Illinois Association for the Treatment of Sexual Abusers

ATSA

December 2015

President's Message

~ Rhonda Meacham

Season's Greetings to all IL ATSA members and colleagues. I'm hoping that many of you were able to take advantage of the expertise of the presenters that took center stage at this year's national conference in Montreal. Per usual, the conference was professionally done, offered a wealth of research and clinical information, and inspired healthy debate! I take great pride in being a member of an organization that is dedicated to the eradication of sexual abuse. It is apparent that ATSA is a dedicated group of individuals providing the highest quality of care to those we serve and who genuinely want all to heal from the pain of abuse. This is true for everyone involved: those providing direct services, those mentoring new professionals, and those conducting important research. I would like to take this opportunity to thank all of you for the work you do to keep our communities safe and to assist individuals, families, and communities in transcending the harm that is caused by sexual abuse. You are appreciated!! As the holiday season continues, I hope our members and colleagues find many things to be thankful for and this upcoming year is prosperous, fulfilling, and full of wonderful memories!

Using Labels: Effective or Problematic?

~ Mark S. Carich, Ph.D. & Kathyrn T. Cathell, M.A.

Introduction

The field of treating sex offenders has changed over the years, moving from a shame based confrontational approach to a non-confrontational approach with a humanistic touch (Carich & Mussack, 2914; Carich, Cameron & Smith, 2015; Marshall, Marshall, Serran & O'Brien; Prescott, 2014; Purvis, Ward & Willis, 2014; Ward, 2002). The harsh treatment of clients who have sexually abused others is a thing of the past, with current emphasis on integrating positive psychology via the Good Lives Model (GLM). This newer emphasis is not meant to minimize the damage or impact on the individual assaulted or the "victim," but to inform others of another side. Society has taught us at that stereotypes and labeling leads to more problems. It is no different with labeling a population that is not welcomed. It seems that the mental health field in general, since the turn of the century has struggled with using labels in describing different facets of the human condition, behavior and experiences. Likewise, in the field of sexual aggression, the use of labels is now being questioned (Leguizamo, 2014). For example, is someone who committed a sexual offense always and just a "sex offender" or someone assaulted always a "victim" or a "survivor"?

This essay uses a post-modern and social constructivist view and is based on introducing the possible problems with the overall effects using labels, as expressed by others (Leguizamo, 2014; Thornton, 2015).

Punctuating Life's Experiences

Keeney (1983) in his classic book, "Aesthetics of Change," emphasized a constructivist's view by emphasizing the individual punctuating reality or drawing distinctions in reality based upon perception (Keeney & Ross, 1983). In essence, from a postmodern view, one constructs their own inner realities by defining and interpreting perceptions (Mahoney, 2003). From a social constructivists view, participants within the social interaction co-construct the interpersonal realities. Becvar & Becvar (2009,p. 89) states: "…this is the notion that our reality is inevitably subjective and that we do indeed dwell in a multiverse that is constructed through the act of observation. Facts are replaced with perspectives."

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~ Mark S. Carich, Ph.D. & Kathyrn T. Cathell, M.A.

Applied to therapy, both the client and therapist co-construct the therapeutic reality and form the therapeutic relationship with their own inner realities. (Carich, Cameron, & Konczak, 2015).

The community of mental health professionals co-constructs professional realties as well in attempts to describe behavioral phenomena. In the course of describing behaviors, labeling and developing classifications systems, they are ultimately creating professional and social stigmas. Over the years, leading professionals have disputed classification systems and global labeling (Bateson, 1972, 1981; Glasser 1975, 1979; Keeney, 1983; Szas, 1962). The professional labels given to these individuals often become their identity. For example, "once an alcoholic always an alcoholic," not to minimize the difficulty of addiction, or an "ex con" instead of returning citizen; the individual takes on those identities.

The Paradoxes of Labels & Labeling: Possible Fallout

Historically, beginning with Freud & his inner circle, mental health professionals have been struggling with describing and defining behavioral phenomena, paradoxically creating boxes and labels to fit people into. Interestingly, with each DSM edition and its professional and social reality changes, some behaviors are no longer considered pathology, while others emerge as new pathologies. Paradoxically, labels help provide definitions and guidance in approaching or working with the individual, however, often leaving a stigma as it becomes their ideals. A constructivists position best describes the process as Becvar & Becvar (2009, p.90) states: "The constructivist perspective is based on the assumption that in the process of perceiving and describing an experience, whether to ourselves or to others, we construct not only our personal knowledge base about reality but also our reality itself." Thus, language plays a role in defining constructs on reality. Language represents the realities of our perceptions. "Thus, a change in language equals a change in the experience…" (Becvar & Becvar, 2009, p.90). Dwyer (2015) emphasizes "Words connect or disconnect us to each other."

The issue of labeling individuals charged with sexual aggressions as sex offenders presents an interesting set of paradoxes (Leguizamo, 2014). Leguizamo (2014) points out problems with a stigma, often creating hopelessness, depression, personal shame, social shame, etc. which can create a self-fulfilling prophecy. Someone who is labeled a victim can also experience this identity issue. When the public finds out someone is a victim, questions begin to emerge: Is a "victim" the individual's identity? Is a "victim" a victim forever, and if not, how long are they a victim for? Is a "sex offender" a sex offender forever? The same questions can be applied with a drug addict or alcoholic, depressive person, schizophrenic, etc. More so, is the label the person's entire identity and does it set up a self-fulfilling prophecy? Interestingly, in working with individuals in both the low and high risk categories, their perceptions of the label "sex offender" is much different, perhaps reflecting the culture of the treatment context of the day and zeitgeist of the field. Several years ago, clients in the high risk group were more accepting of the labels, much as in Alcoholics Anonymous; however the low risk group struggled with the label, often saying "I'm more than a sex offender." The central theme of their struggle is the label superimposing their identity.

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Conversations with Leaders: Interviewing Phil Rich

~ Mark S. Carich, Ph.D

Editor's note: As a follow-up to Dr. Phil Rich's training on Monday October 26, we have chosen to publish an excerpt from the book: "Conversations with the Leaders in the Field of Sex Offender Assessment, Treatment, Research, and Management" by Mark Carich, PhD., Bruce Cameron, MS, and Scott Smith, MA. **Reprinted by permission of Dr. Mark Carich.** *Original interview given in 2008.*

Dr. Mark Carich: *How long have you been in the field?*

Phil Rich: I received my MSW in 1979 (and my doctorate in 1992), but like many people in the field, I began my work prior to that. My first work in human services started when I was a young teenager, volunteering my time in hospitals and later in youth centers. My first paid position in human services was around 1974, when I began working with teenagers. I first began working with sexually abusive youth around 1981, but at that time this population of kids was always included and subsumed within the larger population of emotionally and behavioral troubled children and adolescents. I've been working exclusively with sexually abusive youth since 1999.

Dr. Mark Carich: *What are some of your philosophical notions or assumptions applied to sex offender work?*

Phil Rich: I see people as the products of both their social environment and their biological traits and characteristics. Both of these influences on and sources of human behavior have great significance, in which the developmental-learning environment and the experiences it contains are a powerful shaper and determinant of social behavior. Of special importance in my work and understanding of sexually abusive behavior and its development and maintenance is social connection, shaping both self-esteem and sense of social relatedness. I see sexually abusive behavior, in part, as a problem (and often crime) of relationships and significantly related to deficits in critical social skills, including self-regulation, metacognition, and social interaction, as well as connection to social norms and values. In my thinking, the therapeutic relationship we form with our clients, and our understanding of them, is vital in contributing to the effectiveness of treatment, and of special importance is the way in which our clients perceive us and our authenticity in that relationship. In order for our clients to develop empathy, the capacity for moral decision-making, attunement to and concern for others, and social connection, our clients must first and continually experience all these things from us, their carers and supporters. However, there is also a significant contextual and developmental element to this, which from my perspective is of special importance in work with children and adolescents. Of great importance also, and especially with juveniles, is that we actually care about the people with whom we work (and that they experience this caring) and engage in a real relationship with them, boundaried by the professional dictates of our field and our training.

Dr. Mark Carich: *What do you consider the key elements of treatment with both juveniles and adults?*

Phil Rich: I've already detailed some of these, and as I work with children and adolescents I'll emphasize these again with respect to juveniles, recognizing that adults have different needs and, accordingly, different elements may be at play. In all cases, however, adult and juvenile, I strongly think that understanding each individual as an individual is an important starting point, as well as our evolving understanding of each individual as we work with him or her. Key is the empathic, supportive, and attuned, attachment-oriented approach of the clinician, genuine concern for the well-being of the client, and the provision of growth and learning opportunities that allow for personal and social success and the rehabilitation of ideas about self and others. I also think that supervision and monitoring of behavior are important, as is a recognition that change is enormously difficult for most people to make and comes slowly and usually only through repetitive experiences that support change, and the teaching of skills, ideas, and tools that can aid in self-awareness (aimed at the developmental or cognitive level of the client) and self-regulation. With children and adolescents, of special importance is working with families to help repair and heal damaged family relationships and strengthen (and again rehabilitate) family relationships, including structure, communication, roles, and interactions. Our ability to recognize that development occurs over time, in the social environment, and shapes the physical brain, as well as behavior, thought, and emotion, is central. In recognizing that early adverse experiences are life changing and help set the pace for later behavior we are able to see the events and experiences that have helped create the client before us now,

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~ Mark S. Carich, Ph.D

as well as the sort of interventions that must be provided to create new life experiences. On this final note, time in treatment is important, and not simply the interventions of treatment. The brain changes slowly as it adapts to its environment. It took quite a while to adapt to the external experiences that helped shape problematic and troubled cognition and behavior, and will take quite a while to respond to and adapt to the interventions provided through treatment. Time in treatment counts as a significant element of treatment.

Dr. Mark Carich: *Pertaining to psychopathy and antisocial personality, how do you conceptualize these constructs?*

Phil Rich: One question that is of particular importance in working with juveniles is whether or not psychopathy (I've been referring to it as sociopathy, but use the words as synonyms) is biological or developmental in origin, as they have very different consequences for both conceptualization and treatment. The belief that psychopathy is biological, or that there is a biological predisposition for psychopathy, is quite different from the idea that psychopathy develops over time and through the course of childhood and adolescence. Merely seeing psychopathic-like traits in juveniles is not the same as seeing psychopathy in children and adolescents, although certainly reflects developmental trajectory and signals the potential development of psychopathy in adults if things remain unchanged. In a biological model, one expects to see psychopathic traits emerging in the *unfolding* of biological psychopathy over time. In a developmental model, one sees the *development* of psychopathy as a response to the environment (and of course, the interaction of the environment with biological traits and temperament). Either conceptualization (biological or developmental) leads to the same outcome: the psychopathic adult. Each conceptualization, however, results in a different approach to treatment. The current DSM diagnosis of Antisocial Personality Disorder is developmental, like all of the Axis II personality disorders, and in the case of antisocial personality disorder cannot be made until age 18. DSM offers a broader view of adult antisocial ideation and behavior than a model of psychopathy, and links the development of personality to both adolescent and childhood behaviors, noting that juvenile conduct disorder must be present since at least age 15, and also that childhood onset conduct disorder (say before age 11) has a much poorer prognosis than adolescent onset. Robert Hare and colleagues, currently significant figures in ideas and measurements of adult psychopathy and the detection and measurement of what they consider psychopathic traits in children and adolescents, consider psychopathy a more serious subset of antisocial personality disorder. From this perspective, although all psychopaths have antisocial personality disorder not all people diagnosed with antisocial personality disorder are psychopathic. My own perspective is that there may well be elements of psychopathy in human biology and genetics, but that psychopathy in children and adolescents is in large part a developmental response to their social environments and experiences, and that it behooves us to think about and respond to juvenile conduct disorder as a developmental process rather than a foregone and inevitable conclusion that results from biology.

Dr. Mark Carich: *Do you think that denial, victim empathy, and motivation are related to sexual recidivism, dynamic risk assessment, and/or recovery?*

Phil Rich: I have been involved in a number of discussions, which sometimes raise really strong feelings in others, about denial and recidivism. In general, I think that the obvious answer is that denial is clearly related to both assessment and risk for sexual recidivism. Despite the standing belief that denial is not related to risk, this is based largely on meta-analyses of adult sexual offenders that find other risk factors to be more significant and don't find support for denial as a risk factor.

Nevertheless, there have been several other studies, including some

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Welcome To Our Newest ATSA Members!

Brandon Gorson **Mark Kuzia** **Alex McKibbin**

Robin Motz **Dale Spitler** **Jonathan Tlusty** **Jacqueline White**

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~ Mark S. Carich, Ph.D

recent studies that offer support for denial as a risk factor, and a number of studies that relate unsuccessful completion of treatment (including treatment drop out) as a risk factor, including the very meta-analyses that don't find statistical support for denial. There's an interesting paradox here. It is difficult to imagine that denial of an offense (or all offenses for that matter) leads to successful participation in treatment; in that case, much of the work in treatment cannot be completed as much of the work involves taking responsibility for, exploring, and in some way discussing sexually abusive behavior and its victims. If success in treatment is, in effect, a protective factor (and unsuccessful treatment a risk factor) and full engagement in treatment is required for successful treatment completion, then it is difficult to imagine that denial cannot be a risk factor for recidivism, even if a relatively small risk factor. I suspect that, in fact, the problem here is one of statistical semantics, involving a clear definition of what "denial" means and how and when it is measured (for instance, pre-treatment or post-treatment). Similarly, I see empathy, moral decision making (which are related constructs), and motivation each as key elements in both assessment and treatment, and especially as I think of sexually abusive behavior as a crime of relationships and a reflection of significant deficits in social skills and social relationships. On their own, each of these may not weigh heavily as risk factors, whether in a statistical or clinical model of risk assessment, but that does not mean that they are neither risk factors nor targets for treatment (and there is little point in making something a target for treatment if it is not a risk factor), and it also does not mean that combined their weight is not increased. I think it's probably safe to say that most sex offender specific treatment programs, whether for juveniles or adults, even if they step around denial and minimization, not only treat empathy but also significantly attempt to increase motivation. Frankly, it's difficult for me to imagine how such programs could avoid dealing with denial as well, as it's unlikely that treatment can proceed for someone who plainly says they didn't do it. Motivation implies motivation to engage in treatment and empathy involves concern for others, including those who have been injured (in sex offender specific treatment, usually those injured by the offender), and in the face of denial it is unlikely that the treatment provider will be able to successfully get to or deal with either motivation or empathy. Like denial, empathy also lacks statistical support as a risk factor, yet is clearly a major target of treatment. And, again, I suspect that we lack the ability to define the construct in a way that is specific and sensitive enough, and therefore fail to meaningfully recognize or measure it statistically, even though clinically we can often spot a lack of empathy a mile away. Effective therapeutic relationships help to build motivation for treatment, both of which (therapeutic relationships and client motivation) have been repeatedly cited as factors in successful therapy; without motivation treatment is likely to be tough going, and probably even unsuccessful regardless of the particular treatment problem. So, yes then. I see motivation, denial, and empathy as important elements in risk assessment, important dynamic risk factors (which are the targets for treatment), and important in rehabilitation and recovery. The converse, however, that the presence of denial, lack of motivation, and a failure to experience empathy does not equal recidivism. Many sexual offenders in treatment, whether juvenile or adult, will never sexually offend again for any number of reasons, even in the presence of denial and absent of treatment motivation and empathy with others. For this reason, these factors are simply elements among many that contribute to sexually abusive behavior.

Dr. Mark Carich: *Please comment on the etiology of sexual aggression.*

Phil Rich: What a big question to end on. Before trying to answer the question, though, I think the term sexual aggression is probably less accurate as a descriptor than simply "sexually abusive behavior" and, in juveniles, "sexually troubled behavior" as well. In fact, it would be foolish of me to offer a single model of etiology, especially after everything I've already said. So, without proposing a single path or single etiological model, I do think that the roots and elements of sexually abusive and sexually troubled behavior have everything to do with early and ongoing developmental experiences, mixed up with and amplified, potentiated, and catalyzed by experiences in and messages from the social environment. I think of this set of interactions and transactions occurring in and forming the

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~ Mark S. Carich, Ph.D

developmental-learning environment in which sexually troubled behavior develops and is eventually enacted. This combination of personal development, the social environment, and the development of the social self has been described in the etiological models of Ray Knight and Neil Malamuth (describing adult male sexual aggression), as well as countless descriptions by theorists, researchers, and practitioners alike that heavily implicate early and on-going family and childhood social experiences in the lives of sexually abusive children and adolescents. As sexually abusive behavior involves problems of relationships probably more than any other form of physical crime, it seems clear to me that its origins lie in relationship difficulties, stemming back to early childhood and continuing throughout childhood and adolescent development, and also includes problems in the development of the essential and critical social skills that underlie all human interaction and relationships. So, in a nutshell, I see sexually abusive behavior as the result of social forces and interactions, social learning, and conditioned learning that come together to produce the behavior in individuals who lack self-regulation, lack critical social skills, lack secure and confident attachments to important others, lack secure and confident peer relationships, and lack a confident and secure sense of self, in which, finally, sexually abusive behavior occurs and is best understand in the ecological social setting. Without, then, proposing or offering a single model of etiology, asserting a single pathway to sexually abusive behavior, or describing a model that has or can identify every important element, I do propose these as the elements that contribute significantly to the development and sometimes the maintenance of sexually abusive behavior. However, let me end by quoting Tolstoy (or is this name-dropping?): *"There are other causes which I do not propose to list, but nor do I set forth a single, inadequate cause, claiming that as the only one.*

Labels: Effective or Problematic...continued from page 2

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Contemporary Views

Historically, Cognitive Behavior Therapy and Relapse Prevention was embedded in a shame-based intensive confrontational approach to treatment. Its emphasis was on labels, complete with punitive tactics, thus largely ignoring human dignity, and the therapeutic alliance. Of course this was done in the name of therapy, following the path laid down in drug treatment. In terms of treatment, contemporary views consist of integrating or introjecting Positive Psychology into CBT via the Good Lives Model (GLM) and Motivational Interviewing (MI) (Carich, Dobkowski & Cameron, 2012; Carich & Mussack, 2014; Marshall, Marshall, Serran & O'Brien, 2011; Prescott, 2014; Purvis, Ward & Willis, 2014; Ward, 2002). In terms of a therapeutic model, this integration moves the field beyond basic CBT model. At any rate, emphasis on Positive Psychology transforms treatment with a humanistic touch, pulling away from the harsh confrontational approaches of yesteryear. The current treatment approach is placed on a holistic view; emphasis is redirected away from labeling and the stigmas, now realizing the complexities of the human condition. From a holistic view, the individual is more than the label. Dwyer (2009) calls for a vocabulary to heal not create divides, which ultimately reduces the risk of re-offense. She states: "To challenge words is to challenge our methods of addressing persons and the meaning of words we use in addressing sexual problems. Many repercussions come from our language."

Conclusion

In this essay, the authors pointed out the obvious paradox of using labels. Philosophically and theoretically, the paradox involves describing a behavioral phenomenon and using labels as part of the description, in order to intervene. Labels may have a boomerang effect, adding more issues and risk to the situation. At some level, labels provide an overcast of identity. The ultimate question involved is the individual vs. the label. The ultimate goal still remains: not hurting others and helping clients to live a pro-social life. While the impact of sexual aggression cannot be minimized, questions arise if labeling individuals who are assaulted, commonly referred to as "victims," and those committing the aggressive behaviors as "sex offenders" is useful or harmful (Leguizamo, 2014).

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Are these individuals' victims or survivors forever?
The point of treatment and management is to reduce sexual aggression. As professionals, who are an extension of humanity, and in accordance with the GLM these individuals are more than the label (Carich, Dobkowski & Cameron, 2012; Carich & Mussack, 2014; Marshall, Marshall, Serran & O'Brien, 2011; Prescott, 2014; Purvis, Ward & Willis, 2014; Ward, 2002). The authors don't see any immediate solutions to the paradox of describing behaviors without labeling the descriptions; however, therapists need to be aware of the impact of using labels.

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