

PRINCIPLES AND PROGRAMS FOR YOUNG OFFENDERS

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I. INTRODUCTION AND HISTORICAL OVERVIEW

Perhaps the most important message for this presentation comes not from a great psychologist or criminologist, but from Ringo Starr, who was the drummer for the Beatles. In 1967, he sang a song titled “I Get By with a Little Help from my Friends”. This is how it is when adults come together to try to work with young people who have gotten into trouble with the law. It is very important to remember that every professional in our field is one another’s best resource for working with this often very difficult and challenging population. On that note, I send a special greeting to people who are new to the field. I often like to make the joke that every one of my grey hairs is a teenager whom I’ve worked with.

This presentation first provides a historical overview of the challenges and problems in working with young people who break the law. It next discusses what works in assessment and treatment. It then focuses on the principles of risk, need, and responsivity. These are principles that every professional should know about. I will include a special emphasis on how professionals should conduct themselves when interacting with young people who break the law. I will also focus on what the scientific research says about who these young people are, who we are as professionals, what’s new in assessment, and what’s new in treatment programs. As we enter this field, the most important question that we can ask ourselves is, “Do we want these young people to keep breaking the law, or not?” The reason I ask this question is that our history is filled with many attempts to get young people to behave themselves, and yet these attempts only made matters worse. It’s important for us to consider what we can do and also who we should be when we are interacting with young people who break the law. And so, I will start with a discussion on treatment: where we’ve been and where we need to be.

The take-home message is that when we build healthy lives and safe communities, we need to understand the motivations of all young people, their internal motivations, and the context in which these motivations occur. It’s vital to remember that motivation can never be forced onto a young person. Also, it is vital that our goals in treatment should be goals that every young person can approach and work towards, rather than goals which young people try to avoid. For example, it can be easier and more successful to work towards a goal of a better future and a life worth living than it is to work on a goal that’s based on a goal of not getting into any more trouble. Another important message is that all professionals need to build an alliance with the young people with whom they work, and that we need to measure this alliance in an ongoing and structured way so that we understand our actions from each young person’s perspective.

Let’s take a quick look backwards at the history of our field. I have great respect for everybody who has been involved in this work because adults have had difficulty understanding and predicting the behavior of young people for many thousands of years. My intention is to be tough on issues, but tender on people. It is important to remember what criminologist Vern Quinsey said in 1998, that people are not now as smart as they think and the people used to be smarter than we now think they were (Quinsey, Harris, Rice, & Cormier, 1998).

My primary concern in working with young people who break the law is that during the past 30 years is that the majority of progress that we have made has been technological in nature. We know that from the beginning of time when adults have had concerns about their lives and the lives of others

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they've come together into groups, whether talking as small communities or coming together as professional organizations. It is vitally important that every professional not only attend school and read the scientific research, it is also important that we talk about the challenges we face in working with others. And this is how many of our professions began. Well over 2000 years ago, in ancient Rome, Publilius Syrus observed that the way people talk is a mirror of the soul, and that as a person speaks so is he or she. By the time of the 1600s, Pascal observed that people are generally better persuaded by the reasons which they have, themselves, discovered than by those which have come into the mind of others. What this means is that people are often more convinced by what they hear themselves say than they are by what other people say to them; this latter point was made by Daryl Bem in 1972 with his *self-perception theory* (Bem, 1972). This is particularly true with teenagers. It is a very great challenge for any adult to attempt to directly influence a young person. We can be more effective when we attempt to awaken a young person's internal motivation to build a better life for themselves (Naar-King, 2010; Miller & Rollnick, 2013).

As we review the history of our field, particularly in the large institutions — psychiatric and correctional — of western culture's history, it is striking how much treatment has been done *to* others rather than *with* them or *for* them (Miller & Rollnick, 2013). Western Europe and North America have a long tradition of attempting to impose treatment onto people who get into trouble with the law or cause concern for societies. This has continued up to the present where many attempts have been made to change people, even though these attempts have proven unsuccessful (Parhar, Wormith, Derzken & Beauregard, 2008). A recent controversy in the United States, for example, has included attempts to change people's sexual orientation. Although it is certainly acceptable for anybody to make changes to their own life, too often treatment has been used by some people to get other people to change, despite evidence that it is unlikely to be successful. Much of criminology made a tremendous change in the year 1974 when a criminologist named Robert Martinson published an article on rehabilitation programs in prison services. He asked the question, "Does nothing work?" And his preliminary analyses found that there was no effect of treatment programs on crime within the prison system in North America. However, five years later he admitted that these preliminary analyses had been wrong. Unfortunately, by this time, the damage was done and many prisons had simply eliminated all of their treatment programs. Paul Gendreau, another great criminologist, came along several years later and provided research showing that something works in the treatment of people who had broken the law, and yet for many years it was unclear what it was that worked. This "something works" doctrine then became known as the "what works?" doctrine once scientific research showed that in fact correctional treatment programs can and do work for young people.

By 1979, in psychotherapy research, Edward Bordin found that the therapeutic alliance that so many people rely on in treatment could be defined as building agreement on the nature of the relationship, agreement on the goals of treatment, agreement on the tasks of treatment, and later researcher John Norcross would add that client preferences are important to consider in the construction of treatment programs (Bordin, 1979; Norcross, 2010). Since 1979, over 1,100 studies have emphasized the importance of the alliance in all forms of psychotherapy (Orlinsky, Ronnestad, & Willutski, 2004). This is important to take into account. Just five years after Robert Martinson said that nothing worked, we had the building blocks of understanding what actually are the key ingredients in treatment programs with young people as well as adults. However, just a few years later, in the field of treating sexual offenders, Anna Salter made clear her belief that treatment should be confrontational (Salter, 1988). In fact, she said in a famous book that she wrote, "the process of treating child sex offenders is heavily weighted in the direction of confrontation. Treatment requires continual confrontation." As examples, she included "No, I don't trust you, and you would be pretty foolish to trust yourself." and "Give me a break. What do you mean one drink can't do any harm?"(p. 93). She later says that treatment should not be hostile, and yet many of these statements can appear hostile to those who read her book. Even when Salter's book appeared on the market, it was already known that many of the most important elements of psychotherapy included the therapeutic relationship. However, the belief among those professionals treating violent and sexual offenders was that treatment needs to be confrontational in nature.

By 1990, Alan Jenkins in Australia wrote a book on the therapeutic engagement of men who were violent and abusive, and he emphasized three important areas in this work (Jenkins, 1990). He emphas-

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ized the importance in establishing a mission in responsibility. This involved assisting the people whom the man had victimized, using treatment to prevent further abuse, and developing self-respect and integrity. Alan Jenkins' point is that treating abusive men can be beneficial to the man, to the community, and to the people whom he has abused. The earliest studies of the sexual offender treatment had great difficulty finding significant effects of treatment programming. For example, Furby and her colleagues found no significant treatment effect due to methodological variability (Furby, Wenrott, and Blackshaw, 1989). However, by the beginning of the decade of the 2000s, Karl Hansen and his colleagues found that treatment programs could reduce sexual offending by as much as 40%, and this study included treatment programs for young people (Hanson, Gordon, Harris, et al., 2002). These results were similar to those found in a European meta-analysis (Lösel & Schmucker, 2005). By 1995, GERALD BLANCHARD published the first book on the therapeutic relationship in sexual offender treatment (Blanchard, 1995). However, this book was only 55 pages long. So, for many years, we knew that treatment programs might work for violent offenders and sexual offenders, but there was very little written on how to actually do this work.

In 1998, a method for managing adult sex offenders in the community was published (English, 1998). However, it was described as an aggressive strategy for the community management of adult sex offenders. In other words, this management strategy actually described itself as aggressive in the treatment of aggressive behavior. They emphasized that in this approach the client is the community and that treatment and supervision are meant for the benefit of the client themselves. And so, this meant that people entering treatment for aggressive behavior had to be aware that their therapist was working for the benefit, purely, of the community, and not for them. All of this was despite decades of research finding that the therapeutic alliance is an important part of making criminal offenders less dangerous. In 1999, a researcher named Rick Snyder emphasized the importance of building hope in all forms of psychotherapy (Snyder, Michael, & Cheavens, 1999). He described two key components to hope, including agency thinking, which is an awareness that a goal is attainable, and pathways thinking, which is an awareness of how to do it. He observed that therapists who are burned out or otherwise fail to convey hopefulness are modeling low agency and pathways thinking.

In 2005, an important study appeared on the treatment of sexual abusers (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005). At first, it found no overall differences between treated and untreated clients. However, they noted that sex offenders who successfully completed the treatment program reoffended at lower rates than those who did not demonstrate that they understood their treatment goals. In other words, people who meaningfully and genuinely worked on their treatment goals and understood the importance of treatment were more likely to benefit from treatment than those who simply went through a treatment program as if it was an educational program. This is an important consideration in the treatment of all criminal offenders. Simply putting people through a psychoeducational class is not nearly as effective as meaningfully engaging them in a treatment program where they can examine and rebuild their lives. In 2005 to 2007, researchers Bill and Liam Marshall studied the characteristics of effective treatment and found that the most successful treatment providers are those who are warm, empathic, rewarding, and directive in the way that they provide treatment (for example, Marshall, 2005). These researchers also emphasized the importance of preparatory programming as people first enter treatment programs to become less abusive.

By the time 2008 came around, Karen Parhar and her colleagues conducted a meta-analysis of 129 studies (Parhar et al., 2008). They found that "in general, mandated treatment was found to be ineffective, particularly when the treatment program was located in a custodial setting, whereas voluntary treatment produced significant treatment effect sizes, regardless of the setting". In other words, the more coercive the treatment program, the less effective it can be. Tying all of these threads together, what is important to remember is that the most important aspect of correctional treatment programs is not the custodial setting, it is the people who form the relationships that make it possible for young people to build better and healthier lives.

As an example of how good treatment programs can go bad, in Massachusetts it is now necessary for people who break the law and go into treatment programs to sign a form acknowledging that anything they say in treatment can be used against them in a court of law (Larni Levi, personal communication). Meanwhile, in Texas, the goal of treatment programs for sex offenders make clear

that the ultimate client in treatment is the people who have been harmed by sex offenders and not the offenders, themselves. They explain that sex offender treatment is different from traditional psychotherapy in that treatment is mandated, it is structured, centered on the needs of the victims, and that the treatment provider imposes values and limits. In other words, the treatment programs actually conduct themselves in a way that previous research has shown doesn't work. So, the point that I want to emphasize is that in many areas in North America, we actually know better and yet we continue to do worse. And so, it is vital that treatment programs focus on what we know actually works.

In 2012, Corrections Canada published a study by Robin Wilson and his colleagues finding that collaborative risk management and attending to sound correctional principals as well as holistic community after care can contribute to reduced reoffending (Wilson, Cortoni, Picheca, Stirpe, & Nunes, 2012). This study illustrated the need for community treatment after people had been institutionalized, and what they found was that a central goal of remaining balanced and self-determined was key to the success of the offender. And so, an important aspect of all treatment programs should be to build a balanced and self-determined lifestyle for all clients. Meanwhile, in my home state of Maine, recent laws have instead emphasized public humiliation and shame-based approaches, such as putting signs up in public parks warning sex offenders to stay away. In the American state of Florida, there are some locations that will put a sign up in front of the house of sex offenders to warn the neighbors to stay away from him or her. Even in the weeks before this presentation, the United States Senate passed the beginning of a new law to make it impossible for violent criminal offenders to receive some forms of public assistance. These kinds of public policies are demonstrated clearly in the scientific research not to work, and yet there are many locations that enforce them anyway. The moral of the story is that instead of punishing people at every turn, we need to think about our work as a form of crime prevention. We need to think prevention. We need to be prevention. We need to remember that our efforts in treating young people are prevention, and that we are all in the field of crime prevention.

Perhaps the most important study in this area was conducted by Paula Smith and her colleagues in 2002 (Smith, Goggin, & Gendreau, 2002). They conducted an analysis of 117 studies since 1958. It included 442,471 criminal offenders, including juveniles. They found that no form of punishment reduced re-offense risk. They concluded that prisons and intermediate sanctions should not be used with the expectation of reducing criminal behavior. They found that this included intensive surveillance, electronic monitoring, drug-abuse education, and a program called "Scared Straight". They even found that incarcerating low-risk criminals can actually increase their risk for further criminal offending. This is an important study because it challenges us to think about the differences between punishment and rehabilitation. Punishment is punishment, and efforts to rehabilitate can involve treatment collaborative supervision, and other methods. However, the moment that rehabilitation begins to look like punishment is that moment that rehabilitative efforts are probably not going to work.

A critical message for professionals in our field to remember is that empathic adults will be more effective with young people who break the law. However, research shows us that even the best professionals can become less empathic over time when working with young people. In fact, one researcher named Mohammadreza Hojat found that medical students becoming doctors actually can become less empathic over the course of their education. The challenge for all professionals in our field is to remain empathic and to remain effective with the young people that we work with. In fact, there has been so much research on empathy that it may be wiser for all of us to work to remain compassionate with the young people with whom we work.

II. RISK. NEED. RESPONSIVITY

Across the past 20 or so years, criminologists Don Andrews and James Bonta have researched the principles of effective correctional programming and have found three principles that stand out above all others. These are the risk principle, need principle, and the responsivity principle (Andrews & Bonta, 2010).

The *risk principle* holds that effective programs match the level of treatment intensity to the level of risk posed by the client: higher risk clients should receive higher intensity treatment. Andrews and

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Bonta found that mismatching can increase risk, and — perhaps most importantly — that the extent of one's criminal history is among the most predictive factors that one can consider for each client.

Andrews and Bonta further discussed the big four of risk factors. These are: antisocial attitudes, antisocial associates, a history of antisocial behavior, and an antisocial personal pattern, which can include psychopathy, impulsivity, restless and aggressive energy, egocentrism, thrill seeking, poor problem solving, and poor self-regulation skills. It is not difficult to look at this list and begin devising treatment strategies for many of the young people who come into our treatment programs. It's important to look at this list and consider how many of our actions may benefit and interfere with the progress of many of our young people. For example, if we want to improve the lives of teenagers who get into trouble with the law, it is vital that we provide them with access to situations where they can develop healthier attitudes and friendships with others. Also predictive of future offense are problems at home, such as low level of affection, caring, and cohesiveness; poor parental supervision, neglect, and abuse; problems at school or work, including low levels of education and achievement, and an unstable employment history; or with the use of leisure time, such as time to exercise and substance abuse. The ability to predict criminal behavior increases with the number and variety of these major risk factors and the number of different sources of information that are used.

Factors that are not associated with risk can be surprising. For example, denial that somebody has engaged in problem behavior is not known to be associated with their overall level of dangerousness. Neither is their capacity to have empathy for the people that they have harmed. Many personality features, such as an overall level of confidence or avoidance of relationships, may or may not have anything to do with the likelihood they will commit future crimes. Likewise, psychological maladjustment does not necessarily contribute to future criminal behavior.

It is essential that assessments be done at the start of each individual's treatment. Ultimately, all of our treatment programs should be driven by a solid assessment. There are many good risk assessment tools, although the extent to which they have been tested in Asian populations remains unknown. However, one instrument for sex offense recidivism was recently tested in Indonesia. This was the Estimate of Risk for Adolescent Sex Offense Recidivism (ERASOR; Worling & Curwen, 2001).

In North America, programs such as drug abuse and resistance education have been very popular, and yet have also been found not to actually reduce the likelihood that young people will take up drug abuse. How is this? It seems that the risk principle provides the answer. When one provides the same intervention — drug abuse resistance education — to all people, it reduces the risk of only a very few, and it increases the risk of a small minority, thereby producing no appreciable results. A common belief amongst people who provide drug abuse resistance education is that if it reaches only one person it will have been worthwhile. However, what many professionals don't consider is how many people actually become more likely to take up drug abuse as a result of this intervention.

Likewise, in North America, there has been an emphasis on using technological solutions, such as electronic monitoring and global positioning systems, in the supervision of people in trouble with the law. However, these technological solutions have not yet been shown to reduce risk even a little bit.

There have been many attempts to take all kids who have gotten into trouble with the law and provide them with a similar intervention aimed at making them afraid of continuing in crime. The "Scared Straight" program is one such example. Research has found conclusively that it doesn't work, and yet, it has been very popular (Smith, Goggin, & Gendreau, 2002). The Scared Straight program's intention has been to take groups of young people in trouble with the law and take them inside prisons where the inmates then scare them with stories of what it's like to be in prison. Scared Straight has been very effective at scaring young people in the short term, but very ineffective at actually getting them to change their behavior in the long term.

When considering the risk principle, it is vital to remember that whatever our sense of morals, whatever our values are, they make no difference. We need to remember that risk is an underlying likelihood to continue in problem behavior. We cannot preach bad behavior away. We can only invite young people to reconsider their lives. Our punishments are effective at punishing, but only rehabilita-

tion makes people less likely to continue in crime. The risk principle reminds us that we can make people more dangerous just as easily — and perhaps more easily — than we can make them less dangerous.

The second of the three principles is the *need principle*. The need principle holds that effective treatment programs target identified needs in the research. This means that many people come into treatment programs wanting to work in some area but not others. Effective treatment programs look at what research identified as meaningful treatment goals. The need principle finds that people who have sexually or violently abused require specific kinds of treatment programming and that other kinds of treatment programs may result in some ancillary gain, but that risk for re-offense will likely not be reduced. For example, criminal interests, criminal attitudes and beliefs, criminal cognitive schemas, criminal associates, criminal significant others, self-regulation problems, and deficits in self-management (including problem-solving skills and coping skills) are all important treatment goals for programs seeking to rehabilitate young people. An example of a treatment program that will not work with young people will be leisure gardening. Getting young people to take care of plants or animals will only be good for developing skills in these areas. However, these areas can be meaningful for helping young people develop skills for getting along with one another, which can be related to the need principle of criminal attitudes and associates. However, this is not a direct pathway. Perhaps most important in the need principle is also developing young people's ability to observe themselves, their thoughts, and their actions. This is the focus of a section later in this presentation.

The *responsivity principle* holds that effective programs are those which are responsive to client characteristics. The key element of the responsivity principle is that professionals can build the capacity for young people to respond to the programs in which they find themselves. Aspects such as cognitive abilities, maturity, motivation, the mode of intervention, scheduling concerns, and understanding each person's past history of trauma are all key to building responsivity. Relationship problems, learning difficulties, hyperactivity, communication difficulty, and cognitive rigidity are all important factors to consider, but in assessments and in treatment programs.

Returning to the earlier example of leisure gardening and working with animals: it can be the case that treatment programs can use these ancillary treatment methods to build up the capacity of young people to respond to treatment. However, they cannot, on their own, be expected to result in a decreased willing to commit further crimes. Some simple methods for building responsivity in treatment can included the *4-to-1 rule*. The 4-to-1 rule holds that all professionals should provide four positive messages for every one negative message that they give to young people. In other words, four positive affirmations or validations of the young person for every negative message they send back to the adolescent.

Another method for building responsivity can involve journaling. Researcher James Pennebaker found that simply having people write a journal of all of the challenges they faced was successful in having people develop the ability to reconsider their lives and what they wanted to do with their lives (Pennebaker, 1990). Likewise, adjunctive treatments, such as yoga and meditation, although they don't directly address criminal behavior, can build the young person's capacity to respond to the treatment programs that are available to them.

As an example of the principles of risk, need, and responsivity, let's imagine a brief case example of a young man who I will call Arthur. Arthur came from a broken home where his mother remarried and rebuilt their family. Arthur got into trouble for stealing a car and setting fire to an unoccupied house. He was arrested and came into treatment blaming his peer group for setting him up for this crime. In treatment, Arthur worked to make his family relationships better and establish a new peer group. Arthur had no prior criminal history, and he was able to use treatment to explore his attitudes and beliefs as well as the effect of his relationships and peer groups on his behavior. Arthur worked hard in school and graduated, eventually going off to university. Arthur was an example of a low risk adolescent who was amenable to treatment and able to rebuild his life. An effective treatment program for Arthur would involve lower intensity and provide an opportunity for him to rebuild his life. Because Arthur was of average intelligence and had a high level of motivation to change, he could be considered a low risk, low need, high level of responsivity client.

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Next, let's examine the case of Josh. Josh also came from a broken home. He started drinking alcohol at the age of 10 and listened to his father assault his mother five out of every seven nights for many months. Josh was first arrested at the age of 12 after he broke into a house and stole many belongings from it. He was again arrested at the age of 13 for a violent offense against his teacher. Josh did not want to take responsibility for his behavior and threatened to assault his therapist and the agent who supervised him in the community. Josh was sent to a residential treatment center in another part of the state. He received treatment four days a week and participated in a number of sports activities. Josh continued to receive supervision in the community when he returned, and the treatment providers worked to involve his family in treatment to the greatest extent possible. Josh was able to succeed and went on to lead an offense-free life. Josh was an example of a high-risk, high-need, low-responsivity client. He required a more intensive level of treatment and had a greater number of treatment goals than Arthur. His treatment continued in the community after the end of residential treatment and was eventually successful. However, Josh had a harder time responding to the treatment interventions that were available to him. If Arthur had been sent to a program where he was provided with an intensive level of treatment, it may have happened that he would become more dangerous as a result of exposure to others with similar criminal histories. However, by keeping Arthur in the community, it was possible to provide him with a more actively pro-social peer group.

Next, let's look at some examples of effective treatment programs. In the past 25 years, scientific researchers have examined a number of treatment programs. The first of these is called *multi-systemic therapy for antisocial behavior*. It is an intensive family and community-based treatment. It focuses on environmental systems that impact chronic and violent juvenile offenders. Multi-systemic therapy takes place in the home, in the family, in schools and it can involve teachers and friends. It acknowledges that every system in a young person's life plays a role in their life. Multi-systemic therapy has been shown to be effective in many studies. However, it is not without critics who wonder whether part of its success may have more to do with the intensive level of supervision that the professional receives. Studies conducted by the authors of multi-systemic therapy have not found the same level of results. It seems that an important factor to consider is the intensity of supervision for each professional and the extent to which they actively follow the model that they are working in.

Another example of a successful treatment approach has been *functional family therapy*. This is a short-term program involving 12 sessions over three to four months. It involves five phases, including engagement in a change process, motivation to change, relational and interpersonal assessment and planning for behavior change, the behavior change itself, and the generalization of treatment gains to one's daily life.

A classic form of treatment in North America that has a good scientific basis is *cognitive behavioral therapy*, first introduced by Aaron Beck. It addresses problematic emotions, maladaptive behaviors, thoughts, attitudes, beliefs, and other cognitive processes. It uses goal-oriented and explicit systematic procedures. Please note that cognitive behavioral therapy does not spend a great deal of time going back over the client's history and how they came to develop their problems. Rather, it focuses on the here and now and emphasizes what people can do in their future. A common criticism of cognitive behavioral therapy is that it therefore doesn't always go deep into a client's understanding of the world around them or into their relationships with others and often doesn't explore emotions or behavior at a deep enough level. However, much of this depends on how one administers cognitive behavioral therapy. Another recent development in working with young people who get into trouble with the law has been trauma-focused cognitive behavioral therapy, which is a variation that explores the effects of trauma in the lives of young people.

A very new development in working with people of all backgrounds has been *feedback informed treatment*, also known as *client-directed outcome informed treatment*, developed by Scott Miller, Barry Duncan and others. Feedback informed treatment, which I am discussing today, is associated with Scott Miller. It measures changes in broad areas of clinical change. It measures changes in the therapeutic alliance consisting of the relationship, the goals of treatment, treatment methods, and client preferences. It incorporates feedback on these changes into treatment itself. It has developed a strong research base.

A critical development in recent years has been *motivational interviewing*. Motivational interviewing involves helping people to say why and how they might change, and is based on the use of a guiding style. Many analyses have found that it can be very effective and, unlike many other treatment methods, it tends to be most effective when it is not manual-guided, but rather guided by underlying principles of partnership, acceptance, compassion for the client, and evocation of the client's internal reasons to change. One meta-analysis also found that motivational interviewing gained the best effects with people who in the United States were from ethnic minorities (Hettema, Miller, & Steele, 2005). This included people of Asian descent as well as Native American, African American, and Latino descent. Where traditional forms of communication in treatment might involve a treatment provider giving advice and providing information, motivational interviewing involves offering a reflective statement, exploring the client's statement and perspectives, offering information, and exploring how the client responds to that information. It is an empathic conversation in which the therapist adopts a guiding stance, rather than an overtly directive stance or one in which the therapist follows the client's wishes.

When we consider the motivation of young people, it's important to remember that motivation can change dramatically in a short period of time. Author Daniel Pink has described three levels of motivation and named them as if they were software packages. Motivation 1.0, as he calls it, involves survival. Human beings want to survive. Motivation 2.0 involves rewards and consequences. This is because although all human beings want to survive, we don't always behave as though we are motivated entirely by this desire. After all, we all engage in behaviors, such as eating too much or drinking too much, taking up smoking, driving dangerously, etc. Daniel Pink observed that many people are motivated by rewards and consequences, but that rewards and consequences do not explain all human motivation. He finds that if we only rely on these conceptualizations of motivation, we can actually make matters worse, and he argues on behalf of understanding somebody's internal motivation to change. He says, for example, that students who are praised for their intelligence are more likely to engage in cheating and less likely to persist in academic pursuits than students who are praised for their efforts, that effort is a better internal motivation to tap than traits, such as intelligence, which cannot be changed. This is similar to the work of Ryan and Deci, who have observed in self-determination theory that human beings tend to be motivated in the direction of greater autonomy, greater competence, and a greater sense of connection to others. Ultimately in our treatment programs, we should all work together to build willing partners in change. Effective treatment programs tap into each client's internal motivation to change and address treatment goals that are found in research to be associated with future crime. Treatment should not be something that we do *to* young people; it should be something that we do *with* young people. Ultimately the safest offender is somebody who has a place to live, is connected to support people to whom he or she is accountable, has work or goes to school, and has everything to lose by committing another crime.

III. TRAUMA AND THE BRAIN

Research over the past 25 years has left no doubt that maltreatment of children can have a significant effect on their brain development. All too often young people who have been abused spend more psychological energy simply trying to survive the abuse and to scan their environment for signs of threat and danger that they don't have an adequate chance to develop a more healthy curiosity about their life and the world around them. This simple fact is critical to understanding how young people wind up engaging in crime and how they can develop the hope that will prevent them from engaging in crime in the future. These developmental insults lead to behavior problems quite frequently. Emotional abuse, the loss of important emotional relationships, having caregivers who are impaired, being exposed to domestic violence and sexual abuse, neglect, and physical abuse can all have a dramatic effect both on psychosocial development and on brain development. The key factor to consider is the cumulative harm that takes place. It does not need to be the case that a young person is violently abused in an egregious way on one occasion, but rather, daily neglect can add up to significant difficulties in neurological functioning. As some examples, there can be increased limbic system irritability, heightening of a fight-flight-freeze response, decreased left hemisphere development. It can decrease the integration across the left and right hemispheres, and it can limit the activation of the cerebellar vermis where a considerable amount of self-regulatory activity occurs. All of these, of course, are big words and big ideas.

The central importance for our purposes is the knowledge that we can heal the brain through diverse activities such as exercise and other physical activities, practicing mindfulness — whether this be in the form of meditation or group instruction on mindfulness, and through yoga. In fact, in a recent unpublished study, researcher Bessel van der Kolk and his colleagues have found that practicing yoga can make dramatic changes to the area of the brain associated with self-observation (also see van der Kolk, 1994, 2012).

For our purposes of working with young people who break the law, it can be useful and instructive to review the criteria for post-traumatic stress disorder and ask ourselves in what ways we see these facts in the everyday functioning of young people. Let's remember that the traumatic event is persistently re-experienced in any one of the following ways: recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. In young children, this can include repetitive play in which themes or aspects of the trauma are expressed. It can also include recurrent distressing dreams of the event, and in children there may be frightening dreams without any recognizable content. This can become important when we remember that professionals in many treatment programs can be frustrated by the fact that young people simply don't want to go to bed at night or that they mistake professionals for truly abusive people that they have known.

PTSD also involves acting or feeling as if the traumatic event were recurring. It is very common for kids who have been in trouble with the law to view their world as a dangerous, harsh, or punitive place despite all of our attempts to demonstrate otherwise. PTSD also involves intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. Again, our clients often live with different perspective from our own, and it is unreasonable for us to expect that they will change their perspective on the world quickly when they have had such devastating evidence to the contrary. PTSD often involves efforts to avoid thoughts, feelings, or conversations associated with the trauma. It is, therefore, no surprise that our clients frequently engage in drug and alcohol abuse. They engage in efforts to avoid activities, places, or people that arouse recollection of the trauma, and very often they have an inability to recall important aspects of their trauma. When discussing crimes with young people, professionals frequently experience dismay that their clients don't recall specific aspects of their own behavior. While it is often the case that young people don't want to tell us everything we want them to, they still can genuinely forget many aspects of traumatic behaviors that they have, themselves, engaged in. PTSD also involves marked diminished interest or participation in significant activities. Again, it is vital to recall that the shallow emotional experience of our clientele can be a direct result of the traumatic experiences that they have had.

IV. HOW DO PEOPLE ACTUALLY CHANGE?

Ultimately, all treatment providers are challenged to consider: what are the active ingredients in treatment? Cognitive behavioral therapy emphasizes the importance of challenging distorted thinking patterns, but is that what really gets people to change? Is it the fact that they complete assignments, that they follow the manual? Or, do people change as a result of their experiences and their discoveries? Or, perhaps more specifically, do they change via a relationship experience where hope and possibility are renewed or even born?

Across North America, treatment programs are increasingly looking at the importance of attachment. A problem that we have is that we often treat problems with attachment as mental disorders rather than adaptations to abusive environments, and have very little research about what healthy attachment styles actually look like. I believe that this is further complicated by the fact that many people who provide treatment often have problems with relationships and attachments themselves. This is not to any degree that is greater than in the general population, but it is important to recall that we are attempting to build relationship capacity in young people when, very often, we ourselves have limits in our abilities to form these most important relationships. It is vital to remember that all of our clients come from challenging environments.

Another crucial element of treatment programs that is neurologically based is the idea of empathic attunement, the ability to engage in activities with others, to feel competent within interpersonal relationships and to relate to others at an empathic level. Ultimately, empathic and attuned treatment

interventions will always be unexpected in the lives of young people. They will always be welcome. They will almost always be impactful. What we need, in order to do this treatment, is an appropriate mindset, an appropriate heart-set, the right spirit, the right attitude, and the right intention. Who we are when we walk into a room will be immediately apparent to our clients. When we enter a room in a spirit of acceptance and compassion, we are more likely to get further with our clients than we will if we go in in a spirit of trying to fix things or to punish bad behavior. Ultimately, our efforts will be most effective when we can remain compassionate. Miller and Rollnick, in their recent book on motivational interviewing, have reintroduced the idea of compassion into effective interventions. In their view, compassion involves advocating for the best interests of clients and being motivated at all levels to address the treatment needs of our clients. Whereas empathy can be a cognitive concept, compassion involves cognition, emotion, and behavior. Unfortunately, in North America, the political climate has been anything but compassionate, often focusing on coercion, shame, blame, threats, or punishment. Ultimately, however, we can leave no one behind. Neurological research reminds us that compassion, respect, a sense of social justice for all — including our clients, prizing the differences between all humans, remembering and respecting human potential, and collaboration are vital to successful treatment.

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