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A psychodynamic look at pedophile sex offenders in treatment

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Summary

Aim: *The authors report the main results from a qualitative study on the motivation for, and the daily experience of a specialised treatment for child molesters.*
Method: *Non-directive semi-structured interviews were done with 24 paedophile sex offenders in treatment at La Macaza clinic of La Macaza federal penitentiary (Canada). The data was initially analysed using diverse qualitative methods including theme analysis, comparative analysis, plan analysis and dynamic analysis.*
Results: *The results indicated the importance of the structuring of the treatment program, of the therapists' role, and of the patients' strive for a sense of mastery.*
Discussion: *The data is examined in psychodynamic terms in order to emphasise the dynamic and interpersonal aspects of a manualised treatment procedure such as the one used at La Macaza. The authors also discuss the subjects' comments suggesting that interpersonal aspects were as, if not more important to them than specific therapeutic techniques.*

Key words: pedophilia, sex abuser, treatment, motivation for treatment, manualized therapies

Introduction

One recent topic of interest for clinicians and researchers from all fields and approaches of therapeutic intervention is undeniably the question of manualised and empirically supported psychotherapies (ESP) [1, 2, 3, 4, 5, 6, 7]. A manualised therapy involves the use of a manual on guidelines providing clear descriptions of the techniques used during a given treatment. In most cases, these manuals are used

to rapidly implement the principles and techniques, and present a clear and orderly sequence of operations for session to session intervention. Even psychodynamic [8, 9] and more psychoanalytic [10, 11] approaches have entered this race to develop ESPs and manualised interventions. In the field of treatment of sex offenders, the situation has long been similar as both researchers and clinicians have recommended the use of standardised treatments [12].

On the other hand, as some have suggested [13], what is actually done in therapy with the offenders often seems very different from what is suggested in the treatment program, thus leading to recent efforts -such as in the psychodynamic literature- to develop adherence and competence scales [14, 15]. Nonetheless, all seem to agree that treatments must be better adapted to suit the offenders' needs and conflicts in order to maximise the effects of an intervention [16, 17]. But surprisingly enough, with the exception of a few very rare studies [18], little research has been done to understand what motivates offenders to enter a treatment programme or how they experience it on a daily basis. As Peraldi [19] once put it regarding psychotics, all the research done so far is certainly fascinating but as to what offenders feel about and think of what this literature suggests, no one knows as no one has yet thought of having them read it or bothered to ask them.

A qualitative study of paedophile sexual offenders

With a few rare exceptions [20, 21], psychoanalysis has long been put aside in treating sexual offenders. Although some condemn the lack of interest of therapists for -for example- the object representations of these patients [16, 22], many seem to agree that a psychoanalytic intervention with this population is rarely effective [23, 24]. Furthermore, some even suggest that the use of psychoanalytically oriented therapy may ultimately increase relapse risks [25]. Hence, cognitive-behavioural programmes are now what is mostly used with sex offenders (for a summary, see Ryerse [26]). These interventions have been shown to decrease the frequency of deviant fantasies, and help the patient develop better social and communication skills as well as anger management techniques [12]. Furthermore, these interventions would also help the patient better assert and control himself, present less cognitive distortions, and better manage situations presenting a risk for relapse [27], hence reducing recidivism [28, 29]. But with this switch in treatment procedures over the last 30 years to the almost exclusive use of cognitive-behavioural techniques, and despite indications that technique has less influence on outcome than relationship and patient related variables [30], little attention has been given to the interpersonal and dynamic aspects of the treatment.

In hopes to explore these issues, we undertook in 1998 a qualitative study on 24 pedophile sex offenders from La Macaza clinic of La Macaza federal penitentiary (Canada). The program offered at La Macaza clinic resembles most other programs for sex offenders. Like many others, it is based on principles from both cognitive behavioural therapy and relapse prevention. Thus, it is composed of group sessions, individual sessions as well as regular assessment meetings. The therapy group includes a dozen participants and is led by 2 therapists on a daily basis for a period of 3 hours

per meeting, excluding weekends. The complete programme is divided into 2 phases, each phase lasting 4 months. The first phase involves establishing an initial contact with the patient, discussing motivation for change, analysing his offence cycle, increasing personal responsibility, and cognitive restructuring. It also involves conditioning using aversive techniques such as ammonia. The second phase of treatment includes social skills training, anger management, sexual education, empathy training and relapse prevention.

The subjects we interviewed had all been given a sentence of at least 2 years for various offences involving children of 2 to 13 years of age, and had undertaken the clinic's treatment program for that reason. Furthermore, they presented clear pedophile behaviour and had abused a minimum of 4 victims each. All had had physical contact with the children involving in 45% of the cases a complete anal or vaginal intercourse.

Non-directive semi-structured interviews [31, 32] were used to gather the subjects' thoughts about their experience of the treatment and their motivation to enter the program. The interviews were analysed using diverse qualitative methods. First, text-based comparative analysis [33, 34] was done in order to analyse the different themes the subjects discussed in the interviews. Plan Analysis [35, 36] was then used to further understand the different wishes and means used by a subject to satisfy his wishes. Finally, dynamic analysis [37, 38, 39] was used to better understand the dynamic functioning of the subjects by also considering more unconscious and dynamic elements.

Three of the main findings of our study: a summary of the interpersonal aspects of treatment

Although our study has investigated and emphasised many different themes and elements, some findings appeared to be of significant importance. First, the subjects often mentioned and explained a desire for what we termed "mastery". Hence, they openly expressed their wish to take certain decisions on their own and to be independent, amongst other things. But most of all, they said to want to learn, through therapy and interactions with the treating staff, to better understand themselves and their pathology. Furthermore, learning about pedophilia per se appeared to be of significant importance to them as some subjects said to not want to talk about their sexual deviance but only to have the therapists explain it to them because they do not understand it themselves.

A second interesting point of the study was that the subjects gave much attention to the structuring of the programme. In their opinion, the programme should be well and solidly structured and its rules and procedures should be actively defended and insured by the staff and the institution. Furthermore, all decisions made by the staff should be in accordance with the programme's procedures in order to be predictable. This was the case even when one of the staff's decisions did not please them. It can be seen in the following interaction with a subject who was not admitted to the second phase of treatment:

– Subject: " (…) I mean I worked hard but they said I didn't fulfil the requirements for step 2. Actually they said I was not taking therapy seriously enough. I just wish I

could do the second part 'cause I worked so hard in the first part.

– Interviewer: So you would like them to admit you to step 2 despite…

– Subject (Interrupts): Well actually, it's not that simple! If Z (therapist) lets me back it just wouldn't make sense! I mean, those are the rules and I screwed up. If he just lets me waltz back, then he probably doesn't know what he's doing and I don't want someone who doesn't know what he's doing to be my therapist."

The structuring of the programme – an otherwise essential part of any therapeutic frame – was often said by the subjects to be reassuring in many ways. For example, it helped them contain themselves and avoid certain acting outs. Furthermore, it gave them a sense of security and safety by giving everyone a specific code of conduct and a place in the group and in the programme in general. In that sense, it was essential for them that the programme be predictable and solid.

The third important aspect examined was the therapists. According to the subjects themselves, the therapists were the most important factor of therapy. It was essential that the therapists be strong, capable of leadership and even authoritarian. They were to guarantee order in the group and to insure that all rules were applied. In many ways, their authority was reassuring as it gave the subjects the feeling that they would not be thwarted by other group members, hence putting an end to what was often a long series of past rejections. This could also be seen when the patients were taught about cognitive theories regarding offence cycles. Most subjects said to already know about their own offence cycle but that what they appreciated in having it explained to them was that they felt important enough to be given time and attention without a constant risk of rejection.

But in order to fully trust the therapists, the subjects often said to confront them. This was aimed at guarantying that the therapist was strong enough to contain such attacks and to make sure he was trustworthy, predictable and reliable. Furthermore, the subjects often seemed to re-enact with the therapists many aspects of their own past experiences. For instance, they often felt like children in group therapy. As such, they referred to other inmates in their group as "brothers" or with other family related terms. Even the therapists were often compared to parental figures and occasionally said to be "like a father" or a "mother". The subjects often made a strong contrast between their therapist and their parents, explaining that although their therapist was indeed authoritarian at times, it nonetheless was different from the authority of their father for example, who never "brought (them) anything". Although, as mentioned earlier, other aspects were also examined with the subjects, these three main themes were said, by the subjects themselves, to be the most important factors involved in therapy. It also seemed clear in analysing the interviews that they were the ones most elaborated upon and, perhaps, most invested by the subjects.

When a manualised treatment programme sets the stage for transference and other dynamic issues

Although treatment programmes for sex offenders may have precise and specific steps with clear goals, other aspects of treatment also seem significant. As such, even if the importance, usefulness, and effect of these different phases or techniques have been empirically demonstrated [28, 29, 40], the subjects said other aspects of the

treatment to be of greater importance, namely the therapists and the structuring of the programme.

As mentioned by the subjects, the therapists played an important role in the treatment program as they were appreciated for their strength, leadership, and authority. This was said to be a pre-condition for the subjects to actively participate in therapy. In order to verify that the therapist was indeed "strong enough", the subjects also explained that they would systematically test him. This may be understood in many ways. According to Weiss [41], patients test their therapist from the beginning to the end of the therapeutic process. They do so in order to explore the world and to determine its dangers and opportunities so that they may protect themselves from its dangers and take advantage of its opportunities. As such, "testing" would be a fundamental human activity aiming at a better adaptation to interpersonal dynamics.

Such a position is not without reminding us of Freud's [42] Bemächtigungstrieb and Hendrick's [43] later comments about an instinct to master. Furthermore, as the subjects explained, they did have a strong desire to learn and felt great pleasure in mastering new vocabulary for example. But as the subjects explained and although Weiss's comments regarding testing in general may be true, they did not feel the need to confront their therapist all along the therapeutic process but only at the beginning. Once convinced of the therapist's strength and capacities, they put an end to their confrontations and felt reassured. As Brunet [44] has suggested, this initial confrontation of the therapist may be the result of a necessary illusion on the therapist's capacities through a healthy use of projective-identification. Although the more "negative" or pathological aspects of projective-identification are usually emphasised [45-47], this mechanism may also have beneficial and healthy effects and even be necessary for therapeutic work to take place.

Following the work of Klein [48, 49], Bion [50] has suggested that projective-identification may be related to a patient's need to use the object to contain anxiety provoking material. For instance, a child dealing with an intolerable anxiety may project this material into his mother in order to gain some relief. When the mother is capable of containing these projections, she may then elaborate them and "think" for the child what was initially "unthinkable" in order for the child to take it back and deal with it on his own [44, 51]. As such, projective-identification may have two possible functions. First, a child may use it in order to get back at his mother as he believes her to be the source of his difficulties or in order to better -and omnipotently- control material originating from himself [46, 47]. Second, a child may also make use of projective-identification in order to communicate his distress and have someone else transform and organise it. In many ways, this resembles what Winnicott has described as the mother's holding function [52, 53].

In order for patients to accept to rely on a therapist, they must first have the illusion that he can withstand aggression. This can lead them to verify his capacities to contain and to make sense of aggressive and anxiety provoking material. They need to idealise his capacity to do so and test it through a proportional and overt confrontation. This appeared to be the case with the subjects we interviewed. Not only did they confront the therapist and test his capacities to contain projected and aggressive material, they also asked to not talk about pedophilia themselves but to be told about it as they do not yet

understand it on their own. In other words, they too asked the therapist to think for them what is still unthinkable. Eventually, the subjects came to identify with the therapist's capacity to do so as well as with his "sense making or searching" activities; as some subjects have explained, the therapist knew them better than they knew themselves. Furthermore, they understood themselves better because the therapist understood them. Not only did the subjects appear to identify with this, they also seemed -on a more regressed mode- to introject it. As one subject explained:

"I think they (therapists) are the most important thing here. They help a lot. It's like they go inside you to understand you… Or it's like they go inside you to bring out the bugs".

Furthermore, the subjects appeared to identify with the therapists' holding and structuring function. As they explained, they needed the therapists to be strong enough to contain attacks and to have the rules and procedures of the programme respected. In other words, they needed their environment to change less than they might change themselves, hence remaining a constant point of anchor or of reference. They then learned to contain themselves on their own although, as one subject put it, they "still need much work at it". This same necessity for containment could also be found in the subjects' pressing requests for a stable and well-organised programme. As the subjects explained, the programme needed to be solidly structured in order to limit potential acting outs from themselves and from other inmates. As such, not only did it put an end to action and force the subjects to "think instead" (some may prefer such terms as elaborate or fantasise) -hence introducing them to another option beside acting out-, it also seemed to serve as a protective shield (Reizschutz [54]). As the structure reassured the subjects by giving them " a day to day routine" but also "a clear indication of what to expect and what to do", the program seemed to be essential in giving sense to what is otherwise a chaotic world. Furthermore, it set the basis for further reality testing in helping the patients distinguish external from internal stimuli. Hence, the program, with its rules and procedures, was predictable and enabled the subjects to realise that the staff's actions could be explained through this system. This is significant in a population making use of many projective defences, as the staff's decisions could then be seen as the result of an application of the rules and not as a personal aggression to which one must retaliate. One subject brilliantly explained this process in the following terms:

He (therapist) told me that… what would happen if I didn't do the assignments and if I kept fooling around in the group. I just thought he hated my guts, you know? I thought this guy hates pedos and just comes here to get a chance to make them pay for what they did. Plus, I'm Indian and I thought he hated Indians 'cause he's white (…). I kept fighting him on everything 'cause I thought he was on my case all the time (inaudible) (…). And a few weeks ago, we had a man to man chat and he reminded me of what he had said to the group at the very beginning of the therapy: "no one is here to fool around and huh if they do, these are the rules and these are the conse… hum!… consequences". And I have to admit, I was (raises voice) fooling around! And he said he had nothing against me so… (…). I think I realised he was just doing his job and he wasn't really picking on me all the time. (…) Some guy in the group huh, when we were having a smoke outside (…) said that maybe I hated myself you

know and huh… well just that what I thought the therapist thought was really what I thought of myself (…). He's not a shrink or anything so I don't know if he's right but it's worth thinking about it."

In many regards, the therapists, the offender's sentence, and the programme structure in general became somewhat of an external representation of a law (in both psychoanalytic and general terms) otherwise lacking for pedophile sex offenders. What is interesting about such a setting is that both a maternal holding function and a paternal law function are implicitly offered by the treatment settings, thus setting the first foundations of what may eventually -and hopefully- evolve into a more neurotic functioning. It is then crucial that all staff members stand by this law despite all of the hardships it involves and despite strong wishes to relieve a patient from his distress and suffering coming from the application of the program's or the institution's rules. Even the subjects said this to be a necessity and clearly explained on many occasions that the therapist must stand by the rules even if they – the patients – do not like what consequences it may have for them. As the pedophile is often said to be "the narcissistic doll of his mother" [55, 56] and struggling with symbiotic issues [57, 58], such external representations of the law may be for the subjects a rare opportunity to have access to, and confront, what may symbolically be a father figure for them.

Having access to a strong father imago is in consequence of significant importance in that it may actually help the patient become more autonomous [59, 60] and eventually integrate aggressive and love drives as well as object representations. As many subjects said to have had an inaccessible or simply absent father, interacting with such a father imago offered them the opportunity to be given something, for example through the different "teachings" of the therapist but also by being respected and taken seriously, which confirmed their existence as a person. This seems to reveal the importance of phallic elements in building an existence as an individual or subject with an identity, as defined by French analysts. According to Bergeret [61], for example, it "allows the person to gain access to competition with non-sexualised objects" (p. 214). Evidently, it seems clear that such issues are not yet related to sexual rivalry but more to the essential foundations of narcissism, that is to becoming somebody. Hence, many subjects explained that the therapists gave them the right, often explicitly, to talk and to take their place in the group in order to express themselves in general but also, and more specifically, to express their wishes, thoughts and personal opinions.

Conclusion

No psychoanalytically oriented or psychodynamic therapist will doubt that interpersonal interactions present many unconscious dynamic issues. But one must also admit that a manualised cognitive-behavioural treatment programme such as the ones often used with sex offenders does not emphasise this nor, in most cases at least, explicitly deal with it. Although recent efforts in certain areas of cognitive therapy have given increasing importance to interpersonal and even transferential aspects of the therapy process [36, 62], this apparently has yet to be done in sex offender treatments. Nonetheless, such issues are visibly at play in those programmes. The solid and definite structuring of treatment programmes certainly has beneficial effects according to

cognitive-behavioural therapists and the different steps and phases of the programme seem to attain the objectives they set. As such, these programmes are unquestionably necessary. But one must not overlook the fact that these programmes, precisely because of their structuring, also set the basis for transferential opportunities, which could be explored further and with benefit. As the offenders clearly invest the therapy programme in many different ways, it actually seems as though the patients take fully advantage of this "transference opportunity", with all the anxiety it involves. Even the most aggressive outbursts of these patients should be understood as a result of this process and not be seen, as is often the staff's initial reaction [63], as overt resistance to treatment or as an indication of a definite psychic structure which has to be systematically changed in behavioral terms or before which one can only feel helpless. The critical aspect of treatment then is how the therapists will handle these confrontations and acting outs, for those moments will be crucial in determining whether a patient will remain or not in treatment. For the subjects we interviewed, the therapist's weakness and hesitations were reason enough to quit a treatment programme.

As one of the most central aspects of a psychoanalytic cure is that the analysand undertake his analysis of his own free will and without external constraints [64, 65, 66], analysts have had little concern or interest for questions such as definite and clearly structured programmes or forced treatment. As such, with a few rare exceptions [21], they have often deserted the field of sex abuser treatment. But as the common interest of all clinicians working in this field is to -at least- reduce recidivism, efforts to adapt interventions must be constantly made. And as the subjects seem to fully take advantage of the transferential opportunities they are given and because they constantly request having someone to talk to or with whom they could explore individually and with more depth the causes of their difficulties, providing them also with the opportunity to explore their dynamic and transference issues could certainly be warranted and even become an important correlate to any manualised treatment. Otherwise, a risk with concentrating exclusively on behaviour would be to defeat the very purpose of therapy: how may one truly modify his behaviours, actions, and mostly acting outs, if he is not given greater opportunity to have access to and explore thought, symbolic functioning and fantasies?

On the other hand, one may argue that despite it not being part of the therapists' or program's agenda, the patients nonetheless make good use of the treatment. But this study, in agreement with other studies on psychotherapy processes, reminds us that patients are not passive recipients but rather proactive in making use of the treatment. As such, techniques do not necessarily operate on the patient but rather offer opportunities to set the stage for interpersonal issues. As Lambert [30] reminds us, psychotherapeutic techniques merely account for 15% of the total explained variance in therapy outcome, hence ex-aequo with the variance explained by expectancy and placebo effects, whereas patient related variables account for approximately 40% of the total variance and the therapeutic relationship for another 30%. Furthermore, studies examining the helpful aspects of therapy have suggested that what therapists said to have been helpful to a patient greatly differs from what the patient has thought to be

helpful (see Hubble, Duncan, & Miller [67], for a complete review). The question then is not about whether or not to put aside treatment procedures which have been proven helpful, but rather how to offer correlates to these treatments in order to maximise even more the effects of an intervention. When one can keep in mind that change is more likely to be long lasting in clients who attribute the change to their own efforts [68], one definite field of interest in treating sex offenders would be to complete the "control" aspect of cognitive-behavioural treatments with interpersonal and in-depth interventions aiming idiographic "understanding".

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