TREATMENT OF SEXUAL OFFENDERS AND SURVIVORS OF SEXUAL ABUSE

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Summary: Theories about sexual offences and sexual abuse, treatment strategies for perpetrators and survivors of sexual abuse and relevant aetiological, ethical and therapeutic issues are presented and discussed. Multi-factorial theories appear to best explain the pattern of offending behaviour and provide a framework for relevant prevention, treatment and further development. However, in order to better understand relevant factors, prevention and treatments, it is concluded that more up-to-date research, rigorous evidence and better risk assessments/prediction would be beneficial.

Keywords: sex offending, offenders, sexual abuse, survivors of sexual abuse, victims, treatment

INTRODUCTION

Various changes with regard to sexual ideologies have occurred in our culture; “breaking the silence” (by survivors of sexual abuse), “coming-out” (of homosexuals), and the “recovery” of those addicted to self-damaging relationships are today "stories" (Jamieson, 1998). In line with this, libraries, websites and electronic resources (e.g. Google, Aditus, PsycINFO, Medline) subsequently provide numerous materials on the relevant topics.

Particularly challenging is the area of sexual offending/abuse, which is the focus of this review. The most controversial issues are definition problems (its relativity / changeability), aetiology, over/under-criminalisation, stigmatisation and pathologising, human rights and freedom and professional transformations [1].

In psychotherapeutic, non-forensic practice clinicians typically see victims of sexual crimes and occasionally, also, perpetrators, usually with a history of somewhat less serious, i.e. non-tactile sexual offences (e.g. exhibitionism, watching child pornography over the Internet). However, serious sexual crimes in the UK and the USA are common [2].

There are many valid and relevant theories in this field. Some of these are multifactorial and comprehensive [3], some are single-factorial, thus somewhat biased though convincingly presented [4] and some are rather fresh [5]. On the other hand, some views expressed, e.g. the Treacher’s [6] systemic strategy of frequently suggesting wives of alcoholics to go drinking with them, appear risky and lack face validity and substantive evidence of their effectiveness.

PERPETRATORS

Sexual offending is a controversial issue, defined differently in different cultures [7,1]. However, it usually refers to exhibitionism, voyeurism, frotteurism, sexual assaults/rape and child molestation, which is particularly renowned for its devastating long-term effects [8] and highest rates of occurrence [9], varying from 7% to 62% [10].

Single-factor theories appear fragmented, incomprehensive, biased and insufficient to explain all types of sexual offending. For example, feminists associated sexual coercion with male dominance, sex segregation, inequality, warfare glorification and pornography [11] but their *sociological theory* disregards individual/ personality differences and lacks reliable evidence. *Family-systems theory* focuses mainly on incest and family boundaries [12]. *Biological theory* focuses on males' biological, evolution-based sexual drive that underlines "sexual coercion" [4], sex offenders' brain abnormalities [13] or their (early imprinted) "maladaptive stress response" [14]. However, this complex problem is best explained by multi-factor theories.

In Wolf's [15] (cited in Fisher, 1995) more *psychological theory*, early experiences of abuse are "potentiators" that generate a particular personality (e.g. poor self-image, egocentricity, obsessiveness, distorted thinking, alienation, sexualisation) and lessen inhibitions/fears against deviant sexual behaviour. The focal point of Wolf's sexual assault cycle is poor self-esteem; the offender's withdrawal, unassertiveness, compensatory fantasies, sexual escapism, grooming, outlet and guilt reinforce it.

Finkelhor's [3] psycho-social "four-precondition model" of sexual abuse (motivation -> internal inhibitions -> external inhibitions -> child's resistance) provides some helpful guidelines for treatment and prevention. For example, with regard to *motivation* to sexually abuse, emotional incongruence/underdevelopment, deviant sexual arousal and (cultural) blockages would be considered. Furthermore, various *internal*, individual (e.g. alcohol) and cultural (e.g. sanctions), and *external*, individual (e.g. isolation) and cultural (e.g. gender inequality), *inhibitors* may need to be addressed. Regarding children's resistance, both individual (e.g. deprivation) and cultural (e.g. sex education) factors may need to be bolstered.

Sexual offences have been associated with loneliness and inappropriate attempts at finding closeness [16]. Laws and Marshall [17] explained acquisition and maintenance of sexually deviant behaviours by using principles of conditioning (e.g. proximity of sexual images and violence). The difference between non-offenders ("fantasists") and sexual offenders remained unexplained and Marshall [18] later doubted the conditioning theory's omni-potency. Marshall and Barbaree [19] integrated biological/hormonal (males' capacity for sexual aggression), early learning (e.g. harsh discipline; conditioning,

modelling) and socio-cultural (violence, male dominance, negative attitude towards females, early exposure to pornography) factors that lead to inadequate socialisation and fusion of sex and aggression. Transitory situational/disinhibiting factors (e.g. alcohol, warfare, stress) may trigger offending in these vulnerable, insensitive individuals.

These complementary theoretical developments provide useful frameworks for the treatment and risk management of offenders. Finkelhor's [3] model explains societal, gender and individual factors well but needs some updating, particularly regarding treatment procedures. Wolf [15] fails to explain non-offending "victims" while Marshall and Barbaree's [19] model unjustifiably presents all sexual offences as expressions of aggression and lacks innovation and explanation for female sex offenders, who differ significantly (e.g. regarding suicidality) from their male and female non-offenders counterparts [20].

Due to offenders' lack of motivation to change, denials, addictions [11] and poor cooperation, the treatment of sex offenders differs from other therapies. Salter [21] argued that well-coordinated treatment programs need a "treatment philosophy" that defines relevant issues, goals (set by therapist), responsibilities and support to professionals. Further considerations include mandated versus voluntary therapy, explicit value stance, clear rules and limited confidentiality and trust. Their absence may explain the poor outcomes of punishment, pharmacological, Freudian and Rogerian therapy [22].

Several researchers argue that punishment for sex offenders does not work on its own; however, it may be that these "failing" punishments are just *inadequate*. This notion is supported by Broadhurst's [5] recent findings that imprisonment (and community supervision) of sexual offenders reduces "the rate of speed of re-arrest" and Finkelhor's [3] assertion that both voluntary and mandatory treatments work. Nevertheless, the law based on scientific data may minimise feeling of injustice [1].

Organic treatments, such as castration, neurosurgery and hormonal therapy, aiming at reducing sexual drive in sexually aggressive men [23], has produced inconsistent results [14] and strong side effects. *Pharmacology* offers SSRI-antidepressants [9] for underlying "maladaptive stress response system" [14] and anti-psychotics for violent offenders with schizophrenia and personality disorders [24]. However, there are possible side-effects and one may wonder if (somewhat biased) pharmaceutical industries, that often sponsored research and medicalisations, inflate the rates of their successes (e.g., by using unrepresentative samples or defining and measuring phenomena differently); this requires constant revisions of the data presented and independent empirical studies.

Various *individual* and *group psychological therapies* are available.

There has been a shift from less effective ("pure") behavioural approaches aimed at decreasing deviant arousal (e.g. covert sensitisation/aversive imagery tapes, masturbatory conditioning, masturbatory satiation/post-orgasm masturbation on deviant fantasies) to comprehensive cognitive-behavioural programs and relapse prevention procedures; these focus on risk and addiction [9] and build on cognitive and social learning theories [22]. Many therapeutic programs include specific social and sexual skills, assertiveness training and sex education [21], and advocate systematic approaches and the cooperation of various agencies aiming for both prevention and treatment [25, 26].

Using pro-social activities that interrupt criminal actions (Gendreau & Paparozzi, 1995), effective programs should match offenders' intelligence, mental and physical health [27] and age [28]. Group treatments (stronger confrontations) are particularly effective, though comprehensive programs combine major therapeutic approaches [21]. Dependence on the offender's motivation, longevity and variable attendance and availability and cost are some of disadvantages of such therapeutic programs. Research shows that *recidivism* is higher for non-treated sexual offenders and those with no post-release supervision [9]. It is 30-40% after 20 years [29], varies from 13% (*treated*) to 43% (*untreated nonfamilial)* for child molesters [30] and decreases with age [31]; it remains lower than for non-sexual offenders [5]. However, caution may be needed regarding reported relatively low recidivism of sexual offenders [30]; offenders' self-reports may be of dubious reliability and the sampling of imprisoned participants does not allow generalisation regarding non-imprisoned/undetected offenders. Furthermore, one needs to understand that though abusive sexual fantasies are sometimes seen as the first stage in sex offenders' cycle [32], such fantasies are not dangerous in non-offenders who do not act out and are not at risk and are not characterised by certain (offenders') personality traits (e.g. egocentric, schizoid, obsessive, avoidant) [33]. However, societies frequently fail to provide conditions for the development of healthy and (sexually) non-exploitative "personalities", and programmes for perpetrators do not always aim at "personality changes".

VICTIMS

Victims requiring professional help may feel very anxious, embarrassed and angry but also guilty and confused for experiencing some pleasant sensations during the abuse [12]. They frequently suffer from closeness difficulties ([34, 35] that tend to prevent them from productive sexual, emotional and therapeutic experiences and may require particular therapists' empathy [16].

Nevertheless, voluntary agencies, support groups, authorities, counselling [8] and numerous therapeutic techniques [36] can help.

Young [25] advocated both individual (for children) and group (for adolescents) work; Draucker [8] recommended combinations of both. Finkelhor [3] identified ways (traumatic sexualisation, stigmatisation, betrayal, powerlessness) in which sexual abuse causes continuing problems; Ainscough and Toon [37] detailed ways of addressing these and other problems (e.g. secrecy, self-blame, mistrust, negative feelings about sex, withdrawal/clinginess, aggressiveness/victimisation).

A four-phase therapeutic model (breaking silence, victim, survivor, thriver) is frequently utilised in victims' recovery ([38].

Hall and Lloyd's [36] recovery model and Draucker's [8] *structured* counselling consist of six stages. The former lacks specificity but the latter provides useful guidelines, focusing on disclosure, abuse experiences, adult's reinterpretation of these and their context, new strategies and resolutions.

Some authors approach victims as a homogenous group [8] but others advocate different treatment for different groups of victims [39].

More generalised (psychosexual) therapies, such as "simple counselling", group [40], analytic (explores repressed unconscious conflicts; [41], couple, behavioural [42] and cognitive/cognitive-behavioural therapy that challenge impaired self-image, relevant "faulty assumptions" [43] and irrational sexual beliefs/behaviour [44] may help.

Specific approaches may be needed for victims with learning difficulties who experienced ritualistic abuse [45], young victims [46], young victims in residential care settings [47]or those with particular consequences (e.g. eating disorders).

CONCLUSION

Sex offending is a complex phenomenon that requires coordinated work of multi-agencies, individually-tailored treatments and management/prevention approaches.

Investments in treatment of sex offenders ([48, 49, 22] compared to a lack of adequate prevention programmes appear frustrating. Similarly, the costly and complex multi-agencies' programs give more attention to perpetrators than victims, thus triggering some ethical and moral dilemmas. Furthermore, it is still not clear if sexual aggression is some kind of medical/psychiatric or social disorder. More research, rigorous evidence, large and representative samples (even serious researchers such as Marshall and Barbaree [19] had to deal with small samples), objective and subjective methods of data gathering and specific theories about sex offenders' profiles that provide reliable answers, good predictions/risk assessments and compare the rates of sexual offences across different cultures are required.

Updates on relevant facts and therapeutic interventions, consensus regarding theories of sexual offending, better links between research and clinical practice and investments in sexual health and professional support would be particularly welcome.

TRETMAN POĆINITELJA I ŽRTAVA SEKSUALNOG ZLOSTAVLJANJA

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Kratak sadržaj: Teorije o seksualnom kriminalu i seksualnom zlostavljanju, terapijske strategije za počinitelje i žrtve seksualnog zlostavljanja i relevantni etiološki, etički i terapijski problemi su prikazani i diskutirani. Multi-faktorske teorije najbolje objašnjavaju seksualni kriminal i nude okvir za relevantnu prevenciju, tretman i dalji razvoj. Zaključeno je da bi više istraživanja, rigorozna evidencija i bolje procjene/predikcije rizika bilo korisno.

Ključne reči: seksualno zlostavljanje, počinitelji, seksualna zloupotreba, žrtve seksualne zloupotrebe, žrtve tretman.

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