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Sexual Identity and Male Sexual Offending Against Children

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Abstract

This article reports on the development since 1999 of a sexual identity group programme within the Kia Mārama Special Treatment Unit at Rolleston Prison for men who have offended sexually against children. There are some indications that sexual identity confusion may be a more significant factor in sexual offending than has previously been thought to be the case. The needs of offenders who are or think they may be gay or bisexual have not always been well attended to within treatment programmes. The sexuality group programme developed at Kia Mārama offers one model for better addressing those needs within a comprehensive relapse prevention programme.

The article introduces the Kia Mārama treatment programme and the challenge of working with sexual offenders, outlines a six-session group programme, reports on broad treatment strategy and group process, offers some observations and reflections on sexual identity in relation to sexual offending, and indicates a potential area for research.

Introduction

The Kia Mārama Special Treatment Unit for male sexual offenders at Rolleston Prison was established in 1989. The unit can accommodate up to 60 men. Their participation is voluntary, and restricted to low- and medium-security inmates who have acknowledged their offending. Of those 60 men, at any one time between 24 and 32 participate in the 35-week therapeutic programme, with 40 men being treated over the course of a 12-month period. The remainder are waiting either to enter the programme, or for parole having finished the treatment programme.

The programme itself combines comprehensive clinical assessment, followed by intensive group therapy, with some brief individual interventions for those with related problems (for example, social phobias, addictions, etc.). Therapeutic tasks include norm-building and motivation, identification of offence cycles, exposure to victim impact, empathy development, phallometric assessment and sexual arousal reconditioning, social skills, mood management, problem solving, relapse prevention and release planning.

An outcome study for a five-year follow-up revealed a recidivism rate of about 8% compared with a matched control sample whose recidivism rate was consistent with that of other (untreated) sex offenders at about 22% (Bakker et al., n.d.) A study currently in progress is indicating that the recidivism rate climbs to about 10% over a ten-year period following release from prison.

In 1999, an inmate asked if a group might be established to address issues of sexual identity, as an adjunct to the treatment programme. I was approached by the Psychological Service of the Department of Corrections to develop and co-facilitate a six-week group programme on sexual identity, as an "out" gay man and psychotherapist.

Six men volunteered to join the sexual identity group in 1999. This pilot project was judged by both inmates and staff to be helpful, so a second group was offered in 2000, which eight men volunteered to join. A third group was offered in 2001, with a further eight participants.

This suggests that up to 20% of the 40 inmates in the therapy programme at any one time may have significant questions and conflicts concerning their sexual identity. Various research studies have indicated that men who offend sexually identify as homosexual at a rate (0–4.7%) less than the assumed incidence of male homosexuality in society (Healy, 1998). However, the interest in sexual identity groups at Kia Mārama appears to indicate that sexual identity confusion may be a more significant factor in male sexual offending against children and young persons than has previously been thought to be the case. This in turn indicates scope for research and further development of the Kia Mārama treatment programme itself, particularly given that the needs of homosexual offenders in traditional offender treatment programmes have tended to be overlooked (Healy, 1998).

Working with sexual offenders

The crime of sexual violence against children evokes strong emotions and social responses that can be vindictive in their call for revenge and punishment of "paedophiles". It is, however, neither accurate nor helpful to reify a behaviour (sexual offending) into an enduring identity ("paedophile"). Men who have offended sexually against children remain more than their crime. Research has indicated that actual offending behaviour (including pre-offence planning, grooming and manipulation) occupies less than ten percent of their time (Marshall, 1996). Further, on almost all measures, the heterogeneity of men who offend sexually is more evident than their homogeneity (Marshall et al., 1999, p. 32).

Effective treatment requires of the therapist a willingness to enter into a positive therapeutic relationship with this client group, and an active choice not to mirror

society's punitive and shaming stance toward sexual offenders. Acts of violence are played out against a social backdrop conducive to our individual acts of aggression. Therapy that mirrors violent and vindictive social attitudes leaves unchanged the culture of violence within which sexual offending against children occurs (cf. Blanchard, 1998, pp. 9, 23–30).

Gill Straker (2001, p. 6) has observed that working with perpetrators can be more emotionally taxing than working with survivors, because we are forced to confront our own capacity to oppress and to abuse. Freud once commented, "We hate the criminal, and deal with him severely, because we view in his deed, as in a distorting mirror, our own criminal instincts" (cited in Marshall et al., 1999, p. v). Terence, a North African slave boy taken to Rome by his senator master in the second century BC, and given his master's name, an education and eventually his freedom, had observed much earlier: "Homo sum: humani nil a me alienum puto" – "I am human, and therefore nothing pertaining to humankind is alien to me."

Working with men who have offended sexually challenges therapists to connect with their clients from a position of optimistic, compassionate and positive regard, and to demonstrate consistent respect, empathy and care.

The sexual identity group programme

The sexual identity group programme developed at Kia Mārama since 1999 is structured over six sessions of 90 minutes duration, meeting approximately fortnightly. Most of the men are concurrently working in other therapy groups as part of the treatment programme. The sexuality group appears to have proved most effective when the participants are either currently engaged in or about to enter the general group programme, and specifically analysis and ownership of their own "offence chain".

Participation and attendance are voluntary. Experience has shown that more in-depth and significant work is able to be achieved when the group contains five to eight participants, with a stable attendance of six members.

Prior to the group meeting for the first time, I have found it helpful to be briefed by psychological services staff on the group members. In general, I prefer to meet therapy clients "for the first time", and not to hold information about them that they themselves have not freely consented to share with me. However, given the limited duration of the group, a concern to maximise the integration of the sexuality group work into the wider Kia Mārama programme, and the denial and minimisation frequently exhibited by men who have offended sexually (see Bays, 2001; Marshall et al., 1999, pp. 59–72; Murphy & Carich, 2001; Mussack & Carich, 2001, p. 6), I have concluded that briefing is beneficial both to my own assessment and treatment planning, and to the

wider social objectives inherent in the programme.

The groups have been co-facilitated by a psychological services staff member (a clinical psychologist) and myself. Sexual offender treatment literature commonly recommends co-facilitation by a man and a woman, in part to model appropriate gender relations (see, for example, Lowe, 2001, pp. 42–43; Marshall et al., 1999, p. 36). In my experience, the gender (and sexual identity) of the co-therapist is less relevant than the fact of co-therapy, and clarity about therapist roles.

Group therapy with co-facilitation also reduces the risk of therapist burn-out, which is problematic in this field (Marshall et al., 1999, pp. 35–36). Co-therapy enables peer supervision, close attention to transference and counter-transference issues, possibly different gender and sexual identity perspectives, and mutual support. Quite simply, there is too much "going on" in a group of this nature for one therapist to be aware of and to work with it all.

It is important that both therapists be clear about and comfortable with their own sexuality, have taken steps to address their own internalised homophobia, and be alert to heterosexism and homophobia expressed within the group. It is crucial that at least one of the therapists also be "culturally competent", participating on some level in gay culture. Ideally, at least one therapist will be gay or lesbian, and able to model a positive homosexual identity and lifestyle.

The programme itself is structured as follows.

Session one: Introductions, clarification of group purpose, and contracting for group safety and consent for research and video recording of all sessions. Research questionnaires are distributed and completed.

Session two: A "map" of human sexuality is introduced (adapted from Seligman, 1994), to differentiate gender identity, sexual identity, sexual orientation, sexual preference, and sexual performance. Each participant is invited to introduce himself in terms of these five areas, and to relate this to his own offence chain and change goals.

Sessions three to four: Individual therapy is conducted in the group setting. The co-therapist observes, intervening from time to time to represent the wider treatment programme and to encourage reflection and integration in relation to the participants' offence chains.

Session five: Information is provided on coming out issues, gay community supports, safer sex, and homosexual identity formation (adapted from Rampton & Kinder, 1992 on the basis of Cass, 1979; see also Cass, 1984). We review learnings and negotiate contracts for change.

Session six: We review participants' sexual identity in relation to their sexual offending, and clarify "where to from here?" The research questionnaires completed in

session one are repeated, to enable some quantitative evaluation of the programme's effectiveness.

Therapeutic process

Research has consistently demonstrated that men who offend sexually against children are more effectively and efficiently treated by group therapy than in individual therapy (Marshall et al., 1999, pp. 35–36; Mussack & Carich, 2001, p. 4). Groups provide the opportunity for participants to confront one another's cognitive distortions, denials and minimisations; to experience vicarious learning; to monitor one another's behaviour outside the group setting; to develop relationships of mutual support and challenge; to develop social skills and empathy; and to experience therapist modelling of appropriate ways of relating to others. One comparison of multi-systemic therapy and individual one-to-one treatment (Borduin et al., 1990) found that the recidivism rate for those in the multi-systemic therapy programme was 12.5% after 37 months, whereas the recidivism rate for those in the individual therapy programme was 75%!

Within the Kia Mārama sexual identity groups, the predominant model employed is that of "individual therapy in a group setting". Because of the size of the group, and the limited number of sessions available, in reality only one or two intensive sessions with each participant are possible, for a period of some 20 minutes each. Nevertheless, this brief therapeutic intervention is reported by the participants to be effective, and "enough".

Individual work is balanced by careful attention to group process. Co-therapy is invaluable in this regard, as therapists tend to notice different things. The 2001 group, for example, split into two main subgroups. Seating plans (see Berne, 1963, pp. 4, 42–45; Berne, 1966, pp. 139–42) were recorded for each session, and where participants chose to sit mirrored the subgroup/s they belonged in. One group was characteristically passive, and invited "helping" if not outright "rescuing" behaviours. These members were slow to take initiative or claim group time. The other main subgroup was characteristically more verbal, active (although not consistently assertive), and inclined to adopt helping and rescuing behaviours.

Group process was confronted and integrated from and into individual therapy. For example, one participant entered into a contract not to engage in helping or rescuing behaviours within the group, and to attend to his own goals for change. This was broadened into a group contract not to accept, and indeed to confront, his attempts to be "helpful".

Similarly, when it was observed that the names of two participants were being infantilised (for example, "Bob" to "Bobbie"), and that those participants did not call

themselves by those names, a group contract was achieved concerning naming. This directly confronted symbiotic behaviour, discounting and passivity across the two major subgroups.

Minor subgroups (for example, "the gays", "the bisexuals", "the straights", "the cross-dressers", "the butch ones", "the camp ones") were evident and also impacted on group process. However, the group imago (Berne, 1963, 1966; Clarkson, 1992, pp. 204–227) developed relatively quickly (by session three) in ways that differentiated participants and therapists as individuals and not "types". I have been struck by the diversity within these groups, and the impossibility (not to mention the undesirability) of generalising about the participants as a class ("sex offenders").

Group feedback has strongly affirmed the value of individual therapy in a group setting. Participants observe that much of the work of the group is done outside the group, in individual reflection and informal discussion. For example, one participant reported that a brief (five-minute) piece of two-chair re-decision work (cf. Kasper & Alford, 1988) had helped, and that he had thought about it for a week following the group session and had acted on his re-decision by coming out to family members.

Others affirmed the value of the group as a place to reduce shame in talking openly and honestly about sexuality issues, and being listened to with respect and without being judged or rejected. For some, this prepared them for disclosure in other therapy groups, and also to break isolation and non-communication concerning sexuality in their general relating with other men, and with family and friends. At least four of the participants used the 2001 group as an occasion to "come out" to friends and family concerning sexual identity issues. Of equal value was listening to therapists work with others – learning by overhearing, and by identifying with parts of others' stories. Members reported that this facilitated insight, and reduced psychological and social isolation.

The groups run in 1999 and 2000 had both requested an extension to eight sessions, which was declined. In 2001, it was the therapists who felt the pressure of how little time was available for in-depth work with each participant. Yet the participants themselves indicated that six sessions were "just right". The model of individual therapy in a group setting, their reminder that much of the work is done outside the group, and their willingness to pace that work to their own needs, capacities and involvement in other therapy groups all supported a duration of six, 90-minute sessions. Group members similarly affirmed sessions being a fortnight apart, to allow time for integration of learnings and re-decisions.

Sexual identity in relation to sexual offending

The precise connection between sexual identity confusion and male sexual offending against children remains unclear. The following observations and reflections are offered on the basis of the three sexual identity groups run at Kia Mārama from 1999–2001.

1. The narratives recounted by participants indicate that experience of male sexual abuse as a child may invalidate or otherwise "turn off" homosexuality as a sexual identity for various reasons, and paradoxically open a door to deviant expressions of sexuality. Experience of childhood sexual abuse by men was disclosed as a factor by four of eight participants in the 2001 group.
2. Fear of rejection by family, friends and wider society figures significantly in resistance to affirming a gay or bisexual sexual identity. One participant reported that a family member had told him it was worse to learn that he was gay than to learn that he had offended sexually against children.
3. Fear of rejection is experienced in relation to certain power constructs within society. For a man to be rejected by a man generally carries greater emotional import than rejection by a woman, young person or child. Sexual identities, homophobia and sexual offending are alike constructed within a patriarchal model of structuring gender and power within a society (cf. Fone, 2000; Plummer, 1999).
4. Where a man whose sexual identity is homosexual enters into heterosexual relationships for companionship and/or social conformity, then sexual performance issues can create varying levels of anxiety. This anxiety may be relieved by seeking sexual gratification from someone perceived to have lesser power. Sexual performance and power issues were identified as a factor by six of eight participants in the 2001 group.
5. For men with a history of adolescent homosexuality (three of eight participants in the 2001 group), regression to sex with young adolescent males may be perceived as an easy option, representing familiar experience and a relatively low risk of rejection.
6. Social isolation and loneliness figure significantly in most participants' offence chains.
7. Participants generally have adopted dual or multiple lives to weave a web of secrecy and deception of self and others. One value of my own involvement as an openly gay therapist has been the modelling of the possibility of living an open, honest life as a gay man in society. Homophobia is fed by secrecy, and contributes to the social and emotional climate (especially withdrawal, isolation and loneliness) within

which sexual offending may occur. Seven of eight participants in the 2001 group explicitly affirmed a decision to lead open and honest lives.

8. Gender identity (rather than sexual identity) was an issue for one participant in the 2001 group. Cross-dressing (heterosexual transvestitism) was an issue for two participants, and a factor in the sexuality of a third. Although this was a "sexual identity group" aimed primarily at men who are or who think they may be gay or bisexual, others for whom no alternative group was able to be arranged nevertheless found this group to be helpful as a safe forum within which to disclose and discuss sexuality issues and their own sexual identity, and to break their social withdrawal and isolation.
9. Some participants desired information about sexuality, and particularly gay sexuality. This cannot always be merely responsive, as some do not know what they do not know. This may include information that mitigates against negative sexual stereotypes. Information that increases the range of options and increases autonomy of choice is welcomed by participants and may itself enable a sexual script re-decision. This highlights the need for a "culturally competent" therapist, and preferably an "out" gay man or lesbian.
10. The goal for a number of participants was expressed in terms such as, "knowing who I want to be and how I want to live my life". "Getting on with life" was characteristically contrasted with "getting away from", "getting rid of", and "getting nowhere" (cf. Ernst, 1971). Interpersonal withdrawal, discounting, passivity and symbiosis were acknowledged as characteristic of the behaviours of most if not all participants.
11. Three of six participants who attended all sessions in the 2001 group exhibited confusion about sexuality as something of an excuse or distraction from confronting offence chains; i.e., as a device for continued denial and minimisation. Within the group, such confusion was confronted both as a game ("What does being confused allow you to do – or not to do?") and as a script system masking repressed feelings of rage/anger and/or fear ("What are you angry at?" "What are you afraid of?"). Where sexual identity confusion is pursued as a game, to avoid confronting and owning offending behaviours, the issue for two participants appeared to be less one of sexual identity than of range of deviance and personality disorder. In such cases, the value of group rather than individual treatment was demonstrated, as transactions within the group provided both immediate material with which to work, and the basis for a detailed referral back to the therapists working with these individuals.

A potential research project

Two written questionnaires, both adapted for the New Zealand context, were distributed to participants in sessions one and six (see Davis et al., 1997, pp. 383–84, 392–95). These questionnaires concerned:

- Knowledge about homosexuality (Harris), and
- Attitudes toward homosexuality (Larsen/Herek).

At the time of running the 2001 group, we had been unable to obtain either the Sell Assessment of Sexual Orientation or the Baltar Sexual Identity Inventory. In the absence of either measure, the Kinsey scale was used (Kinsey et al., 1948), while recognising that this is a somewhat crude measure that fails to take account of the complexity and multi-dimensionality of sexual identity. Kinsey's ratings in fact represent a balance between the homosexual and heterosexual aspect of an individual's *history* (both psychological reactions and overt experience), and are not to be reified into a continuing *identity* (Kinsey et al., 1948, pp. 632, 636–59; Kinsey et al., 1953, pp. 468–76). So use of the Kinsey scale in the sexual identity group was balanced by the adapted Seligman model and a narrative style of presentation, and by the reminder that sexual identity is best understood on a continuum, rather than in discrete categories or a dichotomous, either/or framework.

Informing this broadly narrative approach was theory of sexual scripting in the diagnosis and treatment of sexual disorders. Sexual scripts are both storage devices for organising memories of past sexual experiences into meaningful narratives, and cognitive frameworks for overt sexual activity, including guidelines and "performance cues" for sexual activity (who, what, where, when, how and why), decoding both internal states and novel situations, setting the limits on sexual responses, and linking meanings from non-sexual aspects of life to specifically sexual experience. They function on three levels: the intrapsychic, the interpersonal, and the socio-cultural (Byers, 1996; Gagnon, 1990; Gagnon et al., 1982; Meston & Heiman, 2000).

It will be important for the future development of the programme to obtain and use a more precise and objective research measure to assess sexual identity and any changes in sexual identity. Self-evaluation and reporting (particularly across such a small sample) is coloured by internalised homophobia and perceptions of mid-scale ("straight – with a twist!") as more socially acceptable than a Kinsey score of 5–6.

However, the purpose of the sexual identity groups has not been to change the participants' sexual identity, but to facilitate clarity about sexual identity, specifically in relation to an individual's pattern of offending, in order to contribute to a reduced risk of recidivism.

Conclusion

It appears that sexual identity confusion may be a more significant factor in sexual offending against children than has previously been thought to be the case. The needs of offenders who are or think they may be gay or bisexual have not always been well attended to within treatment programmes. The sexuality group programme developed at Kia Mārama offers one model for better addressing those treatment needs within a comprehensive relapse prevention programme.

Involvement in developing the sexual identity group programme has reinforced for me personally the value and effectiveness of contractual group treatment, as a response to the frank recognition that it is difficult to be a healthy individual in a sick society. Male sexual offending against children is more than aberrant individual acts of violence. Sex offending takes place within a broader social context, within which children continue to be viewed as property or as objects, rather than as subjects and persons in their own rights, with their own rights.

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