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Using Mindfulness in the Treatment of Adolescent Sexual Abusers: Contributing Common Factor or a Primary Modality?

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Abstract

Although mindfulness has become a mainstream methodology in mental health treatment, it is a relatively new approach with adolescents, and perhaps especially youth with sexual behavior problems. Nevertheless, clinical experience and several empirical studies are available to show the effectiveness of a systematic mindfulness-based methodology for treating adolescents who engage in sexual and physical aggression. In this article, the authors first explore the elements of mindfulness that are inherent in traditional cognitive-behavioral therapy (CBT) and then review how mindfulness has been systematically incorporated into several "third wave" cognitive-behavioral therapies – ACT, DBT, MBCT, and MDT – each of which have been applied with adolescents. While it can be argued that mindfulness is a "common" therapeutic factor across approaches, mindfulness can also be considered to be, and applied as, a primary modality to enhance the effectiveness of most therapies with adolescents who engage in problem behaviors, including sexual offending. The key, however, is making modifications to accommodate the unique developmental needs of adolescents. A case example is presented to demonstrate the clinical application of mindfulness with an adolescent victim and perpetrator of sexual abuse.

Keywords

Mindfulness, sexually abusive youth, sexual offender treatment, cognitive behavioral therapy, mindfulness-based therapies, "third wave" cognitive therapies

Although the practice of mindfulness is centuries old, it was not applied as a stand-alone technique in clinical psychology until Fritz Perls (1969) attempted to unify mind, body, and spirit with Gestalt Therapy. Drawing from his studies of Zen Buddhism, Perls emphasized the principle of enhanced awareness in the present moment. Perls valued all forms of immediate awareness – sensation, perception, emotion, thought, behavior, and bodily feelings – and understood the natural therapeutic effects of staying with here-and-now experience. In the 1970s, others began to use the term "mindfulness" and began to apply mindful awareness in a systematic fashion (Kurtz, 1990; Kabat-Zinn, 1990). By the late 1990s, mindfulness had become a commonplace term in the field of mental health and is used today as a mainstream technique. The application of mindfulness to adolescents, however, is a relatively recent development and its recognized value with sexually abusive teenagers is just emerging (Apsche & DiMeo, 2010, 2012).

Mindfulness has been defined as the "intentional process of observing, describing, and participating in reality nonjudgmentally, in the moment" (Greco & Hayes, 2008, p. 4). In their definition for adolescents, Jennings and Apsche (2013, p. 5) define mindfulness as "being fully aware of your immediate present experience and accepting yourself as you are in this moment without judgment."

Although some empirical support for the direct use of mindfulness with adolescent sexual abusers is available, the first half of this article reviews the many indirect ways in which mindfulness has been incorporated into other mainstream cognitive treatment approaches that have been applied with adolescents. This raises the question of whether mindfulness is a method unto itself, or reflects a "common factor" across therapeutic approaches. The second half of the article presents empirical studies of mindfulness with adolescents, and presents a case example of how it can be applied in work with sexually abusive youth.

Mindfulness as a Therapeutic "Common Factor" in Traditional CBT

Of all the psychotherapies in mental health today, cognitive behavioral therapy (CBT) has become the predominant approach and, for better or worse, is the principal approach in the field of sex offender-specific treatment (Jennings & Deming, 2013). As such, our discussion of mindfulness begins with traditional CBT, which uses four main strategies to change thinking and behavior: skills training, exposure therapy, cognitive therapy, and consistency management (Young, Weinberger, & Beck, 2001). The exposure therapy component of CBT can be viewed as a process of immediate awareness. Although it may be intended differently, it contains the essential elements of an intense focus on immediate awareness, incorporating mental, physical, and emotional experience, and can yield therapeutic effects through the "acceptance" of the immediate discomfort and irrationality. More broadly, the classic CBT process of identifying and challenging the validity of cognitions can also be seen as a sort of mindfulness to the degree that the client is systematically and repeatedly "exposed" to his or her disturbing and dysfunctional thoughts and emotions and, hopefully, becomes increasingly able to tolerate and accept disturbing cognitions without negative self-judgment (Heimberg & Ritter, 2008). From a mindfulness standpoint, the key therapeutic element in CBT is having the experience of non-judgmental acceptance during the process of challenging negative cognitions, which occurs in the context of a mutually "mindful" relationship with the CBT therapist (Glass, Arnkoff, Woodruff, Maron, McMorran, Monahan, & Hirschhorn, 2013).

Over fifteen years ago, Martin (1997) argued that mindfulness can be seen as a "common factor" that cuts across therapeutic orientations, including CBT, psychodynamic, humanistic, and family systems therapy. The presence and value of mindfulness across treatment approaches has been similarly asserted by Bell (2009). With regard to CBT, specifically, it is argued that a mutual process of mindfulness is occurring on the part of both the therapist and the client (Glass et al., 2013). Mindfulness for the CBT therapist takes the form of consistent and focused attention on the client's thoughts and experiences, while consistently providing nonjudgmental acceptance of the client's reports of dysfunctional thoughts and behavior. Mindfulness for the CBT client takes the form of improving one's awareness of inner thoughts and experience, observing and gaining more tolerance and acceptance of negative thoughts and emotions, and learning to regard one's dysfunctional cognitions as distinguishable from one's core self and value as a person.

Mindfulness as an Explicit Technique in the "Third Wave" of CBTs

While there may be mindfulness elements in traditional CBT and other forms of psychotherapy, the explicit effort to integrate mindfulness and acceptance into traditional CBT has clearly revolutionized the field and spawned the so-called "third wave" of cognitive behavioral therapies (Baer, 2006). Among other therapies, these include, in published chronology, Mindfulness Based Stress Reduction (Kabat-Zinn, 1982); Acceptance and Commitment Therapy (Zettle & Hayes, 1986); Dialectical Behavior Therapy (Linehan, 1993); Mindfulness-Based Cognitive Therapy (Teasdale, Segal, & Williams, 1995); and Mode Deactivation Therapy (MDT) in 2002 (Apsche, Evile, & Castonguay, 2002).

Mindfulness Based Stress Reduction (MBSR). MBSR is a behavioral medicine program that translated the Zen Buddhism meditation techniques of Thich Nhat Hanh into a secular, classroom-based psychoeducational program for stress reduction. It was first introduced in 1979 as a treatment for chronic pain by Jon Kabat-Zinn (1982). in 1979, MBSR is not a therapy per se, but rather a group-based training curriculum that has been successfully applied to various clinical syndromes, including depression and anxiety. MBSR continues to be a widely used program, but it is mentioned here for its important historical role in popularizing mindfulness meditation and bringing it into mainstream clinical psychology.

Acceptance and Commitment Therapy (ACT). Developed by Steven Hayes and his colleagues in the mid-1980s, ACT retains the essential CBT focus on cognition, but shifts the focus from challenging or controlling cognitive distortions to simply noticing and "accepting" the occurrence of negative thoughts and emotions. ACT teaches clients to first become mindful through intensive focus on immediate awareness and then to accept their experi-

ences, rather than suppressing or avoiding them as unacceptable and judgmentally "bad." One of the strongest principles of ACT is helping clients to see themselves as being separate or different from their current negative thoughts and behaviors (Gutierrez & Hagedorn, 2013). ACT applies six core principles of acceptance, cognitive diffusion, contact with the present moment, observing the self, values, and committed action (Hayes, 2004; Hayes, Stroshal, & Wilson, 2013) and has been systematically applied to adolescents (Greco & Hayes, 2008).

The combined ACT principles of *contact with the present moment* and *acceptance* are virtually synonymous with the definition of mindfulness used in this article: immediate awareness of experience with acceptance (i.e., without judgment). The goal in ACT is to help clients to stay aware of their private memories, thoughts, and feelings without the need to change or avoid their experiences. *Cognitive defusion* is learning to reduce the tendency to reify thoughts, emotions, and memories by instead recognizing the transitory nature of thoughts, putting them into context, and making the distinction between one's dysfunctional thoughts and one's core self (Gutierrez & Hagedorn, 2013). *Observing the self* is learning to tap into a transcendent sense of self that is able to neutrally observe one's ever-changing experiences and emotions without judgment (acceptance). At its optimum, the person taps into a calm, deeper continuity of consciousness that is, in the Buddhist tradition, one's "true self," able to view oneself as universal and detached from current behaviors and private experiences. In turn, this transcendent perspective provides the opportunity for the client to discover and clarify his or her most important *values*, and then take *committed action* toward those valued life goals.

Dialectical Behavior Therapy. Published in 1993, Marsha Linehan's Dialectical Behavior Therapy (DBT) is a variation of CBT that teaches skills to cope with stress, regulate emotions, and improve relationships with others. Key components of DBT include cognitive behavioral therapy, validation, dialectics, and radical acceptance. Given her primary clinical population of borderline personality-disordered and suicidal clients, Linehan sought to modify CBT to accommodate their characteristic features of extreme emotional reactivity, high sensitivity to perceived rejection, and inability to self-soothe. To the degree that CBT repeatedly challenges the empirical and logical validity of the client's beliefs, Linehan's borderline clients felt as if their emotional pain was being discounted as not real, that their essential competency as a person was under attack, and that they were being rejected (as we will see later, this is a similar limitation of CBT with adolescents). Therefore Linehan adapted CBT by using *validation* as a way of showing an acknowledgement of the client's experience of real pain. The DBT therapist affirms that the client's illogical or maladaptive actions make sense as a valid attempt to relieve suffering and promotes cooperation with the client in finding healthier alternatives. Linehan, Cochran, and Kehrer (2001) describe the DBT principle of *dialectics* as on-going dynamic application of various therapeutic strategies. Dialectics is the principle that all things are interconnected, that change is constant and inevitable, and that opposites can often be integrated to form a closer proximity to the truth. For example, the DBT therapist and client work together to resolve what seems to be a contradiction between self-acceptance of oneself as is and changing oneself to be better. *Radical acceptance* is helping the client to allow her or himself to have all sorts of thoughts, urges, and ideas (even negative or forbidden thoughts that are typically suppressed), which spontaneously appear in the present immediate moment, but without negative self-judgment.

Mindfulness-Based Cognitive Therapy. Partly inspired by the mindfulness-based stress reduction program first developed by Jon Kabat-Zinn (1990), Mindfulness-Based Cognitive Therapy (MBCT) was created as a group program for the treatment of depression (Segal, Williams, & Teasdale, 2002). Like CBT, MBCT seeks to interrupt habitual ("automatic') negative thinking patterns that can trigger a depressive episode. Whereas traditional CBT focuses on negative thinking in order to challenge its validity, MBCT teaches the person to open his or her awareness to all sorts of incoming stimuli and to simply observe and accept all thoughts and experience without judgment. In MBCT, the clients are taught mindfulness in an eight-week group session format, learning to concentrate attention on their immediate experience, including negative, dysfunctional, and ineffective thinking and beliefs – but without judgment. By allowing and acknowledging the presence of negative thoughts and emotions without judgment or avoidance, the person gains a decentered, objective perspective that is better able to cope with emotional distress and more resistant to depression.

Mode Deactivation Therapy. Apsche developed MDT specifically to overcome the limitations of traditional CBT with disturbed adolescents, especially conduct disordered and aggressive youth. Apsche integrated Beck's (1996) theory of "modes" and schema therapy from traditional CBT with elements from Linehan's DBT and Functional Analytic Behavior Therapy (Kohlenberg & Tsai, 1993). Beck conceived of "modes" as powerful sub-organizations of the personality. Modes are comprised of integrated networks of cognitive, affective, motivational, and behavioral components, which originally developed as protective strategies and beliefs in response to traumatic and abusive life experiences. Modes are emotionally charged and become ingrained, maladaptive, "automatic" responses to perceived threats. Indeed, because clinically dysfunctional adolescents are instantaneously flooded with powerful anxiety, rage, and fear, Apsche et al. (2005) found that they were unable to override their primal, automatic "mode" responses by employing CBT-like cognitive controls. Given their volatility and histories of victimization, such youth are distrustful, guarded, fearful, and acutely sensitive to adult-child power issues in the therapeutic alliance. Like Linehan's borderline clients, Apsche found that traditional CBT was frequently counterproductive and alienating for adolescents. No matter how delicately it may be done, the CBT procedure of repeatedly challenging faulty thoughts and beliefs is negatively experienced by the youth as an attack on his or her fragile sense of self-esteem and world-view, which frequently backfires into increased resistance and distrust. This is especially problematic with dysfunctional adolescents, who have developed rigid beliefs and automatic dysfunctional "mode" responses to protect themselves from the pain and fear of trauma and abuse. Given the developmental primacy of autonomy for adolescents, even non-clinical teens can be highly sensitive to power dynamics with adults and may react with oppositional defiance when their beliefs are challenged.

To accommodate this inherent "oppositional" dynamic with adolescents, MDT adopted the principles of validation, radical acceptance, balancing, and mindfulness from DBT. Rather than challenging cognitive distortions and irrational beliefs, the goal is to join with the youth in collaboratively discovering how the individual's belief system is a legitimate reflection of his or her life experience, relationships, sense of self, and world view. MDT *radically accepts* the adolescent's beliefs as truths in his or her life, no matter how irrational, and even if there is only a "grain of truth." MDT continually *validates* the adolescent's perception of reality, accepting the youth for who he is based on his beliefs, which builds trust and collaboration with the therapist. Then MDT collaboratively applies *cognitive balancing* to introduce increasing flexibility or balance into the individual's rigid and maladaptive dichotomous (either/or) beliefs by opening consideration to a continuum of truth or a continuum of possibilities.

In particular, MDT uses direct training in *mindfulness skills* as a major intervention in the process of deactivating the adolescent's ingrained maladaptive "mode" responses (i.e., emotional deregulation). Given the resistance and reactivity of severely dysfunctional adolescents, Apsche and Jennings (2013) developed a diverse "toolkit" of non-threatening ways of teaching mindfulness skills, including breathing exercises, guided imagery meditation, visual concentration tasks, nature walks, sensory explorations, and intentionally fun exercises that incorporate sports and adventure to engage youth. The diversity of tools offers more ways of engaging youth and gives them the autonomy of choosing mindfulness exercises that they prefer. Since the mindfulness exercises are relaxing in nature, they do not trigger the emotional disruptions and oppositional reactivity of "modes." Moreover, the mindfulness exercises typically do not involve traditional "talking" therapy, which can often be experienced as aversive, intrusive, boring, or upsetting for teen clients.

Most importantly, the mindfulness training component of MDT serves multiple therapeutic purposes. Research with adolescent offenders has shown deficits in identifying, labeling, and managing emotions (Moriarty, Stough, Tidmarsh, Eger, & Dennison, 2001). Mindful focusing on immediate experience directly promotes the development of introspective awareness and helps the adolescent to learn to tolerate emotional pain, negative emo-

tions, and the anxiety of new experiences without avoiding them or losing control. Like DBT, the MDT mindfulness exercises provide opportunities for adolescents to regulate their emotional reactivity and let go of defensive hyper-vigilance. Through calm, neutral observation, adolescents learn to "accept" whatever experiences enter awareness – without negative judgment, reactive fear, aggressive outbursts, or harsh self-criticism – ultimately leading to greater self-acceptance and self-confidence in controlling dysfunctional behavior and emotional reactivity.

Applications of Mindfulness with Forensic and Offender Populations

Although limited, there has been a recent increase in efforts to apply mindfulness and acceptance-based techniques with forensic and offender populations. In their review article, Gillespie, Mitchell, Fisher, and Beech (2012) focused on the potential value of mindfulness with adult sex offenders, in particular, because negative affect and deficient regulation of emotional states often have a causal role in pathways to sexual offending (Hudson, Ward, & McCormick, 1999). In particular, they hypothesize that mindful breathing concentration applies directly to the neurobiological centers of emotional control. Howells (2010) has likewise recommended expanding the "third wave" of mindfulness-based cognitive therapies to include forensic mental health populations. In applying mindfulness to the treatment of anger and aggression, for instance, Wright, Day, & Howells (2009) state that "acceptance based approaches attempt to teach clients to feel emotions and bodily sensations more fully and without avoidance, and to notice fully the presence of thoughts without following, resisting, believing or disbelieving them (p. 398)." Samuelson, Carmody, Kabat-Zinn, and Bratt (2007) directly applied Mindfulness-Based Stress Reduction with male and female inmates to reduce hostility and mood disturbances and to improve self-esteem.

Berzins and Trestman (2004) reviewed six different adult forensic programs that used group-based psychoeducational programs in Dialectical Behavior Therapy, of which two had an explicit mindfulness training component. The Colorado Mental Health Institute program delivered three mindfulness sessions (8% of the total of 37 DBT group sessions) to male forensic patients, while the Correctional Services of Canada program delivered 6 mindfulness sessions (14% of the 42 DBT group sessions) to female forensic patients. No outcome data was reported for either program, but it appeared to help reduce overall physical and sexual aggression and rule-violations.

Finally, in a series of several studies, Singh and his colleagues (Singh et al., 2010) have used mindfulness to treat the aggression problems of adults with mental illness and adults with intellectual disabilities, as well as to manage deviant sexual arousal with adult sex offenders and adolescents with intellectual disabilities. Of particular interest to this discussion, the Singh group used five consecutive days of 30-minute training in mindfulness-based "meditation on the feet" to train three adolescents with autism to self-manage their physical aggression, reducing hitting from 14-20 events per week to 1 per year over three years of follow-up (Singh et al., 2007).

Applications of Mindfulness with Adolescents

The recent growth of interest in mindfulness interventions for youth is reflected in two recent reviews by Black, Milam, and Sussman (2009) and Burke (2010), who conducted the first systematic review of the available research. At that time, Burke found a total of only 7 studies of mindfulness with children and 8 studies with adolescents, most of which were preliminary and exploratory. One large randomized study applied the standard Mindfulness-Based Stress Reduction course (Kabat-Zinn, 1990) as an adjunct to "treatment as usual" (TAU) for a group of 102 adolescent outpatients with heterogeneous psychiatric diagnoses (Biegel, Brown, Shapiro, & Schubert, 2009). Participants self-reported greater reductions in symptoms of anxiety, depression, and somatic distress, and increased self-esteem and sleep quality compared to the TAU control group (without MBSR). Similarly, Zylowska et al. (2008) applied the same 8-week MBSR adult mindfulness training course with a mixed group of 24 adults and 8 adolescents with attention deficit hyperactivity disorder, which reduced self-reported symptoms of ADHD, anxiety, and depression, while improving performance measures in attention and cognitive inhibition tasks. Other examples of research showing the application of MBSR with youth include reduction of childhood anxiety (Semple & Lee, 2010) and improving behavioral control and attention for adolescents with ADHD (Van de Weijer-Bergsma, Formsma, de Bruin & Bogels, 2012).

In a broader meta review, Black, Milam, and Sussman (2009) reviewed 16 empirical studies of the health-related effects of "sitting-meditation" interventions with youth aged 6 to 18 years in medical, school, clinic, and community settings from 1982 to 2008, encompassing a total population of 860 participants. They found median effect sizes were slightly smaller than those for adults, ranging from 0.16 to 0.29 for physiological outcomes and 0.27 to 0.70 for psychosocial/behavioral outcomes (0.5 is considered a medium effect size, and a value of 0.8 or more is considered a large effect size). More specifically, 5 of the 7 studies of anxiety showed improvement, 1 of 3 studies of depression showed improvement, and 7 of 9 studies related to social-behavioral problems showed improvements in various measures of attention, attendance, self-esteem, and school behavior.

Overall, the application of mindfulness with children and youth is becoming well-established and growing, although most of it is focused on stress reduction and/or occurs in medical and school settings and typically entails group-based, classroom training like that of MBSR. The clinical application of mindfulness with adolescents with psychiatric disorders, however, is limited, with perhaps two exceptions. To the degree that DBT and ACT are mindfulness-based therapies, there is a sizeable literature dedicated to both the use of DBT with multi-problem suicidal adolescents (e.g., Miller, Rathus, & Linehan, 2007) and the use of ACT with children and adolescents (e.g., Greco & Hayes, 2008), but such a review would exceed this discussion. Moreover, neither DBT nor ACT is acknowledged as evidence-based practice for sexually reactive or sex offending adolescents.

Modifying mindfulness to meet the needs of adolescents

Although none of the above mindfulness studies involves adolescent sex abusers, a recent study by Jennings and Jennings (2013) is notable for its practical recommendations by which to modify traditional adult mindfulness training to meet the differing developmental needs and interests of adolescents. Each of these modifications can be valuable in work with sexually reactive and sexually abusive adolescents. The first, and most important, assertion is that adolescents respond well to *guided imagery* protocols that incorporate mindful breathing concentration (as long as the skills training is delivered in relatively brief sessions and has appealing content). Based on the methods of MDT, mindfulness guided imagery is a spoken protocol that guides adolescents through an imagined mountain climbing adventure, or a day at the beach, or some other peaceful and safe scenario, while frequently drawing attention to focused breathing and acceptance throughout (Apsche & Jennings, 2013). Youth thus enjoy the relaxing sensations of the experience while actively learning the mindfulness skills of focused breathing, meditative concentration, and acceptance. Critics might reject this guided approach as too structured, arguing that "true" mindfulness should be completely open-ended, allowing any thoughts, images, or feelings to spontaneously enter awareness. Instead, this modified approach for adolescents endeavors to create conditions that are conducive to mindful attention and acceptance, using guided protocols that frequently acknowledge the appearance of spontaneous thoughts and instructing the youth to simply notice the thoughts and let them pass on.

The second recommendation from Jennings and Jennings (2013) is that the content of the guided imagery should be *fun and engaging* and should offer a varied "toolkit" of mindfulness exercises and activities that have an innate appeal to youth, such as sports, nature, adventure, and discovery (Apsche & Jennings, 2013). As practiced in MDT, it is important to present adolescents with *multiple pathways* for learning mindfulness skills, which better accommodates the differing learning styles and preferences of individual teens. This toolkit approach also fosters the adolescent's developmental need for autonomy because each teen is allowed to try various mindfulness tools and choose the ones that work best for him or her.

The third recommendation from Jennings and Jennings (2013) is to deliver mindfulness skill training in *shorter experiential sessions*, which is better suited to the shorter attention spans of youth. Traditional adult programs for mindfulness training require about eight weeks of extended class sessions

(Carmody & Baer, 2009; Segal, Williams, & Teasdale, 2002). In fact, the most widely used program of Mindfulness-Based Stress Reduction entails one 6-hour class and eight 2.5-hour classes (Kabat-Zimm, 1990). However, Jennings and Jennings allowed a teenager to select and deliver a series of mindfulness exercises to a non-clinical group of eight high school peers in just four 50-minute sessions. Results from the 3-week pilot study showed a surprisingly strong reduction in cognitive anxiety and mild reductions in social anxiety. Given the prohibitive time demands of attending an eight week program like MBSR, other researchers have begun testing mindfulness interventions that require fewer hours and/or a shorter period of time. In fact, a recent review showed no evidence that shortened versions of MBSR were any less effective than longer formats with adults (Carmondy & Baer, 2009).

MDT: Applications of Mindfulness with Adolescent Sexual Abusers

To the best of our knowledge, Mode Deactivation Therapy is the only mindfulness-based treatment that has been empirically validated with sexually abusive adolescents. There is a strong body of research studies and meta-analytic studies that show the effectiveness of MDT with a variety of disturbed adolescents. In one randomized controlled experiment, Apsche and his colleagues (Apsche et al., 2005) compared the effectiveness of traditional CBT, Social Skills Training (SST), and Mode Deactivation Therapy (MDT) for 60 male adolescents with serious sexual and physical aggression problems, with an average length of residential treatment of 11 months. While all three therapies were effective in reducing rates of physical aggression, only MDT, with its focus on mindfulness, demonstrated a significant reduction in rates of sexual aggression. Two years following treatment, the recidivism rate for the MDT group was 7% with no serious offenses, such as sexual offenses or physical assaults (Apsche, Bass, & Siv, 2006). By comparison, 20% of the CBT group engaged in chargeable offenses, including sexual aggression and physical aggression, auto theft, and drug sales, while 49.5% of the SST group committed offenses, including attempted murder, rape, aggravated assault, and other serious offenses.

In another study, Apsche, Bass, Zeiter, and Houston (2009) compared the effectiveness of Family MDT with "treatment as usual" (TAU) family therapy and CBT family therapy for 40 adolescents with sexual and physical aggression problems and oppositional behavior. After 18 months, the 20 adolescents in the MDT group showed three incidents of physical aggression compared to 12 incidents for the TAU group.

Apsche and DiMeo (2010) conducted a meta-analysis of the effectiveness of MDT over the course of ten years of application, which included data from all published MDT studies as well as yet unpublished studies. Of the total of 458 male adolescent cases reviewed in the meta-analysis, more than half had sexual offenses (55.5%), while roughly half were diagnosed with conduct disorder (52%), oppositional defiant disorder (45%), and Post-traumatic Stress Disorder (51%). Collectively, 92% of the adolescents had experienced four types of abuse, 54% had witnessed violence, and 28% presented with parasuicidal behaviors. The meta-analysis showed large effect sizes for the use of MDT for the categories of Sex Offender/Physical Aggression (1.78), Conduct Disorder/Physical Aggression (1.85), Total Physical Aggression (1.82), and Sexual Aggression (1.80), in which, as previously noted, effect sizes of 0.5 are considered medium and values over 0.8 represent large effect sizes. This suggests that a mindfulness based approach, such as MDT, is effective in treating complex conditions and behaviors, including sexually troubled behavior.

Subsequently, Apsche, Bass and DiMeo (2011) conducted a larger meta-analysis of MDT effectiveness with a total of 573 adolescents, including 369 adolescents with sexual aggression. The results again showed large effect sizes for Sex Offender/Physical Aggression (1.81), Conduct Disorder/Physical Aggression (1.85). Total Physical Aggression (1.86), and Sexual Aggression (1.94).

Based on the empirical and meta-analytic data, there is strong support that MDT, a mindfulness-based treatment, is effective with a variety of disturbed adolescents, including sexually reactive and sexually offending adolescents, and demonstrates that a systematic mindfulness-based methodology can reduce both sexual and physical aggression in adolescents (Apsche & DiMeo, 2010, 2012; Apsche, Bass & DiMeo, 2011).

Thus, by helping adolescents to stay focused in the here-and-now, rather than in the past or future, as suggested by Apsche and DiMeo (2012), mindfulness can enhance the effectiveness of most therapies with adolescents who engage in problem behaviors, including sexual offending.

Case Example: Applying Mindfulness with an Adolescent Sexual Abuser

The following transcript of a therapy session with an adolescent sexual abuser, excerpted from Apsche and DiMeo (2012), illustrates a blended application of traditional CBT techniques with mindfulness and acceptance techniques from ACT, DBT, MBCT, and MDT as briefly described earlier and shown in table 1 below. The client is a 16-year–old male, who was arrested for having repeated intercourse with an underage female. As a child, from ages 7 to 9, he was abused and repeatedly raped by his stepfather. After failing to respond to outpatient treatment, he had also been terminated from a day program and residential treatment for aggression and fighting. This therapy session was conducted in a subsequent residential program for sexually abusive youth, using various techniques drawn from CBT, ACT, DBT, and MDT (presented in italics).

Therapist (T): Let's take a second and do some breathing before we talk about anything. [*Typically, the MDT therapist both begins and ends the therapy session with a brief five-minute practice of mindful breathing.*]

Adolescent (A): Okay…

FIVE MINUTES LATER…

(T): Open your eyes and allow yourself to get focused in this moment. [*Use of mindful here-and-now awareness.*] Are you good?

(A): I feel like I am moving through these painful feelings and thoughts in a different way than I have in the past with other therapists. [*Based on prior mindfulness training, the adolescent has learned to allow painful memories and emotions to enter awareness and observe them without judgment.*] Now what?

(T): Well, let's talk about it. You have let yourself think these thoughts and feel the pain and you are still here. [*Acceptance and validation*.] So, is it possible that you can accept that these painful thoughts and feelings are part of you, whether it sucks or not? [*Cognitive diffusion: distinguishing core self from the experience of dysfunctional thoughts and painful emotions.*]

(A): Yeah.

(T): And, it's clear you can experience them and not fall apart. [*Validation*.] Can you then commit yourself to move on with all of your pain and thoughts and not let them control your life? [*ACT commitment and cognitive balancing.*]

(A): I can try, but this isn't easy.

(T): You are right. It's not easy. [*Validation.*] However, you have just successfully accepted that they are part of you and you can move on with your life. [*Acceptance and cognitive diffusion*.]

(A): Yeah, I did.

(T): So, maybe there are also times when there are no painful feelings and thoughts? [*Cognitive balancing*.]

(A): Maybe, sometimes there are.

(T): In the last session, we discussed how you couldn't feel anything.

(A): Yeah, I am numb. Empty.

(T): You endorsed the beliefs "Anything is better than feeling unpleasant" and "Whenever I hurt, I do what it takes to feel better" as "Always." Remember? [*CBT. The therapist is referring to an earlier assessment of beliefs endorsed by the client*.]

(A): Yeah, so?

(T): Let's talk about your emptiness and numbness.

(A): Okay.

(T): Tell me what your numbness feels like. [*Mindful here-and-now awareness*.]

(A): It feels like nothing.

(T): And, where is the nothing?

(A): What do you mean, where?

(T): Where on or in your body do you notice the nothing—the emptiness and numbness? [*Mindful here-and-now awareness*.]

(A): [Points to chest.]

(T): Where on your chest? [*Mindful here-and-now awareness*.]

(A): Here, right in my chest.

(T): Describe how the numbness feels. What does the emptiness feel like in your chest? [*Mindful here-and-now awareness*.]

(A): It feels like an empty hole.

(T): What do you notice about this emptiness? Is it there to protect you from pain? [*MDT validation of the protective function of dysfunctional modes*.]

(A): What pain?

(T): The pain of your past physical and emotional abuse. The pain you feel from your mother not being able to take care of you. [*MDT validation of the protective function of modes. While this intervention appears overly directive, it is referring to insights gained by the youth during preceding treatment sessions*.]

(A): No, there was pain there, but I cut it off.

(T): Okay, describe that pain that was there. [*Mindful here-and-now awareness*.]

(A): It was like a burning hole in my chest, like my heart had hot burning lava in there.

(T): Okay, let yourself experience that pain. The hot lava right here [points to chest]…right now. Let's sit with it. [*Mindful here-and-now awareness and acceptance*.]

FIVE MINUTES LATER…

(T): What are the painful thoughts that go with this numbness and pain? [*CBT*.]

(A): I am alone—no good. I am shit, like trash.

(T): Let yourself experience these thoughts and pain. [*Mindful here-and-now awareness and acceptance*.] You know that you have spent your life avoiding these painful thoughts and feelings. They are really hard as hell to deal with. [*Validation. This seemingly directive intervention is referencing insights gained by the client in previous sessions*.]

(A): Yes, it really sucks sometimes that I have to live with pain and bad memories, but at least I can live with them and finally move on in my life. [*Acceptance and ACT commitment*.]

(T): It's not easy, but you have just successfully accepted that they [painful feelings] are part of you and you can move on with your life. [*Validation and cognitive balancing*.]

(A): Yes, I did.

(T): So, you agree that you can experience painful or numb feelings and be okay at times? [*CBT and cognitive balancing*.]

(A): This time.

(T): It makes sense that you are in therapy given your history. Your childhood was filled with hurt and anger and being on your own most of the time. [*Validation*.]

(A): You know it.

(T): So you being here with all these feelings of anger and hurt makes sense and it is where you need to be, but you also can experience your painful thoughts and emotions and be okay. [*Acceptance, validation and cognitive balancing*.]

(A): I don't know if I can.

(T): I mean right now in this moment, you can experience unpleasant feelings and be okay. [*Mindful here-and-now awareness*.]

(A): Right now, yeah.

(T): Tell me how much you really believe you are okay experiencing these painful thoughts and feelings on a scale of 1 to 10, right now. [*CBT*.]

(A): Maybe a 6.

(T): So, 60 percent of the time, you, in this moment, are able to experience unpleasant feelings and be okay. [*CBT and cognitive balancing*.]

(A): Yeah, I need more work with this shit, though.

(T): You will keep working on it, because it works and you are important and can experience some good stuff in life. [*Validation and cognitive balancing*.]

(A): Okay.

(T): Can I ask one more thing? You had endorsed the belief "Always," for "Whenever I hurt, I do what it takes to feel better." Right? [*CBT. The therapist is referencing an earlier assessment of beliefs endorsed by the client*.]

(A): Yeah.

(T): So, before, what did you do to feel better? [*CBT*.]

(A): Fight, drink, smoke weed. You know, stuff like that.

(T): Okay, but you just experienced painful thoughts, hurtful feelings and that hot lava—and you said you could deal with it 60 percent of the time, right here and now. Right? [*CBT and cognitive balancing*.]

(A): Yeah, so?

(T): So, is it possible to hurt and be okay with it in this moment? [*CBT and cognitive balancing*.]

(A): Yeah, right now I can.

(T): So right here and right now in this moment, you can hurt and be okay and not have to fight, drink, smoke weed, or any other stuff like non-consensual sex? [*Mindful here-and-now awareness and cognitive balancing*.]

(A): Yeah, right now with you.

(T): That's where it starts. Good work for today! We'll continue working on this next session so you can feel numbness and pain and be okay in the moment… Now, let's end the session with a breathing mindfulness exercise…

Conclusion: Mindfulness as a Common Factor across Therapies or a Primary Modality?

Besides discussing and, we hope, demonstrating the value of a mindfulness approach in the treatment of sexually abusive youth, an essential question posed is whether mindfulness is actually a "common factor" that permeates all effective CBT and other therapies, or whether mindfulness is, in itself, a primary and distinctly separate modality that can be used in combination with CBT and other third wave cognitive therapies, and perhaps other models of therapy as well. For instance, we believe that a practitioner of traditional cognitive therapy would be comfortable with the therapy session presented above, which appears familiar as an appropriate effort to identify, challenge, and correct irrational beliefs such as "I am shit" and "I cannot experience painful feelings without getting high or sexually abusing someone." However, from a "common factor" perspective, a mindfulness component is both implicit and pervasive in CBT through its repeated focus on dysfunctional beliefs and the mutual mindful attention of both client and therapist on the client's inner thoughts and experience. This is mindfulness in action, and embedded into CBT at its deepest level. From this perspective, mindfulness is central to all forms of therapy that address self-awareness, and is, accordingly, a common factor in effective treatment, described by Martin (1997) as cutting across all therapeutic orientations.

Table 1. Techniques and principles of applied cognitive behavioral therapies

Therapy Model	Main Techniques or Principles
Cognitive Behavioral Therapy	• Skills training • Exposure therapy • Cognitive therapy • Consistency management
Acceptance and Commitment Therapy	• Contact with the present moment • Acceptance • Cognitive diffusion • Observing the self • Values • Commitment
Dialectical Behavior Therapy	• Validation • Dialectics • Radical acceptance • Skills training (emotional regulation)
Mode Deactivation Therapy	• Mode deactivation • Validation (radical acceptance) • Mindfulness skills • Cognitive balancing

From the "primary modality" perspective, however, the above therapy session shows that mindfulness can be actively and deliberately *applied* "on top" of a session (rather than *occurring* as an on-going common underlying factor) to: (1) continually maintain the youth's focus on immediate experience, and (2) to observe dysfunctional cognitions and affect with non-judgmental acceptance. Absent of any empirical research, however, it is not possible to do any more than conjecture whether the mindfulness experience is a common factor or is itself a treatment modality applied to, but not necessarily an underlying element, that is central to all forms of effective cognitive behavioral therapy.

In either case, our belief is that the mindful, here-and-now focus on immediate experience is the essential therapeutic condition that makes it safer and more meaningful for the youth to explore, accept, and overcome dysfunctional cognitions and maladaptive behavior. Thus, although mindfulness can be applied to any form of psychotherapy, including cognitive behavioral therapies, to increase the impact of treatment interventions, it is also clear that treatments that fail to introduce a component of mindfulness are less likely to be as effective. We can think of mindfulness, then, as both a principal modality that can be added to a therapy to increase its effectiveness and as a common underlying factor in effective treatments.

Themes and discussions of mindfulness have become more present in the literature of the field of sex offender-specific treatment; we hope that this article furthers and helps strengthen that direction, and the field's increasing recognition of the importance and centrality of mindfulness in treatment. Moreover, we believe that mindfulness training is especially valuable in the treatment of sexually abusive and sexually reactive adolescents, both victims and perpetrators, because it provides a non-threatening therapeutic experience that is less likely to trigger extreme emotional reactivity and oppositional hostility, while promoting personal safety and trust in the therapeutic relationship.

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