



May God defend me from my friends; I can defend myself from my enemies.
— Voltaire

The scientific and professional community must be open to the possibility that intentions to help may inadvertently lead to unintentional harm.
— Dishion, McCord, & Poulin

Delinquency Training

A discussion of: Thomas Dishion, Joan McCord, & François Poulin, "When Interventions Harm: Peer Groups and Problem Behavior", *American Psychologist* [September 1999: 755-764].

Modality & Outcome (Effectiveness)

In children's & youth programming, there are three primary service "modalities" – *individual, family, and group*. Each of these comes in a variety of forms,¹ and each offers a different profile of advantages and disadvantages. Overall, however, research seems to indicate that every modality is as effective as any of the others. Another way of saying this is:

... the effectiveness of therapy does not depend on the modality in which it is delivered.²

Or does it? Could it possibly be that the structure and form of therapy might – *under certain circumstances* – influence its effectiveness? And if so, is such influence positive (beneficial) or negative (harmful)? And what exactly are the circumstances that determine such an influence?

As it turns out, the magnifying glass of therapy outcome research does seem to make a credible case that *sometimes the modality of therapy can have a harmful impact*. This conclusion is particularly important for those of us working in the youth justice system because:

- (a) the problematic modality identified in the research just happens to be the one that dominates our type of programming, and
- (b) the aggravating circumstance that negatively influences this modality just happens to define the entire youth population that is our bread & butter.

In effect, this research concludes that:

... group programming (e.g., group counselling, guided group practice) with juvenile delinquents is positively associated with "increases in delinquency, substance abuse, violence, and adult maladjustment."³

Of course, we have known for some time (decades, in fact) that one type of group programming – i.e., custody – has been associated with increased recidivism: the longer and more frequently a youth is incarcerated, the more likely he or she is to re-offend. However, the conclusion of this research on group modality with juvenile delinquents cuts much deeper than just recidivism rates – it challenges our profession to look at other, more extensive forms of harm that may be the unwitting result of simply clumping criminally-inclined youths together.

The "Group" Modality

Since its formalization within psychiatric practice in the early part of the twentieth century,⁴ group therapy has enjoyed its share of both

National Academy Press, 2001] and McCord, "Crime Prevention: A Cautionary Tale" (2001, paper presented at the Third International, Interdisciplinary Evidence-Based Policies and Indicator Systems Conference).

⁴ While "group" practice first became self-conscious and elaborated theoretically within Psychoanalysis (rather than its competitor, Behaviorism), we can actually trace its therapeutic roots back much further. According to University of Toronto historian Edward Shorter, it was the discovery that mental asylums could be more than just custodial institutions – in other words, that *grouping* mentally ill people together could have a therapeutic (curative) effect - that led to the birth of psychiatry as a discipline: "It was not the notion that madness was curable that changed at the end of the eighteenth century ... Rather, it was the notion that institutions themselves could be made curative, that confinement in them ... could make the patient better. This insight broke in an almost revolutionary way upon the scene." [A History of Psychiatry, 1997] Some of the explanations given at the time for the success of the asylums were purely functional – e.g., asylums concentrated medical specialists in one place (thereby making expertise more readily available to more people), or asylums simply removed people from the bad family environments that sustained and nourished their mental illnesses. Other explanations, however, were more analytical. Many early psychiatrists identified two key aspects of the asylum experience: (1) the doctor-patient relationship (which, tellingly, was understood as fostering both a sense of *acceptance* and a sense of *hope*); and (2) an orderly routine of diet, exercise, and community involvement. Regarding this last element (community involvement), it was postulated that having to deal with 'strangers' forced the mentally ill person to "exert their faculties", which was the first step in recovery because it engaged "regular thinking". We can see here the

¹ For example, "family" counselling can be couple-based, parent/child, or multi-generational – and "group" counselling can be, amongst other things, office-based (weekly sessions), school-based, conjoint, or residential. Each modality also has a range of "models" that can be used within them – for example, psychoanalytic, systemic, solution-focused, narrative, gestalt, etc., etc.

² See *What Works [Who Works]* in *Talking Incoherently*, v.1, #1.

³ Dishion, McCord, & Poulin [op. cit.]. See also: Joan McCord, Cathy Spatz Widom, & Nancy Crowell, *Juvenile Crime, Juvenile Justice* [Washington:

critics and defenders. The defenders have usually built their case for supporting group interventions around three points:

- (1) A “group” offers unique possibilities for therapy. Unlike the *individual* modality, which capitalizes on a person’s internal psychological resources (e.g., cognitions, affect, habits) – and unlike *family* therapy, which profits from the person’s closest social attachments (e.g., nurturance, authority, sibling differentiation) – *group* therapy accesses the power and resources of our broader social nature (e.g., desire to belong, recognition/status, cooperation/competition, dominance/submission, conformity, companionship, romance, play/fun, etc.).⁵ Such broader resources bring a wider variety of change mechanisms into the therapeutic situation, affording novel ways to help clients change.

Comment: Permit me to give a rather long example of a change mechanism that is unique to the *group* modality. This example will both (a) clarify the way in which *group* intervention is different from *individual* and *family* intervention and (b) foreshadow the dynamic that is presented as problematic in the Dishion, McCord, & Poulin article.⁶

There is a general assumption in therapeutic work that “beliefs” and “actions” want to be consistent. If a person becomes aware that there is a contradiction between his beliefs and his actions, he experiences a mental discomfort that the psychologist Leon Festinger called “cognitive dissonance”. This discomfort can be relieved either by (1) changing one’s beliefs or (2) changing one’s actions. [Interestingly, these options are not equally likely: it is far easier to change one’s beliefs to conform to one’s actions (option #1) than the alternative. But I’m getting ahead of the story.]

Another general assumption in therapeutic work is that a person will accept responsibility for his behavior *if he believes that he has freely chosen the behavior*, rather than being coerced or tempted by external pressures (like rewards or punishments⁷ or promises or threats). Behavior that is chosen – rather than coerced or tempted – is believed by most people to be a reflection of who they truly are. It is, therefore, experientially difficult to deny, disavow, or blame it on other people.

Taking the two assumptions above into consideration, if we want to help a person change, we must do two things – that is., we must establish two necessary conditions: (1) get him to act in a way that is

usually hidden role that the *group modality* played even at the beginning of the modern enterprise of therapy.

⁵ Of course, this particular rationale did not form part of the earliest understanding of the *group* modality. Most early theorists interested in groupwork were psychoanalysts. From their perspective, a group was little more than a human screen onto which the client would project his/her own family dynamics. Just as the client “transferred” feelings about his family onto the therapist, he was similarly disposed to transfer feelings about his father, mother, and siblings onto the other group members. In this conceptualization, the group was reduced to the family – with the consequence that all of its unique therapeutic resources were overlooked. [Again, this is a classic example of what I called “canary thinking” in *What Works [Who Works]*.]

⁶ This example is an elaboration of material found in Denise Cummins’ *The Other Side of Psychology* (1995).

⁷ See a previous *Talking Incoherently* article entitled *Prisms, Pink Waistcoats, Praise & Punishment*.

inconsistent with his beliefs⁸ (i.e., create cognitive dissonance as a motivation) and (2) make him believe that such an action was neither coerced nor tempted, but was freely chosen.⁹

If we were to approach this task from the *individual* modality – for example, using cognitive-behavioral interventions – we could create dissonance by examining & challenging (i.e., *restructuring*) the clients belief system (a *cognitive* approach) or by rewarding or punishing (i.e., *promoting* or *extinguishing*) his actions (a *behavioral* approach). In a similar way, we could work on his sense of responsibility. In short, using this modality we would rely upon *personal* dynamics like *reasoning* and *reinforcement*.

By way of contrast, if we were to approach this task from the *group* modality, we could access entirely different therapeutic dynamics. One of these dynamics is *conformity* – in many areas of life, people will act not in accordance with their beliefs, but in compliance with the actions of others around them. This is a powerful and mostly unconscious dynamic – and it is made more powerful (a) as group size increases and (b) when the person’s action is performed in the presence of the group (or when the person believes the group will learn about his action in some manner).¹⁰

Why should conformity be so influential? Why does it so frequently override our independent judgement? “Why do we conform so readily?” asks Denise Cummins (*op. cit.*) “Perhaps it’s because (James Dean notwithstanding), we tend to like conformers more than nonconformers.” The compulsion behind conformity, therefore, is our desire to be liked. But it doesn’t end there. There are other reasons why conformity is so powerful: “Within limits, this tendency to let the beliefs of others influence our own beliefs is perfectly justified. What other people think and how other people behave are important sources of information about what is correct, valid, or appropriate. Other things being equal, the greater number of people who believe something, the more likely it is to be true; the more people who do something, the more we are well-advised to do the same.”¹¹

Being liked and being well-informed, of course, are important because they have huge survival value: both are primary mechanisms for ensuring our reproductive success. If we are not liked or not well-informed, we will have difficulty attaining the *status* that ensures

⁸ In most kinds of “talk therapy”, we actually approach this condition the other way around – i.e., we try to get the client to believe in ways that are inconsistent with his actions, on the assumption that beliefs somehow direct action (like software in a computer). While such an approach works for some behavioral situations, it is generally a limited approach.

⁹ Unfortunately, by presenting a general case about change, the language I use here makes therapy sound far more manipulative than it really is. I don’t want to create a false impression. People *regularly* act in ways inconsistent with their beliefs – so therapy is more about helping them become aware of such inconsistency than it is about *creating* it. Similarly, *very few* actions are totally coerced or totally bribed – there is always some small element of *choice*. Again, therapy is more about helping the client understand this element than it is about creating it.

¹⁰ Not to be political, but one can see the tremendous power of conformity in the actions of the guards at Abu Ghraib. Possibly such abusive behavior was well within the ethics of some guards, but most participants had family & friends that were profoundly mystified by it: they would never have believed that the person they knew could do (or permit) such things. In these cases, behavior was determined not by character, or past experience, or genetics – but by the context of the moment as the group defined it.

¹¹ Thomas Gilovich, *How We Know What Isn’t So* (Toronto: 1991).

access to social resources – and our chances of attracting sexual mates will be greatly reduced.

Conformity, then, facilitates change in a person's beliefs & actions by fostering the first condition of our task (i.e., creating cognitive dissonance). But what about the second condition (i.e., the person's conviction that the action was freely chosen)? Surely "group conformity" must be an obvious *external* pressure – and, therefore, easy to blame for any behavioral deviation. Conformity may bring a dissonance between belief and act, but surely this won't be sustained once the individual is out from under the spell of the group.

Not necessarily. This is where another group dynamic typically comes into play. One of our species most powerful motivators is our desire to "save face" – i.e., to maintain status and prestige in the eyes of others. "We assume that humans desire food, clothing, and shelter, but we forget that people crave something far more vital: status and prestige. They yearn to move up in the pecking order!"¹² Having conformed to some particular group action, then, a normal person does not want to lose the prestige gained by such conformity: he will preserve his commitment to the action even if it means abandoning or modifying his beliefs. Most importantly, this desire to save face is experienced by the person not as an external pressure but as a strong *internal* desire. As Adam Smith pointed out in the mid-eighteenth century: "Nature, when she formed man for society, endowed him with an original desire to please, and an original aversion to offend his brethren. She taught him to feel pleasure in their favourable, and pain in their unfavourable regard." This internal feeling of pain or pleasure fulfills the second condition necessary for change – i.e., it establishes the person's action as freely chosen, the result of an internal *desire* not an external coercion or bribe.

Now, back to the defense of the group modality ...

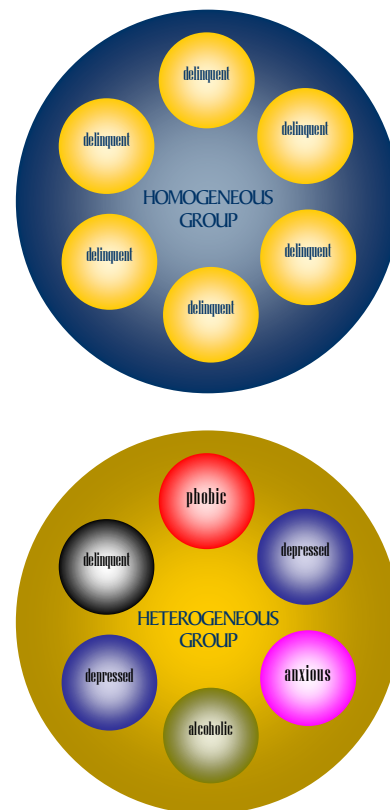
- (2) A "group" helps maximize a person's problem-solving resources by bringing together people with the same problem. This concentration permits three therapeutic advantages: (i) it establishes a *support system* of people who understand the problem faced by the client and who *empathize* with him/her; (ii) it provides a broader range of perspectives on and experiences with the problem than just that of a single client and therapist (and, therefore, more possibilities for a solution); and (iii) it reduces the likelihood that the client can deny, justify, or rationalize his behavior because his thought processes will be evaluated and challenged by a group of people intimately familiar with the problem.¹³

Comment: Therapeutic groups that bring together people suffering from the same problem (e.g., a group comprised of just sexual perpetrators or one with just delinquents) are called *homogeneous* groups. Those that bring together people with different problems (e.g., a group comprised of a depressed person, a sexual perpetrator, an alcoholic, a delinquent, and a person with an anxiety disorder) are

called *heterogeneous*.¹⁴ [See Diagram I] Most research has been done on homogeneous groups because they are the most common type. As a result, the research on group effectiveness in general is somewhat biased: there is hardly any convincing evidence (either positive or negative) about the comparison of the effectiveness of homogeneous versus heterogeneous approaches.

This issue is important clinically because some advocates of heterogeneous group programming have long contended that homogeneous groups do not really offer all the advantages outlined in #2 above – or, rather, that such advantages are only half the story. From their perspective, homogeneous groups often perpetuate or deepen the shared pathology (i.e., problem) by reinforcing negative group dynamics and perceptions.¹⁵ Certainly, this seems to be a conclusion that is supported by the research presented here on group programming with adolescent delinquents (i.e., Dishion, McCord, & Poulin). It's part of our task in writing this paper to understand just what these negative dynamics might be.

DIAGRAM I: HOMOGENEOUS VS. HETEROGENEOUS GROUPS



The potential negative impact of homogeneous groups shows up in more than just the delinquent adolescent population. In 1997, two

¹² Howard Bloom, *The Lucifer Principle* (1995). Compare this statement with Maslow's Hierarchy as laid out in the previous article *Prisms, Pink Waistcoats, Praise & Punishment*.

¹³ One psychoanalytic group theorist cleverly called this capacity of group dynamics "outsight" – i.e., the ability to understand the behavior of others and to help them – in contrast to the individual's capacity for "insight" – i.e., the ability to understand oneself. [S. H. Foulkes., *Introduction to Group Analytic Psychotherapy* (London: Heinemann, 1948)]

¹⁴ See Berne, *Principles of Group Treatment* [New York: 1966].

¹⁵ For a terrifically lucid and compelling theory about why heterogeneous groups are so superior, see James Surowiecki's *The Wisdom of Crowds* (2004).

Washington State researchers found that adolescents with substance abuse addictions treated in homogeneous groups were one-and-a-half times more likely to *increase* their alcohol use than a control group of substance abusers who did not receive any intervention. [Marijuana use did not increase – but it did not decrease either!] The researchers concluded that such groups have undesirable and unintended consequences, probably because close association with substance-abusing peers lead to relationships that support, rather than discourage, substance abuse.¹⁶

Of course, evidence that homogeneous groups may cause harm to certain clients under certain circumstances is not proof that heterogeneous groups are any better. But it is reason to believe that *given the overall positive effectiveness of group programming, when it is identified that a specific client population is harmed by homogeneous group programming, that population should instead be served in a different modality or served by means of heterogeneous group programming.* At the very least, this is a testable hypothesis that deserves further research.

Again, back to the defense of the group modality ...

(3) Finally, groups provide a valuable therapeutic option for people:

- who aren't verbal or articulate;
- who have difficulty with the "insight" required by the other modalities; or
- who don't like to talk about feelings or experiences.

Groups can be structured around "activities" rather than "dialogue" (or, even better, in addition to dialogue), permitting the change process to develop around alternative symbolic and communication structures between client and therapist.

Indeed, some group theorists even promote the group modality as superior to other modalities because it can immediately address (and modify) the interpersonal dynamics that perpetuate so many client problems – i.e., they address the client's interactions with other people in the here & now (where problems typically manifest themselves), not in abstract conceptualizations or unchangeable past experiences.

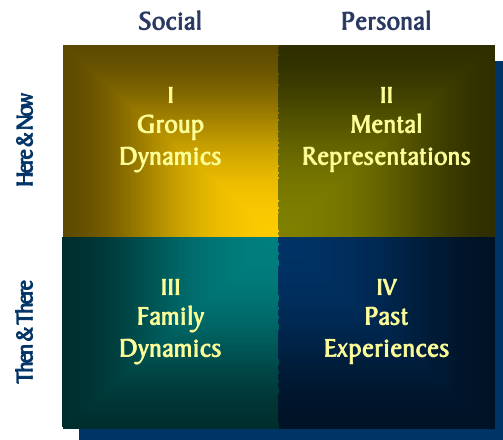
Comment: The last point made above is probably too vague and poorly stated, so I will try to clear it up a bit ... Every "school" or "model" of therapy has a different perspective on where client problems come from. Why, for example, would someone persistently steal?¹⁷ Each school has a different answer (and, therefore, a *different*

proposed solution). We can cluster these answers in the following way [see Diagram 2¹⁸]:

- Some schools propose that stealing originates in the client's *past experiences* [Quadrant IV] – e.g., stealing was somehow reinforced or rewarded by the client's experiences and consequently habitualized (Behaviorism) or it was an aspect of a "game" or "script" learned from one's parents (Transactional Analysis).
- Some schools propose that it originates in *family dynamics* [Quadrant III] – e.g., it is symptomatic of the breakdown of family boundaries (Structural Family Therapy), the displacement of family power relations (Strategic Psychotherapy), or a homeostatic attempt to keep the family together (Systemic Family Therapy).
- Other schools propose that stealing originates in our *mental representations* [Quadrant II] – e.g., it is the manifestation of an *unconscious repressed conflict* (Psychoanalysis) or it is the consequence of erroneous or flawed beliefs (Rational Emotive Therapy and Radical Constructivism).
- Still others propose that it originates in the client's *ongoing social interactions* [Quadrant I] – e.g., it is sustained by maladaptive communication (Brief Problem-Focused Therapy) or by *competition/cooperation* survival strategies (Evolutionary Psychology).

In general, the group modality favors Quadrant I-type formulation of problems and solutions.

DIAGRAM 2: ORIGIN OF THERAPEUTIC PROBLEMS



¹⁶ See D.D. Deck & E.L. Einspruch, *Assessment of the effectiveness of the Washington State Prevention and Intervention Services Program: Final Report* (1997), Office of Superintendent of Public Instruction. The possible harm from homogeneous group programming is also confirmed by *Francois Poulin, Thomas J Dishion, & Bert Burraston* in "3-Year Iatrogenic Effects Associated With Aggregating High-Risk Adolescents in Cognitive-Behavioral Preventive Interventions", *Applied Developmental Science*, October 2001, Vol. 5: 214-224.

¹⁷ You can substitute "steal" in this example with *any* problematic behavior: lying, aggression, truancy, phobia, nail-biting, temper tantrums, depression, anxiety, hyperactivity, and on and on and on ...

¹⁸ Diagram 2 is a simple matrix with two dimensions to measure where problems come from: the vertical dimension locates the time & place of the problem's cause (i.e., distant past/other place versus here & now); the horizontal dimension locates the social theatre of the problem's cause (i.e., interpersonal versus intrapersonal). Each school or model of therapy will favor one pole or other of each of these dimensions – allowing us to broadly categorize them into four quadrants. [Thus, for example, "group dynamics" theorists locate the origin of therapeutic problems in the here & now and in interpersonal interactions – whereas "past experience" theorists locate it in the impressions left on the individual from events experienced long ago, usually in childhood and traumatic in nature.]

Whether it's because it exploits unusually powerful therapeutic resources, because it concentrates expertise and support, or because it provides a forum for clients who can't take advantage of the other modalities, *the group modality has proven itself to be just as effective as all other therapeutic modalities*. Why, then, does this effectiveness seem to disappear when the group is comprised of adolescent delinquents?

Delinquency Training

... in practice and in theory ...

From a practical perspective, it shouldn't really be much of a surprise that grouping delinquent adolescents together causes increases in negative outcomes (i.e., increased delinquency, substance abuse, violence, and adult maladjustment). Those of us who have worked with such groups know that huge amounts of our programming time and effort go towards either (a) *protecting* vulnerable clients from the influence of their antisocial peers (whether such influence is abusive or intimidating or seductive) or (b) *disengaging* criminally active youths from the attitudes, beliefs, and values of the peers they interact with during programming activities. Especially in a residential context, it would take a heroic form of self-deception to believe that the puny efforts of the counsellor are any match for the giant waves of procriminal sentiment and encouragement generated by the peer group.¹⁹

Neither should it be a surprise from a purely theoretical perspective. Indeed, one of the dominant theoretical schools for understanding criminal behavior [see Table I for an outline of these dominant theoretical schools²⁰] posits that criminal behavior is actually fostered and sustained when we (i.e., "society") create a number of outcasts

with a common fate who face the same problem. "These outcasts therefore commonly band together and create deviant subcultures that provide social support for deviant behavior."²¹ By grouping the members of this subculture together in therapeutic activities, we are unwittingly reinforcing negative dynamics and delinquent activity.

Called "Subcultural Theory", this school of thought maintains that the motivation behind criminal behavior is essentially the same as any normal conforming behavior – i.e., "the desire to satisfy the expectations of significant others in a membership or reference group".²² Having failed to gain status, recognition, or acceptance through socially acceptable groups (e.g. school or positive peer subcultures), the *protocriminal* youth solves his dilemma by banding together with similarly unsuccessful youths, creating an alternative subculture with its own rules and expectations.²³

Such rules and expectations are not – as one might expect – purely a *reaction formation* against the dominant or rejecting culture. Rather, they are more frequently just a *dissociation*. In other words, the criminal subculture doesn't *invert* society's rules and expectations so much as it simply withdraws interest in prosocial activities and values. [One criminologist, David Matza, calls this dissociation "drift" – i.e., criminal subcultures *allow* delinquent activity but do not *demand* it, so the participant can *drift* between criminal and conventional actions as he sees fit.]

... dynamics of procriminal group membership ...

According to Subcultural Theory, there are two primary means by which procriminal subcultures differ from prosocial culture in maintaining cohesiveness:

- (a) *tolerance of delinquency* – procriminal groups generally (but not absolutely²⁴) tolerate a broad range of deviant or delinquent attitudes, values, and behaviors; and

¹⁹ Still, we do seem to be quite comfortable with such an illusion. No doubt, it is sustained in large part by the general invisibility of the increase in negative outcomes – they are, after all, only *statistically* relevant (and therefore not apparent in every client's actions). As clinicians, we are more likely to focus on the clients we see being helped by our efforts. As a consequence, we are more likely to remember our successes than our failures – thereby finding a distorted confirmation and support for our belief that we are being effective. This is often referred to as *confirmation bias*. [In technical terms, the perception of success/failure in therapy is what Thomas Gilovich (*op. cit.*) calls "one-sided". One-sided events are simply those that "stand out" or "come to our awareness" only when one outcome happens – as opposed to "two-sided" events where we notice two or more outcomes. (An example of a two-sided event is buying a lottery ticket: you notice *both* when you lose *and* when you win, and you have an appropriate emotional reaction.) Failures in therapy – especially in the kind we practice as part of youth justice programming – do not generally stand out. They happen either in the future (after the client has disappeared from the program) or they are discounted as part of the client's current state (which is already a state of failure). In either case, they do not reach the threshold of awareness and emotional reaction. (There are, of course, exceptions to this assumption – e.g., suicide – but the point is nonetheless generally valid.) ... Interestingly, according to Gilovich, when an event is two-sided, we are most likely to attend to outcomes that are unanticipated or unfavorable, rather than those that confirm our biases – exactly the opposite of what happens when an event is one-sided. But why should this be so? Jerome Kagan contends that it is because humans are by nature *risk-averse* – i.e., we would rather avoid a loss than seek a gain; we are hard-wired to deal with threat more diligently than with benefit. After all, capitalizing on a benefit might improve one's life, but ignoring a threat could cause one's death. The stakes of the latter are far higher than the former.]

²⁰ As outlined by John Braithwaite in *Crime, Shame And Reintegration* (1989, Cambridge University Press).

²¹ *Ibid.*

²² Indeed, there is evidence that criminal subcultures (e.g., gangs) are not just a matter of "birds of a feather flocking together" – in other words, they are not groups of "criminals" who subsequently seek each other out. Rather, membership in such a subculture often comes well before any overt criminal behavior. The group attracts kids to it not because of criminal acts *per se*, but because it satisfies needs not addressed by other prosocial groups (or because membership to such prosocial groups is denied to the kid).

²³ One of the obvious dimensions of this failure is *powerlessness*: "Being pushed around puts the delinquent in a mood of fatalism. He experiences himself as an effect. In that condition he is rendered irresponsible." [Matza, *Delinquency And Drift* (1964)] Joining a procriminal subculture permits the protocriminal youth to accept his irresponsibility while accessing a support structure that promises (and often fulfills the promise of) power. In my personal experience, this sense of powerlessness converted to power has been frequently expressed in the challenges "Make me!" and "What are you gonna do about it!?" It's in moments like these – so infuriating to the adult – that the criminal youth reveals the core of his existential condition.

Another obvious dimension is *stigmatization*: "By segregating and rejecting outcasts, stigmatization fosters a search for, or at least an attraction to, others who have been similarly rejected by the wider culture. The coming together of these folk with similar axes to grind accounts for most of the forging of criminal subcultures. The group supplies the venues where reinforcement, rationalizing, modeling, and social learning of criminality occurs in interaction with other persons." [Braithwaite, *op. cit.*]

²⁴ Even within procriminal subcultures there are unacceptable deviants – e.g., pedophiles, child rapists, etc.

**TABLE I: WHAT CAUSES CRIME & CRIMINALS?
THE DOMINANT THEORETICAL SCHOOLS**

Labeling Theory - *When people are labeled or stigmatized as “delinquent” or “deviant” or “criminal”, they are treated as such by society and eventually assume the identity and behaviors associated with the label.*

Subcultural Theory – *When people fail to succeed in or are cast out from prosocial groups, they will meet their need for acceptance & belonging by joining groups that condone and support procriminal attitudes, values, and behaviors.*

Control Theory – *This theory assumes that people are naturally attracted to any rewards that will bring them personal benefit, whether such rewards require criminal behavior or not. If the individual fails to develop the social bonds that prevent criminal behavior (or these bonds are somehow broken), he or she will indulge in criminal behavior.*

Opportunity Theory – *This theory assumes that every individual internalizes certain social aspirations (or goals). When the legitimate, socially approved means for reaching these goals are blocked, the individual will resort to criminal means.*

Learning Theory – *Based on a behaviorist model, this theory assumes that learning is the result of reinforcement and punishment. When criminal rewards (combined with lack of consequences for criminal action) outweigh prosocial rewards, the individual will choose criminal behavior.*

- (b) *mechanisms of moral disengagement* – procriminal groups employ distinct cognitive strategies that neutralize the influence of the broader moral consensus. [These strategies are detailed in the previous article [Crying Shame](#).²⁵]

The research provided by Dishion, McCord, & Poulin elaborates a further developmental process active in groups of delinquent youths – a process that these researchers believe ultimately contributes to the negative outcomes associated with therapeutic intervention by means of the group modality.

Dishion, McCord, & Poulin began their analysis by asking the age-old criminological question: “If peers support growth in adolescent problem behavior, what is the influence process?” To answer this question, they focused on the talk that goes on between youths in group settings. To categorize and code this talk, youths were divided into delinquent and nondelinquent *dyads* – in other words, youths were examined in pairs, with some pairs comprised of youths with a history of delinquency and others comprised solely of non-criminal youths. Each *topic* discussed by these pairs was also coded as either

²⁵ See page 13. In an important sense, it is precisely these mechanisms of moral disengagement that define and structure procriminal subcultures – rather than any learned set of values, attitudes, or expectations.

“rule-breaking” or “normative” – i.e., it encouraged criminal attitude (or reflected criminal values) or it supported a prosocial attitude. Finally, each *reaction* was coded as either positive or neutral – i.e., as either supportive of the topic (e.g., a laugh or gesture of agreement) or non-responsive.

The results? Dishion, McCord, & Poulin found that “... delinquent dyads react positively primarily to deviant talk [i.e., rule-breaking talk], whereas nondelinquent dyads ignore deviant talk in favor of normative discussions.” Dishion, McCord, & Poulin named this tendency to positively reward rule-breaking talk “deviancy training”. The important finding, however, was how well this “deviancy training” correlated with future negative outcomes (i.e., increased delinquency, substance abuse, violence, and adult maladjustment). [Notably, this correlation held *even after* Dishion, McCord, & Poulin *controlled for other well-known criminogenic influences* – in particular, a history of antisocial behavior and harsh, coercive parental discipline.] The researchers hypothesized that “deviancy training” not only increases the likelihood of future delinquent activity on the part of delinquent youth, but it also provides the cognitive basis for future delinquent attitudes and values.²⁶

Unfortunately, the news takes an even more depressing turn – although Dishion, McCord, & Poulin underplay this aspect (it is tucked away in a short, unelaborated paragraph near the end of their article). But it’s a turn I think worth mentioning. When trying to understand how therapist and client behavior predicted the magnitude of this negative outcome, the researchers “... found that observer impressions of therapist effectiveness were positively associated with growth in subsequent problem behavior.” Huh?! It appears that the more troublesome a youth was (*client behavior*), the more likely this was to elicit a higher level of therapeutic skill from the therapist (*therapist behavior*). While that makes sense, it leads us to believe (or, at least, *hope*) that this higher level of skill will result in some kind of positive outcome (like reduced delinquency, etc.). Apparently the exact opposite happens: increased skill & effort do *not* provide a corrective – they too makes things worse!²⁷

In the end, Dishion, McCord, & Poulin conclude that there is good evidence that we should be “cautious” about aggregating delinquent youth into intervention groups. The preferred strategy is to mix delinquent youth in with prosocial youth (a context that yields positive therapeutic outcomes).

... what’s the baby and what’s the bathwater? ...

Let’s be clear – even if we have to risk a tiresome repetition – about what this line of research is saying: In the normal course of events

²⁶ To put this influence in perspective, Dishion, McCord, & Poulin point out that in institutional settings (like our custody or detention programs), youth-to-youth interactions outnumber adult-to-youth interactions by about 9-to-1. If the basic nature of such youth-to-youth interactions involve deviancy training, it is little wonder that such settings facilitate negative outcomes by undermining adult influence.

²⁷ Of course, this conclusion depends entirely on what constitutes “increased skill and effort”. If the “observers” measured these qualities from a “Specific Factor” perspective [i.e., the “canary thinking” outlined in [What Works \[Who Works\]](#) that focuses on things like techniques and compliance with a manual], then it is not particularly surprising (to me, at least) that outcomes get worse: *increased attention to techniques and manuals inevitably dehumanizes the therapeutic alliance, fostering a client perception of the therapist as mechanical and disengaged*. On the other hand, if the qualities were measured from a “Common Factor” perspective [“horse thinking”], the conclusion is truly depressing ... however, I will wager that the former is the case.

(i.e., without any form of therapeutic intervention), delinquent youths will continue to commit delinquencies, abuse illegal substances, indulge in acts of violence, and be maladjusted as adults. [We could call this a *base rate delinquency*.] Our hope as therapists is that active intervention (by means of therapeutic programming) with these youths will *reduce* the future rate of such occurrences. Dishion, McCord, & Poulin, however, contend that research shows that the rate of these occurrences actually *increases* when the type of intervention used involves treatment *groups* comprised primarily of delinquent youths.

Should we panic? Should we rush out and close down all group interventions with delinquent youth? Well, not quite yet. There's a little more to this story than meets the eye.

Whenever research reveals a conclusion that flies in the face of one's deeply held beliefs, there is a tendency either to ignore it (*fright*), deny it (*flight*), or to criticize it (*fight*). Because of such tendencies, I want to be scrupulous about evaluating the research conclusions of Dishion, McCord, & Poulin. My attempt to put this research in a certain perspective is not (I believe) a way to discredit its value. While I *am* somewhat skeptical about its grand conclusion (i.e., that *group interventions increase delinquency, substance abuse, violence, & adult maladjustment*), I nonetheless respect and approve of: (a) its delineation of "deviancy training" as an important dynamic in procriminal youth subcultures; and (b) its message that we should be cautious and vigilant in our delivery of service to this population.

So, why am I skeptical?

Dishion, McCord, & Poulin base their research results principally on three experimentally controlled intervention studies: (1) the Oregon Youth Study (OYS) – 206 boys (and their friends) who were videotaped and interviewed over a period of 5 years using the "deviancy training" construct discussed above; (2) the Adolescent Transitions Program Study (ATPS) – 119 high risk youths (male & female) assigned to 4 different interventions and a control group of 38 youths; and (3) the Cambridge-Somerville Youth Study (CSYS) – 320 boys (divided into a treatment and a control group), begun in 1939 and terminated in 1945 with follow-up over 40 years. Each of these studies confirms the basic conclusion that intervention can sometimes be harmful. [In all three studies, youths that received treatment achieved higher levels of delinquency (or some form of negative outcome) than youths in the control (i.e. "no treatment") group.]

I have no concerns regarding the validity of the research design of any of these studies. In other words, I don't think we can impugn or discount the *specific* conclusions they come to because their methodologies were in some way flawed. I think we can take it in good faith that their conclusions follow soundly from their evaluative processes – and the evaluative processes seem to be exemplary instances of good scientific research. Rather, my concerns relate to: (a) the appropriateness (or relevance) of including one of these studies in their assessment of the effectiveness of therapeutic intervention; and (b) the *general* conclusions that can be drawn from the research as a whole.

First, regarding the question of one of the studies, we saw in a previous article (i.e., *What Works [Who Works]*) that there has been a school of thought within criminological research that claims that "nothing works!" Indeed, the Cambridge-Somerville Youth Study (CSYS) has long been a poster-child and mainstay of this school.²⁸ By itself, it represents a rather well-documented proof that

²⁸ It has earned this position precisely because its methodology was so rigorous.

therapeutic intervention with delinquent youths does not work – in fact, it seems to make things worse.²⁹ Or does it?

When a study yields a valid result (whether positive or negative), the next step in our investigation is usually to try to gain some explanation for that result (because we want either to repeat it or avoid it in the future). We want to know "why" the result turned out as it did.³⁰ In the case of CSYS, there is every good reason to believe that the result (i.e., failure of therapeutic intervention) was caused by the fact that *there wasn't really any therapeutic intervention going on!* The study is a great measure of "something" – it's just that the "something" is not therapeutic programming. Jerome Miller pointed this disturbing fact out in his own summary of the problems with CSYS:

*Three hundred and twenty boys were assigned to ten counselors who were told to do 'whatever they thought best' for their clients. Counselors had no formal training in the mental health field, much less in psychotherapy. Each youth was seen an average of five times per year during the early years of the project in meetings directed at such things as arranging physical exams or interesting a boy in summer camp. Not surprisingly, the subjects showed no drop in criminal behavior at 10-, 20-, and 30-year follow-ups. It seems bizarre to have expected otherwise.*³¹ [emphasis in original]

We have good reason, then, to be doubtful that neither the "who" (the therapists) nor the "what" (the therapy) of CSYS had anything to do with real therapeutic programming. If this is true, it's hard to understand why it continues to be included as valid research on the effectiveness of therapy.

Even if we can eliminate CSYS from the evaluation of therapeutic effectiveness, we would still be left with the general conclusion Dishion, McCord, & Poulin draw from the OYS and ATPS studies – i.e., *sometimes interventions can cause harm*. But what exactly are we to make of such a claim? This brings me to my second concern with this body of research.

At one level, the conclusion that therapeutic programming can sometimes cause harm really doesn't tell us anything new or surprising: *of course* it can sometimes be harmful – that's a price that inevitably comes with its being effective. The arrow of therapeutic influence points *both* directions – i.e., towards positive *and* negative outcomes.³² Both of the meta-analyses discussed in the previous article [i.e., those meta-analyses conducted by Lipsey & Wilson (2000) and Andrews & Bonta (1998)] identified a large number of interventions that were either ineffective or negatively effective, including: (a) psychodynamic or client-centered approaches; (b) non-

²⁹ McCord found that there was a 10% increase in the number of treatment youths going to court and a 21% increase in the number of charges against them. Not only that, but they were also more likely to die younger and to be diagnosed as having alcoholic, schizophrenic, and manic-depressive conditions as adults.

³⁰ Indeed, this is precisely what Dishion, McCord, & Poulin did: having seen that group interventions harm delinquent participants, they set out to understand why. Their answer was "deviancy training".

³¹ Jerome Miller, "The Debate on Rehabilitating Criminals: Is It True that Nothing Works?", *Washington Post*, March 1989.

³² Otherwise, we wouldn't have to worry so much about whether to do therapy or about what kind of therapy we should do: *any* intervention would have some level of positive outcome. In reality, however, the overall effectiveness of therapeutic programming is the average of all its effects, both positive and negative.

directive, unstructured, or vague interventions; (c) programs that target *noncriminogenic needs* (e.g., anxiety, self-esteem, depression); (d) medical interventions (i.e., drug treatments); (e) “punishing smarter” approaches (e.g., Intensive Supervised Probation, boot camps); and (f) physical challenge programs (e.g., wilderness survival or Outward Bound).³³

Still, it’s hard to believe that Dishion, McCord, & Poulin are simply making this general (and obvious) kind of point. Because they see “deviancy training” as the explanation for harmful outcomes, they have located the causal factor (i.e., the independent variable that causes the harm) in the *modality* of the therapeutic programming used³⁴ (as opposed to the usual suspects blamed for therapeutic failure – i.e., the “model” or “techniques” of therapy used, the characteristics of the therapist, or the characteristics of the individual client). This attribution forces them to imply negative effects to all therapeutic programming that uses a group modality with young delinquents.³⁵ As they say: “Based on the studies reviewed, there is reason to be cautious and to **avoid aggregating high-risk adolescents into intervention groups**” (emphasis added)³⁶ This is the point, however, where their reasoning falters slightly. If their conclusion were generally true, we would expect to see this negative effect showing up in the meta-analyses of program effectiveness in juvenile delinquency (e.g., the comprehensive work of Lipsey & Wilson) – *but it doesn’t!* Overall, those “group” interventions with juvenile delinquents are just as positively effective as other modalities. [Conversely, “non-group” interventions are also frequently found to be ineffective or harmful in pretty much the same way Dishion, McCord, & Poulin find group intervention to be.]

Again, just because I can’t follow Dishion, McCord, & Poulin to their grand conclusion (i.e., that we should avoid aggregating high-risk adolescents into intervention groups), this doesn’t mean that I don’t find their work incredibly valuable – and not simply because it stands

as a caution that all intervention should be conscientiously and meticulously evaluated for its effect on our clients. When we study the outcomes that our programming has, we generally want to know two things:

- (1) If they are successful, what explains or causes the success? – and
- (2) If they fail or cause harm, what explains or causes the failure?

Dishion, McCord, & Poulin have opened important new possibilities in the second area. Their concept of “deviancy training” – which I translate to “delinquency training” – is both a powerful insight into the functioning of criminal subcultures and a challenge for therapeutic programming. It is a dynamic that we cannot afford to ignore if we want our programs to be as effective as possible.

- Terry Henry

³³ As a matter of interest, I would classify the type of intervention offered in CSYS (assuming that we must concede it was indeed therapeutic intervention) as falling in categories (b) & (c).

³⁴ In other words, they are saying that it is the youth’s experience in interacting with a *peer group* inclined to train its members for deviancy that ultimately causes increases in delinquency, substance abuse, etc. They offer two possible mechanisms to explain how this happens: (1) “... youth being actively reinforced through laughter, social attention, and interest for deviant behavior are likely to increase such behavior”; and (2) “... high-risk adolescents derive meaning and values from the deviancy training process that provides the cognitive basis for motivation to commit delinquent acts in the future”.

³⁵ To be fair, Dishion, McCord, & Poulin do make the following reservation about their conclusions: “Clearly, more research is needed to understand the processes that account for the iatrogenic effects of interventions targeting high-risk youth – not all interventions using peer groups with difficult children have had iatrogenic effects.”

³⁶ The point is made even more forcefully in the McCord, Spatz Widom, & Crowell book (*op. cit.*):

Placing one or two antisocial juveniles in a group of primarily prosocial young people can decrease their antisocial behavior without negatively influencing the prosocial youngsters. Some well-designed evaluations of treatments for at-risk juveniles found, however, that placing such youngsters in groups, even under careful adult supervision, had the undesired outcome of increasing their antisocial behavior.

Recommendation: Federal and state funds should be used to develop treatments for misbehaving youngsters that do not aggregate aggressive or antisocial youth. [emphasis in original]