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The Rashomon Dilemma: Perspectives on and Dilemmas in Evidence-Based Practice

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Abstract

Professionals working with adolescents who have sexually abused are under ever increasing pressure to engage in evidence-based practice (EBP), or treatments that have demonstrated proof of their efficacy. While the quest for EBP is certainly praiseworthy, it has been an elusive concept for many professionals. Further, development of evidence-based treatment curricula has prompted questions as to their best usage, in light of actual practice and at the level of each individual client. When one examines the data on groups of clients, the evidence for such curricula can be impressive; however, questions remain about specific applications and the human frailties of those administering and providing these treatment curricula. The Rashomon dilemma adds to these questions the effect and impact of differing interpretations shaped by the legitimate, but often different, perspectives held by different stakeholders in any given case.

Keywords

Evidence based practice, sexually abusive youth, juvenile sexual offenders, sexually abusive behavior, sexual offender treatment

To place what follows into context, consider the following vignette. During a chance encounter in a hotel coffee shop, a conference attendee who had attended a workshop presented the author the previous day on assessing and treating adolescents who have sexually abused commented, "I thought your field was more evidence-based." The workshop itself had focused on the considerable research that has emerged in the past two decades. What prompted the dismissive tone of the attendee, however, was the fact that no available treatment manuals have been empirically proven to be effective under the stringent conditions of a randomized clinical trial.

This article explores the dilemmas professionals face at the front lines of assessing and treating adolescents who have sexually abused. It explores how the varying perspectives on "evidence-based treatment" can both help and hinder our field. As with the characters depicted in the 1950 Akira Kurosawa film *Rashomon*, different professionals and other stakeholders in treatment may see dramatically different things when observing the same client, or considering different aspects of the same model of treatment. In *Rashomon,* different characters experience widely different views of exactly the same incident, showing us that there may be significantly different interpretations of the same circumstances, each of which are credible even though quite different from one another. Perhaps none are actually the "correct" version or interpretation; alternatively, perhaps each version is accurate in its own right when seen from that particular perspective.. Using a case example to illustrate the points made, this article addresses that very phenomenon as we consider the basis for and actual application of evidence based treatments, and perhaps can help us prevent unnecessary arguments in our attempts to build healthier lives for the young people who come into our care, and safer communities. Indeed, *Rashomon* ends with the rescue of a child after much arguing among the adult characters, mirroring our presumed goal in treatment.

What Exactly is Evidence-Based Practice (EBP)?

Use of the term "evidence-based" has expanded dramatically in the past two decades. In 1994, it turned up about three times in scholarly publication titles in the behavioral health literature. Ten years later, the number of titles using this term grew closer to 600 (Chaffin, 2007). There are good reasons why stakeholders would want evidence that what they are delivering, referring clients to, and/or are paying for actually works. For example, in 2001 the United States Surgeon General published findings purporting to show that residential treatment is ineffective in reducing youth violence (U.S. Department of Health and Human Services, 2001). The failure of programs such as DARE, Scared Straight, and boot camps to produce the desired outcomes of reduced drug abuse, criminality, and re-offense is a sobering reminder that not all of society's efforts have borne fruit (Smith, Goggin, & Gendreau, 2002).

In 2007, Mark Chaffin defined evidence-based practice in the field of treating adolescents who have sexually abused as "the competent and high-fidelity implementation of practices that have been demonstrated safe and effective, usually in randomized controlled trials (RCTs)" (Chaffin, 2007, p. 661). For the purposes of working with adolescents who have sexually abused, the words "safe and effective" appear particularly important. Indeed, some researchers have questioned the extent to which interventions with youth can actually cause harm (e.g., Dishion, Poulin, & McCord, 1999; Lilienfeld, 2007; McCord, 2003). For example, more recently, Chaffin (2011) examined the use of the polygraph, questioning its effectiveness and whether it can help protect adolescents from the consequences of re-offending. Also of note, Chaffin acknowledges, "Fidelity to an intervention protocol raises questions of how strictly protocols or manuals must be followed and the extent to which practitioner creativity, idiosyncratic practice styles, and individualized treatment approaches can be retained in EBP" (Chaffin, 2007, pp. 661-2). This is not merely an academic question. Some evidence-based methods are more prescriptive (e.g., aggression replacement training: Goldstein, Glick, & Gibbs, 1998) than others (e.g., motivational interviewing: Miller & Rollnick, 2013).

Chaffin's observation about strict adherence to protocols is worth exploring further. Although it has yet to receive much attention in research, there is a serious question about the generalizability of findings from their original setting to another. While a school-based curriculum developed in one state can likely be used with same-aged students in the classroom of a neighboring state, strict adherence to protocols can result in unanticipated problems in other situations. In one example from the author's experience, a protocol developed in one part of the northeastern U.S. was implemented in another. A significant difference, however, was that it was now to be applied in home-based services rather than an outpatient clinic, where the manual had been developed, changing the circumstances under which the model was to be applied and creating potential, but unforeseen, obstacles to providing effective treatment. For instance, as a part of fidelity monitoring, deemed vital by the developers to service delivery, each therapist was required to videotape every session. One clinician summarized the experience:

> *I've been through video-based fidelity monitoring before; I know how it works and I'm no longer afraid of the feedback. What's getting lost in the implementation of this curriculum is the fact that we're entering people's homes. That's the greatest honor a clinician can have…. That's a big deal, because this family is in pain and they're embarrassed about their situation. Now I need to set up my video camera to prove to someone outside of there that I'm doing it right. So right then the family is seeing that I'm not there for them, and that I'm also there to perform for the consultant. Whose treatment is it? Then it gets worse because the family, in granting permission, is saying out loud "we'll do this for you," when I'm the one who should be doing things for them. "We'll do this for you even though we don't really want to" is an abuse-enabling dynamic and that's what I'm trying to stop.*

In the author's experience, it is not uncommon to hear that a video review of session material is vital to ensure fidelity to a model. Indeed, video review has been part of the author's supervisory practice. Explored from another angle, however, other questions emerge. For instance, how should treatment programs understand treatment failure when it occurs under the conditions briefly described above? Is it a failure in implementation or of the clinician's allegiance to the model? In terms of fidelity to the model, where does "strict adherence" begin and end, and does fidelity in the case described, in which video recording is required, also serve as an obstacle to treatment? Addressing issues like this, Wampold (2001) and Duncan, Miller, Wampold, and Hubble (2010) have written extensively on the factors involved in treatment, including the therapeutic alliance and the allegiance of clinicians to an approach or model (as opposed to the specific techniques within that model). Their findings are important for any program considering EBP implementation, and lead to several questions:

- How should we understand the value of empirically supported treatments, such as Multisystemic Therapy (Borduin, Henggeler, Blaske, & Stein, 1990; Sawyer & Borduin, 2011) when studies of these approaches by people other than the developers do not find the same results (e.g., Harpell and Andrews, 2006; Leschied & Cunningham, 2002; Littell, 2005)?
- Evidence-based treatment approaches can be challenging to implement. In fact, doing so can take years and result in staff turnover (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). They can also be very expensive At what point to the costs outweigh the benefits?
- At one level (e.g., CBT versus an unspecified "treatment as usual") a specific approach might seem to present a significant advantage. However, what should professionals make of the fact that when all bona fide treatments are compared to other treatments-as-usual, all treatments appear to do equally well (Wampold, 2001)? For example, a recent implementation of cognitive-behavioral therapy (CBT) across Sweden did not produce evidence of improved psychotherapy outcomes over other therapeutic approaches (Miller, 2013; Werbart, Levin, Andersson, & Sandell, 2013).
- Given that adolescents who have sexually abused are a heterogeneous population (Hunter, 1999; Longo, Prescott, Bergman, & Creeden, 2012; Rich, 2011;), does it make sense to seek out a single, evidence-based treatment method?
- Does a treatment proven effective with one client population in a particular treatment setting retain its evidence based status when used with a different client population and/or in a different treatment setting?

Returning to Chaffin's (2007) definition of EBP as "the competent and high-fidelity implementation of practices that have been demonstrated safe and effective, usually in randomized controlled trials (RCTs)" (p. 661), it is also possible that this definition might include practices for which there is an evidence base but are not comprehensively manualized. For example, journaling has demonstrated its contributions to psychotherapy outcomes, although in itself it is not nor does it provide a comprehensive treatment curriculum (Pennebaker & Chung, in press). Therefore, the focus of many professionals on finding a single treatment package that works well for all clients in all treatment settings may preclude their discovery or use of other safe, effective, and evidence-based treatments that can serve as components of a broader and perhaps more versatile and comprehensive treatment package.

In 2008, a task force of the American Psychological Association for EBP with children and adolescents stated that, "(EBP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Task Force on Evidence-Based Practice with Children and Adolescents, 2008, p. 5). Like Chaffin's (2007) definition, the APA emphasizes the evidence base even as it emphasizes the role of clinical expertise and the individual characteristics of the client. Far from having all adolescents of a certain background receive the same treatment, this definition virtually demands individualized treatment (i.e., "patient characteristics, culture, and preferences"). This brings with it an inherent dilemma. On one hand, EBP requires tailoring treatment to the individual characteristics of each client. On the other hand, while many curricula provide some flexibility in order to accomplish this, there is still the problem that making too many adjustments can compromise the integrity and effectiveness of the model, at least according to the developers of many treatment curricula.

Balancing the APA's triad of research evidence, clinical expertise, and individual characteristics at the front lines of treatment becomes more challenging than it might appear when reviewing the evidence base of a treatment approach in a scholarly journal article. As an example, the author was called upon to consult in a case in which a 13-year-old set fire to an empty building. This followed a series of horrific events, including the sudden and unexpected death of the boy's father when the child was aged 9, the absence of his mother from his life following repeated physical abuse since around the same time, placement with ineffectual relatives, and – most recently – the death of a classmate in a traffic accident. This young man was taking medication for Attention Deficit Hyperactivity Disorder and receiving special education services. There were also concerns that he and a foster brother had engaged in unspecified sex play. However, the case manager and other professionals involved in the case were under fierce pressure from their superiors to provide only evidence-based treatment. Further, the state agency's mandate was such that it would prioritize only the most urgent treatment needs due to budgetary constraints. In other words, treatment for trauma and complex grief reactions was less a concern to the state agency than the fire setting that arguably stemmed from experiences of trauma and loss, and the focus on only an evidence based treatment narrowed the choice for a treatment approach. The result was a referral from the agency's area manager, over the objections of the front-line clinician who had worked with the family, for MST to address the boy's fire setting. Whether MST under these circumstances would be helpful was open to debate. However, the use of an evidence-based treatment approach to address only antisocial behaviors or traits, in the absence of a comprehensive assessment or accommodation for the other factors in this adolescent's life, meets only one of the three prongs of the APA's definition of EBP.

The different perspectives of each player in this situation are worthwhile considering. The area manager was aware of MST's successes, although maybe not its practical and scientific limitations. The clinician recognized the many stresses in the young man's life and hoped that the family-based focus of MST would result in some larger benefit for each family member, as well as the young man. Representatives of the legal system would be reassured by the confidence of the area manager in the status of MST as evidence-based. However, questions remain, perhaps beginning with the fact that, despite a highly engaging MST specialist who clearly believed in the model, in this case no one asked the young man or his family whether, as stakeholders, they felt MST was a good way forward. Under these circumstances, in which the family may themselves may not be fully on board, and considering the different perspective held by different stakeholders, whose responsibility is it if the intervention fails? Do we blame the poor fit between the model and the client, or do we attribute failure to poor implementation? Depending on the personalities involved, some might go so far as to blame the professionals involved, or the client himself.

Summarizing to this point, the current usage and concept of EBP remains quite new in comparison to the general study of psychotherapy, which dates back many decades. In fact, the definition of EBP has been in flux and only more clearly defined and settled within the APA in recent years. At the front lines of practice, ideas about what does and doesn't count as EBP vary based upon circumstances and the perspectives of those involved. Finally, while there is no question that many of the available evidence-based curricula, protocols, and techniques have performed admirably in the settings where they were developed, implementation in newer or different settings, or with different client populations, can be challenging at best. Indeed, a treatment model that is evidence based, or empirically validated, in one setting or under a defined set of treatment circumstances may not be empirically validated or proven in a different setting, even though it may remain "evidence informed."

An In-Depth Examination: A Case Example

A case study can help to illustrate some of the dilemmas, competing demands, and differing perspectives about the same case, involving many different aspects of or related to the case. In the case presented below, we can see that approaches to assessment and treatment, and their resulting outcomes, may be shaped and experienced very differently by different stakeholders in the case, and that different perspectives can not only drive treatment, but also our view of what counts as evidence based practice and what does not.

The Case of Nick

Further exploring the dilemmas in EBP in practice, consider the case of an adolescent who had sexually abused his cousin. "Nick" came into residential treatment at the age of 15. Nick's full-term pregnancy was the result of a sexual assault by his mother's boyfriend, whom Nick never met. His mother's subsequent boyfriend was also periodically abusive, with the result that Nick was exposed both to violence and neglect from an early age. However, he generally reached developmental milestones on time or a little early, and started kindergarten at the age of 5. By the time he was in first grade, his mother had a new partner, who sexually abused Nick on a number of occasions. Records are unclear about how this came to the attention of the authorities, but Nick was placed with his uncle and aunt at the age of 8, where he stayed until his placement in residential treatment at the age of 15. Also in their home was his cousin, who was five years younger than Nick.

By most appearances, Nick's ability to adjust to his new home was remarkable. His uncle and aunt had very clear, predictable routines within their family. Nick's uncle worked in construction, and his aunt maintained a small Internet web design business, which allowed for considerable flexibility and attention to Nick's needs. For his part, Nick seemed to flourish in the home, but had difficulties in school. He was diagnosed with Attention Deficit Disorder and received low doses of stimulant medication with mixed results. Results from educational testing were not firmly conclusive, but suggested an expressive/receptive language learning disability. From everyone's perspective, however, Nick appeared to have a very difficult time making new friends and trying new social activities. While he could appear diligent and task-focused with schoolwork despite his difficulty focusing, he seemed unwilling, even uncurious, about socializing with same-aged peers. From the ages of 8 until 11, this was less of a concern for his (by now) adoptive parents, but by the age of 12, it became a concern: Nick did not see himself as competent within his peer relationships and did not seem to relate to others. He also continued to hold on to hobbies that others appeared to be shedding as they matured, or at least he was still quite open about his affection for fantasy-based card games. This would make him something of an outlier among his peer group in the coming years.

Although he rarely expressed these thoughts, Nick frequently worried that he would never fit in anywhere. Despite his adoption into a stable and supportive family, the process of disclosing abuse, as well as his subsequent placement and adoption, seemed, on a daily basis, to reinforce Nick's belief that he is not like others. From an early age, he looked at education as being his only ticket to a better life somewhere, despite his struggles. However, he tended to view himself as childlike and wanting to have the kinds of experiences that other children seemed to have. When others were growing up, he simply wasn't quite ready to join their ranks. He enjoyed the company of those younger than himself and felt more at home with them, despite aging into early adolescence. Of note, Nick's cousin was significantly younger as well. Nick spent considerable time after school with his cousin. They would play in the refurbished basement of their home while their father was at work and mother focused on her tasks upstairs. When Nick was 13 and 14, and his cousin was 8 and 9, he talked and cajoled her into a variety of sexual activities, primarily involving fondling over and underneath her clothes, and occasionally involving oral sex. Eventually, his cousin objected and told her parents, who immediately called the police. Nick was placed in a crisis shelter, where he responded very poorly. Frightened for his safety, he engaged in a number of highly problematic behaviors, including opposition, defiance, and sexually provocative to others. Between this and the fact that his adoptive parents were adamant about keeping their daughter safe, Nick was placed in residential care.

An initial risk assessment concluded that Nick was generally at low risk for continued sexually abusive behavior . Using the *Estimate of Risk for Adolescent Sex Offender Recidivism* (ERASOR; Worling, 2004; Worling & Curwen, 2001), the evaluator found that Nick presented with only a handful of risk factors, each of which were easily addressed with treatment. Much of Nick's relatively good prognosis resulted from the fact that his adoptive parents were committed to his successful treatment and reunification (the cousin entered into her own treatment and made excellent progress). However, as a part of the initial assessment process, Nick presented with two issues of serious concern. The first was that he appeared to lack empathy for his cousin and her experience of abuse. The second was the fact that even at his age of 14-going-on-15, he was clear that he was more sexually attracted to prepubescent girls than he was to young women his own age or older. The evaluator confirmed this latter concern through the use of a viewing time measure to assess sexual interest.[1]

Dilemmas and Differing Perspectives. Concerns regarding Nick's apparent lack of empathy presents its own dilemma. From one perspective, it appears manifestly obvious that empathy for others would be a protective factor against further abuse. On the other hand, there is little research in the field of treating sexual aggression to support this (e.g., Curwen, 2003). From another perspective, sexual offenders themselves have described empathy as a very important component of treatment (e.g., Levenson & Prescott, 2009; Levenson, Prescott, & D'Amora, 2010). An additional perspective is that there is little or no evidence that empathy can be "taught," although it is clearly a developmental process that can be enriched through experiences within other empathic relationships with adults (Longo, Prescott, Bergman, & Creeden, 2012). In summary, it appears that working on empathy should be part of EBP, and yet the evidence for this is thin. On the other hand, the evidence for improving one's capacity for empathy may have more to do with the *responsivity principle* of effective correctional programs (Andrews & Bonta, 2010), which holds that treatment should be tailored to the characteristics of the client, as well as the *needs principle*, which asserts that risk must be understood and treatment geared toward the individual needs of each client. In Nick's case, by improving his capacity for empathy, other interventions will have a greater impact on his life. We thus see two very different evidence-informed aspects of empathy. In one case, there is little to no empirical evidence that empathy is an important target in treatment; in the other, there is evidence that treating empathy, on an individualized basis, may be an important target in treatment.

A second set of related dilemmas related directly to the assessment process is the nature, accuracy, and application of the risk assessment itself. While the term itself has a longer history and larger evidence base in the assessment of adults, it is nonetheless important to referring agencies to have some sense of how best to prioritize cases and treatment needs. However, it can be easier to use available risk assessment measures than meaningfully interpret and convey their findings and limitations to other professionals. An additional dilemma for risk assessment is that outside agencies and professionals are anxious to have concrete recommendations upon which they can rely, while the most truthful reports will emphasize the difficulty of the task and urge caution in interpreting findings (Prescott, 2006; Rich, 2009). Another frequent quandary is how best to interpret research findings. From one perspective, a recent meta-analysis of risk assessment instruments for adolescents found them to have predictive validity that is rather close to those of adults (Hanson & Morton-Bourgon, 2005; Viljoen, Mordell, & Beneteau, 2012). However, the empirical study of risk assessment instruments for adults who have abused has involved many more studies and larger samples. A final dilemma for professionals may well lie in terminology, where risk assessment for adults typically involves judgments and predictions made regarding the next ten years to the rest of one's life, whereas the authors of the current measures for adolescents emphasize the importance of short-term assessment of risk and re-assessing youth as often as every six months. Risk assessment is simply different for adolescents than for adults, even as virtually every adult desires a way to predict the future behavior of young people. Under these conditions it is easy to misinterpret findings.

Given Nick's placement in residential care, a further dilemma involves the nature of residential treatment programming. Around the United States, the demand to implement "evidence-based treatment" has never been higher, including within institutions. At the same time, residential treatment is itself a venue that has no evidence base of its own. As mentioned earlier, the United States Surgeon General's report on youth violence (U. S. Department of Health and Human Services, 2001) found that residential treatment is ineffective for reducing youth violence. One might believe that this would settle any argument, until one considers the number of young people that cannot function under any circumstances without this level of care. The question for professionals may not be whether residential treatment should be abolished, but rather what is its best use. It might be that the best use of such programming is to stabilize young people enough that they can return to their communities and complete a sequence of meaningful treatment. While it can be easy to fault residential programs from a distance, their value becomes apparent when a family or agency is in desperate need for services that will prepare a young person to change, or provide an environment in which treatment and change can occur. Questions about residential treatment remain, however.

Research has shown a contagion effect from placing troubled young people in close proximity to one another (Dishion, Poulin & McCord, 1999), although this needn't be the case in all situations (Weiss, Caron, Ball, et al., 2005). After all, at their age young people are often more easily influenced by one another than by the adults who treat them. Seen from this perspective, the wisdom of implementing an evidence-based treatment curriculum in a program that hasn't first fully studied the research on contagion effects and taken every precaution to ensure that its treatment milieu is itself evidence-based seems questionable. Unfortunately,

1 The Abel Assessment for Sexual Interest and Affinity Measure of Sexual Interest are two commonly used measures of viewing time.

more of the systems for evaluating programs are based on juvenile correctional facilities (e.g., the Corrections Program Assessment Inventory; Gendreau & Andrews, 2001) than on residential centers treating adolescents referred by child welfare and other agencies.

Residential Placement. Nick's placement into residential treatment highlighted another dilemma in attempting to provide the most evidence-based services to Nick. Decades of research have pointed to the importance of three basic principles of treatment design and implementation. The *risk principle* holds that programs should allocate the most intensive services to those who need it the most. The *need principle* holds that treatment should target known risk factors for recidivism, and in particular needs related to each individual client, and, as mentioned earlier, the *responsivity principle* holds that treatment should be tailored to the individual characteristics of the client. Failure to adhere to these principles can, according to research, result in diminished effectiveness (for instance, Hanson, Bourgon, Helmus & Hodgins, 2009). In Nick's case, one could argue that, as a low-risk client, placement in a program in which he was surrounded by higher risk clients could actually elevate, rather than mitigate, his risk. However, his referring agency had little choice in this matter due to the absence of other services. Attempts to correct this mismatch of risk level and service provision were taken into account, and the professionals involved actively sought to keep his placement as brief as possible. However, a possible flaw in this plan was that in order to make the most of his therapeutic experience he needed to form a positive alliance with his treatment team despite knowing that he would not work with them for long.

While in the program, Nick received a number of services, including Aggression Replacement Training (ART; Goldstein, Glick, & Gibbs, 1998), which is recognized as an evidence-based practice. Among EBT curricula, ART is less flexible than many other approaches, including explicit instructions on arrangement of the tables in the room. In Nick's case, this worked well, and he appeared to benefit from the directive approach of the facilitator, which resulted in little ambiguity about physical or psychological safety during the class. To this end, ART was clearly beneficial where it might have been far more difficult to implement in a more traditional outpatient setting, suggesting that in this case, although ART is itself an evidence based practice, it may have been less effective, or ineffective, if not delivered in residential care.

As suggested earlier, there remain questions at the individual case level about what actually works in a situation like ART. Given that meta-analytical research in general psychotherapy has found that specific techniques and models account for very little of the variance in treatment outcome (Asay & Lambert, 1999; Wampold, 2001, 2010) this is no small consideration. Was it the thinking skills learned in ART that made the difference? Or did the relationship he formed with the confident, directive facilitator provide him with an experience in which he came to believe that he could build a better life for himself? Additionally, did the provision of ART in the residential treatment environment make a difference, adding to the effectiveness of ART in Nick's case, even though the provision of residential care is not considered to be evidence based? In other words, did the protocol itself actually make the change, or did Nick change himself based on the therapeutic factors of hope, expectancy, placebo, and self-talk to the effect of "I've completed that class and the facilitator even seemed to like me. I guess I can be a real person after all," and was the power of these factors more salient in the residential environment compared to an outpatient treatment setting?

Nick was discharged after several months and returned to his family. The ART and other forms of treatment had addressed his overall self-management skills and whatever attitudes and beliefs he had that were tolerant of sexual abuse. Nick completed a heartfelt process that involved accepting complete responsibility for his behavior in the presence of his cousin. He explained that he had worked in treatment to discover how he had come to abuse, and made a commitment to doing whatever it would take to prevent further abuse. Often known as "clarification," it has no direct evidence base whatsoever, but few who work with families where abuse has occurred doubt the importance of careful attempts at reconciliation and safety for the person who has been victimized.

Trauma Treatment. In order to ensure a smooth transition back to his home, Nick was provided with in-home services. In the state where this family resided, there was a major incentive towards providing an evidence-based treatment curriculum for addressing past trauma. Following on the heels of successful approaches such as exposure therapy (Foa, Hembree, Cahill, et al., 2005), the idea was that Nick would discuss thoughts, behaviors, and emotions related to having survived abuse. As a part of this, he would develop his capacity to describe his trauma history. However, for his part, Nick wanted no part of it. He was now 16 years old and wanted only to stand up for himself, complete his schoolwork, and get on with his life. With each day that passed, Nick felt more confident that he could make his mark on the world successfully. He had developed a number of social skills and – having been provided with a fresh start at the residential program – was eager to make begin again with a new peer group his own age.

The adults in Nick's life saw things differently. They were of the belief that if Nick did not re-visit and work though his past trauma he might be at risk for psychological distress later in his life. Although it is common for survivors of abuse and the professionals who treat them to emphasize the importance of allowing survivors to enter treatment in their own time and in their own way, the belief within the treating agency and the family was that it was better to provide this treatment now and make sure. Part of the logic was that no harm could come from expressing one's self and exploring one's life. Sadly, the available evidence does not support this perspective. It is now well established, for instance, that discussing traumatic events too soon after they occur can actually cause harm (Lilienfeld, 2007; Mayou, Ehlers, & Hobbs, 2000).

It was in the provision of trauma treatment that the numerous disparate perspectives on EBP became most clear. The therapist, Jackie, who had been included on a grant to roll this evidence-based curriculum out across the state, worked closely with a consultant. Following a typical pattern, Jackie would participate in telephonic supervision every two weeks. After a requisite period of time attempting to engage Nick in the process, she brought to the consult call the fact that Nick was adamant he did not want to recount his trauma history in the immediate or the distant future, and that he wanted to "move on" with his life. Familiar with this scenario, the consultant provided excellent assistance on how to overcome client reticence in an apparently collaborative fashion. The consultant was quite self-confident. Assuring Jackie that this was a common experience, the consultant hinted that the best way to break down client resistance was for Jackie to overcome her own internal resistance to pushing the client in this direction. However, the consultant's advice about pushing Nick in the direction of recounting his trauma history placed Jackie in a bind. She was not as convinced that this was the right time for Nick to discuss these experiences, and was concerned that she might lose whatever therapeutic alliance she had worked to build. Although the consultant's advice seemed certain to work in the short term, Jackie was concerned about the longer term work that she was endeavoring to complete with Nick. Further, Jackie felt divided in her allegiances. She had an ethical obligation to Nick, whose position was clear, and a contractual obligation with the consultant. At the same time, she had to cope with the unwritten expectations of the agency's licensors and funding sources that had made a commitment to this curriculum as part of a state-wide initiative. The consultant had already subtly suggested that it would reflect poorly on Jackie if she was unable to gain Nick's buy-in to telling his story about his traumatic experiences. After all, many high-quality therapists had overcome this challenge. To this point, Jackie and the consultant understandably saw Nick's case differently. The consultant was responsible for successful implementation of the curriculum, while Jackie was responsible for the case. In fact, Jackie had a license to practice in this state, while the consultant almost by definition was not engaged in actual practice.

Jackie took her concerns to her clinical supervisor, Vanessa, at the agency, who agreed that if Nick was not ready to discuss his history, alternative situations should be pursued. Vanessa was additionally concerned about the pressure from the consultant to follow the protocol, and questioned whether the vested interest in the curriculum didn't, in itself, pose a subtle conflict of interest. Further, Vanessa wondered about the possibility of boundary confusion: was the consultant providing consultation on curriculum implementation or the case itself? If it was the latter, Vanessa wanted it to be explicitly clear that she, not the consultant, was responsible for the supervision of the case.

Vanessa asked this question during the next consult call, and as a result of the discussion the consultant sent an email to the agency director and deputy commissioner to express concern that the curriculum was not being implemented properly

and that he was meeting with resistance from the agency. This led to the agency director ensuring that the staff would continue to work diligently to ensure that implementation would continue as quickly and efficiently as possible. He directed Vanessa and Jackie to continue implementing the curriculum and that should the treatment start to appear detrimental they could stop. The agency director did, however, express some frustration that the consultant had included so many stakeholders in his email rather than coming to him with concerns directly.

Jackie continued to work with Nick and eventually persuaded him to engage in a lengthy self-disclosure process. Nick agreed reluctantly, secretly hoping it would get the adults in his life off his back forever. The process was difficult; Nick lost sleep and became withdrawn. His new friends at school noticed that things weren't right with him, but felt he could not discuss what was happening with him. His adoptive parents became concerned and wanted to withdraw him from treatment, but felt compelled to continue as it was an expectation in order to prevent legal action due to his crime. Jackie noticed that Nick's presentation in treatment had taken on a slightly rote, even dissociated quality. Despite having earned considerable praise from the consultant, Jackie and Vanessa were concerned that treatment had done more harm than good in the long run. When treatment was over, Nick and his family requested – and received – a new therapist from a different agency.

There remains a question of how professionals account for their failures in administering evidence-based treatment curricula. Indeed, in Nick's case the application of one evidence based model, the trauma model that was provided despite Nick's resistance to it, seems to directly contravene the tenets of motivational interviewing, another evidence based model, which asserts that treatment providers should "roll with resistance," rather than pushing through resistance (White & Miller, 2007). Moreover, in this instance one could argue that the high-fidelity trauma curriculum was not EBP as applied to Nick because it met only one of the three criteria of the American Psychological Association's definition. Despite the curriculum's excellent basis in research, it was applied in a situation where clinical expertise suggested it was a poor choice, and it did not match the unique characteristics of the client. When treatment failed, the consultant could easily blame the implementation efforts, the deputy commissioner of the state agency could easily blame the treatment team, the agency director could blame circumstances, Vanessa could blame the consultant and/or Jackie, and Jackie could blame either the consultant or herself. Nick could say that he never wanted it in the first place. Only those furthest from actually working with Nick could console themselves with the fact that the approach had, at least, been evidence-based.

Like the movie *Rashomon*, each of the players in this situation had a unique perspective. The deputy commissioner was rightly desirous of making a science-based approach available to traumatized youth across the state; the science seemed clear that this approach would help the greatest number of adolescents for the money involved. The consultant legitimately wanted to contribute to creating better lives for as many children and adolescents as possible. The agency director's perspective was to help as many young people as possible, while keeping the agency growing. Vanessa, the supervisor, wanted the highest quality of care for Nick, and to remain poised to assist Jackie's long-term professional development as a clinician. Jackie wanted Nick to have a good life and to do her job well. Nick and his family's perspective may have been that he was forced to accept an unwanted treatment that met the agency's needs and mandates more than Nick's, and that the agency considered Nick's needs and preferences to be unimportant. Each of these views shaped the approach to and experience of treatment for each of the stakeholders, and the application what we might consider to be, or not to, evidence based treatment.

Outpatient Treatment and Sexual Interest. Having displayed no further behavioral issues, Nick's adoptive parents and case manager agreed that he could participate in outpatient treatment. Throughout his residential and in-home treatment programs, he had not addressed the sexual interest in prepubescent girls that had been revealed in his initial psychosexual assessment. To his credit, Nick was open with his outpatient therapist, Matt, and acknowledged that he continued to find young girls sexually interesting, even as he was now also dating a girl his own age. The therapist used cognitive behavioral therapy, as well as a computerized system for measuring overall therapeutic progress; this system had demonstrated its effectiveness in psychotherapy outcome studies. Just the same, the therapist was concerned that, despite Nick's improved self-management abilities, he still stated that he found younger girls attractive.

Matt consulted with other professionals, and found a software package that used aversive video vignettes paired with client self-recorded sexual fantasies. The evidence for this approach was slim (only one unreplicated study many years earlier), but enough that it seemed worthwhile. For his part, Nick was very interested in completing this process, as difficult as he sometimes found it to be. Where many therapists might have found it a questionable and intrusive practice, and certainly not an evidence based treatment, Nick nevertheless made it explicitly clear that it helped:

> *All the other things I've learned in treatment with you have helped. When I see little girls, I have these new tools for keeping myself away from trouble and focused on the things that matter. Before, I just had my thoughts and my coping skills. Now I actually have these images that come into my mind whenever I notice a little girl. It's actually making my relationship with my girlfriend better, which I never would have expected. This stuff is really hard, but it is really helping me.*

Nick's adoptive parents were initially concerned by the process, but reassured by Matt's confidence and Nick's positive descriptions of his gains, and happy enough with the results. In order to have tangible results to bring back to the case manager, Matt requested a re-examination of Nick using the same measures in order to provide assistance in determining next steps. Nick's risk assessment scores indicated even less risk than before, which was not surprising given his investment and progress in treatment. His clinical outcome scores also indicated progress. However, there was no change in his sexual interest scores when assessed by viewing time measures, which continued to demonstrate sexual interest in younger girls. Nick was deeply confused by this. This was not news to him, and he had been telling people all along that he was interested in younger girls, but was also grateful for the skills he had acquired, rehearsed, and enacted in order to manage that interest. At the same time, Matt was disheartened and concerned that this sexual interest hadn't been completely eliminated as he had hoped. Nick's parents silently wondered what it would take for the professionals in Nick's life to be satisfied with the progress that he'd made, but were reluctant to say anything due to their concerns that they might appear to minimize any treatment needs that might exist.

In this case, the *Rashomon Dilemma* has to do with differing perspectives on assessment and treatment. Nick had twice been assessed as being at low risk, and all indicators pointed to his having made considerable progress in treatment. The therapist was focused on Nick's risk and needs, whereas Nick and his family were more focused on his future, as well as his newly developed self-management skills. On the other hand, many professionals might have justifiably considered the use of the intrusive and aversive visual imagery introduced by the treatment software to be potentially harmful, as well as unproven. Nevertheless, Nick, who was discharged from treatment and entered a community college several months later, found the treatment to be highly valuable.

Here we see several different perspectives: Nick was focused on changes that he made, which allowed him to recognize and manage a problem. His parents' perspective was that Nick had made clear progress and was moving in the right direction, and that the continuing problem of sexual interest was now far less of a concern. Nick's clinician recognized and appreciated the progress made by Nick, but nevertheless had to balance the perspective provided by a risk assessment instrument that indicated lowered risk against the perspective provided by viewing time measures that indicated continued concerns with sexual interests. Other professionals may have taken the perspective that, despite Nick's positive experience with the treatment software in developing protection against troubling sexual interests, the use of the treatment protocol was not empirically validated and therefore not evidence based, and perhaps an example of treatment "quackery" (For instance, Mann & Barnett, 2013).

Conclusion

The advent of evidence-based practice definitions and empirically validated treatment protocols and curricula has enabled professionals working to prevent sexual violence to ask questions that would have been unimaginable twenty years ago, and ideally deliver treatment interventions that have provided evidence of their efficacy. In many ways, however, this work points to the remarkable work that lies ahead, described by Fixsen et al. (2005) in

terms of the immense amount of work that goes into successful implementation. However, our understanding, our development, and our application of evidence based treatments is far from complete, and as I hope we have seen remain subject, not only to continuing questions but also to the different, and sometimes subjective, perspectives brought to bear by different stakeholders in the application and interpretation of evidence based practice. The *Rashomon dilemma* address this very issue, an issue with which we must contend in our practice of evidence based treatment.

Further, studying specific the application of EBP on a case-by-case basis, as illustrated in this paper, can help guide our efforts to integrate science with clinical expertise, per the recommendations of the American Psychological Association (2008), while accommodating individual client characteristics, supported by the evidence-based principles of risk need, and responsivity. Where once a central concern was whether professionals had the data to show that treatment works, it is now time for every professional to ask whether they have the data that show that what they are doing works at the level of each specific client. Described by Hogarty, Scuooler, and Baker as far back as 1997, it is now "professionally correct to conclude that the results of controlled clinical trials should inform but not dictate practice" (p, 1107). Here, we must consider the effect and application of evidence based treatments in "the relatively uncontrolled environment" (Hogarty et al., p. 1107) in which our clients actually function and treatment is actually delivered, and in which we must address the *effectiveness* of a treatment, or how well as a treatment actual works in practice, at the level of the client.

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