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'Treating Incest Offenders', Dr. David Murphy

I started to treat Sexual Offenders 15 years ago, soon after I took up the full-time practice of Psychotherapy. I had decided to focus my practice on treating survivors of childhood sexual abuse and so I thought that it would be a good idea to also prevent childhood sexual abuse by treating the offenders. I was very fortunate that a close friend and colleague is a Forensic Psychiatrist. When I started to treat Sexual Offenders, he was willing to act as my Mentor and continues to do so.

I started by using first principles and common sense. The offenders that I started to meet had found it very difficult to find a therapist to take them on. I also found that they mostly needed someone to just listen. I soon found that I learned a lot about how to treat sexual offenders just by listening to them.

Many therapists will be scared by the prospect of treating Sexual Offenders or find it impossible to avoid judging them. I have found that most of the Sexual Offenders that I have met are nice people who have done stupid things and they will usually be the first to admit that. At the outset, they are usually willing to admit that they have done stupid things that have done incredible damage to a child and to the child's family. Many have already made the decision never to commit a similar act again and are asking for my help to make sure that it never happens again.

Over the years, I have primarily focused on treating Incest Offenders, although my practice does include other types of sexual offenders. This article will therefore primarily focus on a brief outline of the treatment of Incest Offenders. The principles of treatment that I will outline could, however, be used for treating any sexual offender.

TERMINOLOGY FOR CHILD SEXUAL OFFENDERS

The terminology of child sexual offenders is confusing. The legal and medical professions sometimes use different meanings for the same terminology. The term "Child Sexual Offender" applies to anyone, male or female, who commits an offense against a child. The legal definition of child is any person under the age of 18. The term "Pedophile" is often applied by the courts to anyone who has committed a sexual offense against a child of any age. The Children's Aid Society tends to have a similar view.

The medical term "Pedophilia" only applies to someone who is sexually attracted to a pre-pubescent child. The term Hebephilia is applied to anyone who has a sexual attraction to pubescent children, usually about age 12 to 15. The term "Ephebophilia" is applied to a person who is sexually attracted to a mid to late adolescent, approximately

age 15 to 18. The terms Hebephilia and Ephebophilia are used in the context of sexual development more so than actual age. The Courts and the Children's Aid Society tend not to discriminate between the different medical definitions and assume that all persons who have committed an offense against a child are Pedophiles and that all children of any age are at risk from them. This is not true.

CATEGORIES OF CHILD SEXUAL OFFENDER.

It is possible to categorize Child Sexual Offenders in two ways. Firstly, by their relationship with the victim and secondly, by their behaviour toward the victim.

Relationship:

There are three categories of Child Sexual Offender, based on their relationship to the victim.

1. The child is a stranger to the offender.
2. The child is an acquaintance of the offender.
3. The child is a relative of the offender.

The **"Stranger"** offender is perhaps the most dangerous of the three groups. This is the type of offender who may abduct a child and also commit some type of violence towards the child. Another type of 'Stranger' offender will befriend a child, either on the street of in a location such as a video arcade, and groom the child for a sexual offense. 'Grooming' is the process whereby a child's boundaries are gradually eroded on an emotional level, in preparation for the sexual offense being committed.

The **'Acquaintance'** offender can be a hockey coach, a Scout leader, a neighbour, a babysitter or a minister – any person who has a friendly relationship with the child without being a relative. This group of offenders can also include other children or adolescents. The sexual offense usually includes a grooming process but the offenses can be impulsive and opportunistic, particularly in the case of child or adolescent offenders.

The **'Relative'** offender is usually a parent, step-parent or grandparent. Uncle, aunts, siblings and cousins can also be 'Relative' offenders. When the abusive event is isolated, occurring only once, it is often impulsive and opportunistic and can be associated with substance abuse. When the abuse occurs many times, grooming will often a part of the process.

Incest became a crime in England and Wales in 1908 and was defined as, "any male person who has carnal knowledge of a female person, who is to his knowledge his grand-daughter, daughter, sister or mother". The Criminal Code of Canada defines incest as, "…knowing that another person is by blood relationship his or her parent, child, brother, sister, grandparent or grandchild, as the case may be, has sexual

intercourse with that person.... 'Brother' and 'sister', respectively, include half-brother and half-sister". In Forensic Medicine the term, "Incest-Type Offense" is applied when a Step-Parent has sexually abused their Stepchild. The vast majority of incest offenders are male. However, a small minority are female.

TREATMENT

I like to use the analogy of a Plane Crash, when I am working with Incest Offenders. When a plane crashes, there is never just one cause for the crash. A series of events has to occur for the plane to crash or to fail to take off successfully. The plane may have needed de-icing, the runway may have been due for snow removal, a sudden gust of wind may have affected the flying characteristics of the plane, a component in the plane's engine may have failed, the pilot may have failed to appreciate the seriousness of the situation, the airline may have a bad maintenance program for their planes and the mechanic may have failed to tighten an important bolt. All these factors came together to cause the plane to crash.

Sexual offenses are just the same. There is never just one factor that leads to a sexual offense. All of these varied factors need to be defined and addressed, if the offender is to avoid committing similar offenses in the future. The offender usually wants to know 'why' he committed the offenses. The answers, however, come from asking 'How did it happen?', 'What happened?', 'When did it happen?', 'Who was involved' and 'What factors were involved?'

The therapeutic process usually takes about two years, seeing the patient every other week. Initially, the sessions may need to be weekly, as the offender is often in a state of emotional crisis. Immediately after being arrested, he may have been ousted from the family home or been fired from a job and lost his livelihood. I have found that a session every two weeks is a comfortable pace for most offenders, once the therapy settle down into a routine. Offenders tend to need two weeks in order to process new information and to complete homework assignments. Weekly sessions can be overwhelming. Other offenders, who are not great talkers, need the two weeks to accumulate enough to talk about.

It can be a challenge building rapport with the offenders who find it difficult to talk. But every man has a passion and will be willing to talk about his passion. Building rapport by listening to offenders' passions, I have learned how to frame a house, fix a computer, play golf (I wish), build and drive a race car, buy and sell just about anything, fix an aeroplane, act in a movie and many, many other things. Sometimes I feel a little guilty sending the bill to OHIP, when I have spent a session listening and learning - all in the cause of building rapport.

In guiding therapy, I use a *"Perceptual Positions"* model. There are four Perceptual Positions in a relationship. *'First Position'* is myself, seen through my own eyes. *'Second*

Position' is the person with whom I have the relationship, seen through the other person's eyes. *'Third Position'* is and objective viewpoint from which I can observe the relationship, noticing how I affect and influence the other person and noticing how the other person affects and influences me (For example, noting 'Transference' and 'Counter-Transference' in our relationship). From *'Fourth Position'*, I am able to notice all the outside influences on my relationship with the other person - people, places and things.

For the offender, *first position* is himself, *second position* is the victim, *third position* is an objective viewpoint on his relationship with the victim and *fourth position* includes all the outside factors that contributed to the offenses – for example, behaviours of other family members, previous childhood trauma, previous offenses, events that caused psychological stress, role models growing up.

Therapy needs to start in Third Position. The offender is often in a state of emotional crisis and overwhelmed by anxiety, loss and guilt. It is important for him to get grounded in order for therapy to proceed successfully. If the offender has not yet gone through the entire court process to sentencing, then much time is spent in sessions dealing with the stresses of the court process and dealing with the many decisions that need to be made. This can only be achieved from a grounded state of mind. From Third Position, the offender is able to observe his relationship with his victim and understand how he influenced the victim's behaviour and how the victim's perceived behaviour influenced his own. He is able to watch how the plane 'crashed' and what happened.

The next step is to go into Second Position with the victim. The offender needs to be able to empathize with the victim. He needs to understand what the impact of the offenses was, from the victim's point of view, both at the time of the offenses and since the offenses. Empathizing with the victim is a necessary pre-requisite for making amends to the victim.

The offender is now ready to process the offenses from first position, seeing hearing and feeling (touching) what he did and how he did it. He will learn to understand the thinking processes he went through and appreciating the distorted values he brought to the situation. He will need to learn about the emotions he experienced that motivated him to commit the offenses and equally to learn about the emotions that he did not experience that could have prevented the offenses. Associated disorders, such as Substance Abuse and Mood Disorders need to be full addressed in this phase of therapy. If the patient has a Personality Disorder, such as Antisocial Personality Disorder or Narcissistic Personality Disorder, then this phase of therapy may be very difficult for both the patient and the therapist. Patients with these disorders typically find it difficult to achieve the necessary introspection.

Fourth Position involves learning to understand the outside influences that facilitated the offenses, such as the offender's own childhood trauma, and includes the

development of a long-term Safety Plan to prevent future offenses. From Fourth Position, the offender is able to appreciate that there is a wider circle of victims. Many family members are emotionally traumatized, when the offenses come to light. A Safety Plan needs to involve friends, family and therapists in a support network for the offender. The members of the support network need to be both supportive of the offender and have the ability to challenge him, if they perceive him to be going down the road to relapse.

SUMMARY

In summary then, many Child Sexual Offenders are nice people who have done very stupid and very hurtful things. Once the police have knocked on their door to arrest them, many offenders will have fully realized what they have done and will be very willing to prevent future offenses. They do not have a 'criminal' mind and will want to avoid all future contact with the criminal justice system. In particular they want to avoid jail. Jail is a very useful deterrent for them.

To provide offenders with effective psychotherapy, it is necessary to be compassionate for both the offender as well as the victim. It is essential for the therapist to be non-judgemental and to be able to deal with his or her own Transference and Counter-Transference issues that may interfere with successful therapy. In my opinion, having a Mentor is essential.

Therapy with Sexual Offenders can be extremely rewarding for the therapist. Being part of a successful family re-unification and helping that family to be way more functional than it was before the offenses is satisfying indeed.

Dr. David Murphy