

**Characteristics And Treatments For Male Sexual Offenders:
Can Client-Centred Therapy Fill The Gap And Facilitate
Offender Responsibility Through Empowerment?**

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Introduction

The vast majority, if not all sexual offending behaviour, elicits social opprobrium. The sex offender, the paedophile in particular, is regarded as a social pariah. Sex offenders living in prison, where their offence is known by their inmates, require segregation to reduce the risk of them experiencing physical and verbal assaults. Similar attitudes infiltrate the therapist world. Barnard, Fuller, Robbins and Shaw (1989) noted that therapists treating offenders may experience ostracism and criticism from members of their community and a degree of censure or disapproval from fellow mental health workers, particularly those working with victims of sexual offences. In addition, numerous negative impacts have been reported from workers treating sex offenders. Reports suggest that workers have a loss of innocence; increased awareness of feeling the world is unsafe; (Freeman-Longo, 1997; Jackson, Holzman, Barnard, & Paradis 1997) a feeling of being vulnerable to violence; (Bengis, 1997) vicarious traumatization (Rich, 1997) and emotional hardening (Edmunds, 1997). Both these attitudes from society and these impacts on mental health workers, likely hamper staff recruitment in this field.

Whilst Lakey (1993) report treatment centres for youthful sexual offenders in the US mushroomed from 20 in 1982 to about 650 in 1994, further researchers have reported a variety of shortfalls in the treatment of sexual offenders. There is a paucity of funding (Charles & McDonald, 1997); a lack of sexual offender units (Smith, Hillenbrand & Goretsky, 1991) a lack of treatment programs (Mathews, 1997) insufficient knowledge about offending (Mathews, 1997) poor training among professionals in the community (Lombardo & DiGiorgio-Miller, 1988) and a lack of resources or expertise to provide supervision of sexual offenders through probation officers (Lurigio, Jones, & Smith, 1995). In addition, further researchers have noted that whilst sex offender treatment is better than no treatment at all, (Fagan et al 2002; Walker, 2004) several research studies have evidenced poor results (Rosenburg et al 2004, these are discussed in chapter two under effectiveness).

For many, the solution to sexual offending would likely be to 'lock them up and throw away the key' or to castrate the offender, rather than to offer treatment or psychotherapy. However, partly because of prison overcrowding (Corbett and Harris, 1995) but also because sex offenders are seldom locked up for life, most convicted sex offenders eventually live in the community (Talbot, Gilligan, Carter & Matson, 1997). In addition, castration or physical treatments are reported to have poor outcomes, particularly when used in isolation (Rosenburg & Associates, 2002; Sturup, 1968). Hence whilst the outrage projected onto this client group may be understandable, these solutions are both impractical, unlawful and often ineffective.

In summary, society's negative attitude, the negative consequences for some practitioners working with this client group, poor outcome statistics and under

funding, give an insight into some of the numerous obstacles which continue to hamper research and practice in working with sexual offenders. Consequently, relative to other client groups, research in this area is in its infancy with many areas hitherto unexplored.

Research Parameters

As males constitute approximately 95% of sexual offenders (Kemshall & McIvor, 2004) this article critically evaluates the literature on male sexual offenders only. Specific attention has been paid to material reporting on the characteristics of sexual offenders, as well as looking at the extent to which treatments address them. The aim of this emphasis is to reflect that observed in the general literature, where many researchers have focused on the offender's poor relationships in childhood and the offender's own abuse issues. Areas which require further consideration are highlighted, particularly the role of power and control in offending, which will be discussed alongside cognitive behaviour treatment, the prevailing treatment reported in the offending literature at present. Traditionally, treatments have stressed the importance of confronting and challenging the client and teaching specific skills such as victim empathy. Some of the possible negative consequences of using these methods, e.g. dis-empowerment, will be explored and alternative approaches suggested.

Chapter 1.

Sexual Offending

Prevalence of Offending

Defining Offending Behaviours

Typologies of Paedophilia

Fixated or Preferential and Regressed or Situational

Childhood History of Offenders

Poor Attachments, Experiences of Abuse...

Prevalence of Offending

Crime statistics for England and Wales (2001) report that 1.5% of men and 7% of women have suffered a serious sexual assault at least once in their lifetime, since the age of sixteen. Statistics on the prevalence of sexual abuse of children are more widely quoted. Fagan, Wise, Schmidt and Berlin (2002) report that 12% of men, and 17% of women, reported being sexually touched by an older person when they were children. These figures are similar to those of Baker and Duncan (1985) who report 8% and 12% respectively. However, reports from Salter, McMillan, Richards, Talbot, Hodges, Bentovim, Hastings, Stevenson & Skuse (2003) and Russell (1984) suggest figures may be notably higher, the former estimating between 3% and 37% for boys, and between 7% and 53% for girls, the latter reports on women only, and found 28% in their large community sample of over 900 women.

Charles and McDonald (1997) argue that the actual figures for the prevalence of victims of sex offences, are likely to be higher than those reported, with many unreported by the victim and the offender. Charles and McDonald, (1997) also note that figures tend to account for adjudicated cases only, which may be dropped or discounted and relabelled as adolescent experimentation.

In addition, statistics on offending rates are often confusing. Some refer to a specific sex offence, for example rape, whilst others relate to all sex offences. Additional statistics only look at a specific group, for example children, or adults, and still others look at statistics within a particular time frame, for example over the last year, or in someone's life time. All these methods mean it is difficult to make comparisons across studies and reliable prevalence estimates.

In respect to who assaults whom, Fagan et al (2002) quote findings from the Federal Bureau of Investigation's National Incident-Based Reporting System which is based on reports from twelve states across America from 1991 to 1996. Sixty seven percent

of sexual assaults involved juvenile victims, one in seven of whom were younger than six years and a third of whom were younger than twelve. Eighty three percent of the younger than twelve years were female. Ninety six percent of the offenders were male, presumably leaving the remaining four percent female. Kemshall & McIvor (2004) state that research has consistently quoted the number of female sex offenders at around five percent, although they concede that the research in this area has been hampered by a general reluctance to accept that women sexually abuse.

Defining Offending Behaviours

According to Charles and McDonald (1997)

'The same criteria are used for both adults and adolescents in terms of what constitutes a sexual offence. Behaviours deemed inappropriate and illegal include fondling, frottage, digital, penile or object penetration of the vagina or anus and oral copulation. Also included are such behaviours as voyeurism, exhibitionism and obscene phone calls' (p. 16).

Carich, Newbauer and Stone (2001) add stalking, verbal sexual harassment, physical sexual harassment and necrophilia.

Whilst these behavioural descriptions are clear, in reality researchers tend to use broader definitions which suggest the approximate age of the victim e.g. child versus adult and the type of offence e.g. molestation and rape. At this point in time, it is difficult to assess what ramifications there may be for using these types of classifications. Also, whilst there has been a reasonable amount of research on the treatments of rapists and molesters against both adults and children, (see below under typologies) there has been less research on non contact offences such as voyeurism.

Typologies of Paedophilia

Fagan et al (2002) remark that some investigators have used typologies to gain an understanding of paedophilia. Thus this particular group of offender has been divided into familial versus non familial, touching versus non touching, seductive versus aggressive. However, Fagan (2002) warns against the use of researchers adhering too closely to these categories stating they are not mutually exclusive.

A further categorisation they note is one in which the offence is classified according to one of three specifications based on a.) the child's age, b.) the child's sex and c.) the range of attraction e.g. incest only, or familial and extra familial. However, whilst over specification may mean that some significant behaviours may be overlooked in treatment programmes that adhere too closely to schedules, without an adequate categorisation system comparisons across different types of offenders can not easily be made.

Further researchers have created subdivisions of types of offenders. For example, findings from Ivey and Simpson's (1998) small scale qualitative study (of six volunteers) suggest two styles of paedophilic sexuality may be evident, based on the onset of interest in children which may be adult, or adolescent onset.

Fixated or Preferential and Regressed or Situational

In addition investigators have also categorised male sex offenders into two broad types; 1.) fixated or preferential and 2.) regressed or situational (Knight & Prentky 1990; Carich et al, 2001; Groth, 1979). 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 (for a further similar category system see Lurigio, Jones, & Smith, 1995). Presumably this group of offender is more likely to fit Ivey and Simpson's (1998) early onset category i.e. in adolescence. In addition, many of these characteristics may be the result of poor relationships in childhood and thus are also echoed in the research outlined below on the childhood history of offenders.

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). This literature is partially supported by research finding that offenders often have poor social skills and low self esteem (see under childhood history of offenders below). 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.

Childhood History of Offenders

Poor Attachments, Experiences of Abuse...

The most prevalent description of sex offenders in the literature is that which looks at their childhood history. Several researchers note that sex offenders are not a homogenous group (Charles & McDonald 1997; Greenberg, 1990). However there is substantial agreement amongst researchers over a number of characteristics found in the backgrounds of offenders. In approximate order of prevalence of reported findings for each sub category of characteristic, numerous researchers report that sex offenders have experienced poor parent-child relationships (Marshall & Marshall, 2000; Marshall, Serran and Cortoni 2000,) including a discontinuity of care in

childhood e.g. parental separations, periods of care in a children's home or similar, or a move to a foster home (Salter et al, 2003); a history of physical and / or sexual abuse, and / or neglect (Charles & McDonald, 1997; Salter, McMillan, Richards, Talbot, Hodges, Bentovim, Hastings, Stevenson & Skuse, 2003; Egeland, 1993); witnessed repeated episodes of violence (Salter et al, 2003) and whose parents suffer from mental ill-health (Salter et al, 2003). In addition, many offenders have poor social skills (Katz, 1990) low self esteem (Katz, 1990) and poor impulse control (Kavoussi, Kaplan, & Becker, 1988).

Marshall and Marshall (2000) note that;

'offenders may have a vested interest in exaggerating their childhood sexual abuse; ..[seeing] this as diminishing their responsibility' (p. 253 brackets added).

However, Salter et al (2003) argue that being of male sex and having been a victim of abuse in childhood, are *the* most frequently cited risk factors for becoming an abuser in later life. The prevalence of conformity amongst countless studies thus warrants stringent investigation and may add insight into the specificity of sexual offending from other forms of offending where characteristics are similar.

Chapter 2.

Hypotheses of Pathways to Offending

Pathways to Sexual Offending

The Victim to Victimiser Hypothesis

Poor Attachment and a Vulnerability to Experience Abuse

Sexual Abuse Experiences and a Vulnerability to Sexual Offending

The Sex Hypothesis

A Power-Control Hypothesis

Limitations of the Power-Control Hypothesis

Multiple Pathways to Sexual Offending

Pathways to Sexual Offending

Marshall and Marshall (2000) make sense of this list of characteristics by postulating a sequence of unfolding events in the offender's development. They suggest that this sequence often may begin with poor parent-child attachments. They support their arguments with the work of Bowlby, (1969) and Ainsworth (1978) specifically noting the adverse influence of insecure bonds and the role this may play in the child's ability to develop future secure attachments. These researchers argue that attachments in childhood provide the child with a template for all future relationships. Where they have learnt through parental relationships that people are inconsistent and offer little or no support, then they are more likely to develop anxious/ambivalent relationships. In this instance the child likely wants to feel close to others but is afraid of intimacy through a fear of rejection. Avoidant children may be the product of parents who were cold or distant. It is argued that these children develop a belief that all relationships are untrustworthy and hence are more prone to avoid them (Haapasalo, Puupponen & Crittenden, 1999).

The Victim to Victimiser Hypothesis

Poor Attachment and a Vulnerability to Experience Abuse

Marshall and Marshall (2000) argue that the experience of a poor attachment creates a vulnerability in the child. They suggest this encourages the generation of a poor relationship style where the child may latch onto anyone who shows them attention. In this sense the child is likely to be more vulnerable to abuse as well as have low self esteem (two further main characteristics of offenders). This argument has received additional support from Katz (1990) and further researchers who have noted that a significant number of offenders have inadequate relationships with

peers, often coupled with an inability to form age appropriate sexual relationships (Hilton & Mezey, 1996). Numerous studies have found that the offender attempts to get his needs met through relationships with people he finds less threatening, typically children or people with learning difficulties (Carich et al 2001; Hilton & Mezey, 1996).

Sexual Abuse Experiences and a Vulnerability to Sexual Offending

Marshall and Marshall (2000) further state;

‘it is reasonable to suggest that there is a pathway involving insecure attachments → a greater risk to be sexually abused and to → heightened sexualization (particularly masturbation) → which finally results in adult sexual offending’ (p. 254).

Hence, Marshall and Marshall (2000) suggest that offenders rape for sexual reasons and sexual abuse leads to sexual offending, this could be called the sex hypothesis.

The Sex Hypothesis

Sexual offending for sexual reasons

Haapasalo et al (1999) looked at the pathway from victim to victimiser using a case study of a six time sex offender. Their findings support Marshall and Marshall (2000) in so far as their offender reported physical and sexual abuse from his father and results from his adult attachment interview suggested his attachment style was dismissive avoidant, or avoidant defensive. In addition, Haapasalo et al (1999) suggest that the morphology of the childhood event may be indicative of the morphology of the adult offence. Their case study found that their offender’s;

‘pattern of sexual offending against children was similar to [their] own experiences of abuse’ (p. 98).

They further argue that;

‘physically abused children tend to commit physically violent crimes, whereas sexually abused children are prone in adulthood to sexual violence’ (p. 98).

In addition, they cite further researchers espousing this view (Hilton & Mezey, 1996). Hence there is some agreement amongst these researchers of an offending pathway.

However, the specificity of sexual abuse, as opposed to all types of abuse and neglect influencing the likelihood of future sex offending, may fit the general research literature less parsimoniously. Whilst numerous researchers have found that offenders have experienced *a* form of abuse, the link between sexual abuse and sex offending is weaker, based on prevalence of reporting of sexual abuse incidents from

sex offenders. Hence a slight adaptation to Marshall and Marshall's (2000) model suggesting that *all forms* of abuse are *more likely to follow* poor attachment may be more reliable. In addition, Marshall and Marshall's (2000) hypothesis suggesting sexual abuse experiences lead to heightened sexualization is unclear, if the type of abuse is not confined to sexual abuse. In instances where offenders have been physically abused, neglected or neither, their theoretical link to heightened sexualization, with masturbation as a coping strategy, is less convincing.

Further support for the notion that offenders offend for sexual reasons, stems from literature which finds that offenders have;

‘difficulty forming intimate relationships with people of their own age’
(Hilton & Mezey, 1996, P.5).

In these circumstances, the child often becomes a substitute sexual partner. The paedophile uses the child as a ‘safe’ outlet for expressing and meeting their sexual or intimacy needs which would otherwise not be met. This research links to that reporting poor attachments amongst the offending population (assuming poor attachment and poor intimacy go hand in hand) and numerous articles outlining the difficulties offenders have in developing satisfactory adult relationships (for example see Needs, 1992; Lurigio, Jones, & Smith, 1995). This research therefore may contribute to our understanding why this particular class of offender offends sexually, as well as offering an alternative or additional explanation over and above the offender's own sexual abuse experiences.

Power - Control Hypothesis

A further link which may contribute to our understanding of the pathway from childhood experiences of abuse to sex offending relates to power. Issues relating to power and control may be evident in *all* forms of abuse, rather than just sexual abuse and in this sense would encompass a larger proportion of the research findings in terms of the characteristics of offenders. All experiences of abuse have the potential to leave the victim feeling powerless (Sabatino, 1999). Psychodynamic theory, in relation to identification with the aggressor, may offer support for the role of power and control in the aetiology of offending (Sabatino, 1999 & Van der Kolk, McFarlane & Weisaeth 1996). Mark Dombeck (2000) writes;

‘when someone is a victim of violence from another person, their self-concept is likely to include the idea of being powerless, while their other-concept for the abuser is likely to include the idea of being powerful. Given the choice of feeling powerless or powerful, most persons will want to feel powerful... some victims start to reject being a victim and start to want to be powerful like the abuser’... the victim [then] goes looking for other persons to victimise... by

becoming an aggressor him or herself, the victim gets to feel more powerful and in control'.

(extract from web page www.mentalhelp.net, brackets added).

Perhaps it is not always the abuse per se which increases the likelihood of offending behaviour, moreover the underlying feature of powerlessness in abuse victims. This hypothesis would be more inclusive of research findings relating to general abuse experiences in offenders as opposed to Marshall et al's (2000) model which ignores this group in favour of offenders who had experienced sexual abuse.

However, Hilton and Mezey (1996) find a major flaw with the identification with the aggressor theory. They note that most sex abusers are men, whilst the majority of victims are women. Hence, the identification with the aggressor model cannot explain why more women don't offend. Nonetheless, there are numerous further explanations why men are more likely to sexually offend than women. For example, women are more likely to project anger inwards onto themselves and become depressed, whereas men typically 'act out' or use alcohol and drugs (Finkelhor, Hotaling, Lewis & Smith, 1990). Also, Sabatino (1999) writes, males who have been abused experience a double hurt, the hurt which stems from the abuse experience itself and a hurt to their manhood, as men are not supposed to find themselves helpless, 'real men stay in control'.

Several further researchers have also noted that sex offenders do not offend for sexual gratification but out of a desire to exert power over their victims, what could be called the power-control hypothesis (Sabatino, 1999; Beaty, 1996; Deisher, 1982; Reynolds, 1984; Lurigio & Loyola, 1995; Hobson, 1985; Matsuda, Rasmussen & Dibble, 1989). Indeed, four criteria used to define juvenile sexual offending, all refer to the perpetrator's use of exploitation, power and control over their victim (for further details see the Utah Network on Juveniles Offending Sexually in Charles & McDonald, 1997).

In addition, Sabatino (1999) writes;

'my experience confirms that most men who sexually offend are primarily acting not out of a need for sex but rather a need for power and control, especially over those more vulnerable, namely women and children' (P.86).

Whilst against the power hypothesis, Palmer (1988) wrote;

'the most popular explanation of rape holds that rapists are seeking power, control, violence and / or domination instead of sex' (p.512).

In addition he states;

'proponents of the 'not sex' explanation hold that the occurrence of rape cannot be accounted for by the hypothesis that sexual stimulation is the goal of rapists' (p.512).

A significant issue Palmer (1988) raises is that of gratuitous violence in sexual offending. He states that it is crucial to make a distinction between violence necessary to perpetrate the crime, and violence administered over and above this. Excessive violence may be an indication of a violent motivation, rather than a sexual one. He quotes research from Harding (1985) who supports the power and control argument.

'In most cases the use of force goes beyond that necessary to compel the victims compliance with the rapist's demands' (p.51).

However, probably one of the strongest supporters for the role of power in offending is Groth (1979). In his book *Men Who Rape* he argues rape is a sexual expression of power and anger. He notes that whilst rapists who cannot gain meaningful intimate relationships but nonetheless want sex could turn to prostitution, he claims they don't want 'to pay for it', 'they want to take it' (in Reynolds, 1984, p.150). Groth (1979) also outlined three types of rapists; anger rapists, power rapists and sadistic rapists. Anger rapists express anger through rape, power rapists wish to dominate, control and display their superiority and mastery, whilst sadistic rapists enjoy their victims suffering and humiliation or degradation through sexual exploits.

Limitations of the Power-Control Hypothesis

Neither the power-control hypothesis, nor the broad characteristics outlined at the beginning of this chapter, offer insight into the specificity of offending. These characteristics may hold some explanatory power in respect to offending in general but don't tell us why the offending behaviour is sexual in nature. Offenders could exert power and control over victims without sexually abusing them. Therefore, in cases where the offender experienced some form of abuse himself, which was not sexual in nature, the pathway to sexual offending in particular is unclear. An interesting area to research would be one which compared the characteristics of other offences which involve power and control, for example non sexual murder, with sexual offences, with a view to exploring possible differences between the two.

In addition, the power-control hypothesis sits more comfortably when exploring the motivations behind the more serious sexual offences but is less likely to be applicable to other forms of offending such as frottage, fondling, voyeurism, exhibitionism and obscene phone calls, where the use of force is absent or less

evident. Lastly, the power-control hypothesis fits less easily with rapists who offend by grooming their victims, than those who use physical aggression and violence.

Palmer (1988) is sceptical about the sole adoption of the power-control hypothesis as an explanation for sex offending. He fears the consequences this attitude may have on treatments which may focus on the power issue at the cost of not attending to the offenders difficulties in sexual relationships.

Multiple Pathways to Sexual Offending

What seems most likely, is that there is more than one pathway on the route to sexual offending. For example, it could be that abuse of any type has two major influences on the victim, one which heightens sexuality, the argument espoused by Marshall and Marshall (2000) and a further influence which results in some offenders who have been victims themselves wanting to exert power and control over further victims, as a by product of their own experiences. A further subset of sexual offenders may never have experienced abuse, instead their poor relationships mean that they turn to children or adults more vulnerable than themselves as a way of attempting to meet their sexual or intimacy needs. It may therefore be that some offenders are more likely to offend for sexual reasons, others for reasons related to power and control and some in an attempt to satisfy intimacy needs, in still further cases these factors may be intertwined.

Chapter 3.

Treatment Programmes

Group Treatment

Efficacy

Voluntary versus Compulsory Treatments

Confrontation of Distortions, Minimisations and Denial

Treatment Limitations

Further Components of Treatment Programmes

Advantages and Further Limitations of Treatment Programmes

Group Treatment

Efficacy

Three broad categories of therapeutic treatments, surgical, pharmacological and psychological are available to sex offenders at present. This article explores psychotherapeutic approaches only (for information on other treatments see Perkins, Hammond Coles & Bishopp, 1998).

Voluntary versus Compulsory Treatments

Many treatment programmes stipulate that the offender admits guilt, before being admitted onto the programme (Mamabolo, 1996; Newbauer & Banks, 2001). As the most significant factor in the probability of offenders re-offending is their level of motivation (Chaffin, 1994) and as an admission of guilt suggests commitment to change, treatment programmes admitting only those accepting responsibility, are likely to be treating the clients most likely to change. However, offenders in secure units, such as prison, will arguably find it harder to refuse treatment, for fear of losing privileges such as leave, or association time. Given what we know about internal and external motivation, it would seem likely that where treatment is 'compulsory' offenders would be more likely to fair poorly compared with those who join voluntarily. In addition, forced attendance increases the likelihood that offenders will drop out of the programme altogether (Simkins, Ward, Bowman, Rinck and De Souza, 1990) and the strongest predictor for recidivism is an offender's failure to complete the programme (Perkins et al, 1998). Nonetheless it seems likely that those who refuse treatment or enter programmes under duress will fair poorly in comparison whatever approach therapists adopt. Conversely, in out-patient clinics, attendance is more likely to be voluntary, suggesting a higher level of motivation to therapy and frequently a commitment to a life of not re-offending.

Group therapy has been argued the most appropriate form of treatment in the United States (Borzecki & Wormith, 1987) and the Sex Offender Treatment Programme (SOTP) in the UK (which is largely group based) is the largest of its kind in the world (Perkins et al, 1998). Morrison and Print (1995) argue there is strong evidence to support the idea that group therapy is the most effective offence-specific intervention for adolescent sex offenders because; it breaks the isolation and secrecy which supports abuse; it is a forum for confrontation, support and education; it facilitates disclosure and promotes empathic interaction. In addition, Yalom (1985) describes a curative factor of group therapy in respect to providing the needed identification with other male survivors of abuse thereby reducing the feelings of isolation and aloneness.

Morrison and Print (1995) recommend groups of between six and eight people to meet weekly, with members staying about 12 to 18 months. In addition, they note the desirability of having an ongoing group with members joining and leaving because of the positive influence more experienced group members bring to newcomers. Further researchers write of programmes which are much shorter in duration, Mamabolo (1996) state fifteen sessions in total.

Confrontation of Distortions, Minimisations and Denial

Treatment, typically entails the offender recounting their offending past. In the retelling of their offending history, the offender is challenged by other members of the group and the group facilitator (Carich Newbauer & Stone, 2001; Fagan et al, 2002; Marshall et al, 1999; Talbot, Gilligan, Carter & Matson, 1997). Their cognitive distortions, denials, minimisations, justifications, blaming of others, lies, self pity and depersonalisation are all confronted or challenged in order that the offender bring into his awareness how he came to perpetrate his crime(s) (Beech & Ward 2003; Carich, Newbauer & Stone, 2001; Corbett & Harris, 1995; Lakey, 1994; Mamabolo, 1994; and see Marshall et al 1999 or Morrison & Print, 1995, for a more detailed description of group therapy). Newbauer and Banks (2001) elaborate on the confrontation process they state;

‘the adolescent will learn... to accept total responsibility for their sexual offence, to identify and restructure beliefs and cognitions so that the thinking distortions and misguided values that triggered the sexual abuse are no longer problematic’ (p. 40).

Treatment Limitations

These sorts of treatment programmes suggest that part of the reason why the offender is able to offend is because of a lack of guilt or remorse. Therefore, by challenging distorted thinking used to allay guilt, the offender learns to feel appropriately and the likelihood of re-offending will be reduced. This assumption

follows the basic cognitive behaviour principal, change the cognition, and the feeling behind it will change similarly. However, some clients may simply learn the desired response and blindly follow instructions without fully accepting the consequences of their offending past into their core way of being (Kear Colwell & Pollack 1997). Where this occurs, the client's risk of re-offending, is likely to remain similar at the end of the programme, to the beginning.

Carich, Newbauer & Stone (1998) write;

'another critical difference in offender treatment is the initial *induction of pain* by inducing victim empathy and remorse in conjunction with issues of accountability and responsibility. The offender's realisation ...of the impact of his offending behaviours on others *hurts* as the offender identifies the pain of the victim. In essence the offender learns to feel bad for violating his victim' (p. 9, italics added).

However, where clients accept responsibility for their offending past, challenging and confronting them may be inappropriate but nonetheless incited by the client. Some offenders feel extremely guilty, to the point of inciting punishment from the therapist. Drapeau et al (2004) argue abusers feel that the therapist must be confrontational in order to help them realise the harm they have done. They also report findings from Federoff, Hanson, McGuire and Moran (1997) who suggest that up to 20% of sex abusers in therapy have exaggerated their deviant behaviour, they suggest in order to enter or remain in treatment. However, these clients may be playing a variant of the game 'kick me', as outlined in transactional analysis (T.A.) (Stewart & Joines, 1989). According to T.A. theory, clients who have experienced abuse throughout their childhood and have come to accept it as part of a way of life, may incite negative feedback from therapists and those around them. As a large percentage of offenders have experienced abuse in one form or another, this factor needs to be taken into account. In these circumstances, inducing 'pain' and 'hurt' through confrontation and challenge may be harmful because it simply repeats abusive experiences from childhood.

In addition, it is apparent that some clients have accepted, and demonstrated their acceptance, that they have caused pain to their victim and with this demonstrate pain of their own. These clients often come to view themselves as 'all bad' their disclosures suggest a belief that this is a stable, generalised characteristic which is permanent. Carich Kassel & Stone (2001) use the phrase 'toxic shame' to describe the client's excessive feeling of shame and guilt associated with violation of another person. Toxic shame is likely to be unhelpful to either therapist or client because it carries the potential to lower the client's already low self esteem. As a consequence clients will find it difficult to move forward. Newbauer and Banks (2001) write, towards the end of therapy;

'the goal is self forgiveness for what they have done. [Clients] are helped to move beyond shame and self loathing to an adequate sense of self worth and a positive self image without diminishing the seriousness of their offence behaviour' (p.42, brackets added).

Where this goal is not attained, offenders may leave programmes with very low self esteem, potentially lower than when they arrived and low self esteem has been earmarked as a major risk factor for re-offending (Morrison and Print, 1995). Therefore, elements which potentially lower self esteem should be applied with caution, particularly if there is little to no opportunity for the client to recover some self worth before leaving treatment.

Lastly, in the writer's experience, a significant minority of clients have an inability to see, acknowledge, or accept that they too have pain and that it is justified. Clients frequently have suppressed their anger at their own injustices, believing that because they perpetrated a crime they are not allowed to be angry. This anger usually has arisen from their own negative experiences, typically either of abuse or disrupted relationships or both. In these cases, it is of paramount importance for the client to have the opportunity to go through these experiences in therapy without which arguably they carry a ticking time bomb.

Further Components of Treatment Programmes

Further treatment areas which focus upon the offence, which are typically provided in a group situation include a.) an understanding of the assault cycle (the pattern of behaviours from non offending to offending) b.) victim awareness, particularly victim empathy (see Carich, Kassel & Stone, 2001 or Marshall et al, 1999, for a detailed description of techniques) including experiencing remorse for the offence (Newbauer & Banks, 2001) c.) arousal control / fantasy modification (Carich Newbauer & Stone, 2001; Corbett & Harris, 1995; Laws, 2003; Rice & Harris, 1998; Beech & Ward 2003) d.) assertiveness and anger management (Rice & Harris, 1998) and e.) relapse prevention (Carich Newbauer & Stone, 2001; Launey, 2001; Laws, 2003; Marshall et al 1999) or a protection plan against recurrence of the offence (Newbauer & Banks, 2001) all of which are purported lacking in offenders (Carich Newbauer & Stone, 2001; Morrison & Print, 1995). Drapeau, Korner, Brunet and Granger (2004) add social skills training, sexual education, and problem solving.

Advantages and Further Limitations of Treatment Programmes

The majority of these areas of treatment have been broken down into a detailed analysis of constituent components, with suggestions of how each specific area may be addressed in treatment (for examples see Laws, Hudson and Ward (2000) for a

detailed breakdown of the cognitive behavioural model of relapse and Carich, Kassel and Stone (2001) for victim empathy). These treatments focussing on the offending behaviours are thus very comprehensive. They also may be reassuring to the therapist, in that they can evidence the treatment process more readily as each stage is completed and ticked off, in this sense treatment may be seen to accomplish the goal of leaving less to chance. This is particularly significant in the current climate of litigation, where therapist's fear comeback (both financial and moral) if clients re-offend following treatment. Also, some offenders are likely to feel a sense of achievement after completing something tangible and constructive, knowing that it may help to reduce their risk of re-offending. This in itself is of value, given the very low self esteem evident in this client group. Perhaps more significantly however, high risk offenders may be unlikely to want to voluntarily address their offending behaviour and without this direct approach may avoid disclosure or exploring their offending past. In circumstances such as these, and where the practitioner believes that the way to reduce the likelihood of re-offending is to look at it directly, are they practising ethically or morally if this type of approach is not adopted?

However, efficacy studies for treatment programmes have produced mixed findings. Some researchers have stated that cognitive behavioural therapy is the most effective treatment with adolescent male sex offenders (Walker, 2004) and with adults (McGrath 1995; Abracen, 2004). Nonetheless, research into the effectiveness of behavioural treatment for deviant arousal (Laws, 1989; Rice, Quinsey & Harris, 1991; Marshall & Barrett, 1990) relapse prevention (Laws et 2000; Laws, 2003; Marques, 1999) and treatment with offenders classified as having high deviancy behaviours, have yielded poor results (Beckett, Beech, Fisher & Fordman, 1994). Perkins et al (1998) quote research undertaken by Hanson and Bussiere (1998) which looked at a number of different treatments. They found that sexual recidivism rates were 47% for rapists and 37% for child molesters. Their meta analysis note the influence the type of offending has upon the effectiveness of treatment. The effectiveness research is therefore mixed in respect to supporting treatment.

Further differences in effectiveness are likely to be found based upon a number of offender variables, for example a.) the relationship the offender has with the victim b.) the number of different victims, c.) whether the victims are both male and female, or of one sex, d.) the age of the victim in respect to whether the offender has offended against adults only, or both adults and children and e.) the age of the offender (see Perkins et al, 1998 for further predictive factors). It would therefore seem likely that adult sex offenders, who have offended against both children and adults, males and females over a protracted period of time and where the offending behaviour is more violent, are likely to be amongst the hardest to treat. The way in which studies have been performed make it very difficult to separate out treatment effects from these other variables (Rice & Harris, 1998). Without detailed analysis

exploring all these variables in relation to one another, it is difficult to identify what aspect of treatments are the most effective for whom. For example, it seems likely that victim empathy would be less important in terms of treating extra familial abuse perpetrated by a 'situational' paedophile than it would be for treating a 'fixated' paedophile.

Many investigators argue that the use of these treatments in isolation is insufficient (Hall & Hirschman, 1992) that different offenders will respond to different treatments, (Charles & McDonald, 1997) that it is important that treatment addresses the sex offender's own childhood sexual victimisation (Guidry, 2000; Lakey 1994; Newblauer & Banks 2001; Woods, 1997; Mamabolo, 1996) and personality problems (Hall and Hirschman, 1992) and trauma (McMackin et al, 2002). Further, that greater emphasis needs to be given to the ideographic and dynamic features presented by individual offenders (Perkins et al 1998) and that clinicians need individual formulations and treatment plans for each patient (Charles & McDonald, 1997).

In summary, group treatments using a cognitive behavioural approach are the most widely reported and tested treatments for sex offenders. Group treatment tends to follow a fairly specific pattern, the components of which have been listed along with some of their advantages and disadvantages.

Chapter 4.

Individual Therapy

Differences Between Treatment and Therapy

The Necessary Addition of Individual Therapy

Power and Control in Treatments and Therapy

Differences Between Treatment and Therapy

Commonly, no distinctions are made in the literature between treatment and therapy. In respect to sex offender literature the two terms suggest different emphases in how the client who has offended is supported. Perkins et al (1998) report that treatments are techniques used to implement change. Frequently, the main 'problem' deemed for client's who have offended, is the offending behaviour, which therapists in treatment programmes set out to target (Wakefield & Underwager, 1991; Lakey, 1994). In contrast, in individual client-centred therapy with clients who haven't offended, clients are assumed to be experiencing some form of mental distress and the client's goal for therapy is not usually predetermined by the therapist but by the client themselves (Rogers, 1959). Therefore, strictly speaking, therapy may not necessarily look at the client's offending behaviours. This factor, coupled with the location of the client, in prison, in hospital, or in the community, is likely to have an impact on who the therapist feels most responsibility towards, i.e. the client, or the general public. The therapist working on a treatment programme in prison, is arguably more likely to see their primary responsibility as being that of public protection and risk reduction. This means that therapy is less likely to be value free. Conversely, in individual therapy in a hospital or out-patient community setting, the therapist's primary responsibility is more likely to be towards their client's treatment goals and meeting the client's needs, which arguably may be unrelated or less related to risk issues and aims to be value free. In addition, this emphasis likely impacts on the format of therapy. In treatment programmes, treatment tends to be more instructional and directed by the therapist and is commonly based on a cognitive behaviour approach. Whereas in individual therapy outside of prison, therapists may adopt one of a number of different approaches, or an integration of several and the therapist tends to adopt a more facilitative role than instructional. Where these latter differences exist, the client's perception of their level of power is likely to alter, whereby clients in prison settings on treatment programmes are more likely to feel they have less power than clients outside of prison in the community. These differences have been summarised in table one below.

Table 1. Differences between Treatment and Therapy for Sex Offenders

Treatment	Therapy
The therapist directs the client's exploration of material in key specified areas relating to offending.	The therapist is more likely to encourage self (client) directed exploration of material based on client disclosure of the key issues which, may or may not relate to offending.
Therapy is based on the moral values of society.	Therapy aims to be value free.
Greater emphasis on risk issues.	Greater emphasis on therapy issues.
The therapist aims to teach new skills thereby modelling a parent or teacher role. Therefore a 'power over' relationship exists between therapist and client (Proctor, 2002).	The therapist is more likely to facilitate the process of therapy modelling an adult to adult relationship, where power differentials are less obvious by comparison.

Based on this information, the emphases in the content, process and goals found in SOTP's in prisons are likely to be different to those found in therapy in the community. Greater clarity in the literature in this respect is necessary in order that theoreticians and practitioners can more easily identify the limitations attributable to each approach. Specifically, the emphasis in the SOTP in the UK is to focus on the offence, ensuring the offender explores their offending past to the exclusion of spending time looking at their other issues relating to their childhood histories. Individual therapy outside prisons and secure units is likely to focus upon the offence and the offender's childhood history but with perhaps less stringent focus on the offender's offending past. Hence, therapy may be criticised for not paying sufficient attention to the client's offending past, whereas the SOTP may be criticised for ignoring or paying very limited attention to the client's childhood history and issues such as the offender's own experiences of abuse.

The Necessary Addition of Individual Therapy

Numerous researchers espouse the importance of the addition of individual therapy over and above group treatment programmes in order for the perpetrator to explore their own experiences of trauma (Davidson, 1984; Lee, Jackson, Pattison & Ward, 2002; McMackin et al, 2002; Morrison & Print, 1995) which may have influenced the development of the problematic behaviour (Saleh & Guidry, 2003). Where clients have held onto and distorted negative childhood experiences, it seems likely that

these experiences will influence current offending behaviours. Travin Cullen and Potter (1990) argue;

‘some children who have been sexually abused re-enact their own abuse on others in a perverse attempt to gain mastery of their own experience’ (in Charles and McDonald, 1997, p.36).

Victims of trauma, re-victimise (Briere, 1989; Haapasalo et al, 1999; Hilton & Mezey 1996) and most are out of touch with their own experiences of victimisation (Polson & McCullom, 1995). Charles and McDonald, (1997) further argue clients need therapy and help to deal with their victimisation.

‘It is incumbent upon the therapist to not only help the offender to prevent re-molesting, but also to heal’ (p.36).

Drapeau et al (2004) found most offenders wanted support with their experiences of victimisation but found it was lacking.

Whilst some treatment programmes offer the opportunity for disclosure of childhood trauma (Drapeau et al 2004; Marshall, Anderson & Fernandez, 1999) this is likely to be limited in group treatment programmes due to the teaching emphasis. Whilst there are undoubtedly many advantages for those offenders able to disclose their past in a group situation, clients on some programmes don’t appear to do so. Whether this is because clients haven’t had that opportunity, or whether it’s because they don’t feel the environment is sufficiently safe is unclear. However, Drapeau et al (2004) reported that six of their twenty four participants reported their own abusive history, whereas further reports in the literature suggest childhood adversity is evident in the history of *most* offenders (Charles & McDonald, 1997).

Furthermore, some potential offenders may never have the opportunity to enter a treatment programme because they haven’t been in prison. Some men may have looked at sexualised pictures of children, or may have had thoughts of offending but nonetheless have not done so (Fagan et al, 2002). It seems outlandish that potential offenders may need to offend before they can receive treatment, individual therapy fills this gap without this necessity.

It has been argued, where some clients have been unable to talk through their past histories, they may continue to harbour unexplored angry feelings (Palermo, 2002). Without adequate attention being paid to childhood adversity, the underlying causes of the offending behaviour may not be resolved (Palermo, 2002) and the resulting treatment, superficial. During treatment, clients may simply learn the desired response (shame and guilt) to a set stimulus (victimisation) without fully integrating what they have been taught into their core self because it doesn’t fit with

how they have come to interpret their own experiences of victimisation. This could also mean that the gap between the client's core beliefs and the external valuing system instead of shrinking, is widened.

Whilst Marshall et al (1999) acknowledge the benefits of some offenders experiencing individual therapy, they write;

'it is considered essential by the majority, if not all, sexual offender therapists to overcome issues of denial and minimisation... if effective progress is to be made with this client group... these issues should be the *first* step in treatment as it is difficult to see how other problems could be addressed unless the offender admits full responsibility'.

(p.62, italics added).

However, it is difficult to imagine how a sex offender who has minimised their own experiences of abuse and who believes that this has done them no harm, could possibly accept that their abuse of another was harmful. Therefore, challenging distorting thinking and placing offenders on victim empathy teaching programmes before they have developed empathy and understanding of their own experiences of trauma, seems like putting the cart before the horse. The same criticism could be waged at the policy of permitting only those offenders who demonstrate guilt in relation to their offence onto treatment programmes. At the risk of overstating a point, how can an offender feel guilty for an offence which they perpetrated, if they have no feelings against the offender who perpetrated against them?

Whilst the knowledge that the majority of offenders experienced adversity in their childhood can never excuse their offending behaviour, it may nonetheless provide insight into what may start and perpetuate offending. Individual therapy with sex offenders, where offenders have the opportunity to explore their childhood, may have the added benefit of contributing to theoreticians and practitioners research in the area and further enhance future treatments. For example, whilst the ideal may be for sex offenders to have the opportunity to receive both treatment and therapy, this often may not occur due to cost, resources and the offender's motivation amongst other reasons. Hence, it may be possible to add further elements to the already existing treatment programmes which would address childhood adversity but which can be more readily available to offenders on existing treatment programmes.

Ideally the two types of support, individual therapy and group treatment should occur alongside one another. It seems probable that offenders would be less likely to take up therapy after treatment, in the belief that they had already completed the necessary work. Moreover, where therapy is an adjunct to treatment following on afterwards, this approach may reinforce the split the offender may create between himself and his offence. Where both treatment and therapy co-occur the offender

may more readily make connections between his feelings and those of his victims. Clients often find this experience overwhelming and threatening, they therefore require a great deal of containment which is better suited to individual than group therapy (see page 28 under increased risk of suicide or self harm in the offender).

A clear distinction between treatment and therapy is necessary in order to alleviate the difficulties which ensue when therapists are forced to take the moral high ground in therapy sessions (Wakefield & Underwager, 1991). Wakefield & Underwager (1991) state that treatment needs to be separated from therapy, because the latter is not closely tied to a theoretical base. They further suggest;

‘Moral treatments, such as those currently vended for perpetrators of child sexual abuse, should be labelled for what they are. It is professionally irresponsible to call a procedure therapy, implying it is value free, when, in fact, it is based upon moral values and pursues goals defined moralistically’.

(ibid., p.9)

How “value free” any therapy is, is a matter of debate, nonetheless this fact does not detract from the ideal that this is a primary aim. A further advantage to the addition and separation of individual therapy from treatment relates to clients who may be vulnerable to experiencing ‘toxic shame’, as outlined in chapter one. This group of clients may provoke a ‘kick me’ response from the therapist due to their abusive past. These clients would have the opportunity to experience a different relationship in individual therapy, one which challenged their underlying belief that they only deserve abuse. In individual therapy the therapist is arguably in a better position to control the environment in such a way which doesn’t respond to their invitations to be kicked.

Power and Control in Treatments and Therapy

Arguably the most critical argument for the separation of treatment from therapy relates to power. As discussed in chapter one, some offenders offend, not for sexual reasons but for reasons relating to power and control (Groth, 1979). The power differential between client and therapist is highly variable dependent upon the context of therapy (see table one and discussion above). Nonetheless, in all therapy, the therapist is likely to be perceived to hold the knowledge and expertise to help the client (Proctor, 2002). Prisoners and in-patients in particular but all patients, are likely to feel less powerful than their therapist. In treatment programmes where the content of sessions is taught and follows issues stipulated by the therapist and where the therapist uses confrontation and challenge they are modelling a ‘power over’ relationship (Proctor, 2002). In these circumstances, the treatment of the offender may parallel the offender’s treatment of the victim. This approach is questionable

when working with offenders whose reason for offending may partly be attributable to gaining increased power. Proctor (2002) writes;

‘the more power over exercised by the therapist, the less power the client has’
(p.94).

If offenders offend because they want to feel powerful, dis-empowering them in treatment would be more likely to increase, not decrease, their need to take their power inappropriately. Treatment programmes are likely to dis-empower offenders to a greater degree, than therapies which strive for a more equal power relationship. Some offenders will need a high level of directivity and possibly confrontation in their treatment, without this they may be seen to humour the therapist by simply going along with the therapist’s beliefs. However, the modelling of a ‘power over’ relationship with a group of offenders who may have offended partly for reasons relating to them feeling powerless, seems counter intuitive based on the arguments outlined above. The ideal scenario would be one in which offenders experience both treatment and a less directive or non directive form of therapy.

Chapter 5.

Client-Centred Therapy

Client-Centred Therapy

Cognitive Distortions, Minimisation and Denial

Increased Risk of Suicide or Self Harm in the Offender

Confrontation and Threat to the Self

Congruence

Limitations in the Practice of Client-Centred Therapy

with Sex Offenders

Client-Centred Therapy

Client-centred therapy takes a non directive approach, a consequence of which is that clients are more likely to feel empowered (Proctor, 2002). The therapist facilitates therapy through their communicating, and the client's receiving of the core conditions, empathy, congruence and unconditional positive regard (Rogers, 1951). The adoption of a non directive attitude means that the content of sessions endeavours to follow the material brought by the client, where the therapist takes the client's lead. Typically, therapy has no goals ascribed by the therapist *for* the client, instead the client formulates their own agenda and process. Underpinning client-centred philosophy is a belief in the actualising tendency of all individuals, that is;

'persons have a biological tendency toward constructive fulfilment of [their] inherent possibilities' (Rogers, 1980, p.117 in Brodley, 2006, brackets added).

Client-centred therapists thus engage in more collaboration with their clients, than is evident in other approaches, regarding decisions such as when they wish to attend therapy and when therapy ends. Most classical client-centred therapists would argue that this is the client's, not the therapist's decision and responsibility, although there may be limitations imposed upon this by the therapy organisation within which the therapist practices.

In client-centred therapy, clients are said to enter therapy in a state of incongruence (Bozarth, 1998) that is, there is a mismatch between their felt sense (their organismic valuing of reality) and their cognitions (Rogers, 1951). Client-centred therapists would argue that this is partly attributable to the client's introjected conditions of worth. Conditions of worth are beliefs which have been formulated based upon the attitudes of others, rather than those of the client themselves but have been adopted

by the client out of a need to feel loved and valued, or a fear of being rejected by key people in the client's past, typically parents or parental type figures (Merry, 2002). These introjected conditions of worth contribute to the client's incongruence. Through the experiencing of the conditions, the client re-evaluates past experiences relating to their incongruence and begins to accept beliefs based upon their own feelings and attitudes, rather than those of others (Natiello, 2001). As a consequence of this re-evaluating process the client's behaviour becomes more congruent and more self governed, rather than governed by others, and therefore therapy promotes a movement towards an inner valuing system or internal locus of evaluation (Rogers, 1951). This must be the aim for all therapists working with sex offenders. Offenders are highly likely to leave secure units and thus need to control their own behaviours, not have them controlled for them through containment on locked units or through monitoring by probation officers. An approach which promotes client responsibility through empowerment is therefore necessary.

Cognitive Distortions, Minimisation and Denial

Many researchers argue that sex offenders fail to take adequate responsibility for their offences, their use of cognitive distortion, denial, minimisation and justifications are demonstrations of this. Taking a 'power over' stance where clients are told what to do, when and how, decreases, not increases, client responsibility (Proctor, 2002). A form of therapy which promotes client responsibility is therefore favourable. Rogers (1959) postulated that if certain conditions exist in therapy then a certain processes in the client will follow. Bozarth (2002) lists twelve of these processes;

1. The client is freer in expressing feelings.
2. That the client's ...expressed feelings increasingly have reference to the self rather than the non-self.
3. That the client's ...experiences are more accurately symbolised.
4. That the client has increasingly more reference to incongruity between certain experiences and their concept of self.
5. That the client is more able to experience the threat of incongruence.
6. That the client experiences in awareness feelings which have been denied or distorted in the past.
7. That the client has the concept of self reorganised to include previously distorted or denied experiences.
8. That the client's concept of self becomes congruent with experiences including those which would have been too threatening in the past.
9. That the client... becomes increasingly able to experience without a feeling of threat, the therapist's unconditional positive regard.
10. That the client... feels an unconditional positive self regard.
11. That the client experiences self as the locus of evaluation.

12. That the client ...reacts to experience less in terms of his conditions of worth and more in terms of an organismic valuing process.

(Bozarth, 1998, p. 44)

All these points are extremely significant in terms of therapy with sex offenders. The literature states that through individual client-centred therapy, clients are able to increasingly express their feelings and their experiences begin to more accurately resemble their core self, *without distortion* (Rogers, 1951). That is, there is more accurate symbolisation, and *less need for distortion of reality* because the self doesn't feel threatened. When the client feels free from threat they can re-organise the self to include previously distorted or denied experiences. The client's concept of self becomes congruent with their experiencing, including experiences which would have been too threatening in the past for the client to accept. As the self becomes more congruent and integrated there is an increasing acceptance of responsibility. Where the client is free to explore difficulties, absent from threat, and without direction from the therapist, they are more likely to accept the previously denied material because it has been derived out of self exploration and not imposed on them by others. Rogers (1951) formulated nineteen propositions. Proposition seven states;

'the best vantage point for understanding behaviour is from the internal frame of reference of the individual himself' (ibid. p. 494).

And;

'in successful client-centred therapy there appears to be a decrease in current defensive behaviours and a greater awareness of those defensive behaviours which are present' (ibid. p. 182).

Increased Risk of Suicide or Self Harm in the Offender

When the client's defences are challenged (through the experience of the conditions) and they are faced with the reality of their offending behaviours, risk to the public is likely to decrease but occasionally may initially be replaced with an increased risk of suicide or self harm from the offender (see Tolan, 2003, for an example of increased congruence and increased risk of suicide). Whilst this risk is undesirable, it is nonetheless manageable where therapists convey to the client that they value them as a person but not their offending behaviour. This separation of the person from their offending past carries the potential for change and with this the client is offered hope (Marshall et al 1999). (In reality this may be a fine balancing act because where the offender removes himself too far from his offence, this splitting carries an increased risk of him re-offending). Also, the client comes to accept the parts of the

self hitherto denied in a safe environment, one in which the conditions, empathy, congruence and unconditional positive regard are sufficiently conveyed and accepted despite the disclosure of offences.

Confrontation and Threat to the Self

The above client-centred literature contradicts that which states sex offenders accounts of their behaviour must be confronted and challenged when they use cognitive distortions. Further research relating to threat similarly argues against confrontation because it encourages defensive reactions. Hogan (1948) lists eight statements describing how defensive behaviour occurs. These are;

1. Threat occurs when experiences are perceived or anticipated as incongruent with the structure of the self. [The client's use of cognitive distortions is demonstration that they have not integrated their offending behaviour as part of their self, their offending behaviour is thus incongruent with their belief about themselves].
2. Anxiety is the affective response to threat.
3. Defence is a sequence of behaviour in response to threat, the goal of which is the maintenance of the structure of the self.
4. Defence involves a denial or distortion of perceived experience to reduce the incongruity between the experience and the structure of the self.
5. The awareness of threat, but not the threat itself, is reduced by the defensive behaviour.
6. Defensive behaviour increases susceptibility to threat in that denied or distorted experiences may be threatened by recurring perceptions.
7. Threat and defence tend to recur again and again in sequence, as this sequence progresses, attention is removed farther and farther away from the original threat but more of experience is distorted and susceptible to threat.
8. This defensive sequence is limited by the need to accept reality.
(Rogers, 1951, p. 516 words in brackets added)

This literature strongly outlines the possible negative influence confrontation may have on the client's ability to accept their responsibility for their offending behaviours. Contrary to the view that confrontation and challenge may be necessary in order for offenders to explore their offending past, according to this literature, where the client perceives threat through challenge and confrontation this is more likely to increase client distortions and minimisations and particularly denial, as the client attempts to protect the self structure from threat. This is most likely to happen because the values have been imposed on the client from outside of their own valuing system. As this happens, client's risk may potentially increase as they learn how they are supposed to feel and behave and learn ways to demonstrate this to the trainer but without fully accepting what has been taught.

In proposition sixteen, Rogers (1951) defines threat as;

'any experience which is inconsistent with the organisation or structure of self may be experienced as threat, and the more of these perceptions there are, the more rigidly the self structure is organised to maintain itself' (ibid. p.515).

Inconsistent or incongruent material may be evident from a number of sources, for example it may be found in relation to the client's beliefs about abuse. Their childhood history may have taught them that abuse was normal, rather than harmful, they may believe and feel they hadn't suffered as a result. It would therefore be difficult for the client to accept that they had caused harm to another through their abuse of them. In circumstances such as these, this would constitute incongruent material which the client would likely believe doesn't fit their own internal valuing system. Where this happens, clients may blindly follow what they have been taught but the material would not become fully integrated into their own valuing system.

Congruence

If client-centred therapists avoid direct confrontation and challenge how do they respond to the client whose disclosure suggests they are not taking responsibility for their offences? This is a difficult area for all therapists who aim to practice in a value free manner but particularly difficult for client-centred therapists who do not have an agenda for their clients, only that which the client brings themselves.

Congruence is one of Roger's six conditions for therapeutic change (see above). Due to the brevity of this dissertation, it is not possible to explore each condition. Congruence has been selected because it offers therapists a way of challenging clients' distorted reality, something many theorists and practitioners have argued is necessary, in a less threatening way than direct confrontation. Also, it is key in terms of modelling an authentic way of being, this is particularly important when clients have lost touch with their core self and who they feel they are.

Congruence is the accurate symbolisation of self experiences (Merry, 2002). Frequently client-centred therapists make a decision as to whether or not to share with the client their congruent feelings in relation to what the client discloses. As client-centred therapy has no goals, typically therapists who share their authentic response to client's narrative do so not to effect change but because their reaction to the client's discourse (their felt response) gets in the way of them being able to be empathic or be unconditionally accepting of the client or both (two of Roger's further conditions) (Merry, 2002). Hence client-centred therapists who hear material which suggests to them that the client is not taking responsibility for their offences (minimising, denying or distorting) may respond by overtly sharing their authentic

feelings to what the client has disclosed to them. Traditionally client-centred therapists respond congruently not out of a need to teach the client the correct way to respond but out of a need to be able to continue offering the core conditions without the therapist's negative felt responses getting in the way. This modelling of the therapeutic conditions facilitates a strong therapeutic relationship and promotes feelings of safety. Although paradoxically, the non directive approach may engender feelings of insecurity, as some clients may feel they have been put on the spot. Nonetheless, it is the therapist's observation and conveyance of the client's feelings in this regard which tend to allay these fears.

In the context of therapy with sex offenders the therapist is arguably more likely to offer a congruent response in relation to the client's cognitive distortions, denial and minimisation because not to do so could be classed as colluding with the client's 'distorted' reality. Tolan (2003) writes;

'if there is an area which seems painful or dangerous, a situation can arise where you collude with your client in avoiding it' (ibid. p.38).

In responding congruently, the therapist speaks from their own frame of reference and makes a statement regarding what has been said and how they experience it. For example, a common cognitive distortion offender's use is that the victim was 'asking for it' in some way, usually the offender supports their understanding by stating the victim was dressed provocatively. A congruent response to this might be 'you understood from what the woman was wearing that she wanted to have sex with you. I do not share this same opinion. If I see a women dressed in a short skirt, I do not assume she is wanting to have sex'. Further congruent responses may result in the therapist conveying their felt reaction to the client's disclosure. For example, clients may smile at inappropriate moments. A congruent response in this situation may be 'I note that when you talk about x, you smile at the same time. I don't share your same feelings, I feel upset and angry when you talk about x'. This remark may be followed by letting the client know that although you don't share their same feelings about their reality, you do nonetheless value their courage in sharing how things are for them. In addition, as mentioned earlier, it is also important to convey to the client that you separate them as a person from their past offending behaviours. This is necessary in order that the client can understand that you can value them as a person but not a particular past behaviour. Without doing this, there is a risk that the therapist's communication of congruent responses will mean the client is less likely to disclose sensitive material in the future.

Where the client's disclosure suggests that they are avoiding talking about something, by congruently stating an awareness of that avoidance it is not necessary to push the client into an area which they feel is too dangerous at present;

'You can acknowledge that it is difficult for your client and at the same time convey that you yourself are not afraid' (Tolan, 2002, p.38).

A by product of the open expression of congruence on the part of the therapist, is that they model authenticity (Barrett-Lennard, 2002).

'Congruence is the part of the self which is open, flexible, not given to distortion or denial. In other words, the *you* in which there is no conflict between your self structure [assuming you have a known self structure in which to draw on] and your experiencing. This is the area of the self which can be available in a very open, non-defensive way to clients (Tolan, 2002, p.44 words in brackets added).

The modelling of congruence,

'encourages similar behaviour in others, and that while some factors of modern society tend to produce guardedness and incongruence, others give people more opportunities to be responsive to their own nature' (Tolan, 2002, p.44).

Barrett-Lennard (2002) suggests that a counsellor's faith and confidence in the importance of congruence increases its effectiveness as a therapeutic condition (in Merry, 2002, p.46). Honesty, specifically authenticity, is particularly important in relation to therapist mistakes. Where therapists admit errors in therapy this can be potentially very powerful because clients learn that therapists are also fallible, that they are comfortable sharing their errors and they don't expect themselves or others to always be perfect (Tolan, 2002). It may also convey to the client a message about the therapist's likelihood of casting judgement upon clients, should the client choose to disclose something they feel the therapist would dislike.

The therapist's congruent responses to the client's narrative also convey a sense of equality between therapist and client. This is more easily managed in individual therapy than in a group situation where there are numerous group dynamics at any one time. This models a mutual, reciprocal relationship where power differentials are minimised. This modelling is particularly important amongst this client group because past relationships have typically been unequal. By modelling equality, past interpersonal relationships where domination and submission prevailed are less likely to be replicated in the client-therapist relationship and the client will experience an alternative way of interacting in relationships. The intonation, context and content of the congruent response is therefore vitally important in terms of the client not experiencing the response as one of them being told off, or told what to do.

There are numerous possible congruent responses to client disclosure. However, to detail these here is beyond the scope of this report. Suffice to say, client-centred

therapy training is extensive, typically taking four years at post graduate level and includes a high level of exploration of congruence in relation to the trainees incongruences, as well as looking at incongruence when working with clients, particularly in relation to whether or not the therapist's felt experiences are shared.

Due to the brevity of this dissertation, it has not been possible to look at each of the conditions of client-centred therapy in relation to working with sex offenders. However, numerous researchers have espoused the highly significant role the therapist's empathy plays in relation to working with sex offenders (Marshall et al 1999; Marshall, 2005; Martin, 1996; Miner & Coleman, 2001; also see Regehr and Glancy 2001 for an excellent critique on empathy training with offenders). Just as when clients experience therapist congruence, they become more congruent themselves, similarly, therapists who are empathic, provide a role model for empathy, thereby increasing the offender's ability to be empathic with others. This is crucial when working with sex offenders, where there is strong support for the notion that this group of clients lack this quality.

In contrast little has been written in relation to unconditional positive regard (UPR) when working with sex offenders. It seems unlikely that therapists would espouse unconditionality irrespective of the client's disclosure, to do so would be colluding with the client's offending behaviours. However, it is possible to show unconditional positive regard for the person but not their behaviours, although two authors have argued this is not appropriate (Willshire and Brodsky, 2001). In view of the influence UPR has upon increasing the individual's internal locus of evaluation (Bozarth & Wilkins, 2001), and the desirability that self determination brings in relation to clients monitoring their own behaviours when released into the community, this area warrants investigation.

Limitations in the Practice of Client-Centred Therapy with Sex Offenders

This article has been written by a client-centred therapist working primarily with mentally disordered low risk offenders currently living in the community and who have typically undergone the SOTP. As with all deliberations involving what constitutes best practice, arguments will be biased by the experiences of the writer. Hence, the positive outcomes witnessed in this particular context through the practice of a client-centred approach may not transfer to other contexts where offenders may be completely lacking in motivation.

No doubt therapists adopting a directive approach to their work with this client group, will argue that a purely client-centred and non directive approach leaves too much to chance and allows the offender to avoid talking about their offending behaviours. Where offenders repeatedly avoid bringing issues relating to their offences, the client-centred therapist has the choice over whether or not to reflect on

this with a congruent statement. In cases such as these, not to do so, would likely hamper the therapist's ability to offer the client the core conditions and without these a poorer relationship will ensue and limited change will result.

However, sex offenders who are sufficiently motivated to change, tend to talk about their offending behaviours without prompting, perhaps because their offences are what trouble them most and in most cases are the main reason for them entering therapy. Perhaps a more reliable criticism, is that therapy may take longer, depending upon the length of time it takes for the client to trust the therapist's unconditionality in respect to them as a person. In the writer's experience, clients assume that when the therapist offers the core conditions, they believe this is because it is their role, rather than the therapist likes them as a person, even if they dislike some of their past behaviours. This message often takes time for the client to accept, without this acceptance, the therapist may be perceived as mistrustful and disclosures regarding offences are less likely to occur. On this point, Marshall et al (1999) quoting research from Schaap, Bennun, Chindler & Hoogduin, (1993) write;

'Clients do best in treatment when they feel supported and are comfortable discussing personal problems without feeling attacked, and they do better when they perceive the therapist as sympathetic, warm, understanding, empathic and confident' (p.44).

A further criticism to a non directive approach, is that some clients want and feel they need instruction. For example some offenders have asked for more guided support in relation to issues around relapse prevention work, cessation of masturbation to childhood images, or to gain a greater understanding of their offences (offence cycles). Where this occurs the therapist has the choice of whether to refer the client to someone else, or do the work themselves. Where the therapist continues the work, although non-directivity is compromised, this can be managed by dividing sessions into directed and non directed parts. Whilst this is not ideal, for reasons outlined above in relation to power, clients seem to prefer this to experiencing a new therapist. This is the main purpose for advocating sex offenders attend both group treatment and individual therapy because the two compliment one another. Perhaps the one unanimous finding from sex offending research is that they comprise a heterogeneous group. Therefore what may be beneficial to some sex offenders, is likely not to be beneficial to others. By offering offenders the opportunity to attend both non directive individual therapy and cognitive behaviour group treatment this is more likely to be beneficial to a larger group of offenders.

Chapter 6.

Conclusion

Recommendations

Concluding Remarks

Recommendations

On the basis of the aforementioned discussions several recommendations are proposed.

- a. A clearer distinction in the literature between individual psychotherapy and group treatment programmes, in order that the advantages and limitations of each are more easily visible than at present.
- b. Individual client-centred psychotherapy needs to be more widely available to sex offenders in order that potential offenders have somewhere to go for support *before* they offend. At present in the UK, sexual offenders tend to need to have committed an offence in order to get any form of specialist treatment or individual therapy.
- c. There needs to be greater emphasis in respect to sexual offenders exploring their own childhood adversities. Without a reasonable understanding and empathy for their own adversities, it is difficult to understand how these offenders can have empathy for their victims. In order to meet this aim, either offenders need to have greater access to individual therapy, or current treatment programmes need to pay more attention to this aspect of treatment.
- d. Greater attention needs to be paid to the role of power in both group treatment and individual psychotherapy. At present, some therapist's use of confrontation and challenge appears to be modelling a 'power over' relationship. If sexual offenders offend partly out of a need to exert 'power over' people, then not modelling 'power over' relationships is desirable. Ideally individual client-centred therapy needs to occur in addition to group treatment in order for the offender to experience a relationship where the therapist limits their own power and authority, creating an ambience of safety and a non judgmental atmosphere. It is hard to see how therapists on group treatment programmes can diminish their power to the same extent when they take an instructional role in treatment and have less control over power issues because of group dynamics. However, diminishing the therapist's power reduces the client's fear of being judged unfavourably and limits their feelings of being under threat. This promotes the adoption of a non or less defensive attitude with the result that clients are better able to explore their past offending behaviours without the need to distort, minimise and deny. In addition the modelling of a more equal power relationship minimises the risks of clients experiencing 'toxic shame' or playing

the game 'kick me' (see pages 18 and 27) and carries greater potential to increase the offender's self esteem.

- e. Further development of theory is necessary from other perspectives which pay greater attention to the offender's feelings than that offered in cognitive behavioural treatment. A combination of client-centred therapy or humanistic therapy in conjunction with structured cognitive behaviour treatments may yield more promising results in terms of treatment efficacy.
- f. Therapists working with sexual offenders need a high level of support, particularly if they work with clients on an individual basis. Therapists may experience animosity from the general public (due to them 'siding with the enemy') and are exposed to significant trauma on a regular basis. Clients may take a long time to show any sort of change. In the meantime therapists may carry a huge burden in terms of fears of their own safety, fears of the client's risk to themselves but mainly fears for the risks the client poses to the general public in respect to re-offending.

Concluding Remarks

Researchers have found that most sexual offenders have experienced some form of adversity in their childhood. Typically offenders have come from disrupted families, where many have experienced some form of abuse or neglect. Treatments tend to be based on CBT, are instructional, and centre on the offender's offences and offending behaviours. The advantages and disadvantages to treatment programmes have been discussed, with particular emphasis on the detrimental effect confrontation and challenge may have upon the offender's ability to take full responsibility for their offences and how this relates to their future risk. The separation of individual therapy from treatment has been advocated, and purposes for this outlined. Lastly, the importance of the addition of individual non directive therapy, over and above cognitive behaviour treatment has been recommended. However, if society's attitudes of victimisation and punishment towards sexual offenders remain static, then the above recommendations are unlikely to be implemented because society would not want to pay the necessary additional costs.

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