

Is Cognitive Behaviour Therapy (CBT) the method of choice for working with sex offenders?

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When we use the term sex offender to whom are we referring? The lack of uniformity between researcher's definitions of aspects of sex offending is problematic. For example, Fagan, Wise, Schmidt, & Berlin (2002) note that researchers use the global term paedophilia to describe child sex abuse, incest child molestation and pederasty. He states that these are not equivalent to paedophilia but are often referred to as such. The diagnostic term for a paedophile is someone who has an attraction to prepubescent children *and* a psychiatric disorder. Hence, a paedophile may not have committed an offence. Nonetheless the majority of treatments tend to focus upon offending behaviour, for example looking at victim empathy, in such cases the type of therapy is likely to be either inappropriate or poorly researched by comparison. Moreover, I would argue that fertilisation of concepts has implications in other respects, specifically in relation to; a) quantifying the overall rate of sex offending; b) identifying the rate for each different type of sex offending behaviour and c) identifying the most appropriate treatment. Lastly, all these factors make cross comparisons, looking at efficacy between studies, problematic.

Whilst sex offending comes in many forms; child abuse, rape, sexual murder, exhibitionism and internet offences such as downloading pornography (Kemshall & McIvor 2004) the most commonly researched is child abuse, arguably because it is the least tolerated by society. Baker and Duncan (1985) found that 12% of women and 8% of men report being sexually abused before the age of sixteen years. Fagan et al's (2002) findings from a sample of the American population, are higher but similar, 17% and 12% respectively. From

a sample of 900 women, Russel (1984) found that 38% had been sexually abused before the age of seventeen. Further statistics obtained by Fagan et al (2002) estimate that women are three times more likely to be sexually abused than men (i.e. not less than twice as quoted above). He also found that children from the lowest income families are eighteen times more likely to be abused than children from other families.

Regarding who abuses, the NIS-3 reported that natural parents account for 29%, other parents, 25%, and others in a care-taking role, 46%. They found that approximately 89% of children were abused by a male figure, compared to 11% by a female. However, Kemshall & McIvor (2004) state that research has consistently quoted 5% for female sex offenders, although they concede that the research in this area has been hindered by a general reluctance to accept that women sexually abuse. The federal bureau found that 96% of offenders were male and strangers only accounted for 5%, which in view of public concern seems low. It seems likely however, that whatever figure theorists derive from these studies it will be lower than the reality, due to under reporting. Also the above statistics are for sexual abuse only and therefore do not cover all forms of sex offending.

Further researchers have identified clusters of characteristics typical of sex offenders. The majority of this research has been in relation to male offenders and includes low self-esteem (Marshall & Mazzucco, 1995; Rosenberg and Associates 2002; Ward Hudson & France, 1994) having an over powering father (Barbaree, 1989); a dominant but distant mother (Fraser, 1976); an inadequate attachment style or a dysfunctional family (Hanson & Slater, 1988) experiencing or witnessing intra-familial violence; a discontinuity of care (Skuse, Bentovim, Hodges, Stevenson et al, 1998); a fixation on an era in the offenders childhood (Fraser, 1976); a difficulty in establishing intimacy

with adults and a preference to be amongst children (Seidman, Marshall, Hudson, & Robertson, 1994; Rosenberg & Associates, 2002); a history of bullying in childhood and a lack of social maturity (Rosenburg and Associates 2002).

Specifically in relation to female sex offenders, almost all report being sexually abused as children, some have suffered another form of abuse, typically emotional abuse, and some saw the child as an extension of themselves (Hanks & Saradjian 1992). Rosenberg et al (2002) write that children who are sexually abused learn about sex through inappropriate means, and if exposed enough, children may internalise this learned behaviour (this is the explanation used by social learning theorists).

Further researchers have categorised male sex offenders into two broad types; 1.) fixated or preferential, which includes those primarily aroused by children and 2.) regressed or situational (Knight & Prentky 1990). The fixated child abuser is exclusively sexually attracted to children and prefers their company socially. Needs (1992) describes fixated abusers as usually having difficulty in developing satisfactory relationships with adults and tending to validate their sense of self from an intense involvement with children. Their whole life may revolve around children whose relationships they find much more validating and rewarding than those with adults. Hence, many of these characteristics fit those outlined above in the previous paragraph.

In contrast, situational abusers are usually sexually attracted to adults and typically abuse children when there has been a build up of stressors. Sexual activities with children are much more intermittent, feelings of inadequacy and self doubt and sexual offending against a child may be an experiment to create a powerful image of themselves, and the child may be used as a

substitute sexual partner (Knight & Prentky 1990). Further researchers have argued that the idea of the fixated and situational offender is too simplistic. For example, see Finkelhor (1986) for a more sophisticated typology.

The explanation used to describe how the sex offender has come to have these characteristics, frequently influences which approach is favoured in treatment. Hence, if the practitioner feels that children learn behaviour through modelling, then arguably they are more likely to treat sex offenders using an approach which reflects social learning theory (SLT). This has probably been the most popular theory and practice, at least until recently (for example see Abel Becker & Cunningham-Rathner, 1984).

In support of SLT, Laws and Marshall (1990) argued that children may be exposed to poor or inappropriate role models and experience some early arousal to non-normal stimuli which, when combined with inappropriate masturbatory fantasies during adolescence leads to child molestation. This would suggest that the offender learned their behaviour from watching someone else behave in a similar fashion or even by their own sex abuse. As mentioned above one of the characteristics of offenders is that they have frequently been abused themselves, Rosenberg and colleagues (2004) quote anything between 30% and 80%.

There are aspects of these profiles which fit with the six committed sex offenders I see, in so far as they have all experienced some form of abuse as children, typically sexual abuse, although some have experienced physical abuse and neglect as well. All have experienced very severe physical punishment as a means of control and have come from families where there was a high level of conflict throughout their childhood. Three of my clients have become fixated upon childhood images as a means for sexual

gratification. However, not all children who are sexually abused go on to abuse others and not all sex offenders have been abused. Hence, social learning theory in isolation cannot explain why offenders offend, nor has the sole use of social learning techniques been effective in treatment.

In more recent years there has been a shift from a social learning to a cognitive behavioural perspective, where cognitive behaviour therapy (CBT) has been portrayed as the treatment of choice for working with sex offenders by many theorists (for example, Marshal & Barbaree, 1990; White, Bradley, Ferriter & Haatzipetrou, 1998). CB therapists' focus on the offender's use of cognitive distortions in the therapeutic relationship and the sex offenders treatment programme has this same emphasis. Cognitive behaviour theorists and therapists argue that sex offenders use three main cognitive distortions in order to be able to perpetrate their offences, denial, minimisation and lack of victim empathy (Horley, 2003). These are typically challenged as they arise in therapy. In respect to denial, Horley (2003) writes that it is of little surprise that sex offenders deny they have a sexual problem or fail to admit responsibility, given the benefits that denial brings.

Examples of the types of distorted beliefs and attitudes offenders use may include, sexual activity with children is an appropriate means to increase the sexual knowledge of children or, if children fail to resist advances, they must want sex (Abel Becker & Cunningham-Rathner, 1984). Similar types of distortions are reported by numerous others researchers and practitioners (for further examples see Stermac & Segal 1989; Barbaree, 1989; Mc Cagy, 1967).

In my own practice, distortion and minimisation is more prevalent than total denial, maybe because all of my clients have been convicted of a sexual offence and four of the six have undergone the prison's sex offenders

treatment programme, whereby an admission of guilt is necessary in order for the offender to “pass”. Minimisation comes in many different guises, the sorts of things I have heard include; I never did anything she didn’t want or that would physically hurt her, it meant that she could explain sex to her friends, children dress like teenagers nowadays, I didn’t drag her into the bushes, it was done in a loving way. Other theorists have reported similar minimisations such as the use of the “little lady” to describe a nine year old girl (Barbaree, 1989). In respect to victim empathy, whilst I feel that this is evident by the time my clients reach me, I feel it must have been lacking at some point in order for them to have been able to carry out their offence.

CBT treatment sometimes begins with the completion and signing of a contract where the client agrees to the type and form of treatment outlined in a detailed proposal. Part of this proposal typically states that the client will be expected to talk about their offences and must be willing to accept being challenged in respect to them (Horley, 2003). Therapy may begin with a focus on the offender accepting responsibility, recognising their behaviour is problematic and must stop and the offender must show that they are willing to change (Drapeau, Korner, Brunet & Granger, 2004). A client’s desire for change has been reported as the single most important factor for admission, as motivation for change indicates the likelihood of a client re-offending.

During CBT, the client is also likely to undergo some form of victim empathy work, where the client and therapist explore how the victim may have been affected. Also, the client typically will go through some form of relapse prevention work, where the client and therapist will explore the antecedents to the offending behaviour and ways to minimise the risk of re-offending, through avoidance of certain activities e.g. not going out after dark, not watching pornography, not working or living near children and so forth.

What should be evident from the above discussion is that the emphasis in CBT is on challenging, confronting (Borzecki & Wormith 1987; Drapeau, Korner, Brunet & Granger, 2004) learning skills such as relapse prevention, (Beech & Ward 2003) fantasy modification (Morrison & Print 1995) and re-educating the client (Horley, 2003; Beech & Ward 2003). This involves a focus on distorted cognitions and their influence on offending behaviours rather than an emphasis on the exploration of the client's feelings around their offending behaviour. This form of therapy is highly structured, with clear goals or targets the client is encouraged to meet, without which therapy may not be deemed effective. The idea of change in CBT is thus central, with one of the main goals being the cessation of offending behaviour.

This is almost the antithesis of Client-Centred therapy (CCT). In CCT, therapists' have no goals, for some CC therapists, the concept of change is not important, the therapist's agenda is simply to understand the client from their frame of reference. Hence, the idea of challenging distorted beliefs, paying attention to minimisations and confronting denial, would all be considered directing the client towards the therapist's (and maybe also the client's goal) which is not to re-offend. However, the client is free to choose what they wish to bring to therapy which may or may not relate to their offending behaviour. This has obvious advantages over the CBT approach but in my opinion also brings its own drawbacks.

It seems likely that the inability to set your own agenda in CBT therapy sessions will negatively influence drop out rates and there are likely to be more missed sessions if the client feels the therapy they have been ascribed is unhelpful. Also, I would argue that challenging clients may encourage defensiveness and may run the risk of pushing the client away permanently,

may lead them to distance themselves further from their offending behaviour and also may distance them from their therapist. As the therapeutic relationship has been seen as the most important factor in therapeutic change (Mearns and Thorne, 1992) then this seems a risky strategy. Lastly, the client may not have the opportunity to access underlying feelings which may have caused the offending behaviour in the first place.

A further disadvantage of CBT relates to self esteem. As outlined above, many offenders have very low self esteem, I would argue that focussing solely on offending behaviour, a very negative behaviour, is likely to have an adverse impact on their self esteem, even if only in the short term. In contrast, CCT assumes that, given the right conditions of empathy, congruence and unconditional positive regard, clients will become more congruent and grow emotionally healthier without the need to be confrontational or to use these other strategies and techniques. I believe, although I have been unable to find literature pertaining to the subject, that it is through the offender achieving greater congruence which results in the offender not needing to re-offend.

However some abusers want their therapists to be confrontational and some report that being challenged, particularly in relation to victim empathy, "helped me change my bad sex behaviours" (Borzecki & Wormith 1987). This suggests guilt may be a motivating factor for some clients and therefore in these instances, forcing the client to talk about their offences may be beneficial, as frequently clients avoid difficult issues when given the choice (Drapeau, Korner, Brunet & Granger, 2004). Borzecki and Wormith (1987) also support this view, when clients were told they must describe their offending behaviour in detail, all reported this to be the most difficult time in therapy but all said it was the most helpful, bringing them relief, helping them to realise they weren't alone and helping them better deal with their

feelings regarding their offending. If we assume that the client has to talk about their offending behaviour in order for congruence to be attained (a big assumption) and we assume that greater congruence will eliminate the need to offend (another assumption) then given the benefits outlined above and the common use of avoidance, maybe CCT is insufficient in this respect.

Clients have also reported that explanation, education and learning about offending behaviour is sometimes helpful; "I just wanted them to explain to me why paedophiles do what they do, I don't wanna talk about it cos I don't understand it anyway.. I just want them to tell me" (Drapeau et al, 2004, p.4). Also in relation to confrontation; "In my file someone wrote that I'm not motivated to change...when I heard that I asked to do therapy... I'm gonna go through this and show em.. Drapeau et al, 2004, p.5). Lastly, "I kinda think that they should force us to do therapy. I thinks its part of the process... we have to understand reality: we're in therapy because we fucked up... being forced to do things forces you.. you can only realise that way that this is not a joke or a dream but reality...(Drapeau, et al, 2004, p.4). Hence the Psychodynamic and Client-Centred approaches may fail where clients are unable to voice their needs.

However, Drapeau et al (2004) found that the commonest benefits of treatment were the client's chance to express themselves freely and openly without being thwarted or rejected, they said they benefited from being given permission to talk and cry which some reported led to a better understanding of themselves. These elements are fostered in Client-Centred therapy but as these reports came from offenders having CBT it may be that CBT offers the best of both worlds. Marshall and Serran (2004) drew similar conclusions from their research using CBT, they stated that the therapeutic relationship, trust and rapport were essential components for effective therapy.

However, further researchers have noted that CBT may be insufficient in some severe cases where offenders have repeatedly re-offended. In such circumstances physical treatments may be necessary in combination with CBT (Rosenburg et al 2004). Evidence from biomedical research suggests that sex offenders produce more testosterone than non offenders (Rosenburg & associates 2004) and inhibiting testosterone production through physical means, either castration or through drug treatment aimed at suppressing the libido (the most common of which in the UK is Androcur, in the US, Depo-Provera or Depro-Lupron) have been shown to reduce recidivism rates in offenders when combined with CBT (Rosenburg & associates 2004). The targeting of testosterone in treatments is also supported by literature demonstrating the very high prevalence rates of sex offending in men, who produce more testosterone in comparison to women. Further support for the use of physical treatments is found in research relating to evolutionary theory (see Rosenberg et al 2004 for further exploration).

Lastly, in relation to physical treatments, aversive behavioural procedures such as masturbatory satiation (Marshall,1979) covert sensitisation (Cautela, 1967) and orgasmic reconditioning (Marquis, 1970) have all been demonstrated effective in respect to “treating” sex abuse. However, these treatments, like the behavioural learning theory from which their application was derived, seem to be on the decline, particularly their use in isolation. Hence, although there is a vast amount of literature supporting a variety of physical treatments for sex offending behaviours, I feel it would nonetheless be crass to suggest that they should replace CBT, despite the noted problems with the use of CBT in isolation and its use in conjunction with physical treatments.

In contrast, Freud's psychodynamic (P) theory suggests that the three constructs of the psyche, the id, the ego and the superego are in constant turmoil and sex offenders have very weak superegos (morals) and very powerful ids (sexual impulses, libido) (Rosenburg & associates, 2004). Further P theorists and therapists have argued that paedophilia is a "manifestation of underlying conflict that developed during a maladaptive childhood" (Freund, 1983), is a "courtship disorder", or is the result of a "distorted love map" (Money, 1980). In all cases, it seems that the "cure" is for the client to develop insights into the source of their inner conflict (Drapeau et al, 2004). However, generally speaking, the decision of when and how the client brings their conflicts appears to be left for them to decide. There is, therefore, an underlying assumption that by the client discovering their underlying conflicts in therapy, then this will help reduce the likelihood of them re-offending, will result in a feeling of increased wellbeing, or both.

At present, I would argue that it is nigh on impossible to compare findings from CBT to those from P research. CBT and the physical treatments lend themselves to being measured quantitatively, whereas, in my opinion, P and CCT would be better suited to being studied qualitatively. However, whilst quantitative research has been in vogue for some time, it has only been in the last twenty years that there has been a steady increase in the use of qualitative research and thus research into the effectiveness and efficacy of CCT and P is still in its infancy by comparison. Also in the past there seems to have been a favouring of quantitative over qualitative research, I believe because of the dominance of psychiatry in mental health settings. I argue there is a desperate need for CC and P theorists and therapists to compile effective qualitative measures in order that these therapies may compete in the mental health market. If drug treatments and CBT continue to demonstrate their effectiveness whilst CC and P therapy cannot "prove" that they are

economically viable, then I feel that the latter will be further squeezed out of the market.

Perhaps a more damning criticism of CCT however is the idea that change in the client's behaviour should not be a goal in therapy because this means that the therapy may have to become directive. As aforementioned, some argue that it is sufficient for the client to be understood. How does this ideal fit when working with sex offenders? Is this realistic? Is it acceptable on moral grounds? Can the therapist who believes that child molestation and abuse is wrong, practice congruently without having a goal for change? Given the high level of denial, minimisation and avoidance, can we rely on the client to bring their offending material to therapy? Is it necessary for them to do so in order for them to change and if so whose agenda are we following, the clients or the therapists? Most sex offenders avoid the guilt, which would otherwise arise from their behaviour writes Houston (1990). This has been my own personal experience when working with six sex offenders, four who offended against children two against adults. All these clients use any manner of ways in which to try and diminish their guilt and subsequent emotions.

Therefore, in conclusion, CBT seems to leave little to chance. The therapy is highly structured focussing on distorted beliefs, minimisations, victim empathy and education to prevent re-offending. It has been compiled based on a very solid research base where I have found by far the greatest amount of research written extorting its efficacy and effectiveness in working with this client group. In comparison, there is little research on CC and P therapy. They both rely on the client setting their own agenda and reaching their own goals. This means there is arguably a lot left to chance as to whether clients bring their offending material and as to whether or not they derive any benefit in terms of their offending behaviour. This at times feels risky.

However, I believe CBT takes a nomothetic approach, to what may be an ideographic problem. I feel that CB therapist's are perhaps more likely to try and mould the programme and its aims to fit the individual. This is likely to have varying degrees of success as it has been derived from an amalgamation of global traits, where in reality only some will fit each client. More significantly however, I would argue that some clients are likely to rebel against what may seem a very strict regime by not attending, leaving sessions early or giving up on therapy altogether. Again a very risky strategy.

So what is the answer? I feel fortunate because, despite noticing that my clients use denial, minimisation, and distortion in their sessions, I have never felt any of them needed challenging. They have all been motivated to change their sex offending behaviour and have all regretted their offences. In this sense my therapy sessions have been easy. However, I know that I would not be able to work with a client with a sex offending history, who is unrepentant and has no inclination to change. In my opinion, it wouldn't matter which approach was adopted (though despite some counter arguments, I would still favour the CC) in this instance the client would remain offending.

References:

Abel, G.G., Becker, J.V., & Cunningham-Rathner, J. (1984) Complications consent and cognitions in sex between children and adults. *International Journal of Law and Psychiatry*, 7, 89-103.

Baker, A.W. & Duncan, S.P. (1985) Child sex abuse: A study of prevalence in Great Britain. *Child Abuse and Neglect*, 9, 457-467.

Barbaree, H. (1989) *Denial and Minimisation Among Adolescent and Adult Sex Offenders*, In James Horley (2003) *Personal Construct Perspective on Forensic Psychology*. Bruner-Routledge.

Beech, A.R. & Ward, T. (2003) The Integration of Aetiology and Risk in Sexual offenders: A Theoretical Framework. *Aggression and Violent Behaviour*, 295. *Article In Press*.

Carmen, E.H., Rieker, P.P. & Mills, T. (1984) Victims of Violence and Psychiatric Illness. *American Journal of Psychiatry*, 141, 378-383. In M.R. Hilton, & G.C. Mezey, (1996) *Victims and perpetrators of child sexual abuse*. *The British Journal of Psychiatry*, 169, (4), 408-421.

Drapeau, M., Korner, C.A., Brunet, L. & Granger, L. (2004) Treatment at La Macaza Clinic: A qualitative study of the sexual offenders perspective. *Canadian Journal of Criminology and Criminal Justice*, 46, 1, 2-10.

Fagan, P.J., Wise, T.N., Schmidt, C.W. Jr., & Berlin, F.S. (2002) Paedophilia. *Jama*. Chicago: Nov 20. Vol. 288, 19, pg. 2458.

Finkelhor, D. (1986) *Abusers: Special topics*. In Julia Houston (1998) *Making sense with offenders personal constructs therapy and change*. Wiley.

Fraser, M. (1976) *The Death of Narcissus*. London: Secker & Warburg.

Freund, K. (1980) Therapeutic sex drive reduction. *Acta Psychiatrica Scandinavia Supplement*, 5, 38, 287.

Freund, K., Scher, H. & Hucker, S. (1983) The courtship disorders. *Archives of sexual Behaviours*, 12, 369-379. In Fagan, P.J., Wise, T.N., Schmidt, C.W. Jr., & Berlin, F.S. (2002) *Paedophilia*. *Jama*. Chicago: Nov 20. Vol. 288, 19, pg. 2458.

- Hanks, H. & Saradjian, J. (1992) The Female Abuser. *Community Care*, 25th June, vii-viii. In Kemshall, H. & McIvor, G. (2004) *Managing Sex Offender Risk*. Jessica Kingsley Publishers: London & Philadelphia.
- Hanson, R.K. & Slater, S. (1988) Sexual victimisation in the history of child abusers: A review. *Annals of Sex Research*, 1, 485-499.
- Hilton, M.R. & Mezey, G.C. (1996) Victims and perpetrators of child sexual abuse. *The British Journal of Psychiatry*, 169, (4), 408-421.
- Horley, J. (2003) *Personal construct perspective on forensic psychology*. Bruner-Routledge.
- Houston, J. (1998) *Making sense with offenders personal constructs therapy and change*. Wiley.
- Kemshall, H. & McIvor, G. (2004) *Managing sex offender risk*. Jessica Kingsley Publishers: London & Philadelphia.
- Knight, R.A., & Prentky, R.A. (1990) Classifying sexual offenders: The development and corroboration of taxonomic models. In Julia Houston (1998) *Making sense with offenders personal constructs therapy and change*. Wiley.
- Launay, G. (2001) Relapse Prevention with Sex Offenders: Practice Theory and Research. *Criminal Behaviour and Mental Health*, Whurr Publications Ltd. 11, 38-54.
- Laws, D.R., & Marshall, W.L. (1990) A conditioning theory of the aetiology and maintenance of deviant sexual preference and behaviour. In James Horley (2003) *Personal construct perspective on forensic psychology*. Bruner-Routledge.
- Marshall, W.L., & Barbaree, H.E. (1990b) Outcome of comprehensive cognitive behavioural treatment programs. In Houston, J. (1998) *Making Sense with Offenders. Personal constructs therapy and change*. Wiley and sons.
- Marshall, W.L., & Barbaree, H.E. (1990) An Integrated theory of the aetiology of sexual offending. In Houston, J. (1998) *Making sense with offenders. personal constructs therapy and change*. Wiley and sons.
- Marshall, W.L., & Mazzucco, A. (1995) Self esteem and parental attachments of child molesters. *Sexual Abuse: A journal of Research and Treatment*, 7, 279-285.

Marshall, W.L., & Serran, G.A. (2004) The Role of the therapist in offender treatment. *Psychology, Crime and Law*, 10, (3) 309-320.

Marquis, J.N. (1970) Orgasmic reconditioning: changing sexual object choice, through controlling masturbation fantasies. *Journal of Behavioural Therapy and Experimental Psychiatry*, 1, 263-271. In Hilton, M.R. & Mezey, G.C. (1996) *Victims and Perpetrators of Child Sexual Abuse. The British Journal of Psychiatry*, 169, (4), 408-421.

Mc Caghy, C.H. (1967) Child Molesters: A study of their careers as deviants. In James Horley (2003) *Personal construct perspective on forensic psychology. Bruner-Routledge.*

Mearns, D. & Thorne, B. (1992) *Person centred counselling in action.* Series editor Windy Dryden. Sage Publications.

Money, J. (1980) Love and love sickness. Baltimore, Md: The John Hopkins University Press. In Fagan, P.J., Wise, T.N., Schmidt, C.W. Jr., & Berlin, F.S. (2002) *Paedophilia. Jama. Chicago: Nov 20. Vol. 288, 19, pg. 2458.*

Murphy, W.D. (1990) Assessment and modifications of cognitive disorders in sex offenders. In Houston, J. (1998) *Making sense with offenders. Personal constructs therapy and change. Wiley and sons.*

Needs, A. (1992) Some issues raised by the application of personal construct psychology to the sexual abuse of children. In Julia Houston (1998) *Making sense with offenders personal constructs therapy and change. Wiley.*

Rosenburg & Associates. [Http://www.angelfire.com/mi/collateral/page1.html](http://www.angelfire.com/mi/collateral/page1.html)

Rosler, A. & Witztum, E. (1998) Treatment of men and paraphilia with a long acting analogue of gonadotrophin releasing hormone. *New England Journal of Medicine*, 338,416499.

Russel, D.E.H. (1984) *Sexual exploitation. Beverley Hills, California: Sage Publications.* In Hilton, M.R. & Mezey, G.C. (1996) *Victims and perpetrators of child sexual abuse. The British Journal of Psychiatry*, 169, (4), 408-421.

Seidman, B.T., Marshall W.L., Hudson, S.M. & Robertson, P.J. (1994) An examination of intimacy and loneliness in sex offenders. *Journal of Interpersonal Violence*, 9, 518-534.

Skuse, D., Bentovim, A., Hodges, J., Stevenson, J., et al. (1998) Risk factors for development of sexually abusive behaviour in sexually victimised adolescent boys: A cross sectional study. *British Medical Journal (International edition)*. London, 317, 7152, 175-180.

Stermac, L.E., & Segal, Z.V. (1989) Adult sexual contact with children: An examination of cognitive factors. *Behaviour Therapy*, 20, 573-584.

Sturup, G.K. (1968) *Treating the untreatable chronic criminals at Herstedvester*. Baltimore, MD: John Hopkins Press.

Talbot, T., Gilligan, L., Carter, M. & Matson, S. (2002) An overview of sex offender management. Centre for sex offender management. www.csom.org

Ward, T., Hudson, S.M., & France, K.G. (1994) Self reported reasons for offending behaviour in child molesters. *Annals of Sex Research*, 6, 139-148.

White, P., Bradley, C., Ferriter, M., & Haatzipetrou,, L. (1998) Management for people with disorders of sexual preference and for convicted sexual offenders. [Http://www.angelfire.com/mi/collateral/page1.html](http://www.angelfire.com/mi/collateral/page1.html).