CHAPTER 7

Meaningful Engagement of Adolescents in Change

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Knowledge is just a rumor until it's in the muscle
New Guinea proverb

Introduction*

Before reading this chapter, it may be helpful to engage in a brief self-assessment. Put the book down and ask yourself whether there is a change you want to make in your life. Please take a moment to picture this change in your mind. It could be losing weight, stopping smoking, drinking less alcohol, reading more, calling friends and family more often, etc. Now ask yourself: For how long have you been thinking about making this change? What would be some of the good things about making this change? And, honestly, what would be some of the less desirable things about making this change? What part of you might object to making this change? If you are like many others who have asked themselves these questions, you might smile and admit you have been thinking about this change for many years. Yet you still have not made it.

The circumstances that convicted sexual offenders find themselves in are, of course, very different from yours. However, this exercise points out that there are many people who desire to change and are able to change, but don't. Many intelligent people have gone to their graves without having made necessary lifestyle changes that would have provided them with a longer life.

Next, imagine some negative experience in your life that you would not want to discuss with anyone under any circumstances. It could be something that you did to someone, or something that happened to you. Now imagine that the legal system wants you to work on it in treatment, and that failure to do so could result in significant time spent incarcerated. Imagine that you have no choice of where to go to obtain treatment related to this issue, and that the only accepted modality is group treatment. Now, imagine yourself in a group session, surrounded by men with antisocial personality disorder. There are two therapists, each taking notes as you talk. You know that these therapists aren't perfect and that some of their notes will be incorrect. Keep in mind that all of these notes will be visible to the forces of the legal system that have taken away your liberty. It's important that you know that the disclosure of this negative experience could take several weeks, as your antisocial associates ask questions aimed at getting you to be completely honest about an experience that you don't want to talk about. Depending on the program, you may also be required to demonstrate aspects of this experience in role play.

Again, readers of this book probably don't have much in common with sexual offenders. Research has shown that adult sexual offenders themselves are clear about the need to be accountable for their actions (Levenson and Prescott, 2009; Levenson, Prescott, and D'Amora, 2010). However, it is vital to remember that no matter how important it may be, being open and honest in group therapy is not easy for any human being. It can be easy for professionals treating sexual offenders to lose sight of the client's experience of treatment (Beech and Fordham, 1997).

Historical considerations: sexual offender treatment across the life span

Many elements of sexual offender treatment remain controversial. In a recent review, Glaser (2010: 261) described it as 'a form of punishment' generally. Elsewhere in the literature, seasoned professionals (eg Chaffin, in press; Prescott, 2006; Prescott, 2010; Vess, in press) have expressed concern about the best and most ethical use of actuarial measures and polygraph examinations. Although there are plausible responses to the

*The author is grateful to many colleagues in developing these examples, including Allan Zuckoff, Yolanda Fernandez, and Ruth Mann.

argument that sex offender treatment is inherently punitive (Prescott and Levenson, 2010; Ward, 2010) there is no remaining question that entering and participating in a sexual offender treatment program can be a highly challenging experience. Despite an emerging literature regarding ethical issues in sexual offender treatment, little has been written about ethical concerns in the assessment and treatment of young people who have sexually abused (Letourneau and Miner, 2005; Zimring, 2004)

The controversies do not end there. Many professionals continue to wonder whether treatment actually works. Many cite the highly respected SOTEP study as cause for concern (Marques, Wiederanders, Day, Nelson, and van Ommeren, 2005). This study, which met a very high degree of scientific rigor, found no difference in re-offense rates between treated and untreated offenders. However, the authors were clear that the offenders who 'got it' and meaningfully completed their treatment goals did, indeed, demonstrate lower re-offense rates. To the present, no further analysis of this sub-group has occurred. Elsewhere, although meta-analyses of the past decade have provided cause for optimism (eg Hanson et al. 2002; Lösel and Schmucker, 2005) many professionals remain concerned that these studies do not account for individuals who drop out or otherwise fail to complete treatment. Fortunately, the juvenile literature is more optimistic regarding treatment outcomes (Reitzel and Carbonell, 2006; Worling, Litteljohn, and Bookalam, 2010).

Further, newcomers to the field often encounter a divergence of opinions as to the best treatment style to adopt. Much of the original literature in the field was based on populations of incarcerated adult males, and many of the first texts appeared to advocate a harsh and confrontational approach to treatment. It wasn't until within the past ten years that research has shown what is already clear in other areas of psychotherapy research: the most effective treatment provider style is warm, empathic, rewarding, and directive (Marshall, 2005). In fact, decades of psychotherapy research shows that the most successful treatment regimes share a few vital elements. These include the therapeutic alliance, hope and expectancy, and the client's own strengths and positive attributes (Hubble, Duncan and Miller, 1999; Prescott and Levenson, 2009). Much of the juvenile literature has focused on these most important aspects (eg Ryan, Leversee and Lane, 2010).

Taken together, it seems that professionals treating sexual offenders have an obligation to recognise the ethical dilemmas inherent in this work, and – to the greatest extent possible – use therapy to invite clients to be willing partners in change, and not simply the recipients of services. This is especially true for children and adolescents. Providing services is one matter; having clients 'get it' is something else. Although critics make important points about the ethical concerns and limitations of treatment programs, the research continues to show that sexual offenders who are motivated to change and can use treatment programs build healthier lives and contribute to safer communities. The real question becomes how best to awaken the internal motivations of sexual offenders in this direction.

Getting the context right for change

Recently, Mann (2009) observed that it is also vital for treatment programs to consider and address the context in which general sexual offender treatment occurs. Describing prison-based treatment programs, she points out several obstacles to establishing an environment that is conducive to change. These include:

- *Being uninformed about treatment/believing that treatment is ineffective*. In one study, Mann and her colleagues found that about half of those interviewed after refusing treatment were uninformed about the aims of treatment and had drawn unhelpful conclusions. In contrast, most of those who accepted treatment believed that the aim of treatment was to prevent future offending. Given that adolescents are inherently more dependent on their families and other supports, this speaks to the importance of drawing family members into the treatment process.
- *Concerns about poor individual responsivity of the program*. For example, offenders who are intellectually disabled may fear that treatment will be like school, and that they will not be able to understand what they will be taught. It is easy to forget that for many clients, treatment programs can appear to be like schools where they didn't learn, with clinicians similar to teachers or mentors who somehow failed them in the past.
- *Distrust of key professionals*. It is well established in the medical literature that patients often

refuse medical treatment because they do not trust their doctors. It is easy to see the potential parallel with sexual offenders. Fortunately, recent studies (eg Levenson and Prescott, 2009; Levenson, Prescott, and D'Amora, 2010) have found that sexual offenders often perceive their treatment providers in a more favourable light than they do their legal circumstances. Similar findings have appeared in the intimate partner violence literature (eg Shamai and Buchbinder, 2010). Given the often abusive or otherwise traumatising environments that adolescents find themselves in, this distrust of adults should come as no surprise.

- *Expectation of hostile responses from others.* Typically, sexual offenders are reviled in prison, just as they are in the wider community. They face danger of physical and verbal assault because of the nature of their conviction. For this reason, it is all the more important to maintain an environment in which young people experience psychological as well as physical safety.
- *Fear of stigma.* In most situations in the western world, engaging in treatment regimens, whether medical or psychological, raises the risk of the client feeling stigmatised by his illness or condition. Sexual offender treatment is no different, even in a program that specialises in treating those who have abused.

The role of the client

The single most important factor in any treatment is the client and his or her willingness to change. Although this may appear obvious at first, it is particularly important to consider within inpatient settings. Programs for lower risk offenders frequently emphasise psychoeducational aspects and/or afford limited opportunities for clients to demonstrate change over a sufficient period of time. Although these programs may adhere to the principles of risk, need, and responsivity for the clientele they serve, it is important to note that programs treating clients with higher levels of risk and need (as well as the tendency of higher risk offenders to present with responsivity concerns) require a more comprehensive approach. There are many reasons for this.

Bem (1972) called attention to the fact that how people perceive themselves throughout the change process is critical to the success of treatment efforts, and that people develop and come to 'know' their attitudes by observing their behavior and concluding what attitudes must have caused them. His research demonstrated that people are often more convinced by what they hear themselves say than by what others say to them. Likewise, new beliefs and attitudes can result by practicing new behaviors. This is an important consideration in the treatment of sexual offenders: it is very often not enough to simply provide education or a venue for self-exploration. Rather, the client must make his own case for change within the context established by the therapist and the program beyond.

Likewise, Ryan and Deci (2000) have examined the change process extensively, noting that motivation to change often begins with outside forces (such as parents teachers and carers) which can become internalised over time. Internalised ('intrinsic') motivation refers to engaging in activities for their own sake because it is interesting and satisfying in itself, as opposed to doing an activity to obtain an external goal (extrinsic motivation). Internalisation refers to the active attempt to transform an extrinsic motive into personally endorsed values and thus assimilate behavioral regulations that were originally external. Also of note, Deci and Ryan (2002) contend there are three psychological needs that motivate people to initiate behavior, and are essential for psychological health and well-being. They argue that these needs are universal, innate, and psychological, and include the need for competence, need for autonomy, and the need for relatedness (Deci and Ryan, 2002). Treatment that enables clients to make progress towards these goals will therefore have a greater chance of being personally relevant and meaningful to the client.

Another easily overlooked element in motivating sexual offenders to change is in understanding hope. Moulden and Marshall (2009) highlight the importance of transmitting to sexual offenders a belief in the usefulness of change and a sense of ownership of that change. Snyder, Michael, and Cheavens (1999: 182) emphasise the importance of hope as a psychotherapeutic foundation, and describe it as consisting of agency thinking (believing that a goal is attainable) and pathways thinking (having ideas about how to attain it). They further emphasise that 'therapists who are burned out or otherwise fail to convey hopefulness implicitly

model low agency and pathways thinking'. Given the importance of therapists within the therapeutic relationship, it is surprising that the use of hopefulness in sexual offender treatment has not received wider attention.

These are crucial considerations in the treatment of sexual offenders. It is common for outside stakeholders, the lay public, and clients themselves to view treatment programs as being entirely responsible for client change. In this mindset, treatment is something that therapists do 'to' their clients. The findings above show that although providing a sound treatment program is the responsibility of clinicians, the ultimate responsibility for committing to and maintaining change lies with the client. In this case, a better metaphor may be treatment following a heart attack. For most adults, this treatment will involve losing weight, proper exercise, and eating appropriately.

Stages of change

It is vital that treatment programs for sexual offenders take into account that not everyone who consents to treatment is ready or willing to make dramatic changes in their lives. Further, young people can change dramatically, often with little apparent notice or reason. People who succeed in making changes in their lives often proceed through five 'stages of change' (Prochaska, 1999; Prochaska, DiClemente and Norcross, 1992). It is helpful for clinicians to recognise where each client is at with respect to these stages and use relevant interventions to help the offender move to the next stage. Briefly, the five stages are:

- *Precontemplation*. Literally, this is the stage before the client begins thinking about change. At this stage, the client may not acknowledge having any need to make changes in his or her life and may deny having engaged in sexual abuse. Appropriate treatment activities can involve exploring what areas of their life the client might be interested in changing and exploring the pros and cons of both change and maintaining the status quo.
- *Contemplation*. At this stage, the offender has considered that he has a problem but may be ambivalent about change. This can appear as minimising the seriousness of his actions or reluctance to make changes in his life that would reduce risk of re-offense. Appropriate treatment activities at this stage can include motivational enhancement, values clarification, psychoeducation, exploring and resolving ambivalence towards change, and working out what meaningful change would look like in the client's life.
- *Preparation*. As its name implies, this involves preparing to engage in action toward change. Appropriate treatment activities at this stage can include motivational enhancement, psychoeducation, and self-monitoring of areas that the client would like to change.
- *Action*. This involves the client actually taking steps to modify his or her thought patterns and behavior. It is at this stage that standard sexual offender treatment activities such as disclosure of offenses and exploration of the factors that contributed to one's offending become possible.
- *Maintenance*. This involves the client maintaining the changes made during the action stage. Treatment activities at this point involve managing the factors that contributed to one's offending in daily life, in the here and now.

Movement through these stages is typically sequential and, ideally, progressive. However, sexual offenders, like anybody else, can move back and forth among these stages in their change process. Further, they may be ready to change in some areas and not others. This can be particularly true of adolescents, who by definition are more dependent upon their environment, and for whom a willingness to change will therefore be less straightforward than for an adult. Therapists must continually assess the stage at which their clients are functioning and adjust their approach accordingly. The stages of change model is not without critics. Some have observed that it does not adequately account for situational factors and that its practical application in some situations can be limited. For that reason, it is a guiding framework but not a stand-alone treatment model.

Skill acquisition, rehearsal, and enactment

The tendency of humans to return to an earlier stage of change, or even to become ambivalent about the changes they are making, speaks to the importance of the maintenance stage of change.

Some programs for lower risk criminal offenders emphasise the acquisition and even rehearsal of skills. Because being able to maintain change is so vital to long-term risk reduction, skill *enactment* becomes particularly important in the treatment of sexual offenders. In a study of enhancing treatment fidelity in health behavior change, researchers from the National Institute for Health (Bellg et al., 2004) state that enactment of treatment skills involves self-monitoring and improving one's ability to perform treatment-related behavioral skills and cognitive strategies in relevant real-life settings.

What makes adolescents so different?

It can be easy to forget that the natural push of adolescence towards independent adulthood means additional challenges for adults attempting to guide youth in a healthy direction. While resistance may best be thought of as an interpersonal phenomenon generally (Prescott, 2009), There is much within the resistance to treatment providers by young people that is indicative of normative developmental processes. The following are a few examples of what professionals can expect to see:

'I'm not going to/you can't make me.' Inherent in this statement is the young person's drive towards independence. That very same drive is what will assist them in making their own decisions not to abuse in the future. A helpful response might be to reflect on this drive and discuss its importance. Professionals might further want to consider that protest is a basic human right (see also, Jenkins, 2006).

'It's not fair.' Similar to 'you can't make me', part of the developmental task of adolescence is to explore fairness as a part of developing their own set of values. Professionals can be more effective when they are prepared to discuss the reasons and values underlying their rules and expectations. Not doing so can replicate the often traumatic and chaotic environments where young people who have abused have lived. 'It's not fair' signals the same youthful idealism that will one day prevent the abuse of others. It may be more effective to conceptualise these young people as learning morality for themselves rather than being amoral. In this case, professionals can pursue a more nuanced path of guidance as opposed to overt direction.

'It's not like this where I'm from. You don't understand.' As mentioned elsewhere in this chapter, it can be easy to forget how dependent young people often are on their environment and family. This statement can be a clear invitation to explore further and understand. Further, if the young person's home is itself abusive, treatment may place the young client in a bind of mixed allegiances.

'I don't have a future.' Although on its surface this is a sad statement, it can also signal the fact that adolescents often have an entirely different perspective on time than adults do. It is easier for a 25-year-old to imagine the age of 40 than it is for a 15-year-old. Given the developmental tasks of adolescence, it is entirely appropriate that young people are more focused on the here and now than their adult counterparts. They are, in many ways, making their identities up as they go along.

Some principles for engaging young people who have abused meaningfully in change

To summarise to this point, programs treating sexual offenders will likely be most effective when they attend to the contextual factors that make change more difficult. For larger programs, this can involve administrators ensuring that the culture of the work environment is conducive to growth and change for their clinical staff (eg Miller, 2006). Programs can also adopt a perspective that they are building willing partnership with participants who will view themselves as responsible for their own change and maintain a hopeful approach towards it. Clinicians who consistently employ a warm, empathic, rewarding, and directive (in the sense of guiding) approach are also more likely to engage their clients meaningfully. With that, the following ideas can also help professionals build willing partners in change:

Willingness to change is different from willingness to enter a treatment program. Although clinicians can understand the expectations of their treatment program from the outset, clients often do not. Clients can often appear more ready for change than they actually are. The client does not necessarily share the clinician's view of what is important in change. Likewise, some clients are more willing to change than they are to enter a treatment program where they have to work

collaboratively with others. For these reasons, it can be useful to separate treatment from change conceptually.

Focus more on awakening internal motivation to change than on imparting it. There is a time and a place for encouraging those who are attempting to change. However, active attempts to motivate others to change (eg persuasion, cajoling, and making the case why another person should consider changing) rarely work. In fact, making the case for why clients should change can create resistance. Even when clients appear to respond well to therapists leading the cheer for change, this extrinsic motivation is rarely enough to keep another person's internal motivation going, particularly in therapeutic circumstances where the treatment is one of many experiences in the client's lifetime. Both self-perception and self-determination theory (as well as the research underpinning them) illustrate the importance of the client's ability to make their own case for change. Likewise, a recent study (Amrhein, Miller, Yahne, Palmer, and Fulcher, 2003) found that client verbalisations regarding change were predictive of whether or not change occurred.

Setting the stage for someone to make their own case for change can come in many forms. The skills, principles, and mindset of motivational interviewing (Miller and Rollnick, 2002) present several stars for the clinician to steer by. A helpful strategy among these is the double-sided reflection, in which the therapist verbalises both sides of the client's ambivalence to change. Very often, these reflective statements involve 'one the one hand . . .' formats. For example, 'This is a dilemma for you. On the one hand, you would really like to complete the treatment program, and on the other hand you're not sure you can trust that others have your best interests at heart. What do you think about that? What do you think you might do?' These kinds of statements are often much more difficult to formulate than it seems. They require that the clinician have an accurate knowledge of the client's internal world. It helps to be able to use the client's own internal lexicon when making them. For example, if the client has earlier said that he doesn't want to 'take treatment,' it can be useful to use this same terminology. The exception is when by doing so the therapist appears unnatural, disingenuous, or abusive.

Another method for exploring the client's internal motivation to change is to draw a single vertical line on a chalkboard or piece of paper and ask the client first to list all the good things that making a change in a given area might bring, and writing these down on one side of the line. The clinician can next ask about what sorts of less desirable things might happen if they were to change. A variation on this involves dividing the paper or chalkboard into quadrants and exploring good and not-so-good things about change, as well as good and not-so-good things about *not* changing. In all of these activities the clinician must be careful not to impose their own agenda on the client.

Seek out 'change talk' and explore it with clients. Amrhein et al. (2003) have highlighted the importance of client verbalisations of commitment to change. These statements can be predictive of client success at change efforts. Often, change talk appears as statements indicating a desire, ability, reason, or need to change. It can also come in the form of 'commitment talk', which involves statements related to explicitly planning for change, taking steps to initiate change, or beginning a change process. One method for eliciting change talk is the use of scaling questions related to change. Two useful questions are 'On a scale of zero to ten, how important is it to you to make a change in this area?' and 'On the same scale, how confident are you that you can make a change in this area?' When the client answers, the clinician can then explore the number provided. After some discussion, the clinician next inquires as to why the client did not choose a lower number. Typically, the answer to this 'backwards question' involves some form of desire, ability, reason, or need to change. The clinician can then explore this change talk with the client.

In eliciting and exploring change talk, a key skill involves remaining focused on these self-motivating statements and less so on the resistance statements that may accompany them. There is always time to explore the reasons why a client might feel unready, unwilling, or unable to change.

Beware the righting reflex. When awakening internal motivation and eliciting change talk, it is vital to remember that expressions of each frequently occur against a backdrop of resistance. This can be a frustrating experience for clinicians who may feel they must redouble their efforts to enforce change or somehow set the record straight with their clients (Miller and Rollnick,

2002). Very often, clinicians working with young people feel this reflex particularly strongly, as they experience themselves as functioning *in loco parentis*, or as custodians responsible for the young person's best interests. Under these conditions, it can be easy to return to harsh and confrontational approaches that – research shows – are less effective. This reflexive response to make things right can serve the end of short-term compliance. However, it frequently comes at the expense of long-term change. It can be helpful for clinicians to establish ground rules for themselves to simply notice this reflex without acting on it. After all, it is a byproduct of their best wishes for the client. There is always time to provide respectful feedback later. An awareness, acceptance, and expectation of resistance can keep clinicians grounded. When working with resistant clients, it can be useful to remember the saying that very often 'the slower we go, the faster we get where we're going'.

Remember that therapeutic engagement is vital throughout the treatment experience. It can be easy to think that developing rapport takes place at the start of treatment, while forgetting how important it is to maintain that rapport. Miller, Hubble, and Duncan (2008) have demonstrated the importance of the therapeutic alliance throughout treatment, and have highlighted the importance of soliciting feedback from clients in order to make sure that they actually have the alliance in treatment that they believe is there. Like Beech and Fordham's (1997) classic study of sexual offender treatment providers, Miller, Hubble, and Duncan illustrate how psychotherapists typically view themselves as more helpful than their clients do. A therapeutic alliance is not like painkillers that prevent the patient from feeling the unpleasant effects of recovery. It is the context in which genuine change takes place.

'*Treatment is just the roadmap; meaningful personal change is the goal*.' These words, uttered by a civilly committed sexual offender in the Midwestern United States, are helpful to remember. Although research shows the success of cognitive-behavioral and community-based interventions in reducing sexual re-offense, more important is the actual change of cognition and behavior, preferably within the context where the client will enact new skills. Although research highlights the importance of treatment completion, it can be easy to focus too narrowly on service provision and not on the changes that the client is actually making. An unforgettable example from popular culture is in the lyrics of the song 'Rehab' by Amy Winehouse. In it, she offers roughly three minutes of repeated reasons why she does not want to enter treatment. Buried within the resistance is her internal motivation for change ('I don't ever want to drink again. I just need a friend'). Even within trainings of sexual offender treatment providers, many professionals miss these most important lyrics.

Focus on approach goals. There is a body of literature showing the importance of desirable 'approach goals' (ie goals that one can work towards rather than avoid; Emmons, 1999). Unfortunately, traditional treatment approaches have not always paid adequate attention to what offenders seek to attain or achieve through offending so that they can develop ways to achieve these ends in healthy, safe ways (Yates, Prescott, and Ward, 2010). The development of approach goals is vital to building willing partners in change and a meaningful shared vision of the future. Very often, a specific choreography takes place between the client and therapist in order to develop these goals. For example, the client may enter treatment not wanting to let little things irritate her. This avoidance of irritation focuses only on the problem itself. The clinician can then work with the client to re-cast this into an approach goal of being able to stay calm at all times. Likewise, an avoidance goal of not wanting to feel inadequate all the time can be more effective when broadened to a goal of feeling competent within relationships. Ultimately, the approach goal of building a happier and healthier life that involves satisfying relationships is likely to be more appealing than simply to stop offending.

Engage in collaborative treatment planning. In the author's experience, it is common for treatment programs to engage in a treatment planning style in which a clinician or treatment team imposes goals on the client. In inpatient settings, this can occur when representatives from each department (clinical, residential, health services, educational recreational and occupational therapy, etc.) state their goal on behalf of the client. Very often these goals are avoidance-based (eg 'John will not be belligerent about taking medication' as opposed to 'John will follow through on plans he establishes with others, including the psychiatrist and other service providers').

A more effective approach may be to listen to what the client wants from treatment, collaborate with him on crafting it into an approach goal, considering how this goal serves the purposes of meeting criminogenic needs along the way (Andrews and Bonta, 2010). Recent research has demonstrated that sexual offender treatment programs that are matched to Andrews and Bonta's principles of risk, need, and responsivity are more effective than those that are not (Hanson, Bourgon, Helmus, and Hodgson, 2009). For example, a client goal of not feeling angry might better be re-cast as developing inner peace, which in turn can be one component of the criminogenic need/dynamic risk factor of emotional regulation.

Shift the balance from command to leadership. Leadership has been defined in many ways, and for purposes of this chapter, it is most helpful to think of it as a guiding influence (Maxwell, 2007). Many professionals have viewed treatment provision as something done to clients (Glaser, 2010; Jenkins, 2006; Ward, 2010). This kind of command mentality may be less helpful than establishing a confident role of guiding influence.

All treatment providers would like nothing more than to stop offending quickly. However, the research cited throughout this chapter suggests that clinicians will be more effective in creating long-term change by amending their view of themselves from that of a commander (or perhaps a lion tamer) to that of a wilderness guide who helps a client explore how and why they might change. This requires a different perspective, away from visions akin to a surgeon who does the work so that a patient can heal. Rather, clinicians may be at their best when they view themselves as being akin to a wellness consultant. From this perspective, the clinician can help guide the client in the healthiest direction, and ultimately it is the client's responsibility to invest in their future health and well-being. It is noteworthy that this approach is not necessarily easier for the client. Moving the responsibility for change away from a commanding presence to the client him- or herself can be an entirely new experience for sexual offenders.

In the author's experience, it is all too common for professionals working with sexual offenders to confuse leadership with command. Just as employees respond poorly to supervisors directing them about in a heavy-handed fashion, a more guiding approach can build longer-lasting voluntary change. Short-term compliance is not the same thing as long-term change for either professionals or their clients.

Focus on research rather than media accounts of sexual abuse. It is easy to find pessimistic media accounts implying that treatment does not work. Sample and Kadleck (2008), for example, found that lawmakers were more likely to follow media portrayals than research in establishing policies related to sexual offenders. Elsewhere, Wilson, Leaver, and Rathjen (2008) likened media portrayals of sex crimes to news items about airplane accidents. Each account seems to negate the fact that thousands of other airplanes landed safely that day. Under these circumstances it can be easy for clinicians to lose faith in the ability of their clients to change. This, in turn, can lead to the modeling of low levels of hopefulness that can be detrimental to clients.

Keep that focused sparkle in your eye. Sexual offenders, like any other clients, are quick to notice when a professional's heart and mind are somewhere else. Just as clinicians who model low agency and pathways thinking can reduce client hopefulness, it is easy for professionals to underestimate the amount of influence they have on their clients. Although it is clear that in many jurisdictions a clinician's report can mean the difference between incarceration and community placement, it is easy for professionals to forget that often they are among the first pro-social models the client has ever known. If we are not respectful of our clients, who will be?

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