ETHICAL ISSUES IN THE TREATMENT OF CHILD SEX OFFENDERS: A TIGHTROPE WALK OVER A PRECIPICE OF PARADOX

Peter Toman
Therapist, SA

Paper presented at the
Child Sexual Abuse: Justice Response or Alternative Resolution Conference
convened by the Australian Institute of Criminology
and held in Adelaide, 1-2 May 2003
This paper discusses some of the ethical issues in treating child sex offenders who are mandated into a treatment programme, and who, to a greater or lesser extent, resist treatment.

There are a number of ethical issues to consider in the treatment of child sex offenders, and while I do not intend to attempt to deal with them all here, I will attempt to address what I consider to be major difficulties.

I will not, for instance, attempt to deal with the issues that I see as being conflict of interest issues, relating to providing evaluations and also providing treatment to the same client. I think that these are largely procedural and can be dealt with by administrative practises. Some of the other issues however, are more difficult to deal with. Some of these are:

- Whether or not the treatment of choice, Cognitive Behaviour Therapy (CBT), is possible, when the underlying assumptions of CBT may be violated
- Whether or not CBT is valid when the central concepts of CBT are themselves flawed.
- Whether or not I am value free or neutral therapist
- Whether or not I can do treatment when individuals are coerced into treatment
- Whether or not I can do treatment on an individual who denies that he committed the behaviour in question

I want to attempt to address these issues by, in the first instance, discussing an approach to the whole problem of Child Sex Offending (CSO), which I think not only makes it possible to do treatment, but also makes it possible for offenders to genuinely participate in the process. For without genuine participation, genuine treatment cannot take place, and genuine change, if it occurs, is pure chance. We need to do better than chance if we are to effectively make a difference in recidivism rates.

I will then discuss how this view changes the challenge that the underlying assumptions of CBT are violated, and how it is then possible to validate the concepts of CBT which may be open to challenge.

The primary question we must answer is, what is it that we are dealing with? Is it behaviour of choice, in which case CBT is appropriate, or is it something else? The behaviour we are referring to is CSO. Or sexual behaviour where the object of choice of that behaviour is a child. Paedophilic behaviour. We wish to change paedophilic behaviour. So we need to ask where does this come from and is it changeable?

In 1988 Anna Salter wrote that the “…underlying issues in CSO were either, a deviant arousal pattern and/or the conversion of nonsexual problems into sexual behaviour” (pg 66). Morrison (1994) explicated this somewhat and suggested that “Sexual assault results from an intention on the part of the offender to seek both sexual and emotional gratification from the victim” (pg 47). What is clear from this is an attitude that the behaviour is behaviour of choice but that there is another component to it that may not be so open to being labelled as choice. That is, the deviant arousal aspects of it.

Deviance is a social construct. So for now, let us discard it and simply examine the issue of a pattern of arousal, and ask if the individual in question has any choice about his arousal pattern. When we talk about deviance, we effectively differentiate that behaviour from our own. We inoculate ourselves from it, and demonise the subject.

In common with my practise in therapy of demystifying the issues, let us do that to the concept of arousal. Let us look at the behaviour as a part of human behaviour that is common to all of us. Let us examine what we know. Let us examine similarities rather than differences.
So let us start by talking about arousal. Something common to all of us, and known to all of us. Let us look at what we have in common with these men. Look first at my own clearly unambiguous heterosexual arousal. Did I make any choices about this pattern of arousal? Could I change it if I so desired? Am I responsible for this pattern of arousal? I would suggest that you would answer with me in the negative.

Now extend this argument and, for a moment, presume that I am unambiguously homosexual. If we ask the same questions, then I suggest we will come up with the same answers.

So far nothing controversial. Let us then extend this idea to another type of arousal. That of arousal to children and ask the questions of someone who is unambiguously sexually aroused to children. I fail to see how we can answer any differently. We must allow that they made no choice to be aroused to children, that they cannot change it, and that they are therefore not responsible for it.

While they cannot be held then to be responsible for their pattern of arousal, they can be held responsible for their behaviour. All of us are held responsible for our sexual behaviour. It is this very sameness which opens up the possibility of change.

In some of his recent writing Bill Marshall refers to “Getting to Yes” by Fisher and Ury (1983). “Getting to Yes” is about principled negotiation, the process of negotiating a result without giving in. It requires that we talk not about positions, but about interests. It requires that we not talk about what people are, but about what people want. What their underlying interest is. It talks about separating the people from the problem. It also talks about the possibility of proceeding independent of trust. I suggest that if we view the problem in this light, then we can begin to see a light at the end of this twisting tunnel. The people may have particular arousal patterns, but the problem is their behaviour. The problem is that they act on those arousal patterns.

When we put lots of effort into changing homosexuals, we were undeniably failures. Our efforts were wasted. But these same efforts, pointless though they were at changing sexuality, did in fact lead to an understanding that while the underlying sexuality cannot be changed, sexual behaviour can change. Such a view, rather than demonising these men, opens up a possibility for change. It refuses to demonise them. It refuses to make them responsible for something that they are not responsible for, and know that they are not responsible for no matter how much or how often we tell them that they are, and in so doing, opens up a doorway to the possibility of changing that which they can change, their behaviour. It changes it from the failed sexual conversion therapy, to a cognitively based programme which allows them to examine how they allow themselves to act in this way in the face of undeniable damage to the victim, and undeniable damage to themselves.

So if we refuse to demonise these individuals, we open up the possibility that the treatment of choice is in fact valid. We can work with these individuals to change the way they act.

The recent article by Mark Brown (2002) highlighted nicely the problem of some of the terminology that is extensively used in CBT. Terminology such as Cognitive Distortion (CD). This reminds me of a colleague who, on initially being faced with the whole idea of CD’s, laughingly and naively commented that CD’s were obviously anything that we didn’t agree with. I think, on reflection, that he was absolutely correct. The problem is, that over time, these ideas and terms become written in stone, and we forget the underlying rationale for the whole concept. So let us examine that idea and see where that takes us.

CDs are ways of seeing the world which are distorted in such a way as to validate an unacceptable belief. They are in fact flawed ways of thinking. More importantly they are logical errors and can be seen as such. To explain this idea, think of the logical error of composition. Or of inferring a generalisation from an individual instance. Or of inferring consent from assent.
If CD’s then are ways of thinking, they are ways of thinking that are pro offending ways of thinking. Permission giving ways of thinking. And we can challenge these in a way that is respectful and non demonising. In so doing we can uncover the beliefs and attitudes that underly these ways of thinking. It is these beliefs and attitudes that lead to particular ways of thinking about and seeing the world.

Values Freedom

This leads me to consider then the ethical issues involved in imposing my attitudes and beliefs on these individuals. In fact are we neutral therapists. My answer is no, I am not neutral nor value free. I do in fact very definitely wish to impose my way of seeing some parts of this world onto the individual. The question is how can I align such a view with the generally accepted standards of treatment.

I believe that it is impossible for me to do this work without a very clear value base, without some moral basis for the attitudes that I wish to engender in the individuals with whom I work. As Mark Brown (2002) clearly states, “…therapy with offenders is a special case: it is unlike therapy with any other group in our society.” (pg 165). It is not designed to change their underlying sexual arousal patterns, but to change how they behave in the face of that arousal. What it is that is special is that the victims of these offences have no choice in the matter. In fact they are unable to make the choice, they are unable to consent to the activity in question. However, the offenders are able to make choices about their behaviour. The aim of the therapy is to inculcate the offenders with attitudes which make it unlikely that they will commit these offences again. Not that they will change their arousal patterns, but that they will change their behaviour.

I make no apologies for the values that I hold. Where children are concerned, I believe that no others are acceptable. It is not acceptable to harm children. The children cannot agree to any of this behaviour, their assent in some cases, is still not consent. That nonconsensual sexual behaviour, particularly with children, is unacceptable is a core belief. The underlying value is that children in our society are to be protected and cared for. I believe it is this core value that leads me to an understanding that I am not value free when I do this work, and I believe it is impossible to change this behaviour in a way that will allow the perpetrator to move on to a more positive lifestyle until they hold this core value.

Trust

This issue of trust needs some explanation. I suggest to clients that the trust of those close to them is critical if they are to move on in their lives. But how are they to gain that trust, how are those people expected to trust when I will not. We must proceed independent of trust. We must act so that trust is not necessary. If an offender is to be trusted by his family, he must act so that they have no need to trust him. He must ensure that their concerns are accommodated at all time, even if they are not valid. He must ensure that at no time, is he alone with a child, he must refuse all requests to look after or care for ANY child. He must avoid places where he could be seen to be enjoying the company of children.

For a client to expect me to trust that he will not offend when he is alone with his children is too much for him to expect. The probable costs for possible victims are too great. He does however gain my respect when he acts in ways that protect the children. More importantly, when he agrees to move out of the family home, when he refuses to see them alone, when he turns away from opportunities of interactions with children however innocent that activity, he develops respect in himself. In so doing he is also demonstrating the ability to empathise with others. To understand the complexities of the situation and the costs of failure. As I suggest to them, would you as a
parent ask me to NOT act in the best interests of your children? And yes this is a barbed question, a leading question if you like, but the answer must be and is invariably no. Often it is true, with an argument that I don’t understand the interests of those children, but this can and does lead to the opportunity for some discussion about how that interest might best be served.

I had a client come into see me one day and he expressed his anger toward me. I asked him why he was angry and he told me of his journey on the bus to see me. A woman had sat in the seat in front of him with a young child. The child had looked at him and smiled, as they do, and his response was to smile at the child and engage in some harmless interaction with her. He said that he remembered our discussions and turned away thinking how horrified the mother would be if she thought that her child was playing or talking to a pedophile, and how she might be less upset if she thought that he had turned away. He said he felt as if he was being denied a simple human interaction which we all crave and he believed are entitled to. He was angry that he was denied this. His immediate reaction was to be angry with me. But that woman, had no need to trust his responses, his intentions. He acted independent of her trust. In fact, he had not denied himself a simple human interaction, he had denied himself some of the pleasure that he gets out of interacting with children, interactions which in the past had led to sexual play. This same man was in fact at the time involving himself in community work where his background was known and he was involved in providing palliative services for aids victims. Each time he turns away from a child he feels stronger, and more valued, and he has found an extremely valuable way of gaining human interaction where his very presence is valued.

**Therapy With Resisters**

I believe that the central task of therapy is to engage the client. To make a connection with the client such that we can work cooperatively to develop attitudes and beliefs that will lead to a change in the behaviour of the offender and ultimately to a better life for that individual. I make no apology for my belief that not behaving in this way is a better way of living for an offender. This belief is based on my understanding of Judith Herman’s (1992) work and my understanding of her work that the perpetrators of trauma suffer from this even as the victims suffer. Maybe not as noticeably or as clearly, but suffer they do. I take the liberty of paraphrasing Herman’s words, therapy with child sex offenders is about getting them “…to face the unspeakable” (pg4) and to speak of it.

Let us consider therapy in general and examine how this work with sex offenders in general and resistors in particular, is different.

Firstly it is different because I need to work from a clearly stated value base.

Secondly, I need to act independent of trust. I need to be prepared to state that the individual in question will act in particular ways and limit their behaviour. I need in fact to set limits on their behaviour. This limiting of their behaviour may entail a requirement that they not live with their families, and/or not frequent particular places. For instance, if I am working with an exhibitionist who has a propensity to expose himself in multi storey car parks, I have no hesitation whatsoever in refusing to continue to provide therapy unless he is willing to undertake to not use such facilities. Likewise, while the import is greater, I have no hesitation in suggesting that a child molester who has offended within his family, is, in some circumstances and some people would say all circumstances, precluded from living in the same premises. This may seem unproblematic at first glance but the implications are much wider and go to the issue of confidentiality. While I am happier if the individual in question is willing to agree to such conditions, I am not prepared to trust the individual. We should proceed independent of trust and, with agreement and if necessary without, ensure that these restrictions are mandated. But mandated they should be.
On this issue of limiting the behaviour of CSO’s it is interesting to look at the parallels for victims. Herman (1992) talks about a victim who was “…required to make major changes in her life…(that) … entailed difficult choices and sacrifices. (pg172). She goes on to state that “Rarely are the dimensions of this sacrifice fully recognized. (Pg172). The difference with perpetrators is that the least sacrifice that they are required to make is made abundantly clear by the resisting perpetrator.

Thirdly, in working with resisters the question arises should treatment be tied to consequences. In other types of therapy both the treatment and the consequences of non participation are the choice and responsibility of the individual. In the treatment of sex offenders it is not the case. The consequences of no change and born by the community.

However, should parole be based on their involvement in treatment. Should categorical denial be a basis for non treatment. And is it possible to treat an individual who denies the problem. My answer to all of these questions is no. Parole should be based on their entitlement. Their rights. If they have a right to parole, then they should be granted it. If there are designated conditions on that parole which include treatment, and the failure to engage in treatment leads to re-incarceration, then I suggest that the condition is a nonsense.

How then can we proceed to treat deniers and resisters? There are practical problems in doing treatment. Firstly, I cannot treat someone who denies that they have a condition. Yet I am enjoined in the process of providing a condition of their freedom.

If I say I cannot treat them then they go back into the community untreated and with their level of risk unaltered. The issue of treating them should not be about whether or not they admit that they have committed the crime, but rather what their level of risk in the community is if they are untreated. This can to some extent be ascertained regardless of their denial or resistance. A decision then should be based on their level of risk, not their acknowledgement of the crime. If I am working in a system which is inexorably tied in with the political process of punishment it behoves me to acknowledge that fact and act accordingly while at the same time not denying them their civil rights. At the same time the rights of the community at large need to be protected.

So I suggest that for me to act ethically in this matter, the whole issue of the conditional release needs to be clarified. I would suggest that their conditional release be tied in with them being assessed as at a particular level of risk. That the lowering of this level of risk be the aim. This can be done by a variety of means, the easiest of which is an educational programme, the more difficult being an intensive programme of treatment. But the questions still remains how can I do treatment on an unwilling individual.

The answer of course is that I cannot. I am therefore left as before but with an aim of motivating the client into a programme of treatment. A motivational process such as that envisioned by Prochasca and Di Clemente (1998) is a first step, or better still the sort of engagement process envisioned by Alan Jenkins in his “Invitations to Responsibility” (1990).

This of course requires that I acknowledge that this is not treatment but engagement. The whole process of sex offender treatment, in truth of any treatment is founded on engagement. Without engagement no treatment can even begin. With engagement treatment is already well on the way. Geral Blanchard highlights this issue in his seminal work “The Difficult Connection”. Here he points out the difficulties and challenges in the engagement of sex offenders. That these are individuals who are denigrated during their period of incarceration, denigrated by society at large, and treated in less than perfect circumstances by the system as a whole. Engagement with these men requires the utmost in acceptance, in what Carl Rogers (1965) termed unconditional positive regard.
References


Brown, M. & Chan, Kit Yee, (2002) 'We are neutral therapists': Psychology, the state and social control. *Australian Psychologist* (Special Issue on Risk Assessment), 37, 165-71 (see Erratum: v 38 (1), Mar 2003, p 80).


