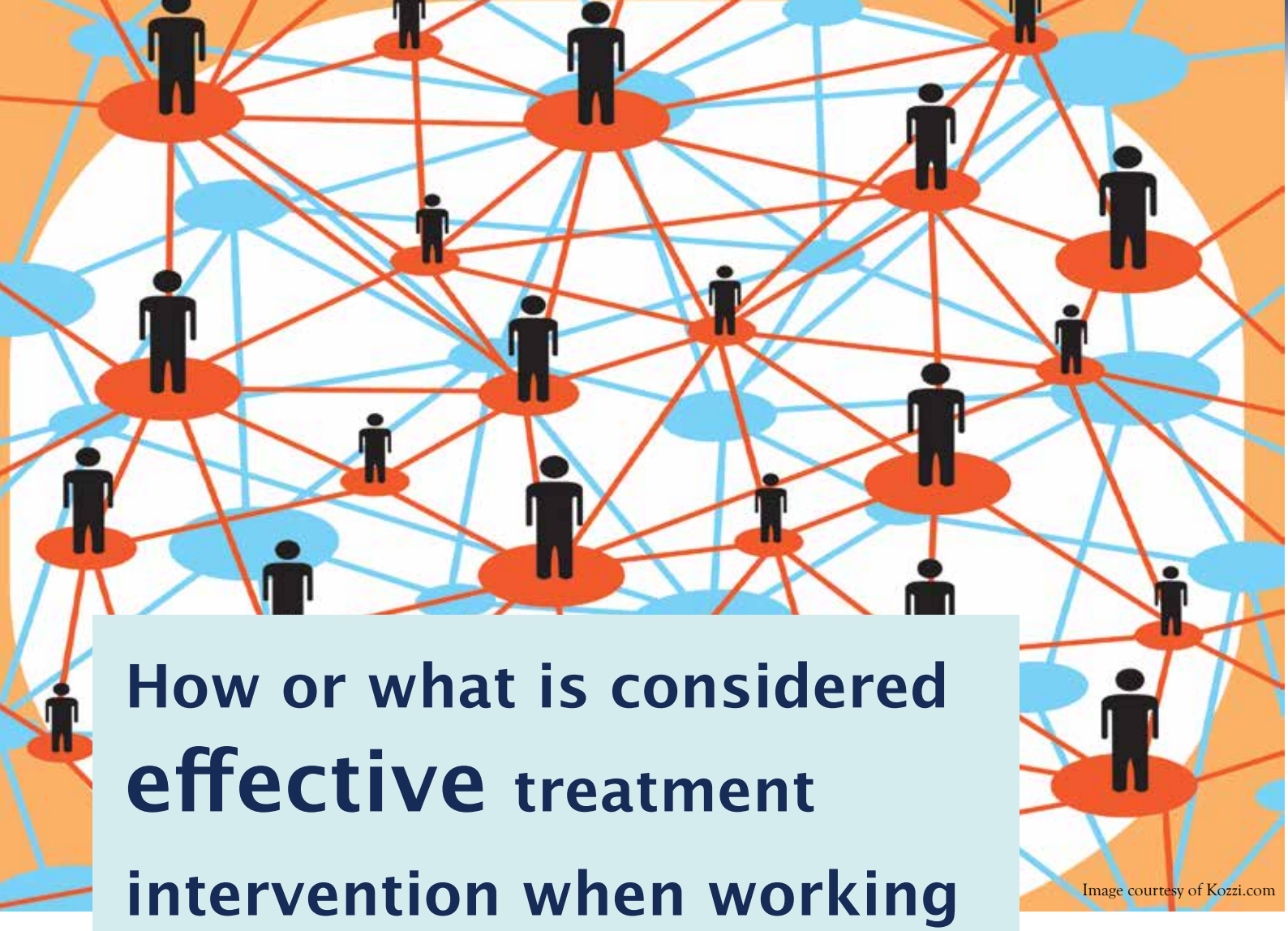

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How or what is considered effective treatment intervention when working with individuals who have sexually offended?

by Eileen Finnegan

How or what is considered effective treatment/intervention when working with individuals who have sexually offended?

Especially as we consider the stigma attached to this client group and how do those who offer treatment /intervention convince the general public and other clinicians as to what is meant by effective treatment/intervention?

When I was asked to write an article for Éisteach many thoughts emerged about this, such as 'it was about time I wrote something' rather than just reading articles that others had taken the time to write. Then the usual issues emerge, how and when will I find the time and would it be of interest to others. Having (as we therapists do best) 'processed' all of the above I came to the place of it being 'good enough'. I thought the words 'good enough' also had relevance with the content of what this article's title and indeed question wishes to address, will there ever be an effective treatment/intervention 'good enough' to break the cycle of offending behaviour. The purpose of this article is not to answer the latter question but possibly hope that one day it would be true.

My wishes are that after you have read this article that you will have more of a professional/academic understanding of the dynamics in delivering this work. That you will have more information about treatment/intervention and what is considered effective from the current research and literature available. That you will have an understanding of what I consider personally as effective treatment/intervention, based on my professional and personal experience that I have gained

through working in this area. My final wish is that you are left with more questions than answers so we can begin a dialogue about this work, especially from an Irish Perspective, and indeed how Mandatory Reporting informs/ impacts on this work and also the many families and friends who are impacted by someone else's behaviour.

Acknowledging families in all of this I am constantly reminded of the film Sophie's Choice and realise that I did not fully understand the choice she had to make - that is until I sat with parents of a victim and an offender and the choices they had to make. I would have felt previously it was clear one child was harmed the other perpetrated the harm, what was the choice. Then as I considered all the factors that would follow the disclosure and I looked at the parents' devastation as they had to choose between their children. When they reminded me of the beautiful child they had and what went wrong and what we can do to make sure it never occurs again; tall order, yet good motivation for the work as we endeavour to break this cycle of offending behaviour or even make attempts to do so. Believe me, this work challenges me deeply, especially considering some of the core conditions: honesty, unconditional positive regard, empathy, etc. It's not always easy to find them amongst the details I gather regarding the specifics of the offending behaviour.

What is considered effective treatment/intervention when working with individuals who have sexually offended?

To attempt to answer this question, within the limits of this article, I will do so by giving an overview or outline of what are considered effective ways to work with offenders from the research point of view and not the specific suggestions of how to do this. However I will endeavour to give more specific suggestions in the section where I will give a personal view of what has been effective in my working with this group of individuals. I will begin with the question, what have they 'done' that they need treatment/intervention? The definition of what they have 'done' from the UK's Department of Health (2003) is described as 'forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) and non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material, or watching sexual activities, or encouraging children to behave in sexually inappropriate ways'. All of the above definition has been described to me from the experience of the victim and the offender, both with a desire in wanting it to stop. If we are to consider the definition described above, the offender is the individual who has carried out those acts of violence against a child. To intervene effectively and protect our children and young people, we want to understand why the individual has chosen this behaviour.

What is effective according to the literature and research in this area?

There is much to write about this question, however for the scope of this article I suggest that we focus on two groups or types of offenders, adult sex offenders and Internet offenders. I consider this important as discussion about each group requiring different treatment interventions is very much in the research discussion arena at present. I do appreciate for most individuals that offending is seen as perpetrated by one group and one group only: 'paedophiles' who are described as monsters, evil people etc. Considering anything other than that is not an option for most individuals. I may have taken a similar position in the past - before I began the current work I undertake, which includes working with all individuals impacted by sexual violence - including the victims, offenders, and families that support both groups. To state the obvious, the reason the majority of individuals engage in treatment/ intervention programmes in the first instance is due to them either acting out in a sexually offending way or having fantasies of doing so. However treatment/ intervention is never mandatory as most research informs that the motivation to attend a programme needs to begin with the individual themselves.

The aim of treatment/intervention is to reduce recidivism which ultimately means we are protecting our children and vulnerable adults. The current developments are moving towards risk management as opposed to risk assessments, as a way to manage the ongoing risk of recidivism. In order to offer treatment/intervention, we first need to understand the motivations and factors that led to the offending behaviour to reduce recidivism.

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There are developments from single aetiology theories to multi factors theories. For example, the knitting together of theories such

as Ward and Siegert's pathways model and Wards Unified theory of sexual offending, and Finkelhor's (1994) preconditioning model, to name just some. These theoretical models support us with the empirical evidence to inform the treating and managing of the offending behaviour. The developers of the above theories, who suggest the influence of multiple factors on offending, as listed above including Ward and Siegert's (2002), Ward (2006), and Finkelhor (1984), also suggest the importance of the single factors theories such as those of Ward (1995) and Wolf's (1985), which give descriptions of offence cycles and are still considered to be of great value in the work.

All of the theories identify certain factors that have been empirically validated as those that have motivated individuals to offend. Factors such as low self-esteem, neglect, violence, poor self-regulation, etc., which have been gathered by recording information on the individual's background, early attachment, relationship and intimacy deficits, social background, etc. The factors themselves have not led to the offending; it is the internalised beliefs or impacts of these factors that the individual has developed in a negative way. While we can argue that many individuals could have had similar difficulties in their lives and not be motivated to offend, we therefore need to also look at the function of the sexual behaviour for the individual which will inform treatment/intervention plans. The empirical evidence suggests the best way to evaluate offenders is by evaluating the risk and then the management of this risk by identifying treatment targets. Examples of treatment targets include cognitive distortions, victim empathy, relapse prevention. The suggested way of doing this is by using instruments such as STATCI 99r, STABLE and ACUTE 2007 (Hanson and Harris) and structured clinical judgement gathering tools that are underpinned by the theories named earlier.

If relationship and intimacy deficits are a common variable with offenders then the therapeutic alliance is paramount in this work.

The therapist's characteristics are also considered a major factor in how the individual engages or does not engage. Scott (1989) contends that the therapeutic interventions with criminals 'are the most demanding task in the entire arena of mental health' and Ellerby (1998) informs that the impact of working with offenders is 'generally neglected'. If relationship and intimacy deficits are a common variable with offenders then the therapeutic alliance is paramount in this work.

I stated earlier that the information gathered to inform treatment/intervention as a way to reduce recidivism for adult sex offenders differs from the information gathered for those who are Internet offenders. The difficulty that emerges when working with Internet offenders is the small amount of literature available, and most of the literature has little or no focus on assessment. So what, or is there, a difference with the two groups? While I certainly would not claim to have all the answers to this question, I can certainly give my understanding of the differences. When we discuss the nature of adult sex offenders there is much research with specific focus on assessment, treatment and intervention goals. Terms such as grooming, manipulating, and distorted thinking become familiar to those working or indeed reading about this group of individuals and how they behave. What becomes evident during the interview taking stages is how they seek out and plan the offending, the sexual preoccupation. There is much evidence to support individuals who work in this area, and over time common themes are emerging that mirror most of the theories mentioned. According to Quayle (2009) 'unlike other paraphilias Internet sexual offenders cannot be easily diagnosed according to criteria set out in categorical models such as DSM'. It is very

difficult to even understand or keep up-to-date with some of the terminology used in relation to Internet Offenders. Terms such as the Internet applications used - which refer to (what I now know as) email, peer-to-peer networks, social networking sites, IRC (Inter Relay Chat), ICQ (I Seek You) chat rooms, the storage medium used, the nature of image organising and cataloging, and electronic attempts to hide activities. This is the terminology needed before we even begin to understand the function of the Internet in the sexual preoccupation of the individual. What is also important to understand is that Internet offending is further broken into different types such as: the downloading of child pornography, the trading or exchange of images, the production of images and the

child grooming and soliciting through the Internet. I think it would be fair to assume that an entire article could be written on this group and their offending behaviour alone.

What is effective from my own personal experience of working in this area?

My place of employment was originally set up to support individuals who had experienced sexual abuse; however as part of their own journey they began asking the questions of how and why individuals offended against them. They felt that as long as they did not understand these questions they were not fully aware of how to protect themselves, or indeed their children, in the future. It was from this that my work to develop treatment/interventions with offenders began. I will now consider what has been effective from my own experience and give more specific details of how the theory has been delivered in practice, and what has worked and what has not. The one sure factor is that the learning and development in this work is ongoing.

One of the first things I decided to do when I began this work was to educate myself, beginning with the Assessment and Treatment of offenders. Five years later, I am still educating myself and I find this to be a huge support in developing programmes in this work.
From this learning, we engaged an external supervisor who was considered an expert in the field, having worked for many years with this client group. This has proved to be hugely valuable in the efficacy of the treatment/ intervention we deliver, and as a personal support. We began developing gathering tools that sought the information the knitted theories had suggested. The information from these informed the treatment plans and the work began. This information is invaluable from a child protection aspect and I gained new insights into how a child is sexually abused. Offenders spoke of how easy it was to offend - in fact for some, they did not have to leave the comfort of their own house or even their own beds. Harrowing to hear that when one considers that the one place a child should feel safe is in their own home. The treatment/ intervention began with initially meeting the individual on a one-to-one basis, and then once they met the criteria for the treatment/intervention they began group work. The criteria were based on: motivation for engaging in the programme, taking responsibility, the financial and time commitments required. All individuals were attending voluntarily, in that they had not been mandated to attend and all financed by themselves. The treatment/intervention was delivered in three modules followed by aftercare. The modules focused on early life history, offending cycle and healthy living plan (relapse prevention), as suggested by the empirical evidence from research. This appeared to be effective in that the individuals were beginning to take some responsibility for their offending behaviour, and to identify possible factors that motivated them to offend, etc.

However, something did not add up for me and I felt 'I have a niggle and it won't go away', yet what is familiar in this work is waiting and knowing all will be revealed.

As I stated earlier, the work included working with family members or other support individuals which included wives, mothers, siblings and friends, which we will for the purpose of this article refer to as 'support' individuals. The engagement of the 'support' individuals began once the individuals had completed all three modules and had identified static and stable risk factors that needed to be managed in the future to ensure they did not re-offend. The support individuals were then met, firstly by themselves to inform them of the risk management required if they were staying in a relationship with the individual and this is where my 'niggle' was answered. I was and still am horrified as I initially meet with the support individuals as they tell me with great clarity and honesty how either they or the victim are the reason the offender offended.

What I consider to be effective treatment/intervention is to say where there is an offender there is a family, a community and all individuals impacted by the offending behaviour need to be included in the treatment/intervention.

I listen to mothers describe how their child came onto their husband and in one case described a three year old child a 'slut' who was born a 'flirt'. There were wives and partners who blamed themselves for not sexually fulfilling their partner's needs thus causing them to offend. One woman informed me that she had told her husband that if she discovered that he offended because of her then she would apologise and he politely said that he would accept her apology. I had to remind myself what century and country I lived in, and maybe realise that some things have not changed. All of the above informed me

that what I had originally thought was going to be effective risk management by including the support individuals was very far from the reality.

So the realisation that whilst the individual had in some ways begun to take responsibility for their offending behaviour, they were in an environment that not only minimised their behaviour but further traumatised the victim and reinforced what they had done as being not their fault. So this was not considered effective treatment/intervention as there were people missing in the picture that could support the breaking of the cycle. These people were the support individuals who needed a programme for themselves and that is what has occurred. The support individuals also have three modules and aftercare. The modules are educative and supportive; they focus on attachment and how they formed relationships, they are educated about the cycle of offending from the grooming to the sexual act, and they form part of the Healthy Living Plan. For many, there is devastation as they realise they too have been groomed and manipulated by the offender. Many of the support individuals begin their own therapeutic journey and discover who they really are in the world, as opposed to what the offender has told them. Highlighting once again the two different offender groups or types, where this is also evident is in the work with support individuals who find it very difficult to understand what is all the big fuss about the Internet offenders; they 'touched nobody', the only harmed person is themselves.

To conclude this article by stating what I consider to be effective treatment/intervention is to say where there is an offender there is a family, a community, and all individuals impacted by the offending behaviour need to be included in the treatment/intervention. The stigma attached to knowing or being in relationship with an offender is often what silences individuals into not disclosing. There is a fear of being ostracised by friends and communities, or worse, being burnt out of their homes or terrorised by others.

While this may appear to be an understandable response from society and the inability to understand why this occurred, it is important to note that most offenders use these very statements to silence their victims.

I end with noting that the challenge is inclusion of this client group rather than exclusion or how else can we consider what is effective? If we are to seriously consider breaking the cycle of offending behaviour and protecting, then we must move from our preconceived judgements of the individual in order to challenge the behaviour. It has not been an easy journey including offenders by offering treatment/intervention. I am daily challenged as to why I would even consider to do this and the only answer I have for now is that the victims informed me of what they needed and asked me support them in finding the answers.

Eileen Finnegan is the Clinical Director in One In Four. The work she undertakes is in developing and delivering the Clinical Programme at One In Four, working with victims, offenders and families of both. She has been in this field for over 20 years. She has been actively involved with her European colleagues in compiling research in how to manage offenders in the community .

Her recent studies are with the Justice Institute of British Columbia where she has now acquired the licence to use the Actuarial instruments STATIC 99r, STABLE and ACUTE 2007 and is currently training in case formulation using these instruments.

The legacy she would like to leave to this field is working towards 'breaking the cycle of offending behaviour 'and creating a safer world for our children.

REFERENCES

Ward T. Devon L.L. Polaschek and Anthony R.Beech, (2006) 'Theories of sexual offending', John Wiley & Sons Ltd, London

Calder M.C. (2009) 'Sexual abuse assessments' (chapter edited by David Briggs) Russell House Publications U.K.

Department of Health U.K. (2003),'Safeguarding Children' Christians Sanderson 'The Seduction of Children' (2004)

Beech A.R., Craig L.A. and Browne K.D. (2009) 'Assessment and Treatment of Sex Offenders'

Quayle et.al. (2009) Calder M.C. (2009) 'Sexual Abuse Assessments (chapter edited by Quayle) Russell House Publications U.K.

Scott (1989) 'School of Psychology - Forensic Section Module 3 Practice Assessment and Clinical Skills' (2007)