MELISSA GRADY

ASSOCIATE PROFESSOR AT NCSSS

Albano: The scholarship that you receive is very prestigious. Could you describe it?

Melissa Grady: It's called Fahs-Beck and they have two different funding streams. One is for doctoral students and then one is for faculty members. And although it's not a lot of money, it's seen as a fairly competitive grant, and you're considered a Fahs-Beck scholar when you get it, and they do a lot of publicity on the website. I guess one of the reasons it's so competitive is because it's very open. It doesn't narrow it down, so it could be any kind of project from anybody. A lot of funders have a particular focus. It might be on sexual violence, or spirituality, or children in schools and it's completely wide open. So, what makes it difficult is how you don't really know what they're looking for. So many people see it as sort of a big victory just to get it because you sort of tapped into something that other people thought was important or relevant. Out of a sea of different subject areas, they thought this was valuable enough to go ahead and work on it.

Albano: So what was your submission? Why do you think it was picked?

Melissa Grady: My area of scholarship is primarily on sexual violence and looking at different ways to prevent and intervene so that it doesn't happen again.

And one of my areas within that broader area is trauma and the impact of trauma on both developmental trajectories toward sexual violence. And also, how do we want to think about trauma within treatment specifically focused on sexual offending. Because there's a lot that we know about how trauma negatively impacts cognition, interpersonal relationships, hormones, chemical imbalances, mental health issues, substance use and all of those risk factors are associated with sexual offending. So being able to think about how are people integrating trauma into the treatment to make sure that potential root cause is being addressed in addition to helping them with impulse control and healthier sexual relationships.

So some of the research that I've been doing lately is looking at how our treatment providers are integrating or not integrating trauma histories into treatments focused on sexual offending, and they're really not. And part of it is that they don't have a great roadmap. They don't have a great way of saying, “OK, well, I've been trained to do this around sexual offending. And then there's trauma over here. But how do I flip my mindset in some ways of integrating, Oh, you were offended? And you're also somebody who's experienced trauma." And so there hasn't been a lot of guidance on how to integrate these mindsets. What's interesting is that when somebody has experienced victimization, they get labeled a "victim". But once somebody commits a sexual offense, they become an "offender.” And we don't treat them any more.

And what I think is becoming more and more clear is that if trauma is a root driver of some of the offending behavior by not addressing that within the broader sexual offending treatment, we're missing a really critical component of what might help them not do this again.

Albano: Now, you noted earlier that there's really not a road map in this scholarship. Does your research, which you presented for the fellowship, offer a roadmap of sorts?

Melissa Grady: Yes. So there is a very well known treatment called trauma focused cognitive behavioral therapy that's been used with children and adolescents very, very successfully. It has a great track record working with those that anywhere from six to eighteen for individuals who've experienced some sort of trauma, could be sexual trauma, could be physical trauma, could be a car accident, anything.

But it hasn't been adapted for working with people with sexual offending behaviors. And adolescents actually comprise a pretty significant portion of all of the crimes that are committed that are sexual crimes. So we know that this is a huge issue, and we also know that adolescents are very amenable to treatment. And we also know that the younger you are, when you commit a sexual offense, the higher the likelihood is that you have also experienced trauma. So it's an inverse relationship as you age the likelihood that you experienced the trauma is decreased. If you see kids with a lot of sexual acting behavior, it's more likely that they've experienced trauma and that they're working it through and coping with it. Not effectively and in fact, in a harmful way. This project is designed around two sets of focus groups. One is going to be practitioners and experts on sexual offending.

So we've got partnership agencies both in juvenile justice and in community outpatient settings who signed on for this project. And they want to participate in focus groups where we say, "Hey, what do you think we need to do? How should we integrate them?" The second group will be adolescents and their caregivers who have already gone through sexual offending treatment and ask them what should have been done? "What do you think should have been included?" How do you think we should be integrating these two different pieces and asking them about that

Albano: Is the second group victims?

Melissa Grady: They're people who have already gone through a treatment focus on sexual offending, but again they also had experience victimization. So they're both and and we want to hear from them around what should have been done.

What do they think could have been done to help them integrate these two experiences, their offending as well as their own victimization? They are going to be helping us build out what we're calling an enhancement model, and we're hoping by the end that we'll have a very clear manual for providers who can then say, "OK, I've got an adolescent who has a victimization history and an a history of sexual offending. This is now a model that I can use to really address both of these identities." Both of these issues that they're struggling with their own victimization and their offending. And then what we're really planning to do next is to take this manual and test it using a clinical trial to see when we compare this integrated approach that might address the root cause of trauma. Is that superior to what people are doing now?

Which is either totally ignoring the client's own trauma histories or they're doing it in sort of a haphazard way because they don't have a roadmap. So the ultimate goal is to to create this roadmap for the huge number of adolescents who have a sexual offense conviction and who also have their own histories of victimization.

Albano: What happens when providers do not have a roadmap?

Melissa Grady: Well your timing is perfect, because what I've been working on all day today is a paper that I'm doing in partnership with a colleague at Barry University in preparation for a conference. And I will just tell you, here are some of the quotes that I was just proofreading when they talk about their treatment experiences:

Some described it as coercive and that it was atrocious and geared to help provoke you. One participant stated "I hated every minute of it."

They go on to describe therapists where they said they were ridiculed, it was horrible, shame based, was demeaning and horrific. And several of them said, "I thought I was going to need therapy after the treatment I got". Or "I needed therapy for the required class." And another said "the state should pay for any mental mental therapy to get over my traumas related to this treatment".

One person said, "I'm a survivor of military related sexual assault. The treatment program will not acknowledge this, and therefore it is never taken into any consideration in my care." He puts in quotes. "On one occasion, I was having a panic attack as someone in the group was

describing sexual harm that they had caused to try to protect myself, I put my head down and discreetly plug my ears. The next week, I was scolded by my probation officer and therapist at the same time, and I was told I was in danger of being kicked out of the group. Why? Because plugging my ears was disruptive. At that moment, I broke down. I was told to apologize to the group for being inconsiderate. When I did, no one in the group knew what I was talking about. Not one of them had even noticed. The whole ordeal eliminated what little trust I had in the program and their therapists."

Albano: Those programs are happening in prisons? Or are they happening outside?

Melissa Grady: That was a community based program. So it really depends on the state. Maryland, for example, does not have a specific program within prisons that focuses on sexual offending. North Carolina has one, but they're only slated to treat about 50 a year, and they have usually over 4,000 a year in the prison system at any one time. But there are a lot of community based programs, in fact, the majority were court mandated of the two hundred and ninety one in the study, over two hundred and fifty were court mandated to receive treatment. But they have to pay for the treatment themselves, and many of them can't get a job because of the felony charges. And it's really expensive, and there's no end to it. So there's so much in this one paper.

So unfortunately, even when they're just sticking to one focus like the offending, many of them don't have a very good roadmap. Many of them aren't following structured protocol that is helpful. And then you add in their own victimization and you've just added another layer of complexity that they don't really know how to manage.

Albano: Compared to other violent crimes, are people who've been arrested for sexual violence, gone to jail, and come out, more likely than other "criminals" to relapse and then attack again?

Melissa Grady: Actually, they're not. The research is one of these huge myths about this population. Now they should be caught, they should be punished and they should receive treatment. Nobody who works with this population should say anything other than that. However, their recidivism rates are actually lower than almost every other violent crime.

And when you compare them, at most, you'll see anywhere from four to ten percent end up committing another crime. Incredibly low. And for adolescents, it's even lower. But adolescents are often treated in the same way that adults are in the courts, even though they're re-offending rate is even lower. In fact, there was a meta analysis that looked across all adolescents, internationally, across countries, cultures, etc, and the max rate was five percent. Five percent is incredibly low. Now again, five percent is still more than we would want. So we need good treatments. We need to figure out what's going to work. But when you put these incredibly punitive policies, like for an adolescent who has a sexual conviction, that kid can't go to school, they can't go to a mall, they can't go to a movie theater, they can't go to a Chuck E. Cheese, they can't go to a McDonald's if the McDonald's has a play structure.

Some can't go to places of worship because there might be a daycare center on site. And so you've taken away everything that helps them build coping skills, helps them integrate into the world, helps them develop positive relationships, and they can't do any of that. They can't even sit at a park bench if it's too close to a park. So by putting all these restrictions and isolating them in such a way, there's more and more research that shows it does not work. There is a huge study in New York that talked about how these policies after they were enacted have actually had zero impact on recidivism.

Albano: When was this?

Melissa Grady: This was fairly recently. Maybe 10 years old now. There was a law passed called SORNA, which is the Sex Offender Registration Notification Act.

And New York looked at 10 years of arrest rates, pre SORNA, and then they looked at 10 years of arrest rates post SORNA and tried to see if there is a difference now that we have these policies in place designed to "protect society". And what they found is it actually made zero difference statistically on it. And because over 96 percent of the arrests were on new people who had just committed the crimes. So new individuals. All these billions of dollars on the registration and notification and databases and all this stuff was targeting less than four percent of all of the sexual crimes that were being committed. So we've spent billions and billions of dollars, and it's made no impact on the crimes because we're not looking further downstream.

As one of my mentors said "we got to figure out why people keep getting thrown in the river." Why are they doing this in the first place? And then make sure we're doing effective treatments that target those contributing factors. Which we're not doing right now.

Albano: So how did you get into this field, especially sexual based trauma?

Melissa Grady: I was not what I planned at all. I always thought I would work in the trauma field, it never occurred to me to work with people who had done the crimes. I always just imagined myself working with people who had experienced different forms of trauma. I was working my first job after my MSW, I was working at a community mental health center, and Pat Van Buren ran the sexual aggressive youth program for the same program.

And this is a program where kids who had been adjudicated through the courts came for mandated treatment. And there was an adolescent component and then a parent component. And the adolescent men met three times a month and the parents met twice a month. One of those times was a joint session with their kids and then the other time by themselves.

I wanted to learn, so I started working with this group and I came to think two things: one, this is the most reviled population/crime that you can do in our society. If you want to be stigmatized and hated, do this crime. It's like the most sure way to be ostracized and hated by our society. And yet, given all of those taboos. Given all of that, people still do it. And so why? What drives it? So that sort of was striking. The other thing is that as Pat said to me, she had started her career working with people who had experienced victimization and she felt like she was standing at the bridge, pulling people out one by one.

And she wanted to go down stream and figure out why they were getting thrown into the river in the first place?

And so when you think about where I am going to get the biggest bang for my back in trauma, I am not saying not working with people who have experienced victimization is not important because I do it. I have a private practice. And I think it's also equally important to work with individuals and understand why they've committed these crimes so that we can prevent it from happening to more people. And the more we learn about the early prevention stuff of what we need to do to make sure nobody does this. So in CDC language that's considered primary prevention, there is a universal approach. What do we need? Healthy families, good, good coping skills, social, emotional intelligence, all of that. That's primary. Who are the at risk individuals that are at higher risk for having this as an issue?

And what do they need? That's considered secondary by the CDC. And then tertiary prevention is where we know people who've already done it. These are people that have been convicted. We know it and we need to make better programs so that we don't so that they don't do it again. So for me, when I think about this work, I am always thinking on these three levels of prevention, and I think we need to be looking at all of them in order to reduce the overall rate of sexual violence. So again, it wasn't really planned, I just became really fascinated and then for my dissertation, I ended up looking at empathy development because I became fascinated with this idea: can you "teach" somebody to care? Can you teach somebody to really think, "Oh, I don't want to hurt this person because I will experience distress myself if I do that"? So I ended up setting that for my dissertation.

Albano: So what's the answer? Can you?

Melissa Grady: It's still uncertain. I don't know. My dissertation did not answer that question, and part of it may be because it's really, really difficult to measure somebody's internal experience. On a paper pencil test, it's easy for me to say, "Oh, I know you want me to say this and I know what the right answer is." And in fact, some people talk about empathy being having two components: cognitive empathy, which is, I see you, I see you're looking at me. I can tell by your expressions on your face what you're doing. And that's used a lot with people on the autism spectrum to help them read. But then there's the affective component, which is I am distressed because you are distressed and I feel moved internally because you are distressed and I want to do something to relieve your distress. And what people have talked about in the literature is actually people who have been diagnosed with sociopathy or antisocial personality disorder are actually really, really, really good at the first kind, the cognitive kind, because they need to know how to read people incredibly well in order to manipulate and get the reactions that they want. But it's not necessarily pro-social. And in fact, most of the time it's not. So it's a really complicated issue, and the issue really comes down to we don't have a great way of measuring empathy.

Albano: After we saw a rise of crime in the 70s 80s, there a slope off in the 90s. Did sexual violence see a decrease similar to overall violence, or has it gone up?

Melissa Grady: It's definitely been going down. You wouldn't know it if you watched any of the news or read anything.

There's a researcher named David Finkelhor at University of New Hampshire, doing reports for the Department of Justice around rates of violence and sexual violence as well. He has it going down. And I think part of that is communication. There's a lot more openness about it and, a lot more psychoeducation about the importance of talking about it so that people are caught and get treatment and get what they need. That's also helped to reduce the number within families. In families communication can stop a cycle. Now that teachers are mandated reporters and there are a lot more regulations within the Catholic Church and other facilities that work with kids.

When my kids were little I picked a daycare based on the fact that I could see if I was in one room, I could see into the other room. And then if I was in that room, I could see the others, whereas there was another one I went to. That was a church, which is super common. Lots of churches have daycare centers.

And it was this long hallway with a door and a little window. And that just felt too isolated. So there's a lot of structural things that have been done to facilities and buildings and rules that have been set up to make sure that there are eyes on kids. But then there are also a lot of educational school interventions. And I think just greater awareness of sexual assault in general and education around that. Pediatricians now ask about it on a much more regular basis.

Albano: So we talked about how the Fahs-Beck Fellowship doesn't offer a lot of money for your research. What kind of doors does it open up?

Melissa Grady: My partner, Jamie Yoder, is a professor at Colorado State in the social work department there. And she and I have done several different projects together.

She's a fantastic collaborator. And she's submitted a grant internally to Colorado State University to then build on a feasibility study so that we can take this manual that we're hoping to have by the end of the project and do a pilot test and see how well does this work? And what is it that we need to tweak? How do we need to change it? What is it that we need to do once it's in the hands of practitioners? And then from there, we want to use that pilot data to apply for a federal grant to be able to do a larger clinical trial once we've done some pilot testing and tweaked it.

Albano: Is there a timeline of that? How long does that kind of academic process take?

Melissa Grady: Well, unfortunately, it's slow because of the grant writing. So our timeline for the Fahs-Beck is probably by the end of the summer to have the manual done. And then we would try and do the pilot data over next winter. And then based on that pilot data, we would probably apply for grants.

Albano: If you were to get the federal grant, would the research be taking place here, at Catholic or Colorado state?

Melissa Grady: Well, it would be a partnership. We would definitely be CO-PIs. We've just alternated projects like this one, I'm the PI. The one she just submitted, she's the PI.

Albano: For students who are trying to join NCSSS and might be interested in this field of work, why should they come to this department?

Melissa Grady: We have a great clinical curriculum, and regardless of which population that they would want to work with, they're going to walk away with a really, really solid foundational experience and foundational knowledge of clinical work.

Another reason to come is that there are opportunities for students to get involved in different research projects. Right now I'm working with four different students on different research projects. And they're going to get publications. They're going to get research experience and that's pretty cool. One of them is going to join this larger national group that I'm working on and attend our meetings with faculty from different universities and doctoral students at other universities.

And that's a really fantastic experience. And I would say another reason is that if there are interested in sexual violence, we have a lot of expertise within the school. And we have this unique certificate program that's really interdisciplinary that people could come and graduate with this certificate in sexual prevention, essentially, and interact with faculty members who have expertise in this topic area.

Albano: I really appreciate you talking about your research. Congratulations on the fellowship!