thank you because the potential abuse won't happen. Many of the contexts in which we provide treatment, however, seem to work against us; living up to our full potential as therapists can be a challenge. Why?

Even the most conservative studies find that people who abuse are often at greater risk to commit non-sexual crimes. Still, programs tend to focus exclusively on preventing further sexual crimes. While this is certainly understandable, the fact that individuals who enter treatment all have different risk profiles for various crimes, sexual or otherwise, argues against one-size-fits-all treatment regimens. Yet, this is exactly what is now happening in many jurisdictions. The more refined our assessment processes have become, it seems, the less assessment-driven our treatment programs actually are.

Scripting was a focus of at least one workshop at this year's ATSA conference in Kansas City, including a debate on the merits of highly scripted treatments. One manual in use is scripted down to the level of client affirmations during exercises. It is not hard to imagine how treatment participants' experience is less one of talking with a therapist, but more about the curriculum itself. Such circumstances should lead us to wonder if it would be more honest to jettison terms like "treatment", "facilitator", or "therapist", etc. and replace them with "class", "instructor", etc.

Throughout 2017, I met with countless people who provide treatment based on various strict curricula, some more recently



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### **SAJRT Bloggers' Profile**

*We are longtime members of ATSA 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.*

developed than others. The most common questions always centered in the same area: How do I use actual therapeutic processes with a manual that tells me what I am supposed to be doing in every session? How do I ensure a strong therapeutic alliance when the curriculum dictates what I am doing and outside stakeholders are clear that they want me to use this curriculum? How do I provide assessment-driven, individualized treatment within a framework like the Good Lives Model when my professional training has always been about following the curriculum? What if I use motivational approaches that help my client meet some goals but not others? How do I interview someone to identify their Self-Regulation Model Pathway?

These questions come naturally in an age of empirically supported treatment protocols, in which methods such as Aggression Replacement Training can be rigidly prescriptive (although the curricula typically used in our field can't claim to be empirically supported). Indeed, these are the right questions for clinicians to ask when considering how best to deepen their practice in individual and group therapies, specialized case management, community supervision, etc. Still, I come to the end of 2017 wondering whether clinicians haven't surrendered our responsibility to clinical decision-making based on the needs of each client in favor of getting through the curricula that directors and outside stakeholders want us to use. Again we come back to the fundamental question asked by a conference presenter many years ago: Are we personalizing our manuals or manualizing our persons?

Whatever one's work environment, my hopes for 2018 include that each person providing bona fide treatment:

- Can work not just within whatever framework they use, but actively attend to the therapeutic processes that decades of research have shown to work (e.g., warmth, empathy, hope, agreement on the goals and tasks of treatment) (Marshall, 2005; Prescott, Maeschalck, & Miller, 2017).
- Privileges the client's voice and gets feedback from their clients.
- Remembers that every conversation is most effective when it involves active attempts by the professional to connect, explore the subject at hand, and offer ideas about the way forward.
- Keeps in mind that the most effective treatments are collaborative and marked by agreement on the nature of the relationship (i.e. do the client and therapist agree on what the therapist's role is?) as well as a shared vision of the goals of treatment and the means by which they are accomplished.
- Works to study each client and delivers truly individualized treatment no matter which curriculum they use.
- Remains committed to the task and rigorous in implementing treatment and supervision.
- Maintains an active dialog with external agencies in order to provide the treatment that each client needs rather than simply what each stakeholder wants.
- Choreographs each session to be a dance between the momentary presentation of each client and what research shows will keep treatment in line with the principles of risk, need, and responsivity.

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- Keeps that focused sparkle in their eyes when working with even the most difficult client.

In short, my greatest hope is that the people doing this work will keep the humanity in human services. It's not just a personal value; it's what is demonstrated to work by all of our extant research!