AN ECOLOGICAL APPROACH TO INDIVIDUAL TREATMENT OF INCEST OFFENDERS

BY
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ABSTRACT

Child sexual abuse cases are coming to the attention of authorities at an ever increasing rate. It is imperative that we develop and implement effective treatment programs for sex offenders against children, if we ever hope to reduce the numbers of children and adults suffering from its' devastating effects.

This practicum report describes an ecological framework to work with three sex offenders against children. A combination of insight oriented and educational approaches in individual therapy were utilized. Issues such as distorted cognitions, victim empathy, the offending cycle, men's and women's roles, parenting, spousal relationship, family of origin, sexuality, anger, and the therapeutic relationship were explored. The student sought to evaluate the intervention using both individual and couple measures. The results indicate that clients made gains in anger control, self concept, and in the areas of distorted cognitions and victim empathy.

INTRODUCTION

Over the last decade the fact that sexual abuse does exist in very large numbers, and can be extremely damaging to victims, to their family members, and to society in general, has gained acceptance (Marshall, Laws & Barbaree, 1990). The student believes that if we are to combat sexual abuse and its devastating effects, we must continue to focus on developing and providing therapy for offenders.

Child abuse cases are coming to the attention of professionals at an ever increasing rate. For instance, statistics from Child Protection Centre, Children's Hospital, in Winnipeg, indicate that in 1982 there were 95 sexual abuse cases referred to that agency. In 1990, there were 453 sexual abuse cases referred.

A number of studies conducted indicate that offenders do not have one victim in their life, but rather multiple victims. For example, Quinsey (1986) in a review of the literature cites Bernard who found that of 50 perpetrators, the number of victims ranged from "less than 10 through 10 to 50, to 50 to 300. In another study found in Quinsey's review, Able, Mittelman, and Becker, report that "the 232 child molesters who were interviewed reported a mean of 238 attempts to molest children under 14 years of age and 167 completed molestation; they reported an average of 76 victims." Also

quoted in Quinsey (1986) another study conducted by Groth, Longo, and McFadin found that the child molesters they studied reported an average of 11 sex offenses for which they were never charged. The 33 men in the treatment program in Oregon collectively committed 25,000 sexual crimes, from obscene phone calls to rape. (Lyon, 1985) Another study, also conducted by Able et. al., (1983), found that out of 238,711 attempted sexual crimes by 411 sex offenders, 218,900 were actually committed. "On average, each offender attempted 581 crimes, completed 533 crimes, and had 336 victims".

Data from Statistics Canada (Canadian Crime Statistics) indicates that in 1985, a total of 423 men and 8 women were charged with sex-related crimes in Manitoba. In 1989, a total of 607 men and 17 women were charged with sex related crimes, showing a great increase in the number of sex related offenses in this province. After examining statistics on the Federal Custodial Caseload (ie: parole) and on the Provincial Custodial and Probation caseload, Ellerby (no date), concludes that " the data suggests that in Manitoba there are in excess of 300 sex offenders in Federal and Provincial institutions and on probation today". Ellerby also notes that the Forensic Behavioral Management Clinic can only engage 30 men every two years in treatment. In this province, a small number of men also receive treatment either through Headingly Correctional Center, or through probation services. The majority of known sex offenders in Manitoba go untreated.

As Able et.al. (1984) state, "If the incidence of child molestation is to be decreased, greater efforts need to be focused on treatment methods which will help the molester gain control over his deviant behaviour".

The objectives of this practicum were both personal and practical. The student's interest in learning about an ecological approach to treating sex offenders against children had arisen out of her work with sexual abuse victims, non offending spouses, and third party sexual assault victims and their families. In working with these populations, and witnessing the degrees of trauma experienced due to the assaults, the student had come to believe that it is imperative that we stop further sexual victimization of children. Although there is no method of identifying a potential sex offender against children prior to his offending, we can work with those that have been identified, and thereby reduce or minimize potential sexual assault of yet another child.

The student's objectives were:

1) To increase her theoretical knowledge of etiology, assessment and treatment of sex offenders against children.

2) To increase her practical skills in working individually with this population using an ecological framework.

3) To implement a treatment program aimed at assisting the offender to gain control over his offending behaviour.

4) To evaluate the applicability and effectiveness of the

intervention.

The purpose of this practicum was to provide long term, ecologically based individual treatment to incest offenders. Part I of this report includes a literature review of etiology, assessment and treatment of sex offenders. A description of a model of causality of offending behaviour which can be adapted to treating offenders, and an ecological framework are discussed.

Part II of the report describes the practicum experience, including setting, a description of the clients, and intervention.

In Part III of this report, the evaluation instruments utilized are described, and results analyzed. Part IV highlights the conclusions resulting from this practicum experience.

LITERATURE REVIEW

Incest, pedophilia, child molestation, and child abuse are all terms that one encounters frequently in the literature, and need defining. Incest refers to a sexual relationship between an adult and a child, who are related, and where the law prohibits marriage. This definition has been muddied, as a step-father/step-daughter or son sexual relationship is also most often seen as incest. The term

pedophile literally translates into "love of children". This term is most often used to refer to a person who is sexually attracted to children.

There are a number of terms used to identify a person who sexually assaults a child and most often used they are used interchangeably in the literature. The terms are; offender, perpetrator, child abuser, and child molester. In this report, the student will also be using these terms interchangeably.

A final note in terms of definitions. Although there have been some reports and studies of women molesting children (Wolfe,1985), and some predict that the numbers will greatly increase, (Sgroi, 1984; James & Nasjleti, 1983), the vast number of reports of sexual abuse disclose a male perpetrator. The literature indicates 95% of offenders who abuse girls are men, and 80% of offenders who abuse boys are men (Finkelhor, 1984). For this reason, the student has focused this practicum on male perpetrators, and will refer to this population using the masculine pronouns.

Characteristics

Sex offenders do not distinguish themselves from the general population, in terms of age, I.Q., assertiveness, social skills, culture, socioeconomic group, or in any other discernable traits. As well, there is much diversity of behaviour within the broad group of sex offenders.

There have been numerous studies that have sought to pinpoint differences in sex offenders and the general population. For instance, some studies have looked at past victimization of offenders. (Groth, 1978 ; Able, 1984). Although there has been some support for this factor, with studies indicating that between 10% and 40% of the experimental population did have histories of sexual abuse, (which is a higher percentage than exists in the general population), there are some difficulties with the methodology of these studies. The subjects have been incarcerated offenders. This begs the question as to how many people were sexually assaulted as children, however did not go on to sexually assault children. Also, we know that many offenders are not incarcerated, but referred for treatment, receive a stay of charges, never enter the judicial system as there is not enough evidence for prosecution, or are never disclosed against. These studies have not addressed the rate of past victimization with these groups.

Similarly, studies have been conducted, examining early sexual experiences of child molesters. There has been some empirical support for this, with a study by Groth indicating 32% of his 106 sample of abusers reported some form of sexual trauma, as compared to 3% of his control group. Langevin, et.al also report that their samples show a higher than average rate of sexual contact with older people for child molesters (Finkelhor, 1986).

Another focus of the research, has been an attempt to differentiate sex offenders from the general population on the basis of I.Q. of the offender, and the presence of any type of diagnosable mental disorder. Finkelhor (1986) cites several studies that "found molesters to have normal intelligence". In terms of diagnosable mental disorders, Barbaree and Marshall (1987) state that "it is quite clear that apart from the paraphilias and personality disorders, serious mental disorders are infrequently observed in sex offenders."

Using psychological tests, such as the MMPI, researchers have found that some offenders may be described as passive, low in self-esteem, poor in social skills, and have a weak psychosocial identity. Again, however, this proves true only for a select group of offenders, and is not a factor that distinguishes sex offenders from other groups. For example, there are many individuals that possess many of the traits listed above, however, they have not gone on to sexually offend children.

Sex offenders come from all socio-economic groups and from all cultures, and educational backgrounds. (Groth, et.al., 1982) Offenders can also be of any age group, although Finkelhor (1986) cites several studies that have indicated modal ages for sexual offending against children to be 35-40 years. Other studies also cited in Finkelhor (1986) have also identified a younger group of offenders, ranging in age from 15, 16, to mid twenties. Age then, is not a

distinguishing characteristic.

Offenders are also a very heterogeneous group, with some offending against females only, some against males only, some cross offending the two sexes, some interested in only a specific age group (ie; pre pubescent, adolescent) and some relatively indiscriminate as to the age of the victim. Statistics indicate that very few offenders are strangers to their victims. In a study by Russel, (1983), she reports that only 15% of the perpetrators of extrafamilial sexual abuse were strangers, while 42% were acquaintances, and 41% were more intimately related to their victims. Succinctly put by Knopp, (1984),

> "Realistically, then the sex offender may be a close relative, friend or acquaintance rather than a stranger; an older person or a youth as young as eight years of age; wealthy or poor; a Caucasian or person of color; gay or straight; literate or illiterate; able or disabled; religious or nonreligious; a professional, white- or blue-collar, or unemployed worker; and a person with an extensive criminal record or one with no recorded offense history." (p. 4)

Related to characteristics within the group of sex offenders against children is a controversy. One school differentiates between incest offenders, and others who sexually abuse non related children, believing incest offenders to have a different etiology, and therefore requiring a different type of treatment. "Although the dynamics of parent-child incest and pedophilia are similar, there are some differentiating factors. A major issue is that

in pedophilia we are primarily dealing with the dynamics of an individual, whereas in every case of parental incest, there is some form of family dysfunction." (Groth, 1978). The other school has developed general theories about child molesters, and integrated incest offenders into these theories. As Finkelhor states, "There is no disagreement between the two schools that incest offenders, at least incarcerated incest offenders, as a group appear to be somewhat different from other incarcerated child molesters. The disagreement would appear to revolve around the question of how much similarity there is." (Finkelhor, 1984.)

"The essential belief that incest is a fundamentally different kind of mental health problem from other types of sexual abuse rests on two questionable tenets. 1) Incest offenders do not act out sexually outside of the family. 2) Incest is the sexual expression of nonsexual needs." (Conte, 1986). In a study by Able et.al. (1984) they found that of 141 men referred for incest, 44% of them later in treatment disclosed they had also been sexually abusing non related children. In the television documentary, "Men Who Molest", (Lyon,1985), the experts estimate that there are four million sex offenders in the United States. Of the number convicted of incest, half molested children outside of their family also.

To highlight the controversy even further, a number of studies have been aimed at testing deviant sexual arousal to

children with both pedophiles, and with incest offenders. The results are unclear, with one study cited by Finkelhor (1986) demonstrating that " incest offenders developed significant erections to pedophilic cues that were not descriptions of sexual acts with their daughters or stepdaughters". Finkelhor (1986) also cites a study by Quinsey, Chaplin, and Carrigan, which concludes incest offenders against daughters or step-daughters showed more appropriate age preferences than their matched controls. The authors conclude that incestuous child molesters appear less frequently to have inappropriate sexual age preferences.

Finkelhor (1984) alerts us to yet another consideration. He asks whether there are many extrafamilial child molesters who have patterns similar to incest offenders. He asserts that many babysitters, neighbors, and teachers who sexually assault are not people with a primary sexual interest in children, but are acting in response to such things as stress and opportunity. Many of these individuals because they do not offend repetitively are not sentenced to prison. Because prisons do not include many of this type of incarcerated extrafamilial offender, the difference between child molesters and incest offenders may be exaggerated.

This type of information is important, and would seem to dispute the argument for different theory for different types of offenders.

Several authors cited by Frenzel and Lang (1989) assert

that both incest perpetrators and pedophiles are known to be mixed groups insofar as their erotic preferences are concerned. Finkelhor (1984) argues that a two dimensional continuum rather than separate theory is beneficial. He outlines the dimensions of "exclusivity" and of "strength of sexual interest in children", and argues that a continuum reflects reality better in that it allows relative rather then only absolute distinctions. Many treatment programs for adult sex offenders in fact, do not distinguish between the two general groups. Rather, individual differences are looked at and a treatment program is offered to the individual (Marshall and Barbaree, 1987; Groth, 1978; Ellerby, 1989).

CAUSALITY

The foregoing highlights the fact that distinguishing factors between offenders and the general population have not been identified, and that basically then, anyone can be an offender. This fact has impacted greatly on theories of causality. Researchers have attempted to explain the behaviour and provide effective treatment, resulting in a proliferation of often competing theories of etiology. In the past, these theories have come primarily from psychoanalytic theory and more recently from sources such as social learning theory and feminism. A common feature has been that they are usually single factor theories (Finkelhor, 1986).

Single factor theory fails to adequately account for

sexual offending. Many of these single factor theories of causality however, point to areas that may contribute to sexual offending with some offenders. Groth (1978) for instance states;

> Sexual involvement with a child may constitute an effort to compensate for feelings of inadequacy and to retreat from conflictual or intimidating relationships with adults to a safer, less-threatening nonadult. It may serve to assert power and strength, to express anger and retaliation, to achieve mastery and control, and to gratify needs for affection and sexuality. It becomes a way to avoid competition, to retain status and identification, to enhance a sense of worth, to discharge tensions and frustration, and to achieve attention and recognition. In short, the pedophile expresses multiple psychological needs by acting them out sexually. (p. 16)

The current trend in the literature on offenders provides a caution that sexual offending is a complex and multifaceted, problem and no one factor is adequate to explain it. (Groth, 1978, Marshall and Barbaree, 1987, Quinsey, 1986). Barbaree and Marshall (1987) state that, "during the past 10 years researchers and clinicians from varied backgrounds have come to recognize that sexual crimes do not result from the operation of a single variable or through a simple unidirectional sequence of events. Instead, theorists now point to a myriad of historical, socioeconomic, cognitive, behavioral, physiological and social variables and their interactions as underlying the commission of these crimes."

Theorists and treatment specialists in working with sex offenders are now advocating a multicausal approach to etiology, assessment and treatment of this population. The

student believes that in essence an ecological approach to treating offenders is being advocated by the experts. The next section focuses on a description of Finkelhor's Four Factor Model which the student believes to be the most useful model of causality, as it helps us to conceptualize and treat the problem of sexual offending from a broad and integrated approach.

Finkelhor's Four Factor Model

David Finkelhor has developed a four factor model that is essentially an ecological framework to work with sex offenders against children. Finkelhor has examined all of the theories of causality on sexual offending behaviour and has found that these theories could be grouped into four separate areas. They are; 1) theories that attempt to explain why an adult would find it emotionally satisfying to relate sexually to a child or "emotional congruence", 2) why an adult would be sexually aroused by a child, 3) why some individuals are blocked in their ability to have their sexual and emotional needs met in adult relationships, and finally, 4) why conventional inhibitions against having sex with children are overcome or not present (Finkelhor, 1983). Although Finkelhor has not developed a new theory on offenders, he has reorganized the existing material into a typology, and developed the "Four Preconditions Model of Sex Abuse",

suggesting a multicausal explanation of child sexual abuse. (Appendix A). Essentially, the model suggests that four conditions need to be present for abuse to occur. The four factors are; 1) motivation to sexually abuse, 2) overcoming internal inhibitors, 3) overcoming external inhibitors, and 4) overcoming the resistance of the child. The first category attempts to delineate how a person becomes interested in having sexual contact with a child. Existing theoretical explanations for this include, arrested social development, reenactment of childhood trauma, and a cultural expectation for males to be dominant and powerful in sexual relationships. The second factor attempts to explain how the offender overcomes internal inhibitions. Theoretical explanations including alcoholism, or impulse disorders, as well as social toleration of sexual interest in children are included. Other factors that Finkelhor has not included in his model, but that may relate to this factor could be a failure to develop internal inhibitions, or distorted cognitions that allow the offender to overcome internal inhibitions. The third factor attempts to account for factors outside of the offender that usually exert control, but which however have now broken down. Factors such as a mother who is absent or ill, social isolation of the family and erosion of social networks, and child pornography are included here. The final factor looks at the child's role in the abuse. Theoretical explanations such as a child who is emotionally insecure, coercion, unusual

trust between child and offender, and social powerlessness of children are included here.

The model incorporates both individual or psychological factors, as well as sociological or cultural factors that may contribute to sexual offending. In looking at the sociological and cultural factors, Finkelhor (1984) argued that "a problem that is so widespread certainly needs to be accounted for in sociological as well as psychological terms." He points out that one of the shortcomings in the literature on offenders is the absence of any attempt to explain the fact that offenders are predominately male. (Finkelhor, 1986) In questioning this Finkelhor has highlighted a number of social factors that may contribute to offending sexually against a child.

In developing the model, Finkelhor (1986), argued that many of the single factor theories "really imply other processes that have not been fully specified before". For instance, as stated by Finkelhor, "some theories of emotional congruence seem to imply that sexual arousal naturally follows without having to be explained: Because a man gets immature emotional satisfaction from relating to children, this explains his molesting. ...The four factor model suggests that, in addition to emotional congruence, arousal needs to be explained, not just taken for granted." (Finkelhor 1986) Another advantage of Finkelhor's model is that it is all encompassing. That is, it attempts to explain behaviour of

all sex offenders, rather than just focusing on intra or extra familial offenders, or homosexual or heterosexual offenders. In the student's opinion, this is an extremely positive feature, since some studies have indicated there is much "cross offending" and many offenders do not fit into one specific category.

A review of assessment and treatment approaches currently employed in work with sex offenders follows.

ASSESSMENT

Assessment of the sex offender, is a prerequisite to treatment, as well as an ongoing process throughout the duration of treatment. Groth states,

> "Assessment refers to the procedure of clinically evaluating the offender in order to identify the factors that are related to the commission of his offense--the characterological features or traits of the offender, the emotional or psychological issues lived out or expressed in the offense, and the situational events or conditions that activated or supported such acts-- as well as the degree to which these same factors continue to operate both in the offender and the environment in which he functions. Through such evaluation, the offender-clients need for, interest in, amenability to, and potential performance in treatment can be assessed" (Groth, 1979, p. 193).

Prior to outlining assessment methods, employed with sex offenders, the student believes it is important to discuss some of the differences between evaluating and working with a sex offender, compared to clients seeking therapy for other

reasons. Drieblatt (1982) contends that, 1) evaluation of the sex offender requires some general assessment, but is very focused on the specific (ie; the offenses,) 2) the sex offender is not usually a voluntary client, "nor have they defined their own problems or needs, lying and deception by the client are typical", therefore, self report is not reliable, 3) the sex offender is a poor predictor of his future sexual behaviour and a poor behavioral manager. As well, sexual offenses and deviancy are defined legally, not by the individuals discomfort, which in work with other types of clients, often provides the impetus for change. As Drieblatt states,

> Mental health practitioners are trained to adopt a helping, accepting, and caring posture. They are discouraged from taking an authoritative and controlling stance. The mental health approach emphasizes client support; one attempts to trust and believe ones client and have confidence in him. Although not completely so, this posture is the antithesis of the authority-based treatment approach one takes with a sex offender. Effective assessment and treatment of the offender requires a degree of skepticism and cynicism on the part of the professional". (Drieblatt, 1982. p3)

Although Drieblatt's statements are valid, and need to be considered in work with offenders, it is equally important for the therapist to "develop a therapeutic relationship", and balance her skepticism with a concern about the offender, empathy for his situation, as well as clearly separating the man and his behaviour. With these issues in mind, we turn to the assessment of the sex offender.

Groth (1978) details an extremely thorough assessment

process, in which information about the individual and his background, as well as specific information regarding the sexual offenses, and other factors surrounding the offenses is gathered. Other authors tend to outline similar assessment procedures, (McGovern & Peters, 1985; Drieblatt, 1982; Wormith & Borzecki, 1985).

Sources of information for the assessment are three pronged, being information obtained from the offender from interviews, information from any existing reports, such as the police statements of the victim, and offender, military or patient history, and finally, information gleaned from psychological testing, and physiological testing. As with any client, one wants to collect information from as broad a data base as is possible. A difference in assessing sex offenders is a focus not only on background information but, also details as to the "mechanics of the offense", including areas such as premeditation, victim selection, style of attack, accompanying fantasies, conversation during the assault, sexual behaviour (ie; sexual dysfunction, response, duration,) mood state, contributing factors, responsibility, recidivism, deterrence, sexual development.

In a paper titled, "A survey of Treatment Programs for Sexual Offenders in Canada", (Wormith & Borzecki,1985) assessment methods for every program include, the use of the plethysmograph in assessment of deviant and nondeviant sexual arousal, social history documentation (including legal

records), psychiatric interview, and a psychometric battery. As can be seen from the foregoing discussion then, there appears to be some consensus on procedures needed to assess an offender.

The assessment of the offender is used to determine the offenders dangerousness, and basically amenability to treatment, as well as to highlight factors related to the sexual offending and areas for intervention (Groth, 1978). Some therapists believe that a proportion of offenders are treatable on an outpatient basis, a proportion on an inpatient basis, and unfortunately, a proportion of offenders are not treatable. Untreatability of the offender however is a point of dispute for some therapists, who are optimistic, and contend no offender should be excluded from treatment. (Knopp, 1984). The decision of who, and where to treat is determined by the clinician, and rests on the assessment, and specifically on such factors as, type of offense, (ie: exhibitionism or rape), degree of violence, alcohol or drug addiction, personality traits, mental and intellectual abilities, degree (if any) of responsibility the offender takes for his behaviour, and access to victims. (Knopp, 1984). "The community's right to safety is one of the primary issues involved in determining which sex offenders get treated in the community and which do not" (Knopp, 1984). "The majority of sex-offender treatment specialists believe that many sex offenders can be treated successfully--if evaluation is

competent, if placement is appropriate, if the treatment mode meets the needs of the client, and if the offender wants to change" (Knopp, 1984). The treatment approaches being employed in working with sex offenders in both inpatient and out patient settings, and the effectiveness of these approaches are explored in the next section of this report.

TREATMENT

Before examining specific schools of thought and techniques used in the treatment of sexual offenders against children, there are several issues that precede this discussion. Firstly, none of the treatment programs this author reviewed claim to "cure" sexually abusive behaviour. Rather the goal in these therapy programs is to help the offender "control" his sexually abusive behaviour. "Predictably, the specialists who are veterans in treating sex offenders eschew the word "cure." None claim that treatment programs will end the problem, and most draw a parallel between sex offenders and persons involved in other long term addictive patterns of behaviour" (Knopp, 1984,).

Secondly, an area of contention between offender treatment specialists is the length of time the offender should be in treatment. For instance, in the Canadian survey of treatment programs, one operated for as little as four months, one for as much as twenty four months, with the others

falling somewhere in between. Some degree of variation in length of treatment programs exists in the United States as well.

As one would surmise, from the previous discussion on causality, treatment focus and methods are also numerous and varied within the field. The literature indicates that there are several types of treatment methods that are common and widely used in the work with offenders. In the next section, the student will briefly discuss cognitive therapy; behavioral therapy; relapse prevention; education and resocialization; psychotherapy; organic treatments; incarceration; and family therapy as treatments related to sex offenders against children.

Cognitive Therapy

Beck (1976) has developed a therapeutic perspective called Cognitive Therapy. The premises of this approach are that emotional reactions are a result of the way in which the individual structures reality. In this regard it is widely held that many of the thoughts an offender holds are distorted and these distortions are an integral part of the offense and its maintenance. (Wolfe, 1986 ; Able & Becker, 1985; Marshall & Barbaree, 1987; Segal & Stermac, 1990). Marshall and Barbaree (1987) believe that, not only are there conscious components of the offender's behaviour, but also aspects of which "he does not purposefully control and of which he is at

best only marginally aware." Often the offender "employs defense mechanisms that serve to repress the anxiety or guilt resulting from their sexual desires rather to repress the desires themselves." (Groth, 1978) These "mechanisms" include denial, minimization, projection onto someone or something else, and rationalization. Cognitive therapy is aimed at getting the offender to take a realistic and responsible interpretation of his behaviour, and the victims in terms of a) admitting the sexual behaviors, b) taking responsibility for the sexual behaviors, c) seeing the victim(s) in a realistic light and developing empathy for them. Cognitive restructuring involves teaching clients to challenge their inappropriate or distorted cognitions. At the same time, more appropriate cognitions are delineated. The majority of the treatment literature reviewed utilize cognitive restructuring as a major component of the treatment package offered to offenders. (Groth, 1978, Marshall & Barbaree, 1987; Able & Becker, 1984;, Ellerby, 1989, Murphy, 1990).

Behavioral Therapy

The behavioral school of thought essentially suggests that behaviour is learned, and reinforced through conditioning. It can therefore be "unlearned". Most professionals working with the sex offender population agree that the offender has developed a pattern of deviant sexual arousal. Some (Wolfe, 1986; Marshall & Barbaree, 1987; Able,

1984) speculate on the role of sexual fantasies in the deviant sexuality. For example, fantasies paired with sexual excitement such as masturbation, act as a disinhibitor, and can create a very powerful cycle. The area of sexuality, and deviant sexuality is addressed in most of the treatment facilities described in the literature. Most therapists employ a variety of classical conditioning, or behavioral techniques in attempting to reduce deviant arousal. As Wolfe states, "Sex-offender behaviour is conditioned on a very basic level--sexual arousal. The individual has a long history of carrying out that particular behaviour, paired with immediate gratification. ...Our theory is, if you are going to deal with the compulsive nature of that behaviour, you are going to have to do some counterconditioning." (Wolfe, 1981) Some of the behavioral techniques include thought -shifting, covert sensation, masturbatory reconditioning, and boredom aversion.

Another method of conducting aversion therapy is to administer a mild electrical shock, or noxious odour when the offender becomes aroused to deviant sexual stimulus. Wormith and Borzecki (1985) state that 75% of the offender treatment programs in Canada used this method of treatment. They further state that this procedure is rarely used in the United States.

The manner in which the effectiveness of these techniques are measured, are, client self- report, plethysmograph assessment, and polygraph examination. Although a number of

authors (Wolfe, 1986; Able, 1984) suggest that these techniques are powerful, and effective, a draw back remains that unless these techniques are continually used, the offender may slip back into deviant sexual arousal/fantasies. (Wolfe, 1986)

Relapse Prevention

Another important treatment that fits into cognitive-behavioral therapies is known as Relapse Prevention. Relapse Prevention was originally devised as a method for enhancing maintenance of change in substance abusers. The method was designed to strengthen self control by providing clients with methods for identifying problematic situations, analyzing decisions that set up situations enabling resumption of substance abuse, and developing strategies to avoid, or cope more effectively with these situations. This model has been modified and adopted in work with sex offenders. (Pithers, 1990).

Relapse prevention is founded on the presumption that sexual offenders are typically not cured, and that they must continually be aware of, and on guard for, any lapses in their thinking or behaviour that may lead them into reoffending. The techniques used in this method include; 1) helping the offender to dispel misconceptions about treatment (ie:I'm cured); 2) helping the offender to explore the antecedents of his sexual offending, and his offending cycle, thereby

alerting him to "high risk warning" situations; 3) teaching identification of "urges" and specific coping methods; 4) teaching problem solving, anger management skills, social skills; 5) relaxation training; and 6) relapse rehearsal.

Education and Resocialization

Another grouping of much touted techniques utilized in working with offenders is education. The belief here is that the offender is lacking in knowledge in a particular area, and given the correct information and skills can and will begin to change his behaviour. For instance, many programs contain a component on the following: 1) sex education, (including stereotypic notions about the roles of men and women, as well as myths and misperceptions about human sexuality); 2) assertiveness training; 3) social skills, including problem solving; and 4) communication skills. Specific and structured curriculum are developed and taught to the offender. Educational techniques such as reading and written exercises, audio/visual material and discussion are all utilized. Homework assignments to enhance the offender's learning in a particular area is a common feature.

Psychotherapy

Historically, one of the first methods used to treat sex offenders was psychotherapy, in the belief that the offender would gain some insight into his behaviour and modify it. Psychotherapy is defined as " treatment of mental or emotional disorder or of related bodily ills by psychological means." (Webster, 1976). As Groth states, " the term psychotherapy encompasses a broad variety of styles and techniques, ranging from individual counseling, psychodrama, self-help groups, and the like." (Groth, 1979, p.217.) Marshall and Barbaree (1987) echo this with, "categorizing procedures as "nonbehavioral psychotherapy" does not do justice to the disparate range of orientations and procedures subsumed therein..." Bolton et al. (1989) cite Parloff as stating that more that 250 conceptually distinct approaches to psychotherapy are now available. As well these authors cite Beutler as asserting that psychotherapy theories are proliferating at the rate of over 13 each year.

Psychotherapy is a verbal interaction, which is aimed at helping the client increase his insight into how past events have effected his life, and current functioning, and to highlight how his behaviour must change in order to cope more effectively, and appropriately. A draw back with this type of therapy is that it is tied to the individual's intellectual functioning, ability to self-observe, and introspect on one's behavior. It is also a slow, and therefore costly manner of

therapy. Using only insight oriented therapy is not recommended in working with sex offenders. It is important to note however, that all therapy involves some form of psychological insight, and attention to the therapeutic relationship.

Pharmacologies

Another method of treatment involves the drug Depo Provera, which is a drug that reduces the offenders level of testosterone, thereby reducing sexual arousal. Although used in some programs, there remains a controversy over the use of the drug. For instance, the possible long range negative effects of the drug are not known. Also, this drug is basically an intrusive therapy, "for which it would be impossible to obtain informed consent from an incarcerated population". Another drawback that Seely (Knopp, 1984) notes is a philosophical one in that some treatment programs maintain that attitudes, values, and behaviors are learned. To administer a drug does not help in unlearning deviant patterns, and substituting appropriate ones. "We continue to be concerned about any approach to therapy that minimizes the assaultive, manipulative, predatory, and aggressive components of the offender's behaviour" (Knopp, 1984).

Another drug that has been experimented with in the treatment of sexual offenders is cyproterone acetate; CPA, which like Provera reduces sexual drive. Barbaree and

Marshall (1987) point out that "while the aim of physical treatment is to reduce sexual urges so that deviant sexuality will be eliminated, it has not been made clear just what assumption underlie these procedures. Critics have suggested that the use of these procedures require us to assume that sexual offenders engage in their deviant behaviour because they have excessive sexual drive. The data and authoritative opinion runs counter to this assumption".

Bradford (1990) believes these drugs can be used effectively, given careful patient selection. In the majority of cases however, he states that once CPA is discontinued, it is useful to follow up with a formal behavioral treatment program, as well as imperative, especially for pedophiles to correct cognitive distortions by way of individual and group psychotherapy.

Incarceration

Although incapacitation (incarceration) is not a form of therapy, it does nonetheless require a brief discussion. Sexual abuse is a crime, and offenders caught for their crimes, are tried in a court of law. Sentencing is left to the discretion of the judge, who has three options, jail, probation (with or without treatment), or a stay of the charges. In the United States, many states courts work in tandem with sex offender treatment programs, and actually sentence an offender to treatment, with the provision that if

he does not comply with the treatment, he will then be sentenced to prison. Many therapists believe that the therapist working with sex offenders needs to have leverage in order to get the offender to confront his problem. Court ordered therapy does just this. In Canada the role of the court imposed sentence as a possible treatment modality or catalyst for the treatment process does not exist to the student's knowledge. If the offender does receive a prison sentence, unfortunately, most correctional systems do not have the specialized professional resources or the financial resources to implement the assessment and treatment methods referred to in the literature. Although the legal sanction has been applied, the individual offender is likely to continue his deviancy, unless some form of treatment is undertaken. Several treatment specialists view prison punishment "...alone not only as unproductive but as increasing the sex-offenders' pathology so that they come out with worse fantasies than before their incarceration." (Knopp, 1984). For the offenders in Canada who are assessed as amiable to treatment, more consideration should be given to conditional release programs which incorporate intensive treatment activities at a point where intervention is legally as well as clinically able to be implemented.

Family Therapy

Although not aimed solely at the individual sex offender, family therapy is another method used to treat offenders. This therapy is used with incestuous offenders. Family systems therapists emphasize interactional patterns and place little significance on psychological functioning or intent, claiming to dispense with notions of individual blame by focusing on patterns that connect all family members. (James & MacKinnon, 1990). The general systems approach to understanding a family in which incest occurs basically views the sexually abusive behaviour as a symptom of an already dysfunctional family system, for example a way of dealing with tension and distance in the marital dyad (Britton, 1989). Mayer (1983) asserts that in father-daughter incest family dysfunction plays the most significant role, while in other forms of incest, (father-son, mother-son, mother-daughter, grandfather-granddaughter) individual pathology assumes greater importance as a motivating force. She further states that in father-daughter incest, the entire family is involved and each member is active in perpetuating the abuse. Incest is motivated largely by urges to satisfy underlying emotional needs rather than by a need for sexual gratification. In rebuttal, it is interesting to note that some authors have argued that many therapists assume a causal relationship between apparent family dysfunction and the occurrence of

incest. They state that one could argue conversely, that the interactions inevitably following an incident of incest can create what appears to be a "dysfunctional family". (James & MacKinnon, 1990).

In regards to the statement that sexual abuse (incest) is not a sexual problem, I believe that we must look at the fact that there are many "dysfunctional" families, but not all of the fathers in these families sexually assault their daughters. Quinsey (1986), asserts that although the importance of sexual attractiveness might seem obvious on the basis of common observation and perhaps even tautological, the idea that child molesters prefer sexual interactions with children because they find them sexually appealing has not won universal acceptance.

There are several models of treatment of the "incestuous family" in the literature. None rely solely on family therapy, but combine individual, dyad, group (both peer, and professional), and family therapy in treating incest (Giaretto, 1981; Anderson & Mayes, 1982; James and Nasjleti, 1983; Herman, 1981). Individual counselling is offered as a preliminary to family therapy. James and Nasjleti (1983), state, "therapeutic help for the family in which sexual abuse has occurred deals with interpsychic and dyadic issues, but within a family system's interactional framework. The functioning of the family-- its roles, alliances, power, communication, conflicts, and so on is the focus of treatment,

whether the therapist is seeing a family member individually, with another person, or in a group setting". A concern that the student has regarding family therapy as a treatment method for offenders, lies in the fact that many incest offenders have been reported to offend non related children as well as their own. Does the offenders wife/partner contribute to his extra familial offending? The student is also greatly concerned, that given the general agreement that offenders are likely to deny, rationalize, minimize, and project blame for their abusive behaviour, that therapists do not provide further opportunity for them to do so. The student does agree that if parents, in a family where the father was incestuously involved with his child(ren) are to reconstitute, there must be some family/couple therapy, in order to explore and consolidate changes the offender has made in his therapy, and to generalize these into his relationships with others.

Marshall and Barbaree (in press) report that offenders typically report dissatisfaction with their current partner and frequently their relationship seems to be dysfunctional and stressful. Stress is viewed as worthy of intervention as evidence indicates that stress increases the probability that various deviant or dysfunctional behaviors will occur (Marshall & Barbaree, in press). They employ brief relationship counselling, emphasizing conflict resolution, effective communications and shared leisure activities. This particular method of couple therapy does not detract from the

offenders ultimate responsibility for his sexually abusive behaviour. Nor in this student's opinion does it blame the victim or non-offending spouse or force them into sharing the responsibility for the man's choice of sexually assaulting his child.

Wheeler (1989), asserts that,

> ...[While] incest may not be the exclusive problem in the family, it is a primary one and is not simply peripheral to, or symptomatic of more central interactional dysfunctions. Furthermore, the responsibility for the abuse needs to be seen as belonging primarily to the individual who offends. Changing the system alone is not sufficient to stop the abusive process. An even-handed distribution of accountability across the system moves the therapist dangerously close to colluding with the offender's attempts at minimization and denial. There is considerable evidence that men who offend within the family do so independently of family dynamics. (pg. 29)

Much of the theory surrounding incest offenders and their treatment involves working with the entire family. In the article, "Working with Incest Offenders", Snowdon (1984), asserts that society believes that mothers are supposed to save the family from any and all problems, and that mother is the one who is responsible for what happens at home. Sandra Butler (1978) addresses this with the statement, "Families don't assault children sexually. Men do."

Modality

In terms of modality, some therapy programs for the sex offender utilize individual therapy as a preferred method of intervention. Drieblatt for instance, states, ..."my own bias is that you have greater flexibility individually with people, and they do not have to fit into an existing scheme. Thus, you can shape treatment a little more readily." (Dreiblatt, 1982, p.82). Others utilize group therapy. Roger Wolfe, of Northwest Treatment Associates states, " the secrecy is broken down in group. An individual in group can't avoid dealing with issues by lying. Lying to one person who hasn't engaged in the behaviour is easier than to 10 who all know what the behaviour is. The greatest experts in sexual deviations is the molester himself." (Lyons, 1985) It appears however, that the majority of programs use a combination of the two approaches, thereby eliciting the benefits from both of the modalities.

In reviewing the literature, the trend indicates that most of the treatment programs reviewed also use an eclectic approach to therapy, combining a number of schools, techniques and modalities in treating the offender. In terms of success rate in treating the sexual offender, Taylor sums up the "state of the art" when he states, "there are things were not doing yet that hopefully will be more successful than the things we are doing. Hopefully we'll continue to learn and develop new techniques and strategies that will work better

than the ones we use now." (Lyon, 1985). Unless we are prepared to make laws to lock up offenders for ever, therapists argue that treatment, while it won't cure offenders, will provide controls to keep the community safe. Until more time and effort is spent in tracking offenders after treatment, we won't really know." (Lyon, 1985).

It is imperative that we continue to treat the sex offender, and to develop new theory and effective therapy methods if we ever hope to decrease the number of victims suffering from difficulties related to sexual abuse.

The student believes that it is important to use an eclectic approach in treating sex offenders against children, as it is clear that sexual offending is a complex and multifaceted problem. In order to comprehensively treat an offender, one must explore a number of issues and factors related to the offending behaviour, which might include cognitive factors, learned behavioral patterns, social skills, relationships with extended family and immediate family, and larger scale societal issues.

An ecological approach provides a framework for incorporating the variety of etiological theories, and treatment approaches currently employed in working with sex offenders. The next section focuses on a description of the ecological approach and it's principles for clinical practice.

ECOLOGICAL APPROACH

The ecological paradigm has its roots in systems theory. Ecology is defined in Webster's New Collegiate dictionary (1976), as, "A branch of science concerned with the interrelationship of organisms and their environment". This concept has been borrowed from the pure sciences by the social sciences, and applied to human interactions. The definition in social services work essentially remains the same; a study of "person-in-environment" and the reciprocity between the two. Germain (1981) asserts that, "most social workers agree that a concern for person-in-environment is the distinguishing and unifying characteristic of social work."

The ecological approach in social work, provides a broad conceptual framework for understanding and intervening in human situations, and demands that we look at person in environment, and transactions, rather than person in isolation. In this perspective, not only do events affect the behaviour of individuals, but the individual is an active agent in influencing the character of environmental events through his or her interpretation, selection and modification of situations (Holahan, 1979). "Adopting an ecological perspective, as Gordon (1969) conceptualized it, leads us to focus on adaptive (and maladaptive) transactions between persons and between the person and the environment-- in other words, the interface between systems. (Hartman & Laird, 1983).

"To facilitate positive human functioning, there is recognition that mental health practice should attend to the social implications of a human act and not attend solely to intra-psychic phenomena largely divorced from a client's natural environment" (Freeman & Trute, 1983). An ecological approach expands the "unit of attention",and with it also the arena of action for the helping person. For instance, Holahan et.al. (1979), writing on an ecological perspective in community mental health state," on the one hand the environmental emphasis of the ecological view supports environmentally oriented interventions directed toward strengthening or establishing networks of social support. On the other hand, the transactional emphasis of the ecological perspective fosters individually oriented interventions directed toward promoting personal competencies for dealing with institutional or environmental blocks to achieving personal objectives".

As outlined by Germain (1981), environment is seen as comprising both the physical and the social environments. The physical environment is layered into the natural and the built worlds. The social environment consists of three sublevels, beginning with the social network of family, friends, workmates, social groups, etc. Next is the layer of organizations and institutions, including education, work, housing, health care, social services agencies, such as the ones involved in providing therapeutic services to sex

offenders, and jails and our probation/parole systems. etc. Finally the social environment is layered at the societal level, with the culture, values, law, political and economic structures. Work or change at one level of the social environment will impact the other levels.

Hartman and Laird (1983) outline four "principles for practice" that grow out of an ecological perspective. Firstly, problems or difficulties are better understood as lacks or deficits in the environment, as dysfunctional transactions between systems, as adaptive strategies, or as results of interrupted growth and development rather than as disease processes located within the individual. Second, because of the complexity and over-determination of causation in multivariable systems, the effort to locate a single cause and cure is largely abandoned in practice. Third, life experience is seen as the model for and the primary instrument of change. Finally, a change in one part of the system has an impact on all other parts of the system.

In utilizing an ecological framework, by gathering data on the person environment interface, we hope to "counteract a longtime tendency toward partialization, which in the past has frequently resulted in reductionist problem definition and solutions."

Utilizing an Ecological Approach With Sex Offenders

In treating offenders, this student believes it is important to utilize an ecological framework, recognizing that offending is the result of influences and transactions at different levels in the offenders environment, or as Fossum and Mason (1986) state, "...that while we are responsible for our behaviour today, we did not become who we are alone". In utilizing this framework with offenders, one could surmise that the offender as a result of transactions (with family of origin, friends, the school system, work environment, and interpretation of societal values and norms about sexuality and a man's role, and so on) has adapted to the stresses in his life by sexually assaulting children. This clearly is not intended to remove the offenders responsibility for his behaviour. Rather it indicates areas for intervention such as helping him to adapt in conventional and socially acceptable ways to stress, helping him to strengthen or discover coping methods, and so on.

Wheeler (1989) works on the assumption that incest is a problem which derives, in part, from a society which sanctions the emergence of autonomy and the self-assertion in men in relationally irresponsible way. She views much of the reparative work with men who sexually abuse children as encouraging them to develop and value a sense of themselves as connected to others. George and Marlatt (no date) state that

for many offenders, sexual deviance has become a maladaptive way of coping with stress. As other more adaptive coping skills fail to develop, offending soon becomes the main way the person is able to cope with stress and to momentarily feel good about himself. Stermac et.al. (1990) urge us to conceptualize sexual aggression within a social context and believe that treatment interventions must consider the context of sexual violence as a socially constructed and socially legitimized phenomenon. Segal & Stermac, (1990), state that we need a greater understanding of the types of stresses which clients may encounter in their natural environments, and what types of interpersonal stress or social environment the individual is likely to return to (after therapy). These authors emphasize that many of the skills learned in therapy will go unused if the individuals returns to an environment which may not elicit the new repertoire of responses. All of these authors are in essence advocating an ecological approach to working with sex offenders against children, urging us to conceptualize and treat the problem by looking at relationships between people and systems.

Finkelhor provides us with a frame for viewing social and cultural factors that impact on the behaviour of the offender, as well as individual and social network factors that impact. For instance, society's tendency to sexualize children in advertising, condone the use of pornography, and socialize males to sexualize emotional needs, may contribute to

offending behaviour, and need to be considered in treating sex offenders.

In his model however, there is no consideration of the second social environment layer--the layer of organizations and institutions and it's impact on offending behaviour and on treatment implications. For instance, strength of ties with institutions of work may be an important consideration in terms of the individuals sense of self worth and his ability to control his behaviour. If the individual has a connection with a religious or spiritual institution, what messages is he receiving from there, and how is this impacting on his behaviour. What is the offenders connection to the parole/probation system, and how is it affected by and is affecting the therapy. Does the offender have school aged children, and if so what is the impact of the school system on him? Finally, are other family members in treatment, and if so what is the reciprocal relationship between their treatment and his.

These types of questions suggest possible areas to be explored with the offender, and may highlight areas for intervention. The therapist may not be able to directly intervene in all areas, however the principles of the ecological approach suggest that intervention in one area will have an effect on other levels and areas as well. For instance, environments may be altered to stimulate the development of competencies, and new competencies may be

generated as the client copes with changing environmental conditions in the presence of social supports.

In reviewing the literature, it appears that many sex offender treatment programs also subscribe to an ecological approach to treatment. Groth, as quoted by Knopp, (1984), states, "We are obviously talking about an issue that is much broader than simply a clinical or a psychological issue. It is a cultural, a legal, a political, an economic, an educational, a medical, and a spiritual issue. And if we are going to be effective in combatting this problem, it really means approaching it from all of these perspectives." (p. 26)

Many of the existing treatment programs do in fact look at sexually abusive behaviour in broader terms than just a psychological dysfunction. In keeping with a multicausal etiology, many treatment programs seek to help the offender control his behaviour by examining a number of factors believed to be contributing to his sexual offending (ie:several levels of transactions) and incorporating these into a treatment program.

INTERVENTION

Practicum Experience

The student contracted to work with three clients on a long term basis, for one year. The student utilized a combination of educational and insight oriented therapy and cognitive restructuring with the clients, maintaining an

ecological framework. The sessions therefore were individually tailored and often focused on issues that the client was dealing with in the here and now. Although these issues were different for each client, there were various themes that were important to cover with all of the clients. An overview of the intervention process will follow. All of the student's clients also attended a weekly offenders group, co facilitated by Forensic Behavioral Management Clinic staff.

Throughout the time of the practicum, the student sought to maintain an ecological perspective in her work with her clients. Prior to describing the content and process of the therapy for each client, the student will highlight how she utilized this "world view" in her work. As detailed elsewhere in this report, an ecological perspective is a framework, and not an intervention in itself. The four ecological principles for practice were used to guide the student's work.

As the reader may recall, the first principal was that problems are understood as lacks or deficits in the environment, as adaptive strategies, as dysfunctional transactions between systems, or as interrupted growth and development, rather than a disease process located within the individual. In working with sex offenders against children, this principle translated into practice by examining the interrelationship between various systems in the clients world, including family of origin work, work with the marital dyad. Individual factors such as poor social skills were

interpreted as a lack of information or ecologically speaking, deficits in the environment or interrupted growth and development.

The second principal stating that efforts to locate a single cause and cure is largely abandoned because of the complexity of causation in multivariable systems very much fit sex offender treatment. As indicated previously in this report, many sex offender treatment specialists are now abandoning a search for an single factor theory to explain sexual offending. Instead, a multicausal theory, is proposed, and therefore often an eclectic approach, combining various theoretical orientations and interventions is utilized. This principle allowed the student to explore a variety of issues with her clients, and not limit the therapy to a focus solely on the sexual offending. For example, the student was able to explore past issues with the clients in terms of family of origin, and values and beliefs learned there. On a larger scale, societal messages about men's and women's roles, and the clients unique manner of interpreting these were also discussed. As well, the student and client were able to explore parenting issues, the marital relationship, and the reciprocity between the community and the individual.

The third principle, life experience is seen as the primary instrument of change, and that natural helping systems are utilized wherever possible, translated into practice by incorporating family of origin work. Also, at times, the

student utilized the client's spouse in the offender's therapy to affect change. Although the victim was never physically present in a session, the child's presence was felt by the offender through victim empathy work, including having the offender write a letter to the child, discussions on the child's feelings, utilization of the victim's statement to police, and the student providing feedback from the child's therapist to the offender as to the issues his child was dealing with and her progress. Another important manner in which this principle was translated into practice involved attempting to help the clients generalize issues to current behaviour and situations in their lives, thereby allowing them to examine and practice alternatives.

The forth principle, change in one part of the system has an impact on all other parts of the system, was incorporated simply by maintaining that all themes the client presented were worthy of discussion and intervention, as a change in parenting style for instance, could impact the client's difficulties in identifying with the needs of his children, in turn reducing the risk for future offending behaviour.

Ellis et. al. (1987) have translated Finkelhor's Four Factor Model into practice, by incorporating existing sex offender treatment methods into each factor. For instance, if the factor of "social isolation" was assessed as contributing to the offending behaviour, Ellis et. al. would intervene through teaching social skills. If the factor of "coercion"

was present, cognitive restructuring, empathy training and probation conditions were the stated interventions. "Male inability to identify needs of children" was seen as best treated through empathy training. The interventions of probation conditions, marital therapy and self control (ie: behavioral techniques) were the interventions applied to the factor "failure of incest inhibition: family dynamics". The student relied on Ellis et. al.'s specifications of interventions as related to Finkelhor's model and incorporated cognitive restructuring, empathy training, and education interventions in her work. Prior to a description of the clients and the therapy, the setting of the practicum and the student's supervision are discussed.

Setting

The Native Clan Organization is a nonprofit organization that was established in 1972 to provide services "to prepare the Native criminal offender for his return and readjustment to society." Native Clan, as the name suggests provides services primarily, although not exclusively to native offenders. The agency offers several different types of programs in order to accomplish its goals. These include counselling both while the inmate is in prison, and post-release, spiritual support, transportation services to the prisons for the family of inmates. The Native Clan operates a half way house, "to ease the transition from

incarceration to freedom", by helping the inmate to deinstitutionalize, and start to make his own decisions and take control of his life. Parole supervision, and information regarding and referral to various services, including vocational training programs, alcohol and drug abuse programs, educational programs, etc, are also services offered. Finally, the Native Clan Organization offers a sex offender treatment program.

In 1985, the Native Clan Organization identified a growing need for a sex offender treatment facility. Through involvement with inmates in the prisons, and in transitional care, it became apparent that the majority of sex offenders in our criminal justice system received no treatment. Based on these observations, the Winnipeg Sex Offender Treatment Program, now referred to as the Forensic Behavioral Management Clinic, began operation in September, 1987.

The Clinic is a community based assessment and treatment facility for sex offenders, including child molesters (extra familial offenders), incest offenders, and rapists. As of October 1991, there were 17 pedophiles, 10 rapists, 22 incest offenders, 7 individuals who committed multiple offenses (against both children and adult victims) who were involved with the program. Although the name Native Clan Organization implies that services are provided only to Native people, this is a misnomer in the sex offender treatment program, as any and all cultural groups are served. The statistics indicate

that 8 Native men, and 21 non Native men were referred to the Clinic for assessments in 1990/1991. Treatment statistics indicate a similar cultural group breakdown .

Comprehensive assessments, utilizing physiological measures of sexual preference, clinical interviews gathering information on a variety of aspects of an individuals background, and psychological testing are developed. Individual treatment is then provided for the offender. The program adopts a cognitive behavioral orientation, and includes modification of inappropriate arousal patterns, cognitive restructuring, relapse prevention and resocialization training. Group therapy is also provided for the individuals in this program.

Referrals to the Forensic Behavioral Management Clinic are primarily received from the Correction Service of Canada, either through individual parole officers, or the Regional Psychiatric Center, located in Saskatoon, Saskatchewan. Referrals for assessment come from a variety of sources, including; defense council, Child and Family Service Agencies, as well as agencies such as Child Protection Center, Klinic, Evolve, and Selkirk Mental Health Center. Individuals referred for assessment must be entering a guilty plea in court. Some of the individuals referred for assessment may continue in the treatment program. Others, may individually decide not to continue with treatment, be referred to other treatment facilities, or not qualify for services. There is a standard

fee charged for assessment services. Fees for treatment services are levied on a sliding scale, although there has been some difficulty in individuals paying in this manner, and the inclination is to accept individuals who are sponsored by an agency.

Although the services of this program are aimed primarily at the individual sex offender, there is an understanding and commitment to providing an ecological based service including significant others in the offenders' life.

CLIENTS

Although this student believed it would be interesting to treat both incest offenders and pedophiles, to allow for a comparison between the groups, a small N of three did not allow for this. All of the student's clients therefore, were incest offenders. The clients were assessed by Forensic Behavioral Management Clinic staff prior to the beginning of the student's practicum, and the student utilized the existing assessments as a guide. It is interesting to note that all three clients showed a "flat response rate" on their plesysmograph testing. This result is interpreted as a lack of response to sexual stimuli, not as an appropriate response. One of the student's advisors having seen these types of responses with other clients, hypothesised that these results could be the result of these men practising a form of aversion therapy on themselves, by "thinking of something awful" as

they viewed the tapes, slides, and listened to the auditory tapes. As a result of this assessment, the student did not employ any behavioral aversion techniques with her clients.

The student's three clients had all served prison sentences, and were residing either in a half-way house, independently, or with their family at the time of the student's involvement. Two of the clients were on parole, and one was on probation. Among various other stipulations in these orders, (ie: to abstain from alcohol, to report to the probation/parole officer, etc) all were required to "attend therapy as directed by their probation/parole officer". As part of her practicum experience, the student also did have an opportunity to observe and participate in the assessment of two other clients referred to this program, both of whom were incest offenders.

Supervision was provided jointly by Dr. Liz Adkins, the student's practicum advisor, adjunct professor from the School of Social Work, University of Manitoba, and by Dr. Dennis Dyck, one of her committee members, Department of Psychology, University of Manitoba. The majority of the therapy sessions were videotaped, and processed by the student and her advisors. As well, the student partook in peer supervision for approximately half of the duration of the practicum, with 5 Forensic Behavioral Management Clinic staff. The student also meet with Lawrence Ellerby, (program manager, and co-facilitator of the group the student's clients were in) on a

bi weekly basis for half of the duration of the practicum,in order to maintain contact and to share information regarding clients issues and progress in the individual and group therapy.

Mr. A.

Offence

Mr. A , a 38 year old Caucasian, received two, two year consecutive sentences for sexually assaulting both his step-son, and his step- daughter. The abuse occurred when the children were between the ages of 9 or 10 and 13. Mr. A. began with the sexual abuse of his 10 year old step-son , which he related was ongoing for a period of three years. When his step-son turned 13, Mr. A.'s interests turned towards his step daughter, who was approximately 10 years old at the time. Mr. A. eventually became so distressed about his ongoing inappropriate sexual behaviour and the possibility that one of his children would disclose the sexual abuse, that after speaking to a minister, he turned himself in to a Community Service's social worker.

Immediate Family

Mr. A. met his wife in 1976. She was five years his senior and had a five year old son and one year old daughter. After dating and living together for approximately one year, the couple married and had four children together (three boys,

ranging in age from 13, 12, and 10, and a girl, 7 years old). Mr. A. described this relationship as unstable and attributed many of the problems to his wife's alcoholism. Mrs. A. has been sober for approximately 8 years. Mr. A. reported that when she was drinking she was frequently absent from the home and neglected her family. He was angry with her for her excessive drinking, her suspected infidelities, and her neglect of the family. He also resented having to take on the care of the children and the home due to her behaviour. Mr. A. was physically abusive towards his wife on several occasions, however claims there has been no further abuse after he received a charge of Common Assault a number of years ago. He has also been physically abusive of all 6 of his children (ie; slapping, choking, hitting, spanking) although there have been no formal complaints in this regard.

Family of Origin

Mr. A. is the second youngest in a family of 9. Both of his parents are deceased. He describes his father as a domineering man who was verbally and emotionally abusive towards him, and verbally and physically abusive towards his mother. His mother is described in terms of being kind, and caring, and trying to help him. Mr. A. describes incestuous activity between an older brother and sisters, as well as between a sister and maternal uncle. Mr. A. describes himself as a child who liked girls and engaged playing dolls with them. In his teenage years, Mr. A. was painfully shy and

states he always had trouble in "getting girls".

Interventions

Mr A. had been involved in therapy with a Forensic Behavioral Management Clinic therapist for approximately 6 months prior to this student's involvement. During this time, the therapy had focused on exploring Mr. A.'s attitudes towards women, attitudes towards violence, Mr. A.'s shyness, difficulties in communication, and beginning discussions regarding the sexual abuse and Mr. A's cognitive distortions.

The student chose to begin the therapy by focusing on a genogram, and looking at Mr. A's family of origin, as a way of joining with the client, as well as providing the student with information on family patterns (McGoldrick & Gerson, 1985). As well as mapping of relationships and patterns, sessions were spent on uncovering what he had learned from his family about being a man, on how women should behave, about his extreme shyness as an adolescent and his feeling of "never being good enough". Through comments the client made, while working on the genogram it became apparent that sexuality was an issue, and we spent sessions exploring what he had learned from his family about sexuality, as well as from peers and experience. Mr A. was able to articulate that he felt that he had his first sexual experience with a partner later than his peers, giving him a sense that he had "missed something" and needed to catch up. This related directly to the sexual abuse of his children in that the abuse provided a manner of

experimenting with what he had read as well as providing him with more sexual contacts. Feelings of loneliness, depression, anger, and low self-esteem often accompanied Mr. A's feelings about sexuality. He was able to acknowledge his belief that sex was one of his most important needs, and that much time was spent thinking about this area. As well, Mr. A. had many faulty beliefs about sexuality, both in general terms, and specifically related to him, including; the belief that it is important to have a high sex drive when young, to ensure that one will have a sex drive when older, and that one needs to have alot of sexual experiences when young, or make up for the lack of experience when older. Mr. A. expressed uncertainty in his ideas about sexuality. For instance, he questioned whether looking at a woman in public and fantasizing about her was normal, asking the student what percentage of males would use this image as a sexual fantasy, and what percentage would "just think that the woman looked nice, and forget about it". He questioned whether his ideas of sexual attractiveness were similar to other men's, and whether his physiological response to sexual arousal was normal, as he felt "out of control". In order to increase his factual information in this area, Mr. A. was given a number of readings on the area of sexuality, and also encouraged to access more materials from the public library. A number of sessions were spent discussing Mr. A's feelings and beliefs in order to help him articulate some of his ideas and to explore

them.

A second general theme explored during the course of the therapy was that of empathy. In order to increase Mr. A's awareness of the trauma he inflicted on his victims, as well as his family, we went over a description of the offenses, paying attention to how the children must have felt. Mr. A. was also asked to write letters to his two children to be processed in our session. The student also utilized the video tapes, To A Safer Place, and Incest the Untold Story as a method of helping Mr. A. to focus on the victims feelings, and difficulties they were now experiencing that were related to the sexual assault. For instance, Mr. A. was able to connect his sons drinking problem, trouble with the law and angry outbursts to the sexual abuse. The student framed these sessions in terms of Mr. A. wanting to parent all of his children differently and in order to help them he had to understand what they may be feeling.

Another focus in many of the sessions was on Mr. A.'s abuse cycle, factors that seemed to signal high risk for future sexual offending, and changes that he would have to make in order to guard against this constant possibility. This work was accomplished by helping Mr. A. to explore incidents of his sexually abusive behaviour, with a view to the situation preceding the abuse, his mood state and reasons why he found children appealing. Related to this area, work was also done in regards to some of Mr. A.'s continued

rationalization and minimization of his sexually abusive behaviour. For example, Mr. A. would continually correct the student when she would refer to his victims as his children, not his step-children. This issue was processed in terms of the meaning for him, (ie: it wasn't my biological children, therefore somehow it really was not that bad), and helping him to restructure some of the cognitions (ie: he was the only father his step-children ever knew), as well as confrontation, (ie: does this mean that other non-related children are also at risk).

Mr. A. was on parole for approximately 3/4 of the time the student was working with him. His parole conditions stipulated that he was not to visit with children unless he had another adult present with him, and that he could not reside in the family home. Although Child and Family Services were involved, no other member of the family was in therapy (either because there were no services available at that time, or as the individual did not want service.) There were two Family Support workers placed in the home to assist Mrs. A. in getting the children up and off to school, to teach Mrs. A. some parenting skills, and to provide support to all family members. Mr. A. would visit regularly with his wife and children. Many of the sessions with Mr. A. involved the theme of "relationship with children". For instance, Mr. A. reported that his Christmas visit with his family had been upsetting and depressing, with him experiencing a lack of

respect, trust and closeness with his children. This presented an opportunity to begin to look at expectations of family, and whether these were realistic or not (cognitive restructuring), his parenting style, (passive, feeling he had no control, and then anger and an outburst, often physical), and finally problem solving, (what else could he do to establish the type of relationship with his children that he wanted).

On a related note, another area looked at in the therapy was "relationship with spouse". Mr. A. would complain that he felt his wife was using him as a taxi service, that in the past he was often used for babysitting, and his fear that this would occur again. Mr. A. would vacillate between feeling that he deserved to be treated like this because of the pain he had put his wife through, and becoming angry at being treated like this. Mr. A. would also vacillate between reconciling with his wife after his parole and leaving her and his children. Since the student was of the opinion that the nature of this relationship was impeding Mr.A's progress in therapy, Mr. and Mrs. A. were seen jointly for several sessions. In these sessions, commitment to the relationship was examined. Both of the couple indicated a wish to reconcile and to improve their relationship. A referral for marital and family therapy was made. Also, the student attempted to refer Mrs. A. for individual therapy, as in the joint sessions it became apparent she had not had the

opportunity to explore her feelings regarding the sexual abuse, and her feelings towards her husband, a service very much needed, but beyond the scope of this student's practicum.

Many of the sessions involved "here and now" issues and the relationship between the client and therapist. For example, in one session, Mr. A. stated that he was angry with the student as he felt that she "pushed him to hard", and expected him to find his own answers when he could not. Further, he believed that he had been feeling depressed and isolated, and the student had not picked up on that, which he viewed as being her job. This issue provided an opportunity to look at the process of therapy, responsibility for the therapy, and a generalization to other situations in Mr. A.'s life. From this, Mr. A. was able to look at his expectations that others "read his feelings" and pick up on these. He was also able to connect loneliness, depression, isolation and anger as emotions that were involved in choosing to sexually abuse his children, and that these emotions were important high risk warning signs for his future. Sessions were then spent problem solving what he could do with these emotions, including: 1) cognitive restructuring---is it that bad? Am I overreacting?, 2) techniques such as leaving the situation and walking or driving, 3) attempting to increase his social contacts, and 4) identifying the emotion and taking responsibility and seeking support from his social network,

including his therapists.

Other process issues in the therapy included Mr. A's tendency to avoid eye contact, to speak very softly in a mumbling whisper, and to leave sentences hanging, or speak in vague terms expecting the therapist to make the right assumption as to the correct meaning. These behaviors were identified in sessions, processed in terms of consequences to him (ie: misunderstandings, frustration, a sense of being invisible --all mood states related to the sexual abuse) and individual therapy framed as an opportunity to practice new skills that could be generalized to his interactions with others. Mr. A. was able to use this process issue to identify feelings, and situations outside of the therapy room. For example, Mr. A. spoke of being frustrated and angry with waitresses in restaurants, as he often found he had to repeat himself several times, or he would receive the wrong order. He was also able to look at his relationship with his wife and children, realizing his family often had difficulty in hearing him.

Summary

At the point of termination this client had made some therapeutic gains. These gains included: an increase in eye contact, and voice levels; developing empathy for his victims, and other family members; and an awareness of some of the contributing factors to his sexual offending.

In the final session, Mr. A. was able to identify areas

that he believed he needed to continue to work on. These included: parenting skills; his moodiness and coping strategies;, increasing his social contacts; and further developing his communication skills.

One of the difficulties in the therapy with Mr. A. was the fact that none of his family were receiving therapy themselves. This further complicated issues for Mr. A. in that he perceived that he was the only family member prepared to make changes. Also, as stated earlier, the student believed that Mrs. A. had many unresolved feelings, and questions related to her husband's sexual offending, resulting in an ambivalence regarding commitment to the relationship. Although the student attempted to locate resources for Mrs. A., these were not available until near termination of the student's contract with Mr. A.

One of the important areas the student missed in working with Mr. A. was to schedule an apology session. This session could have eased Mr. A.'s transition home, as family members could have heard Mr. A.'s acceptance of responsibility for the sexual abuse, and witnessed his openness and willingness to discuss the sexual abuse and its' impact on all family members. This in turn could have affected the manner in which family members interacted with one another. In hindsight, the student believes that this was an example of a breakdown in communication between the systems involved with Mr. A. and his family, with the various systems assuming that the others were attending to this important therapeutic work.

Mr. B.

Offence

Mr. B. is a 37 year old Filipino man, who was sentenced to three years in prison for the sexual abuse of his 14 year old daughter. He served approximately 9 months of his sentence and was then paroled with conditions that he reside in a half way house, attend therapy, and have no contact with his daughter. The abuse occurred over approximately a one year period, and ended when it was discovered he had impregnated the child, and charges were brought against him.

Immediate Family

Mr. and Mrs. B. married when he was 17 and she 15, after they discovered she was pregnant, and after a number of years of dating. The couple were married in a secret wedding so as not to jeopardize Mr. B's emigration to Canada, in that year. Mr. B. departed for Canada three months after the birth of his first child. After a three year separation, Mr. B. brought his wife and 3 year old daughter to Canada. The couple had their second child, a son one year after this. Mr. B. is unable to identify any type of problems in his marital relationship, other than to state that for a number of years his wife worked two jobs, and his daughter was the one who was taking care of him by cooking, and cleaning--a factor he attributes to his sexual offending.

Family of Origin

Mr. B. is the youngest in a family of 7 siblings, two brothers, and five sisters. His mother died 8 months after his birth, and he states he was primarily raised by his second oldest sister, whom he thought was his biological mother during his early childhood. Mr. B. describes his father as hard working, slow to anger, and a responsible man. He was able to recall several incidents such as being hung up in a sack by his father for skipping school, where he states his father was correct in doing this as it stopped him from skipping school again. Mr. B. was extremely protective of his family of origin, essentially claiming a perfect childhood. He states that he grew up with the idea that children are to be seen and not heard, and he was not included in adult discussions. Much of the information he did get was from eavesdropping, and overhearing gossip. Mr. B. claims he treats his children as adults, and includes them in conversations, which he prides himself for.

Interventions

As with the student's other clients, she chose to begin the therapy with Mr. B. by drawing a genogram and looking at his family of origin.

A central theme in working with Mr. B. was victim empathy. Mr. B. could verbally take responsibility for the sexual assault, by stating "yes I did it, I made a big mistake", but

presented as a victim himself (ie: through statements such as I'm being good, what do you guys want? For me to beg and walk on my knees to go home?). In subtle ways, Mr.B. also tended to blame his wife and his daughter for his sexually abusive behaviour. For example, he would often speak of the fact that he had told his daughter to tell her mother about the sexual abuse, however the child did not do so.

Mr. B. denied the fact that the sexual abuse had negative effects on the family, stating that his family still trusted him, and wanted him home. In terms of his daughter, Mr. B. initially believed that she had not been adversely affected by the sexual abuse, stating the child had never said anything, he would have known if she was angry, and that other victims may be harmed by the abuse, however the student could not generalize from these individuals to his daughter as "she isn't like them". Mr. B. displayed a similar lack of empathy for his son, choosing to deny his son had been affected by the sexual assault of his sister. For instance, in spite of a variety of factors which would lead one to conclude the boy was aware of the abuse, (ie: the boy had made a statement to the police regarding his sisters victimization and his observations) and his life had been changed by the disclosure and subsequent events, (ie: the child had been apprehended upon disclosure, his father went to prison, and his father was allowed to visit him, but not his sister, nor was his father to reside in the family home) Mr. B. initially maintained

that he did not have to discuss anything with the boy until the child was an older teenager, and ready for the information. In order to help Mr. B. to work on these areas, the student obtained a copy of the victims statement (including his son's statement) to the police, and went over the statement with Mr. B. The student also assigned a task of writing a letter of apology to the victim, that was processed in the therapy. The student was also in contact with the victims therapist, who was able to provide information on issues the child had or was having difficulty with as a result of the sexual assault, and these were looked at in sessions. Finally as a manner of creating some leverage with my client, the offenders spouse was invited to several sessions, in order to discuss her perspective of how the child has been affected. Several video tapes focusing on the aftereffects for sexual abuse survivors were shown to the couple. On several occasions, Mrs. B. was able to confront her husband's denial, helping him to begin to develop a sensitivity to his daughters feelings.

A technique this student found useful with Mr. B. when he was "stuck" and could not generate ideas or guesses, was to ask him to pretend that another father had sexually abused his daughter and to comment on this. By way of example, in one session while using this approach, Mr. B. was able to state that a child sexually abused by her dad might "feel like a piece of meat used for someone else's pleasure". Prior to

this point it had been difficult for Mr. B. to acknowledge any harm to sexual abuse victims.

The student had to be very confrontive, almost "shocking" Mr. B. into a discussion on empathy, at times. For instance, the student lead a discussion on the daughter's feelings around losing her virginity to her father, which was framed in terms of something which had been taken from her which could not be returned. The issue of the daughter's abortion was another subject broached by the student to assist Mr. B. in connecting with some of the daughters feelings as a result of the abuse. The student chose these areas as she believed Mr. B's religious beliefs (he is Catholic) would provide enough leverage to help him confront the very painful fact that he had hurt his daughter. Although Mr. B. was eventually able to discuss the fact that the sexual abuse had been planned, and was not just an accidental happening, he continued to claim that the first incident had been a case of mistaking his daughter for his wife, and it was after this that he had "become attracted to his daughter" and continued to sexually assault her. The student, believing this first incident was in fact planned, and not "an accident" attempted to help Mr.B. to confront this in several ways. The student employed the leverage the offenders group provided, by asking Mr. B. to imagine that he had told the group his first abusive act had been an accident. Although Mr. B. was able to state that the group would probably not believe him, and in fact raised this

issue with his group when the opportunity presented itself, he continued to maintain the first incident had not been planned. The student believed that to pursue this issue further would only result in a struggle and therefore choose to abandon this particular issue, and continue to work with Mr. B. on the aspects of the abuse he was able to acknowledge. The students belief was that an acknowledgment of planning the abuse was a significant move on Mr. B's part and that there may be some generalization from these other incidents to the first.

A number of sessions focused on the "precursors" to Mr. B's victimization of his daughter, as a manner of exploring high risk factors for Mr. B. and of helping him to identify changes he would need to make upon his return home, to safeguard against future sexually abusive behaviour. He was able to generate a number of factors leading to the abuse, including being over protective of his daughter, placing his daughter in a caregiver role by asking her to take care of his needs, being fairly socially isolated, and problems in the marriage including communication difficulties, the couple's sexual relationship, and a sense of having lost the intimacy and connection that had originally been there. From here, safe guards and changes were explored, and included: developing more social contacts and activities; not being at home alone with the daughter; and taking more responsibility for his own needs, either physically (ie: making his own snack, laying out his own clothes) or emotionally (ie: seeking

out adult supports).

All of these sessions culminated in an apology session, where Mr. B., Mrs. B., the child victim, her therapist, and this student were present. Mr. B. was able to take responsibility for his offending behaviour, begin to identify how he believed he had harmed his daughter, outline changes he would make in order to help his daughter feel safe upon his return home, and to answer some of his daughters questions (which were given to him in advance) regarding why he had done this to her, and her concerns that he may hold her mother responsible.

In terms of the marital relationship, Mr. B. could acknowledge there had been some problems, however presented this in a past tense, suggesting that it had all changed for the better now, and the couple had been able to resolve differences, speak to each other openly, and return to their previous happily married state. The student attempted to help Mr. B. examine these areas, by asking him to describe the current situation, the past situation, and how he could account for the difference. This tactic met with moderate success, in that it forced Mr. B. to look at and verbalize the differences, however did not help him to shift to further introspection. The student also worked hard at normalizing his marital situation (ie; all marriages experience some difficulties some of the time,) believing Mr. B. was fearful that if he divulged marital problems the student would delay

his return home. Finally, in attempts to help Mr. B. to look at his marriage, the student framed the extremely positive portrayal of his marriage in terms of his experiencing " a second honeymoon". The student presented the facts that he had been living away from his wife for two years, the couple were in essence dating as they saw each other 2 times a week, (often without children), and he called Mrs. B daily. Although the couple may have spoken about parenting issues, finances, and so on, the fact remained that he did not reside at home, and therefore was not immersed in marital and family responsibilities on a daily basis. The student suggested this situation would change with the advent of his returning home, with familiarity, as well as day to day "hassles".

Some sessions involved current issues revolving around parenting, and Mr. B.'s expectations of his role, and his wife's role upon his return home. Initially, Mr. B. believed that nothing had changed in this regard, and he would just step back into the role he had been forced to leave. He made some progress in recognizing that there might be changes after his absence. For instance, he was able to recognize that in the past, he would usually be the parent to okay the children's activities and to set the curfews. In one session he informed the student that when his daughter asked him what time she should be home, he told the child to ask her mother, not only recognizing his wife's role in parenting, but also cognizant of the fact that in the past he had been overly

protective of his daughter which he believed had contributed to his sexual offending.

Several process issues emerged during the course of the therapy. For instance, Mr. B. felt that therapy was a further punishment and that he had no need for it as he had "learned from his mistake and that it would not occur again." This issue persisted until termination, with Mr. B. vacillating between "I like coming here -It's good", and "I know I'll never do it again - I already know all of this stuff". The student attempted to help him process his feelings by looking at the concept of punishment, of his feelings of having failed his family (both immediate and of origin), of having just about "lost everything" and around his remorse, and possible feelings of not being able to forgive himself.

Mr. B. was also able to inform the student that he felt his words and his body movements in sessions were being observed and analyzed which he feared would be interpreted negatively and impede his progress in returning home. Related to this was also the issue of "providing the right answer" or emotional response (ie: do not make the therapist angry by showing anger, as it may hinder the goal of going home and second guess what answer the student is looking for). These issues provided the opportunity to discuss the purpose of therapy, expectations of client and therapist and the therapists role. The student found it necessary to clarify these issues with Mr. B. on several occasions through out the

therapy.

Mr. B. very much presented with an attitude of "it used to be a problem, but I've changed and resolved it". It became clear that it was very important for Mr. B. to "be right", and in control, and the student encountered numerous challenges in this regard. At one point in the therapy, Mr. B. in response to the student's statement regarding an observed mood state denied this. At the student's comment that she was confused by this, Mr. B. used an analogy that if you ask a drunk person if he is drunk, he will deny it, and that as a therapist the student should know that. This situation typified many sessions. Believing this attitude related to Mr. B.'s concept of self, and ultimately to the sexual abuse of his daughter, the student intervened through highlighting her observations, and inviting Mr. B. to explore the issue. Mr. B. was able to talk of his feelings that he had been seen as "dirt" by his family. Where siblings had excelled, got honors and were recognized for this, he was not. The fact that he had sexually abused his daughter, and felt that he had disgraced his family intensified this feeling. Mr. B. also commented on his pride of being able to give family, friends, and co-workers "good advice" and the status it afforded him.

Summary

During the course of the therapy, Mr. B. made a number of therapeutic gains. Included were: 1) a reduction in his

tendency of minimization, rationalization and blaming; 2) a greater understanding of victim empathy; 3) some gains in understanding factors related to his offending: and 4) some insights into his behaviour. Future work could have focused on strengthening Mr. B's problem solving abilities, and on helping him further identify his offending cycle. The student believed that some marital as well as family therapy needed to be provided for this family, ensuring that issues that were dealt with individually were also discussed amongst family members. To this end, upon termination, the student referred Mr. B. and his family to another agency for family therapy.

With this particular case, the systems involved with Mr. B. and his family (Child Welfare, Parole services, Child Guidance Clinic, and Native Clan Organization) worked extremely well together. There was ongoing contact between the various therapists and a sharing of information as to the progress of the family members. The systems balanced each other, taking the interests of all family members into consideration. For instance, the parole officer drawing on her positive interaction with Mr. B. as well as her mandate suggested that Mr. B. should be allowed to return home after several weeks of therapy. The child's therapist and this student both believed that there were many outstanding issues for both the victim and Mr. B. To move Mr. B. home at that point would have detrimental effects on the victim, the family

and Mr. B.'s motivation for therapy. The team was able to negotiate a plan taking into consideration all of the individuals in this family, set goals, and future meeting times to monitor progress.

In working with Mr. B. the student was forced to examine some of her own style and reactions to him. For instance, at times she found herself actively attempting to convince Mr. B. of another point of view, often resulting in a struggle, rather than in a collaborative relationship. The student took too much responsibility for Mr. B's progress in therapy, at times working harder than the client. It took time for the student to enter a collaborative relationship with Mr. B, by accepting his frame of reference, and his point of view and working with these. Once the student was able to relinquish her view, the therapy was more productive.

Mr. C.

Offence

Mr. C. is a 35 year old Native man, who was convicted on a charge of incest, and received an eighteen month sentence. He sexually assaulted his oldest daughter over a number of years, until the child was able to disclose.

Immediate Family

At age 17 Mr. C. began dating his wife who was 13 years of age at that time. The two married after having dated and lived together for a period of four years and after already having three children. Mrs. C. was expecting their fourth child when they married. The couples last child was born after they were married. The children, two girls and three boys, are ages 17, 16, 15, 13, and 12 respectively. Mr. and Mrs. C. gave up their second daughter to Mr. C's sister, as at the time of her birth the couple were living with his wife's parents who did not want another child in their house. As Mr. C.'s sister had become attached to the child, the couple did not attempt to regain custody of her when their living arrangements changed.

Over the course of this relationship, Mr. C. has been involved in a number of one night stands both with women in his community and with prostitutes who he sought out when he was in the city. When Mr. C's. wife was in the hospital giving birth to their forth child, he was having an affair with a 15 year old girl, who became pregnant. Mr. C. has not maintained contact with this girl, nor their child.

Despite Mr. C's. history of alcohol abuse, infidelity, physically abusive behaviour towards his wife, and his sexual offending, Mr. C. finds it difficult to identify any difficulties in his marital relationship other than alcohol abuse by both himself and his spouse.

Family of Origin

Mr. C. was the second youngest child in a family of 13 children--six brothers and six sisters. He expresses considerable resentment when recounting his youth, stating that he often felt ignored and uncared for as a youngster. Mr. C. described his father, who died when he was nine years of age, as an alcoholic who was physically abusive towards family members. Mr. C. describes his mother, who died 3 years ago as a kind woman, but also resents her for having not paid more attention to him or expressed more caring for him. As a child, Mr. C's. relationships with most of his siblings who were much older than him were distant, although he maintains contact with the majority of them now. At age 12, Mr. C. was sent to live with an older brother because his demanding and delinquent behaviour made him unmanageable at home. Mr. C. lived with his brother and his family from ages 12- 16, during which time he was often neglected, and physically abused. From ages 16-18 he lived either on his own, with his brother, or with his mother. As a young boy, Mr. C. describes a number of irregular early sexual experiences. He used to sleep in the same bed with 3 of his nieces, (one of whom was the same age, and the other two who were one and two years younger than he) and recalled playing games and wrestling with these girls, which led to kissing and sexual touching. At age 10 Mr. C. related sexually touching and simulating intercourse with one of his nieces friends, who was the same age. By age 12, Mr.

C. was engaging in sexual intercourse with his nieces, which continued for about one year, and ended when he became sexually active with other girls. Between ages 8-10, Mr. C. related engaging in sexual activity with his sister, who was two years younger. He also recalls that one of his brothers, who was two years older than he was, was also involved in some of these sexual contacts. This same brother was also sexually involved with Mr. C's. nieces. At age 10, Mr. C. was abducted by a man who lured him into a car. The man fondled Mr. C. and performed fellatio on him, and then coerced Mr. C. to perform fellatio. Between ages 14-16, Mr. C. states he was involved in a number of casual sexual relationships with same aged girls. At age 16 he related being seduced by the 30 year old mother of one of his friends, with whom he engaged in sexual relationships with on a few occasions.

Intervention

The student chose to begin the therapy with Mr. C. by exploring family of origin and drawing a genogram. This not only provided the student with a non threatening way to join with Mr. C., but also provided valuable insights into continuing patterns. For instance, Mr. C. spoke of his family being the "black sheep of the community", and more specifically of himself of holding this role, and "being picked on". Mr. C. perceived this pattern up until the present time, stating he believed members of the community

were trying to frame him through allegations of sexual assault that he did not commit, and through alleging he had broken his probation order by visiting his daughter (the victim), resulting in his probation being breached, and being returned to prison for a further six months. Mr. C. described his response to feeling picked on as feeling a lack of trust towards others, and to lashing out physically. This theme presented itself many times in the therapy, and the student attempted to deal with it through a variety of techniques. Some of these included cognitive restructuring, where Mr. C. was encouraged to develop alternatives to his perspective. When he could not, the student helped him to begin to generate some alternatives. For instance, the students colleague received a call from a person in Mr. C.'s community, stating Mr. C. had been driving a school bus of children, and there was general concern. The student processed this in session, by framing the situation as community members being concerned for not only the safety of children, but for the safety of Mr. C. and him not putting himself in a vulnerable position.

Relatedly, many sessions were focused on Mr. C's. feelings regarding his community, and his possible return to it. He would vacillate between believing he would return to his community, would hold his head high knowing he was not the only sex offender, but he was the only one to get therapy, and feeling that he would be ostracized, pushed to fight, and that he should "run away". This allowed us to begin to explore

some of Mr. C.'s feelings of self worth, as well as his feelings of betrayal by others, his feelings of being criticized behind his back, his sensitivity to this, and his feeling of shame.

Many sessions also focused on here and now issues, such as Mr. C's stress level (with him complaining that he could not stop thinking about his situation resulting in a lack of sleep), about parenting his sons, about his finances, and his living situation. Cognitive restructuring and problem solving were interventions applied to all of these issues. For instance, in regards to Mr. C's stress level, the student required Mr. C. to keep a journal of the times he was worrying, and the subject of his worry, in order to help Mr. C. pinpoint any patterns or discrepancies there might be in his perceptions of the situation. He was not able to follow through on the task, stating that the situation had dissipated and there was no need to track events.

The student spent some sessions attempting to approach the issue of the sexual abuse head on, by asking Mr. C. to recount some of the abusive episodes. Through discussion with the Child and Family worker involved with Mr. C.'s family, the student was able to obtain a copy of the victim's statement, which also included allegations from several other children in the community. Mr. C.'s response to the query of other victims was denial and anger. He also maintained a blaming posture towards his daughter, as evidenced in statements he

made to the student regarding his beliefs that originally he had been responsible for the abuse, however later, his daughter would set up the abuse, in order to negotiate a privilege, and blackmail him, telling him if he did not comply that she would tell. He also had difficulty in looking at the effects of his abusive behaviour not only on his daughter, but on the whole family. Most often he would refocus the issue to himself, his sense of guilt, shame, self hatred and extreme difficulty in looking at the pain he had caused his family. Upon termination, Mr. C. committed himself to further therapy with a staff from Native Clan. In our termination session, the other therapist was able to inform Mr. C. that through consultation with the probation officer, as well as lawyers, the therapist had learned that all allegations had been dealt with legally, and no further charges would be brought against Mr. C. should he begin to discuss the statements of the other alleged victims. Future work was then framed as an opportunity for Mr. C. to share some secrets that had continued to make him feel badly and interfere in his therapy, without a risk of further charges or a jail sentence for him.

During the course of the therapy, there were also several process issues between the client and the student. One of these was Mr. C's tentative questions regarding the students trustworthiness. This was presented in terms of statements such as "what if you leave here before the end of your

contract? Who would you talk to about me?" This issue allowed us to explore the therapeutic contract, client and therapist roles, and Mr. C.'s world view that given the chance, others will hurt you.

Another process issue that came up several times involved Mr. C.'s ambivalence to being in therapy. He would often complain about the time of the appointments, and the day of the appointments citing he had no time for himself. Mr. C. developed a pattern of attending 2 or 3 individual sessions, and then missing 2 or 3 individual sessions (sometimes calling slightly in advance of the session stating why he could not attend, and at other times not phoning at all). Initially this student sought to utilize the clients probation officer as leverage into forcing the client to attend his individual therapy sessions. The client maintained this pattern. The student attempted to process this pattern with the client in several sessions, by highlighting the pattern, and confronting the fact that each time this occurred it was like "starting over". The client still continued in this pattern. In hindsight, the student believes that she could have requested the probation officer to play a more active role by requesting ongoing reports from the student, and also by scheduling regular team meetings, including the client and his partner.

Summary

In summary, due to the number of sessions missed, the student believes Mr. C. made very few therapeutic gains during the course of the therapy. Therapeutic beginnings were made in terms of addressing Mr. C's world view and the consequences of this to him, and in exploring Mr. C's feelings of anger, guilt and shame. The student was not able to help Mr. C. look at his offending cycle, cognitive distortions in regards to his offending, or protection plans/relapse prevention for the future--important areas of work with offenders.

A Forensic Behavioral Management Clinic staff was included in our termination session as Mr. C. had agreed to continue his individual therapy with that staff member after this student's termination. In this session future work for Mr. C. was outlined and included such topics as victim empathy and a full disclosure of Mr. C's sexually abusive behaviour which would lead into exploration of Mr. C's offending cycle.

In hindsight, the student believes that there was a lack of co-ordination between systems involved with Mr. C. and his family, ultimately resulting in poorer service. No one professional took on the role of "case manager", thus if members of the family were receiving service, this was done in isolation. Unfortunately, the student now believes that this lack of coordination allowed Mr. C. to continue his pattern of minimizing, denial, and anger.

Also at a systems level, the lack of treatment resources

in Mr. C.'s community forced Mr. C. and his family to relocate to Winnipeg. The student believes that the C. family met with many difficulties in adjusting to the city (ie: new schools for the children, applying for city social assistance, and the ensuing involvement with this bureaucratic institution, inadequate housing, lack of employment, as well as being removed from their social supports). These factors added stresses to an already stressed family, further complicating the therapy.

EVALUATION

As a part of the practicum experience the student wanted to be able to evaluate the effectiveness of the intervention provided to her clients. To this end, evaluation of the student's interventions were focused in two areas. Firstly, the individual measures given to clients in treatment with the Forensic Behavioral Management Clinic during the assessment were utilized. These measures were administered on a pre- and post intervention basis, and included, the State-Trait Anger Expression Inventory, (Spielberger, 1988), the Multiphasic Sex Inventory, (Nichols & Molinder, 1984), the Tennessee Self-Concept Scale, (Roid & Fitts, 1988), and a Cognition Scale (Belief Inventory), (Stermac & Segal, 19). (Also utilized was the MMPI, however this measure was only

used in the initial assessment.)

In light of the student's literature review, and the finding of many common areas of difficulty for sex offenders, (ie: anger, poor self-concept, faulty beliefs, poor social skills) the student believed that these particular measures would concretely indicate change.

In order to evaluate her work with the offender and the impact on his relationship with his partner, the student used the FAM Dyadic Adjustment Scale, (Spanier, 1976), the Index of Sexual Satisfaction, (Hudson, 1982), and the Index of Spouse Abuse, (Hudson and McIntosh, 1981). The student also used a social support network measure, designed to collect information on network size, as well as types of social support including family, friends, and professionals, in an individuals environment. As it is believed that many sex offenders against children are socially isolated this measure was included not only as an important assessment tool but also as a potential tool for measuring change. This measure was administered to both the client and his partner.

Prior to describing the measures utilized and the results of these, the fact that the student's clients were in group therapy as well as individual therapy with this student at the time of the practicum bears reiterating. The student could not control for external variables in the client's life, including group therapy as well as influence from other sources. The results of all of the data therefore may reflect

operation of a combination of these factors.

In all, seven scales were administered to the clients. These measures took several hours to complete. The student questions whether this length of time may have influenced the care clients took in answering questions accurately, and whether the results may reflect this factor.

Finally, all of the clients and their spouses had a limited literacy level, either due to a lack of education or English being a second language. Many needed help in understanding the questions, which again may have skewed the scores.

Measures

A. The Dyadic Adjustment Scale (DAS) (Spanier, 1976) (see Appendix B)

This 32 item scale has been designed to assess the quality of a marriage or partnership. The 32 items are grouped into four components--dyadic satisfaction, dyadic cohesion, dyadic consensus, and affectional expression. The average intercorrelation between these four empirically derived subscales is .68, indicating that these factors are interrelated. The internal consistency reliability of the scale is .96.

This scale was designed for use with couples currently living together. Only one of the three clients resided with his wife during the time of this practicum. The other two

clients did visit regularly with their partners, however opportunities to interact with one another were limited. This limitation could influence the results of the data, as questions 23, 24, and 28 for example, involve frequency of certain behaviors. In light of the fact that clients had been married for up to 16 years, continued to perceive themselves as a couple, and could draw on their marital history in completing the first administration of the scale, this student choose to utilize the DAS.

B. Index of Sexual Satisfaction (ISS) (Hudson, et al., 1981) (see Appendix C)

This 25 item scale was designed to measure the magnitude of a problem in the sexual component of a dyadic relationship. Half of the items on the scale are positively worded, the other half negatively worded. The scales internal consistency is .92, and the test-retest reliability is .93. The ISS has a discriminant validity of .76. In utilizing the Index of Sexual Satisfaction, possible scores range from 0 to 100, with a high score indicating the presence of a sexual problem. A score of 28 is recommended by the authors as the proper cutting score for the ISS, although they state that it is wise to suspend judgement concerning the presence or absence of clinically significant sexual relationship problems when the score falls within plus or minus 5.0 points of the cutting score.

As with the other "couple scale" utilized in this practicum report, this student believes the ISS was designed for couples co-habitating, and engaging in sexual behaviour on a regular basis. Both Mr. A. and Mr. B. were residing independently from their partners at the time of this practicum, perhaps resulting in less sexual contact as well as a "honeymoon effect". These factors are important to bear in mind when interpreting test scores.

C. The Index of Spouse Abuse (ISA) (Hudson, et al., 1981)

(see Appendix D)

The ISA is a self report scale that was designed to measure the severity or magnitude of physical and nonphysical abuse that is inflicted upon a woman by her spouse or partner. The ISA comprises two subscales, one that measures the severity of physical abuse, and one that measures the severity of nonphysical abuse. The scale has excellent internal consistency, as well as good construct validity.

D. Social Network/Social Support Assessment Form

(see Appendix E)

This is a detailed social network measure, which includes three dimensions, a friendship dimension, a family dimension, and a professional dimension.

E. Social Desirability Index (SDI) (Strahan & Gerbashi, 1972).

This scale assesses the possible intrusion of the response style bias of social desirability in self report measures. The short ten item version, which correlates highly with the full twenty item version was utilized. As many of the measures the student employed with her clients did not include a social desirability scale, she employed this scale independently in attempts to control for this factor.

Results

Mr. A.

Mr. and Mrs. A's scores on the Dyadic Adjustment Scale (see Table 1) indicate that this couple are experiencing some marital difficulties and that intervention through providing individual therapy for Mr. A. had little impact. This data confirms the student's observations and subjective opinion as well as supporting the student's recommendations and referral for marital therapy.

Mrs. A's scores do fluctuate in particular between the pre and mid points. In discussing these results with Mrs. A. she indicated that she "was tired" when completing the second administration of the DAS. The student therefore questions the accuracy of her score, at the mid point.

Table 2 reveals low scores for both Mr. and Mrs. A. on the Index of Sexual Satisfaction, suggesting that neither

perceive difficulty in their sexual relationship. This result is surprising given the student's discussions with Mr. A. about sexuality including comments expressing some dissatisfaction Mr. A. made regarding his wife. Also, the student believed that the marital difficulties this couple is experiencing would be mirrored in this particular measure.

Again, Mrs. A's scores greatly increased between the pre and mid testings. The student accounts for this by reiterating that Mrs. A. stated that she was tired, and perhaps did not take as great care in answering the items accurately at the second administering of the ISS.

Mrs. A.'s results on the Index of Spouse Abuse indicate that there are no abuse issues in this relationship. As abusive behaviour has been present in the relationship; as the student believes there has been little work on the couple relationship; and as there was limited opportunity for Mr. and Mrs. A. to interact during the duration of this practicum, the student questions these results. Also, generalizing from Mr. A.'s comments regarding his past physically and verbally abusive behaviour towards his children, and at times his difficulty in controlling this, the student wonders if the same pattern is not present in his relationship with Mrs. A. as well.

TABLE 1

PRE MID AND POST INTERVENTION SCORES FOR DYADIC ADJUSTMENT SCALE

	MR. A.	MRS. A
Pre-test	88	80
Mid-test	86	109
Post-test	87	92
Norm	114.8	114.8

TABLE 2

PRE MID AND POST INTERVENTION SCORES FOR INDEX OF SEXUAL SATISFACTION

	MR. A	MRS. A
Pre-test	13	18
Mid-test	10	30
Post-test	11	10
Cutting Score	25	25

A comparison of pre, mid and post social support network questionnaires, indicates little change over the duration of the practicum. At the beginning of this practicum, both Mr. and Mrs. A. were relatively socially isolated, relying on a small number of family and friends for support. Neither of the couple had outside interests, hobbies, or belonged to organizations. Unfortunately, there was little change in this area over the past year, with Mr. A. adding only one individual to the Friend category. Interestingly, two professionals were added. Mrs. A. added two individuals to the friend category, and one other to family category.

Mr. A's results on the individual measures indicate there has been change over the duration of the practicum. The results of the Tennessee Self-Concept Scale, (Table 3) indicate that Mr. A.'s overall level of self esteem has moderately increased, with slight to moderate gains in his identity, his level of self satisfaction, satisfaction with his behaviour, and in his view of himself in relation to others. There was a dramatic increase in score on the personal satisfaction subscale, reflecting improved levels of self-acceptance. Mr. A.'s results on the "moral-ethical" subscale indicate he has made a substantial gain in this area. There was a slight decrease in Mr. A.'s feelings of adequacy, worth and value as a family member. The student views this decrease as positive in that he has begun to look at his relationship with family members.

TABLE 3

PRE AND POST INTERVENTION SCORES FOR TENNESSEE SELF CONCEPT SCALE

MR. A

	Pre-Test	Post-Test
Physical Self	63	62
Moral Self	60	67
Personal Self	59	68
Family Self	69	66
Social Self	60	63
Identity	115	118
Self Satisfaction	100	102
Behaviour	96	106

In examining the data from the Multiphasic Sex Inventory, the scores indicate that Mr. A. is now more open regarding the types of sexually behaviour he did engage in, and the seriousness of those behaviors. As well, he is more open regarding sexual dysfunction and concerns, and in acknowledging paraphalias. His pre-test results of seeing himself as a victim were slightly decreased in the post test. Comparison of the MSI pre and post tests also indicate that Mr. A. has shifted from justifying his sexually deviant behaviour to accepting responsibility for his behaviour. The post test data also indicate that Mr. A. is slightly more motivated for therapy than in the past.

Mr. A. appeared more dishonest in his post test versus his pre-test results in terms of his deviant sexual interests. After conducting an item analysis however, the student hypothesizes that Mr. A. was responding to the items by answering how he currently felt, indicating a positive change between pre and post measures.

This result is indicative of a difficulty in administering measures designed to examine sexually abusive behaviour and distorted cognitions with sexual perpetrators. That is, post test scores often indicate a dishonesty as the individual is no longer endorsing items they did in the pre test.

Mr. A's results on the State-Trait Anger Expression Scale (Table 4) indicate he is less likely to suppress his anger, or conversely to act it out aggressively as was indicated in his pre test results. In short, he is managing his anger better.

Mr. A. results on his pre score of Stermac - Cognitive Distortions Related to Sex with Children indicated little tendency to endorse distorted beliefs about inappropriate sexual behaviour with children. At that time however, he did demonstrate some distortions in items suggesting the child may have enjoyed the inappropriate sexual contact. In his post test scores, he did not endorse these items.

In summary, Mr. A. did make therapeutic gains in terms of his self-concept, the manner in which he manages his anger, and his ability to challenge cognitive distortions, suggesting that interventions directed at these areas were effective.

TABLE 4

PRE AND POST INTERVENTION SCORES FOR STATE-TRAIT ANGER EXPRESSION INVENTORY

MR. A

	Pre-Test	Post-Test
State Anger	69	69
Trait Anger	63	55
Angry Temperament	69	69
Angry Reaction	18	38
Anger In	66	46
Anger Out	77	85
Anger Control	9	16
Anger Expression	91	26

Mr. B.

Mr. and Mrs. B's results on the Dyadic Adjustment scale (see Table 5) appear to be consistently very high at the pre mid and post testing points. The student believes these results are artificially high, and possibly result from the fact that the couple were in essence "dating", as Mr. B. did not reside in the family home during the course of therapy. This of course would mean that Mr. and Mrs. B. were experiencing many of the positives of their relationship, and not the "day to day hassles". This scale does not include a "social desirablilty index". When the student did administer this scale independently, Mr. B's result of 6 on a ten point scale indicate a tendency to respond by choosing an answer that he believed the therapist would like to hear. Similarly, Mrs. B's result of 7 on the ten point scale indicates that she also is more likely to answer according to what she believed the therapist would like to see. The student believed that Mr. B. in particular was concerned that any indication of difficulty in his relationship with his spouse could result in a further delay in his returning home. Therefore, the student hypothesized that this may be a factor accounting for the high scores on this scale. A readministering of the scale a year from the date that Mr. B. returns home would give a more accurate view of the couples relationship.

The results from Mr. and Mrs. B's scores on the Index of

Sexual Satisfaction are depicted in Table 6. In general terms, these scores indicate that neither partner perceives a problem in their sexual relationship. In light of discussions with Mr. B., wherein he indicated some dissatisfaction with the couples sexual relationship, the student questions the accuracy of these results. The student wonders if the same issues of social desirability, concern that an indication of difficulties would delay Mr. B's return home, and the "honeymoon" stage may be clouding an accurate picture. As the couple enter family and marital therapy and have further opportunity to explore this area, it would be beneficial to readminister this measure.

Mrs. B's scores on the Index of Spousal Abuse indicate that there are no problems of either physical or non physical abuse present in this couples relationship.

A visual comparison of the pre, mid and post questionnaire regarding social network, indicates that Mr. B. increased his social contacts during the duration of the practicum. It was interesting for the student to note that individuals added to the category of "friends" included two members of Mr. B's sex offender group at the Native Clan Organization. The student views this as positive in that these individuals are aware of Mr. B's offending behaviour, circumstances are similar (ie: parole conditions, not residing at home, group experience, etc) giving Mr. B. an opportunity to interact without the fear of being "found out".

TABLE 5

PRE MID AND POST INTERVENTION SCORES FOR DYADIC ADJUSTMENT SCALE

	MR. B	MRS. B
Pre-test	103	121
Mid-Test	118	125
Post-Test	134	130
Norm	114.8	114.8

TABLE 6

PRE MID AND POST INTERVENTION SCORES FOR INDEX OF SEXUAL SATISFACTION

	MRS. B.	MR. B.
Pre-test	24	5
Mid-test	26	22
Post-test	22	22
Cutting Score	25	25

In his State-Trait Anger Expression Inventory pre-test anger was situationally determined for Mr. B. Results indicated that he tended to cope with anger by suppressing these feelings. Post test results on this measure indicate that Mr. B. is managing his anger without suppressing it or acting out aggressively (see Table 7).

There was a dramatic increase in Mr. B.'s overall score of self esteem on the Tenneesse Self-Concept Scale, (see Table 8) indicating he is feeling better about "who he is". He showed marked improvements in his feelings of adequacy about himself as a person, about his view of his state of health, physical appearance, social skills, and sexuality, and about his behaviour, or "the way he acts". His sense of worth and adequacy as a family member moderately increased, while his sense of self in relation to others remained the same.

Results on the Multiphasic Sex Inventory indicate that Mr. B. continues to present an asexual image of himself. He thinks about sex less often, and is slightly more honest in terms of his interest in deviant sexual behaviour. In terms of cognitions, Mr. B.'s test results did indicate movement from initially justifying his sexually deviant behaviour to accepting accountability for his behaviour. The data also indicate that Mr. B. is more open in talking about his pattern of sexual deviance, including fantasies, grooming, and the types of behaviors he has engaged in. Mr. B. decreased however in talking about the intensity or degree of sexual abuse, indicating a tendency to minimize.

TABLE 7

PRE AND POST SCORES FOR THE STATE-TRAIT ANGER EXPRESSION INVENTORY

MR. B.

	PRE-TEST	POST-TEST
State Anger	69	69
Trait Anger	1	1
Angry Temperament	29	29
Angry Reaction	1	1
Anger In	89	25
Anger Out	1	10
Anger Control	95	99
Anger Expression	18	1

TABLE 8

PRE AND POST INTERVENTION SCORES FOR TENNESSEE SELF CONCEPT SCALE

MR. B.

	PRE TEST	POST TEST
Physical Self	74	84
Moral Self	68	78
Personal Self	77	90
Family Self	75	78
Social Self	66	66
Identity	130	136
Self Satisfaction	107	122
Behaviour	123	138

The data from the measures suggest that Mr. B. made gains in the areas of self-concept, anger management, cognitive distortions, and victim empathy, indicating interventions directed at these areas were effective.

Mr. C.

The student was only able to obtain pre measures from Mr. and Mrs. C. at the beginning of the practicum work, and therefore results cannot be commented on in this report.

CONCLUSIONS

In undertaking this practicum, the student had the opportunity not only to learn specifically about offender treatment, and her therapeutic style, but also to examine some of the larger issues that impact on offender treatment. In this final section of her practicum report the student will discuss her conclusions.

In terms of her own therapeutic skills and style, the student had the opportunity to learn new skills, as well as enhancing her strengths. For instance, one of the difficulties this student encountered in working with these men involved being cast into a role of "authority", which had the potential to interfere with the therapeutic work. For instance, one client perceived that at team meetings ,the student's input as to his progress, could impede his goal,

(which was to return to the family home as quickly as possible). Many sessions were organized around the client attempting to convince the student he had changed, and the student refuting his statements, attempting to shift his thinking.

The literature indicates number of different positions on this issue, with some espousing that the therapists role is very much a part of the "team" (Drieblatt, 1982). Others tend to hold the position that the therapist is not involved in any of the decision making, and does not share any information as to the clients progress with others involved with the case (Larson & Maddock, 1990).

To extrapolate herself from this power struggle with the client, this student clearly delineated her role to the client. Total responsibility for therapeutic progress was given to the client. He was told that he would be included in any team meetings and would have the opportunity to speak to his own thoughts on his progress in therapy. The student would offer her observations to the team, but not be part of the process as to deciding when he would go home. Other team members were approached, and asked to clearly outline their expectations, of what needed to occur/change prior to the offender returning home, and to share these with the client and his wife at team meetings. The student found that this approach allowed the client and herself to enter into a collaborative therapeutic relationship, focusing on the goals

outlined for the client by other team members.

Also related to the team, to the therapeutic relationship, and to trust was the issue of the students contacts with other professionals involved. For example, one of the student's clients was extremely suspicious regarding any telephone contacts she had with other professionals working with the family, concluding that the student was withholding information or that decisions had already been made and he was not informed. This situation was resolved by telling the client in advance of the student's plan to contact another professional, and to invite his comments on this. Also, the student was very conscious of informing clients when another professional had contacted her, and the content of our conversation.

This student found it very important to find a balance between a confrontative/authoritative stance, and an empathic one when working with offenders. Irwin Drieblatt (1982) in his comparison between "mental health clients" and "sex offenders" suggests that the therapist is, " an objective third party with multiple responsibilities, is skeptical - not trusting, provides no confidentiality, and is authority based, when working with sex offenders. Nicholas Groth (1987) believes the client/therapist relationship must be exactly that--a relationship. He has posed the question "why should an offenders be motivated to share difficulties, and to trust the therapist if only met with adversity"? Groth suggests

given these circumstances, anyone would act to protect themselves. The student found it very important to strike a balance between these two positions. There was a need to be confrontative at times with the clients, however, without an empathic response it was impossible to develop the relationship that was needed for therapy to be effective.

The student had the opportunity to learn more about long term therapy, as much of her past work has focused on brief and short term work. For instance, she learned that an awareness of countertransference issues in the therapeutic relationship is essential, not only in terms of successful therapeutic outcome, but also as related to the therapists own clinical growth and development. In providing long term therapy, the student had to enhance her abilities to approach painful feeling states that the client was experiencing, in order to allow the client to focus inward and to begin to resolve the difficulty. With time, the student became confident in her ability to respond to the client's feelings.

The challenge of allowing the client to set the agenda and focus of therapy, but at the same time sharing control, and ensuring important therapeutic themes were explored was also a source of learning for the student.

The student has made a number of comments regarding the utility of the measures employed in this practicum in Part III of this report. Some of the comments however, bear reiterating.

Although the concept of measuring the impact of the offender's treatment on his marital relationship very much fit the ecological framework this student utilized, she questions the usefulness of these in this practicum. For instance, given the fact that two of the three clients resided separately from their spouse and all of the couple scales employed presuppose couples are living together and interacting regularly, the data is based on limited spousal contact, or on remembered past behaviour, rendering the results as circumspect. The student recommends therefore that these types of scales be administered to the couple once the offender enters therapy, so as to establish some sort of baseline, and again after the couple have reunited and have the opportunity to interact on a daily basis.

A final note in terms of the measures is that in retrospect the student believes there were far too many scales utilized. As noted earlier, these measures took several hours for the offender to complete, which may have affected his responses. This presents a difficulty in that the student believes that the majority of these measures are necessary for assessment, treatment, and evaluating treatment success, as we now know that offending behaviour encompasses a variety of factors, that are intrapersonally related as well as interpersonally related. Perhaps staggering the administration of these measures over several sessions would combat this problem.

Much of the literature this student reviewed focused on short term therapy or on group work where teaching life skills, teaching social skills (ie; assertiveness, problem solving, etc) cognitive restructuring and behavioral interventions were the preferred interventions. This student believes that many of these programs were developed out of economic necessity, as with shorter term programs one is able to serve greater numbers in a given period of time.

Prentky and Wolbert Burgess (1990) in the article, "Rehabilitation of Child Molesters: A Cost Benefit Analysis", address the costs of long term therapy for sexual offenders. These authors conclude that "if the recidivism rate for treated child molesters is 25% and the rate for untreated child molesters is greater than 3% then it is cost-effective to treat." Subjects used in this analysis were involved in a 5 year inpatient treatment program. It has been this students' experience that treating sex offenders is a long term and very slow process, with small steps being viewed as major achievements for the client. More time is/was needed to assist these offenders in dealing with issues that lead them to offend sexually against children. The student believes we must offer treatment to offenders sooner (often time spent in prison is just that---time spent in prison), and mandate treatment over greater periods of time upon release from prison.

The student realizes the difficulties in providing

therapy to sex offenders in prison (ie: a sex offenders life is often in jeopardy from inmates convicted of other crimes). A problem however remains that this second level environment may actively help an offender in maintaining his denial, and minimization by modelling this type of behaviour and encouraging the offender to do so.

There was a coordinated inter agency approach to therapy with the whole family in only one of the student's three cases. In this one family, the non-offending spouse received treatment, as did the victim, her brother, and the offender. The lack of service to the other two families was not due to the families having dealt with the aftermath of the disclosure of sexual abuse, or even due to the family not wanting service, but to the lack of services available. Although the offender must take sole responsibility for his offending behaviour, the sexual abuse has impacted the entire family, and each member must be given the opportunity to explore the effects on themselves as well as in relation to other family members. The student found that work with the offender was further complicated if other members of the family were not also receiving treatment.

Coordination between the legal system and treatment system is lacking at a crucial time. The student found that individual work with offenders was long term. In all cases, once some of this work had been completed and the offender was ready to begin to work jointly with his partner or family, the

parole/probation order had expired or was near expiry. Rather than mandating service then, the choice to continue in therapy was left up to the offender.

The Child Welfare system could provide some leverage in forcing the family into treatment. In the student's experience however, this was done in one of three cases, indicating this leverage is applied on a haphazard basis, depending on the strength of relationship the individual Child Welfare worker has with the family. The system must institute policies ensuring workers will apply leverage on offenders and their families once the legal sanction has expired.

Coordination and communication between the various systems involved with the offender and his family is extremely important. The student found that the system tended to mirror chaotic/disorganized individuals and families in cases where regular communication was lacking. We, like the families were isolated. This disorganization impacted the offender directly by allowing him to maintain various degrees of denial, minimization and rationalization, thereby rendering treatment less effective.

Two of the student's three clients had been relocated to Winnipeg from other smaller communities in order to participate in treatment. The student found it difficult to help all three of these men to increase their social contacts. By requiring offenders to leave their communities in order to receive treatment, the system is actively helping to decrease

the offenders existing support system. More consideration should be given to developing offender treatment programs in rural areas. As it is unrealistic to suggest that a program be located in every community, strategic communities could be identified, thereby allowing offenders to commute to their treatment programs if one is not located in their community.

Finally, it is imperative that we increase the number of programs and services available for sex offenders. As cited earlier in this report, the province of Manitoba alone has approximately 300 known sex offenders in "the system". Treatment currently is available for only a small percentage of them. If we ever hope to combat sexual abuse and it's devastating effects, more treatment resources for sex offenders must be developed.

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APPENDICES

APPENDIX A

PRECONDITIONS FOR SEXUAL ABUSE

FOUR PRECONDITIONS: A MODEL

LEVEL OF EXPLANATION

	Individual	Social/Cultural
Precondition I: Factors Related to Motivation to Sexual Abuse		
Emotional congruence	Arrested emotional development Need to feel powerful and controlling Re-enactment of childhood trauma to undo the hurt Narcissistic identification with self as a young child	Masculine requirement to be dominant and powerful in sexual relationships
Sexual arousal	Childhood sexual experience that was traumatic or strongly conditioning Modeling of sexual interest in children by someone else Misattribution of arousal cues Biologic abnormality	Child Pornography Erotic portrayal of children in advertising Male tendency to sexualize all emotional needs
Blockage	Oedipal conflict Castration anxiety Fear of adult females Traumatic sexual experience with adult Inadequate social skills Marital problems	Repressive norms about masturbation and extramarital sex
Precondition II: Factors Predisposing to Overcoming Internal Inhibitors	Alcohol Psychosis Impulse disorder Senility Failure of incest inhibition mechanism in family dynamics	Social toleration of sexual interest in children Weak criminal sanctions against offenders Ideology of patriarchal prerogatives for fathers Social toleration for deviance committed while intoxicated Child pornography Male inability to identify with needs of children

LEVEL OF EXPLANATION

	Individual	Social/Cultural
Precondition III: Factors Predisposing to Over-coming External inhibitors	Mother who is absent or ill Mother who is not close to or protective of child Mother who is dominated or abused by father Social isolation of family Unusual opportunities to be alone with child Lack of supervision of child Unusual sleeping or rooming conditions	Lack of social supports for mother Barriers to women's equality Erosion of social networks Ideology of family sanctity
Preconditions IV: Factors Predisposing to overcoming Child's Resistance	Child who is emotionally insecure or deprived Child who lacks knowledge about sexual abuse Situation of unusual trust between child and offender Coercion	Unavailability of sex education for children Social powerlessness of children

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APPENDIX B

DYADIC ADJUSTMENT SCALE

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	5	4	3	2	1	0
2. Matters of recreation	5	4	3	2	1	0
3. Religious matters	5	4	3	2	1	0
4. Demonstrations of affection	5	4	3	2	1	0
5. Friends	5	4	3	2	1	0
6. Sex relations	5	4	3	2	1	0
7. Conventionality (correct or proper behavior)	5	4	3	2	1	0
8. Philosophy of life	5	4	3	2	1	0
9. Ways of dealing with parents or in-laws	5	4	3	2	1	0
10. Aims, goals and things believed important	5	4	3	2	1	0
11. Amount of time spent together	5	4	3	2	1	0
12. Making major decisions	5	4	3	2	1	0
13. Household tasks	5	4	3	2	1	0
14. Leisure time interests and activities	5	4	3	2	1	0
15. Career decisions	5	4	3	2	1	0

	All the time	Most of the time	often than not	Occas-ionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	0	1	2	3	4	5
17. How often do you or your mate leave the house after a fight?	0	1	2	3	4	5
18. In general, how often do you think that things between you and your partner are going well?	0	1	2	3	4	5
19. Do you confide in your mate?	0	1	2	3	4	5
20. Do you ever regret that you married? (or lived together)?	0	1	2	3	4	5
21. How often do you and your partner quarrel?	0	1	2	3	4	5
22. How often do you and your mate "get on each other's nerves?"	0	1	2	3	4	5

	Every Day	Almost Every Day	Occas-ionally	Rarely	Never
23. Do you kiss your mate?	4	3	2	1	0

	All of them	Most of them	Some of them	Very few of them	None of them
24. Do you and your mate engage in outside interests together?	4	3	2	1	0

How often would you say the following events occur between you and your mate?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
25. Have a stimulating exchange of ideas	0	1	2	3	4	5
26. Laugh together	0	1	2	3	4	5
27. Calmly discuss something	0	1	2	3	4	5
28. Work together on a project	0	1	2	3	4	5

These are some things about which couples sometimes agree and sometimes disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (Check yes or no).

	Yes	No	
29.	0	1	Being too tired for sex.
30.	0	1	Not showing love.

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point "happy" represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

0	1	2	3	4	5	6
Extremely Unhappy	Fairly Unhappy	A little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describes how you feel about the future of your relationship?

__5__ I want desperately for my relationship to succeed, and would go to almost any length to see that it does.

__4__ I want very much for my relationship to suceed, and will do all I can to see that it does.

__3__ I want very much for my relationship to succeed, and will do my fair share to see that it does.

__2__ It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.

__1__ It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.

__0__ My relationship can never succeed, and there is no more that I can do to keep the relationship going.

APPENDIX C

INDEX OF SEXUAL SATISFACTION (ISS)

NAME:_____ TODAY'S DATE:_____

This questionnaire is designed to measure the degree of satisfaction you have in the sexual relationship with your partner. Answer each iten as carefully and accurately as you can by placing a number beside each one as follows:

1 Rarely or none of the time
2 A little of the time
3 Some of the time
4 Good part of the time
5 Most or all of the time

Please begin:

1. I feel that my partner enjoys our sex life . . . . . ____
2. My sex life is very exciting . . . . . ____
3. Sex is fun for my partner and me. . . . . ____
4. I feel that my partner sees little in me except for the sex I can give . . . . . ____
5. I feel that sex is dirty and disgusting . . . . . ____
6. My sex life is monotonous . . . . . ____
7. When we have sex it is too rushed and hurriedly completed . . ____
8. I feel that my sex life is lacking in quality . . . . . ____
9. My partner is sexually very exciting . . . . . ____
10. I enjoy the sex techniques that my partner likes or uses . . . ____
11. I feel that my partner wants too much sex from me . . . . . ____
12. I think that sex is wonderful . . . . . ____
13. My partner dwells on sex too much . . . . . ____
14. I feel that sex is something that has to be endured. . . . . ____
15. My partner is too rough or brutal when we have sex. . . . . ____
16. My partner observes good personal hygiene . . . . . ____

Page Two
Index of Sexual
Satisfaction

17. I feel that sex is a normal function of our relationship . . ____

18. My partner does not want sex when I do . . . . . .____

19. I feel that our sex life really adds a lot to our relationship____

20. I would like to have sexual contact with someone other than my partner . . . . . ____

21. It is easy for me to get sexually excited by my partner. . . ____

22. I feel that my partner is sexually pleased with me. . . . . ____

23. My partner is very sensitive to my sexual needs and desires. .____

24. I feel that I should have sex more often . . . . . ____

25. I feel that my sex life is boring . . . . . ____

APPENDIX D

INDEX OF SPOUSE ABUSE

This questionnaire is designed to measure the degree of abuse you have experienced in your relationship with your partner. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1 = Never
2 = Rarely
3 = Occasionally
4 = Frequently
5 = Very frequently

_____ 1. My partner belittles me.
_____ 2. My partner demands obedience to his whims.
_____ 3. My partner becomes surly and angry if I tell him he is drinking too much.
_____ 4. My partner makes me perform sex acts that I do not enjoy or like.
_____ 5. My partner becomes very upset if dinner, housework, or laundry is not done when he thinks it should be.
_____ 6. My partner is jealous and suspicious of my friends.
_____ 7. My partner punches me with his fists.
_____ 8. My partner tells me I am ugly and unattractive.
_____ 9. My partner tells me I really couldn't manage or take care of myself without him.
_____ 10. My partner acts like I'm his personal servant.
_____ 11. My partner insults or shames me in front of others.
_____ 12. My partner becomes very angry if I disagree with his point of view.
_____ 13. My partner threatens me with a weapon.
_____ 14. My partner is stingy in giving me enough money to run our home.
_____ 15. My partner belittles me intellectually.
_____ 16. My partner demands that I stay home to take care of the children.
_____ 17. My partner beats me so badly that I must seek medical help.
_____ 18. My partner feels that I should not work or go to school.
_____ 19. My partner is not a kind person.

_____ 20. My partner does not me to socialize with my female friends.
_____ 21. My partner demands sex whether I want it or not.
_____ 22. My partner screams and yells at me.
_____ 23. My partner slaps me around my face and head.
_____ 24. My partner becomes abusive when he drinks.
_____ 25. My partner orders me around.
_____ 26. My partner has no respect for my feelings.
_____ 27. My partner acts like a bully towards me.
_____ 28. My partner frightens me.
_____ 29. My partner treats me like a dunce.
_____ 30. My partner acts like he would like to kill me.

APPENDIX E

SUPPORT NETWORK

Instructions for Use:

1. Using the attached form, the client is to identify family, friends and professionals from whom they can get help. Each name is to be written beside the appropriate category and question 1-5 are to be answered about each person listed.

2. For questions 6-7, the client is to identify the various ways those person(s) assist them by placing an "X" across from their name under the appropriate headings.

3. Under the heading "Family", list family members by name and identify their relationship to the client in the appropriate column below. (ie., spouse, uncle, etc.)

4. Omit the "Friends" column.

5. Under the heading "Professionals", list the professional affiliation of those in the client's support group. (ie., physician, priest, etc.)

6. Identify whether network member is male/female and record in the "sex" column.

7. "How often are you in contact" - list frequency. (ie., daily, weekly, twice a month, etc.)

8. "How long have you known this person?" - list in years or "since birth".

9. Under the column "Near/Far", the client is to place a + if that person lives within 10 minutes from their home or a - if they are more than 10 minutes drive from their home.

10. Aspects of Network Dimensionality: eg: chore/task, social activities, etc. Place a checkmark beside each dimension the client feels they would receive from each person identified in the network listing. Leave as blank those dimensions not received. Remember to place an * beside those people with whom the client has a close emotional relationship. (ie., a confidant). Remember to place a ** beside the name of each person in the network listing with whom the client has discussed the child sexual abuse situation.

SUPPORT NETWORK

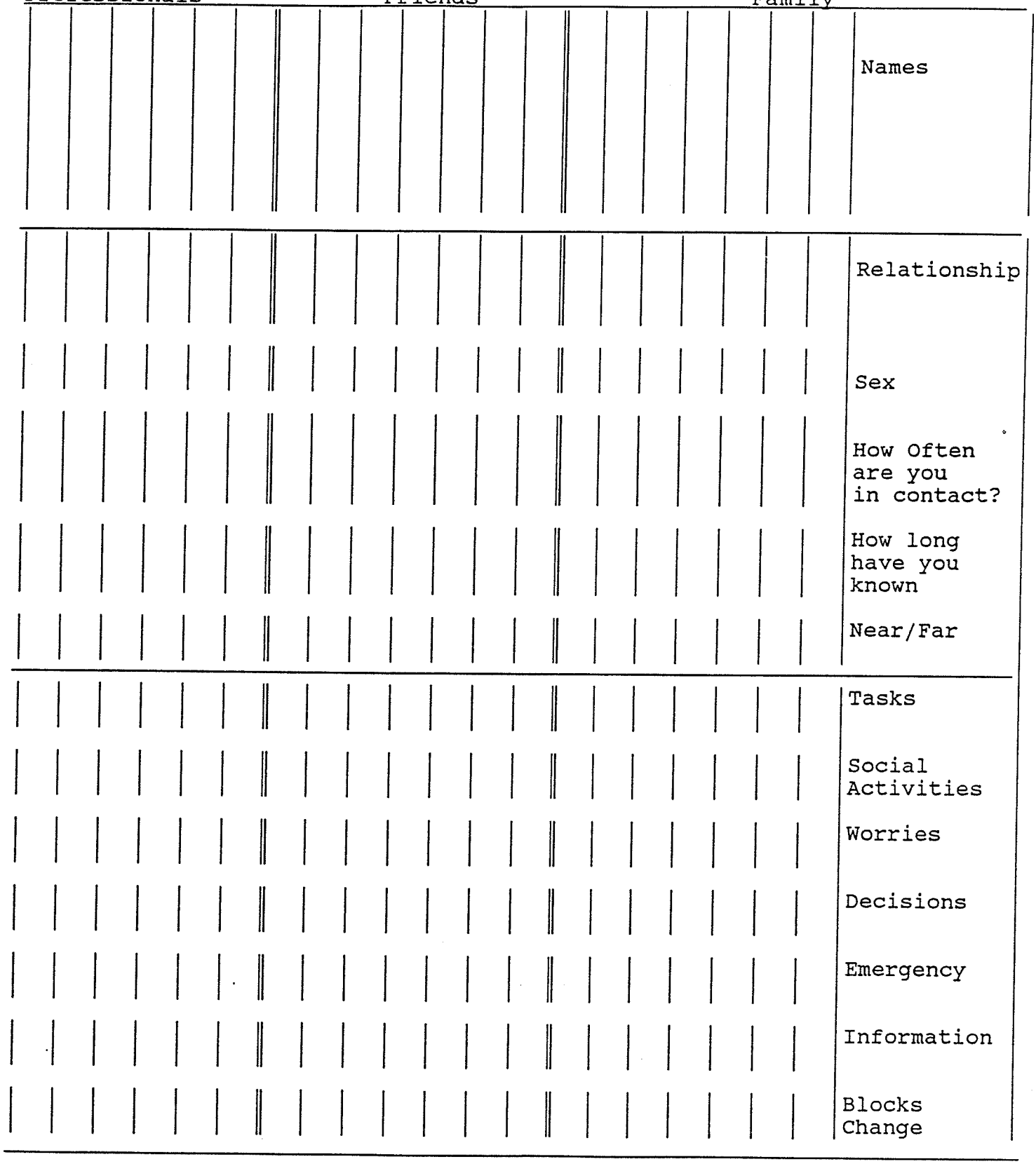
Using the attached form, identify family, frineds and professionals from whom you can get help. Write each name beside the appropriate category and answer the next five questions about each person listed.

Under the column Near/Far, put a + if they live within 10 minutes from your home or a - if they are more than 10 minutes drive from your home.

For each of the remaining questions, identify the various way those person(s) assist you by placing an "X" across from their name under the appropriate headings.

1. Who has helped with tasks (i.e., cleaning, babysitting, shopping)?
2. With whom do you engage in social activities (go to a movies, invite home for dinner, go for a ride, talk, play)?
3. With whom do you talk about personal worres or daily stresses?
4. Whose advice do you consider in making important decisions?
5. From whom would you get needed emergency food, clothing or housing?
6. Who can get information, locate resources, introduce you to new friends or professionals?
7. Who keeps you from changing (makes you feel uncomfortable, influences you negatively, keeps you stuck)?

*Indicate those people with whom you have a close emotional relationship by placing an * by their name.


Professionals
Friends
Family
Names
Relationship
Sex
How Often are you in contact?
How long have you known
Near/Far
Tasks
Social Activities
Worries
Decisions
Emergency
Information
Blocks Change

GROUP SUPPORT

Please list any groups or organizations that you belong to or attend, such as churches, support group, sports team, classes, political organizations, volunteer groups, etc.. Then indicate how frequently you are in contact with the group and how long you have participated with the group.

TYPE OF ORGANIZATION	HOW OFTEN ARE YOU IN CONTACT?	HOW LONG HAVE YOU PARTICIPATED?