**Individuals’ experiences of sexual offending therapy in a forensic psychiatric setting**

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**Abstract**

*There is a paucity of research exploring individuals’ experiences of sexual offending therapy, particularly in forensic psychiatric settings. This study qualitatively explored the perspectives of 6 male medium-secure patients of the treatment programme they completed to address their sexual offending behaviour. Thematic analysis of interviews generated two themes: The experience of transition through the programme; and the experience of engagement. The importance of gaining service-user feedback and the implications for programme design and delivery are discussed.*

**Keywords (6 words/phrases)**

Sex offender treatment; forensic mental health; qualitative; treatment engagement; treatment design; experiences of treatment

**Introduction**

The content of group-based sexual offending treatment programmes is informed by theoretical understanding of factors thought to be related to the risk of recidivism, such as sexual interests, offence-related cognitions, relationships and self-management (Andrews & Bonta, 2003; Hanson & Harris, 2000; Hanson & Morton-Bourgon, 2004). The way that group therapy is delivered (therapist characteristics, therapeutic alliance, and group process) is understood to impact on the effectiveness of treatment (Beech & Fordham 1997). Establishing the effectiveness of a theoretically-evolving evidence-based intervention on sexual recidivism is not straightforward although there are recent outcome evaluations which indicate positive treatment impact on recidivism (Losel & Schmucker, 2005). The majority of research on sexual offending treatment effectiveness has focused on recidivism and quantitative explorations of psychometric measures from prison-based programmes. Exploring the experiences of group members in treatment could provide nuanced information regarding effectiveness that quantitative data alone cannot deliver (Mann & Marshall, 2009; Wakeling, Webster & Mann, 2005), and could inform programme design (Walji, Simpson &Weatherhead, 2013). For example, a group member’s perception of treatment and therapists is likely to determine the engagement in treatment, rather than therapist self-ratings of their behaviours (Horvath, 2000; Orlinsky, Grawe & Parks 1994).

The few studies of individuals’ treatment experiences have mainly explored prison-based programmes in the UK (e.g., Colton, Roberts & Vanstone, 2009; Garrett, Oliver, Wilcox & Middleton, 2003; Wakeling et al, 2005), USA (e.g. Connor, Cope & Tewksbury, 2011; Grady & Brodersen, 2008; Levenson et al., 2014), and Canada (e.g. Drapeau, Korner, Granger & Brunet, 2004; Drapeau, Korner, Granger, Brunet & Caspar, 2005). Additional studies have explored views of community treatment (e.g. Collins, Brown & Lennings, 2010; Greary, Lambie & Seymore, 2011; Williams, 2004) and one has looked at treatment experiences in a high secure hospital setting (e.g. Clarke, Tapp, Lord & Moore, 2013).

The themes from the studies to date are summarised in a meta-synthesis completed by Walji et al. (2013). For example, group members’ motivation (intrinsic/extrinsic) determines whether engagement is meaningful or superficial (Drapeau et al. 2004; Garrett et al., 2003; Wakeling et al., 2005). The quality of interactions between peers and facilitators (supportive vs. critical/judgemental) impacts on the experience and ultimately success of therapy (Drapeau et al., 2005; Grady & Brodersen, 2008; Williams, 2004) and is highlighted as crucial for engendering feelings of reciprocity (Clarke et al., 2013; Collins et al., 2010; Day, 1999; Garrett et al., 2003). Victim empathy was consistently highlighted as an important component for cognitive and emotional change (Clarke et al., 2013; Grady & Brodersen, 2008; Levenson et al., 2014; Wakeling et al., 2005). Walji et al. (2013), suggest this may be because many group members have been victims themselves, and this part of treatment may be an opportunity for connections to be made between their own abusive experiences and offending. A further central theme across studies is the emotional difficulties experienced during the programmes, in particular in hearing other offences (Clarke et al., 2013; Wakeling et al., 2005), being labelled as ‘sex offenders’ (Clarke et al., 2013), and in being identifiable as ‘sex offenders’ and vulnerable to confidentiality breaches (Clarke et al., 2013; Drapeau et al., 2005; Grady & Brodersen, 2008). In general, group members thought that programmes contained key learning to help them understand their offending behaviours (Conner et al., 2011; Grady & Brodersen, 2008; Wakeling et al., 2005), but some raised concerns about applying learning outside of a protected environment (Clarke et al., 2013; Colton et al., 2009). In summary, it seems to be important to enhance participants’ motivation prior to treatment, to have skilled facilitators, increase support during programmes, give participants the opportunity to work through their own abuse histories, and consider how to reduce the stigma of attending such group work (Walji et al., 2013).

The experiences of group members are not a standard part of programme evaluation, but given that it is the individual experience that determines if and how treatment is completed, it seems to be an important consideration of treatment effectiveness (Drapeau et al., 2004; Wakeling et al., 2005; Walji et al., 2013). For example, it is understood that shame is a common experience among people who have committed sexual offences, one which can impact on treatment targets such as developing empathy or challenging cognitive distortions (Marshall, Marshall, Serran & O’Brien, 2009). Individuals with a history of sexual offending hold awareness that the public perception of them and their offending is unequivocally negative (McAlinden, 2005) and stigma is also experienced within secure services. So unlike the support, regard and encouragement that is shown for people who access therapy for non-offending reasons, people who have committed sexual offences might experience shame and fear in anticipation of treatment.

Sexual offenders within secure hospital settings face additional stigma of psychiatric diagnosis and there might be aspects of their experience of mental disorder that influence responsivity to treatment. For example, secure hospital patients often present with a history of significant trauma related to enduring intra and inter personal difficulties that can make engaging in treatment challenging for both clients and therapists alike (Jones, 2009). Treatment therefore requires increased responsivity and formulation-driven planning and sequencing, to enhance effectiveness with such complex needs (Garrett and Thomas-Peter, 2009; Jones, 2009). Understanding how sexual offenders in secure hospitals experience offence focused group treatment could be critical to informing programme design and delivery for these individuals who pose a unique, often long-term, challenge for the criminal justice system. To date, there is a paucity of research on the exploration of experiences of forensic mental health service users (Coffey 2006) and sexual offending treatment experience more specifically.

There is a complex relationship between treatment, punishment, and liberty when considering treatment engagement in secure settings. Glaser (2010) argued that treatment is often imposed as a sanction and therefore lacks true consent. Moreover, some therapeutic strategies include the intentional infliction of ‘harm’, such as cognitive restructuring (where the individual has to feel uncomfortable to facilitate change) which could be defined as punishment (Glaser, 2010). Conversely, Prescott and Levenson (2010) offer a position that therapy includes clear aims of rehabilitation and enhancing wellbeing, delivered by trained therapists, and is therefore not punishment. This debate is important for the development of effective and ethical approaches to treatment (Ward, 2010). However, what has been absent from the debate thus far has been the perspective of the individual in treatment and this is likely to be important to understand (Horvath, 2000; Orlinsky et al., 1994).

With a view to understanding how content, facilitator and programme design factors contribute to long-term detained mentally disordered offender perspectives of engagement in sex offender group treatment, this research aimed to explore the perspectives of group members who took part in sexual offending therapy, designed and delivered in two medium secure hospitals in the UK.

**Method**

*Design*

Semi-structured interviews explored the experiences of male service-users who had completed a group sexual offending treatment programme. The research was part of a broader service evaluation for which approval was obtained from the audit committee and director of each hospital.

*Description of the Programme and Delivery*

The Sexual Offending Therapy (SOT) programme was developed in 2010 by the lead author of this paper and colleagues under the supervision of a specialist external supervisor (a co-author of this paper). The programme was designed to meet the complex needs of individuals with mental health difficulties/personality disorders and convictions for sexual offending, often with histories of difficulties engaging in the therapeutic process. The programme was initially run in one private medium secure hospital, and was then rolled out to a second hospital in the same service delivery unit in 2011 under the supervision of the same external supervisor. Three group programmes were delivered between April 2010 and November 2013. The lead author of this paper was a facilitator on the two groups delivered at the initiating hospital. Participation on the programme was voluntary, i.e. individuals chose whether or not to consent to take part. It is, however, acknowledged that by being in a secure hospital setting progression through the system requires individuals to evidence they are gaining insight and reducing risk, which will inevitably impact on the experience of programme engagement as ‘voluntary’.

All facilitators were subject to an application, selection and training process and received ongoing specialist supervision.

The programme was based on a cognitive-behavioural framework, adopted a strengths-focus, and was designed in line with the ‘what works’ literature (Fernandez, 2006; Mann & Marshall, 2009; Ward & Fisher, 2006). The group programme consisted of:

1. A Foundation Programme: A non-offence-focused preparatory programme to increase familiarity with group work, build cohesion, gain insight, and increase skills and motivation. The programme was approximately 26 sessions (depending on group size and need) and covered modules including: Introducing key concepts (old me/new me Haaven & Coleman, 2001, the ‘Good Lives’ model), understanding mental disorder, problem solving, and social skills, understanding relationships/attachment, and sharing key life experiences.
2. The offence-specific programme: This 10-13 month programme comprised three modules. Group members completed the three modules twice to promote depth of learning and consolidation.
* **Understanding my development**: Attachment, sexual development and schemas.
* **Understanding my offending behaviour**: exploring risk factors linking to offending, perspective taking, consequences, sexual fantasy, and links to personality and other offending behaviours.
* **Staying strong as New Me:** developing and practicing management strategies for identified risk factors through relapse prevention work.

Individual assessment, formulation and preparation preceded the group, and individual support sessions were available throughout. The group sessions ran twice a week for two and a half hours. The same cohort worked through the foundation and offence-specific programme. The content was designed to be delivered responsively and interactively, with a range of visual (images), auditory (an audio case study of an additional group member which was played at the beginning of each new module), and kinaesthetic (role-play, chair work) exercises, tailored to the individuals’ learning styles, cognitive ability, and previous engagement in therapy.

*Participants*

All group members who completed the SOT programme between 2010 and 2013 were approached to take part in the study. Of the nine completers, six agreed to take part in the study after being provided with an information sheet and written consent form. Each participant was assigned a pseudonym to preserve anonymity. Table 1 summarises the sample demographics.

Three men dropped out of the SOT group. One was relocated to his funding catchment area; one completed the foundation module but was not ready to progress to the offence-focused programme; one dropped out after a few sessions of the foundation module and perhaps the timing of the intervention was not best matched to his capacity to respond at that time. Non-completers were not approached to participate because the study aimed to evaluate the whole group experience.

*Materials*

A semi-structured interview schedule was developed which included questions on expectations and experiences, such as “what did you think the group would be like?”, “what was your actual experience of the group?”, “what were the things that made a difference to you in the group?” and “what do you know about yourself now that you did not know before?”.

Table 1: Participant demographics

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Pseudonym** | **Age in years**  | **Diagnosis** **(by Psychiatrist using ICD-10)** | **Length of detention at start of programme** | **Offence/s and victim characteristics** | **Summary of previous convictions \*\*** | **Attended previous group SOT?** |
| Mark | 50-60 | Dissocial, narcissistic PD\* | 20-25 years | Rape, ABH of known adult female | Acquisitive, sexual, substance, violence | No |
| Steven | 30-40 | Paranoid Schizophrenia | 15-20 years | Rape, attempted abduction of stranger adult female | Sexual, violence, acquisitive, substance | No |
| Jason | 30-40 | Paranoid schizophrenia | 10-15 years | Indecent assault, attempted rape of stranger adult female | Sexual, violence, acquisitive  | No |
| Darren | 30-40 | Mixed PD\* | 10-15 years | Indecent assault of known teenage female | Sexual | No |
| Liam | 60-70 | Dissocial, narcissistic PD\* | 30-35 years | Attempting to strangle with intent to rape (female child, stranger), Gross indecency (female child known) | Sexual, violence | Yes |
| Jack | 40-50 | Emotionally Unstable PD\* | 20-25 years | Indecent assault, ABH (3 x known male children) | Sexual, acquisitive | Yes |

\*PD = Personality Disorder

\*\* Acquisitive = burglary, theft; Sexual = rape, attempted rape, indecent assault, sexual intercourse with underage female, buggery; Substance = substance related offending, possession of illicit drugs; Violence = robbery, arson, manslaughter

*Procedure*

Interviews were conducted by a clinician with experience of facilitating sexual offending group and individual therapies. Interviews were conducted after the six consenting participants had completed the SOT group and they had received their end of therapy reports. Individual interviews were selected over focus groups to enhance confidentiality of discussion of group experience and ranged from 19 minutes to 63 minutes. All interviews were audio recorded and transcribed verbatim.

*Analytic approach*

The transcripts were analysed by the lead author using thematic analysis (Braun & Clarke, 2006). An inductive semantic approach was adopted so that a framework of interpretation was not enforced and group members’ interpretations of their experiences could be understood. Thematic analysis allows content-driven analysis that aims to capture rich detail and a range of experiences within the data, thus reflecting the “reality” of individual experiences (Braun & Clarke, 2006). Braun and Clarke’s (2006) six steps for thematic analysis were used and involved repeated reading of the data for familiarisation, generating initial codes across the entire data set, searching for and then reviewing and refining themes until there were clear themes, definitions and extracts which reflect the story of the analysis. The coding of one transcribed interview was quality reviewed by a co-author.

**Results**

Two superordinate themes each with three subordinate themes were identified (see Figure 1).

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*Theme 1: Experience of Transition Through the Programme*

This superordinate theme describes the participants’ experience of initial negative perceptions of treatment, to the development of an understanding of self and offending, reconciling with a past sense of self and constructing a new self.

*Initial negativity*

Participants felt “reluctant” (Steven) and “apprehensive” (Jason) about attending SOT and some felt coerced to attend, experiences that were central to initial perceptions of treatment:

I was more than sceptical… I hated it. I mean I felt that I’d been forced, in fact. I even used the word at that time coerced into doing it… so my attitude was really quite closed. I assumed that I wouldn’t achieve anything. I just expected to turn up every week and go through the motions. I was full of fear, and it wasn’t just fear of failure, but it was also fear that I might fail in some way, and as a consequence it would set me back (Mark).

Some of the initial negativity was also based on previous difficult experiences of group work and more specifically the fear of stigma related to offending:

I got kicked out of nearly every [non-SOT] group I’ve ever been in…I wasn’t necessarily looking forward to it because of how other people were treating the group in various places …I was disruptive and just couldn’t be bothered…there were some stories I’ve heard that not all the group members would have the same offence…so would be bullying and pressure. I was guarded. I was concerned (Darren).

Referral to sexual offending therapy triggered a range of intense feelings and thoughts about the self that are important to understand as a part of a long-stay secure patient experience of SOT. The fear of how to cope with the content and whether they will “get through it” (Liam) and “other peoples’ feelings about this type of offence” (Darren), can mean that individuals enter treatment in a guarded manner, and may intend to “pay lip service… just say what I think you want to hear” (Jack), such are the perceived consequences for not engaging in terms of progression through a care pathway. Although these experiences might be a common reflection of anxieties of engaging in group-based SOT, the participants here raise unique sensitivities to long-stay secure patients in the context of accumulation of group therapy experiences.

*Coming to terms with old self*

Participants talked about their experience of SOT in terms of a process of self-acceptance, addressing shame, sharing parts of their life that had been previously hidden, and learning to live with their offending:

I hadn’t spoken about a lot of what I’d spoke about in the room for most of my life… I’ve always kept it a secret...And I think that’s what the group was mostly to do … it made me learn not to hate yourself, but learning to accept who you are, accept that you’re a person who’s done some bad things. And those bad things don’t make you who you are. Well, not entirely, they make up an aspect of you. But they’re not who you are as a person completely, you’re not the crime (Darren).

Participants spoke about shame acting as a barrier to openness (to themselves and others), and once they felt safe in the group environment they could share their life and as a result start to accept responsibility for their behaviour whilst separating it from their identity:

I began to accept that I can’t change the past… but I can actually change what I’d become… going through the programme for the first time helped me vocalise stuff that I’d never spoke about before and talk on aspects that before I’ve avoided… I began to realise that although I’m totally responsible for what I did I don’t have to be a bad person for the rest of my life … I think this feeling of shame that I had for being a sex offender, I mean it was crippling. It stopped me from fully acknowledging my responsibility really…I think for the first time in my life really I can be honest with myself.

The programme seemed to provide an opportunity for individuals to face, express and start to accept aspects of their life and offending which linked specifically with the stigma of sexual offending. To that extent, ‘coming to terms with old self’ is inextricably linked with the subordinate theme relating to negative perceptions that participants held on embarking on the programme. Furthermore, it might be that the experience of shame (and possibly a ‘double deviance’ of offending and mental health problems; e.g. Gausel & Thørrisen, 2014; Gronholm, Thornicroft, Laurens & Evans-Lacko, 2017) as a barrier to self-exploration and treatment engagement contributed to the lengthy periods of detention for these participants.

*Positive sense of new self*

Participants expressed how their experience of the programme has resulted in a more positive outlook for the future. Mark commented “I know where I’ve come from, I know the type of man that I did turn into …and I have some confidence with that, some self-belief…my future is… something which I can achieve”.

Participants also described how their learning positively impacted on their sense of self, encouraging them to want to be “a role model” (Steven) for others, and “not want to go back to crime again” (Jason). Darren talked about how the programme has helped him go “back to … my true nature. And my true nature is about helping someone rather than hurting them”. Similarly Liam expressed:

I’ve more confidence, where I was not confident before…I feel more confident, I feel more able and in control of myself, where I was letting things be in control of me in the past, …I’m more in control of myself now than I’ve ever been… Yeah, it’s made me a much better person. I feel it inside.

Through overcoming initial negativity, learning about their past, and coming to terms with their old self, it seems that participants were left with a more positive sense of self and hope for the future.

*Theme 2: The Experience of Engagement*

This superordinate theme reflects participants’ experiences of engaging in SOT and how the mode of delivery, facilitator style and peer and external support mechanisms had an impact on internalising the therapeutic process.

*Preparation as part of engagement*

Participants valued the foundation module in preparing them for the offence-focused work. The non-offence-focused preparation programme seemed to work on a number of levels including building trust and reducing fear of group participation:

The foundation module was great because it gave us all the chance to get to know each other … it built that connection… I realised that actually I don’t need my guard up. I don’t need to be protecting myself. And the more open I am the more I’m going to get out of this… And I think that shows just how effective the foundation module really is. I think that was more effective than any of us realised, because you get to know someone for who they are before you actually know about anything they’ve done (Darren).

Participants spoke about how a preparation programme offered a gradual introduction to the content and intensity of offence-focused therapy and enabled them to become established in treatment and remain with emotionally challenging work:

I was quite reluctant and withdrawn at first it was hard to get things out, but the way the group was set up was like it drew you out instead of avoiding stuff. It’s like an initiation thing, like breaking the ice and stuff…You’re finding your feet and you know which direction it’s going to take you instead of being put in the main group and you’re kind of scared off … instead of jumping into the deep end, you wade in the shallow end and then go deep (Steven).

Jason highlighted that “going straight into something like this…a couple of us would’ve thought ‘I can’t handle this’ and maybe just walked out”. Given the complex presentations of the participants engaging in this treatment programme, mental health and personality disorder diagnoses, and the initial negativity, the foundation module seemed to be a key part of meaningful engagement in treatment and in minimising attrition.

*Learning and consolidation*

One of the key aspects that participants described as helping their learning was the way the programme was delivered:

It was adapted to fit all three people within the group, yet still doing a group work. And I think that takes a certain degree of skill, to actually have effectively three individual sessions being one as a group. And it was adapted to fit all three of us as we are, not just one way and that’s it. It’s made to fit me as a person, how I think and how I see things. And once you do that it’s easier for me to understand things, it means I can learn better (Darren).

Mark commented:

There was various techniques used to bring home the information, not just a whiteboard, but cubes and diagrams … this technique of using A4s on the floor and actually allowing myself to stand on a card or talk from a card… was both visual and verbal.

Several participants also mentioned how helpful they found the use of role-play (Jack, Mark, Darren and Steven) and valued the use of an audio case study called ‘Mitch’ presented through the programme. Participants described how they “felt like he was in the group” (Jack) and that listening to the audio meant people could “relate to him” (Liam) which helped with “talking about it and not avoiding” (Steven). Group members talked about the audio case study as if he was real, saying “It just put you at ease that someone’s actually gone through the course before you” (Steven) and “Mitch in the end got out…so that was a lot of encouragement and hope for me and also the others as well” (Liam).

Another aspect that was unanimously raised as aiding the engagement process was the small group sizes (between three and a maximum of five members), thought to be effective because:

I’ve known in my past experiences of large groups… they didn’t work and it was just a waste of time at the end of the day…. Large groups don’t work because you’re not given that opportunity, you’re not given that time, … [a smaller group] made me feel a lot more comfortable, a lot more able to express what I’m trying to express, because you had that personal touch (Liam).

Participants thought the one-to-one work alongside the programme was “ideal” (Darren), and highlighted that it offered “support after the event” and helped to “interpret meaning” and “unwrap emotional problems” (Mark). Completing the three modules of the offence-focused programme twice and the length of the programme, seemed to help consolidate learning: “the second time we knew more so we could see more…we could recollect and say ‘oh yeah we missed this out’” (Steven).

*The therapeutic process*

Participants highlighted how working with peers was a central part of the therapeutic process and was beneficial for several reasons. The group helped to normalise experiences - “listening to others helped” (Jack) – so that participants thought “my story wasn’t exceptional or radically different from other people’s problems and troubles” (Mark). Peer working also helped with learning:

Prior to the group I was very dismissive and quite angry…because I thought they [other group members] would hold me back in some way…when really it was quite the reverse because when I started to acknowledge to myself that some guys needed a different type of help…it was one of the first steps I made in being more capable of perspective taking.

Darren highlighted the importance of peer challenge and support:

I know I couldn’t have done that on a one-to-one, there still wouldn’t have been that open frankness that you get from other guys in the group… it’s sort of a tough love sort of thing, but I think it works really well. It kind of brought out my compassion side a bit more, which was starting to fade at that point… The only thing that mattered then was the group. And I think because that connection had already been made between us all.

Consistent with previous research (e.g. Beech and Fordham, 1997), participants thought the group was “easier” (Liam) to engage in because the facilitators were “understanding” (Jack), “encouraging, concerned and polite” (Liam), and had “patience, fortitude and conscientiousness” (Mark). Steven described how these characteristics “made you come out of your shell into the light…they wasn’t judging us, they were teaching us, educating us”. Darren highlighted that even if there were facilitators that “pushed certain buttons”, “you learn to cope with a situation that outside could be a flashpoint”. He also highlighted, along with Jack, that “working as an entire unit” and “not feeling like them and us” was a contributing factor to experiencing the programme positively.

A way to improve the therapeutic experience was suggested by two participants. Both Darren and Mark suggested training ward staff in the programme so that they could “acknowledge the skills that are being used” (Mark). Darren thought:

 The [nursing] staff should also be trained enough to know when you’re having a rough group and how to help you through that… how to support someone within that group situation or when they come back on the ward from having a particularly tough group.

*Participant follow-up*

Table 2, below, summarises individual progress through secure care since completion of the programme between 2010 and 2013.

Participants were detained for between 10 and 35 years prior to starting the SOT. All had spent time in prison and high secure care during this period of detention and secure care, indicative of the complexities of this client group. The follow-up information highlights that since completion of the programme four individuals were discharged to the community, and two were stepped down to lesser security to address ongoing risks. Although it is not possible to align progression with the SOT programme uniquely, there has nonetheless been positive movement through care plans on the basis of risk judgments and potentially improved risk management plans.

Table 2: Participant follow-up data

|  |  |  |  |
| --- | --- | --- | --- |
| **Pseudonym** | **Length of detention at start of programme** | **Summary of detention prior to current placement** |  **Progress since completion of programme** |
| Mark | 20-25 years | Prison, high security hospital, medium secure hospital |  | Discharged to the community |
| Steven | 15-20 years | Prison, medium secure hospital |  | Low secure hospital ward |
| Jason | 10-15 years | Prison, medium secure hospital |  | Discharged to the community |
| DarrenLiamJack | 10-15 years30-35 years20-25 years | Prison, high secure hospitalPrison, high secure hospitalPrison, high secure hospital, medium secure hospital, high secure hospital |  | Discharged to the communityMoved to lesser security and engaged in maintenance workMoved to lesser security then discharged to the community |
|  |  |  |  |  |

**Discussion**

The themes presented herein reflect the experiences of long-term detained mentally disordered offender perspectives of engagement in a sex offender group treatment delivered in two medium secure hospitals in the UK. Participants’ experience of transition through the programme highlights how treatment can facilitate a process of change across the sub themes of ‘initial negativity’ and, through developing an understanding of early life experiences and how this links to offending, ‘coming to terms with old self’, and ending the programme with a ‘positive sense of new self’, consistent with previous research (e.g. Clarke et al., 2013; Conner et al., 2011; Drapeau et al., 2005; Grady & Brodersen, 2008; Garrett et al., 2003; Wakeling et al., 2005; Walji et al., 2013). However, the themes emphasised experiences of fear (of self-learning, of the behaviours and judgements of others, of confidentially breaches, and feeling forced or coerced into treatment) and shame as influencing participants’ approach to treatment. It is possible that these concerns were barriers to engaging in or completing previous group-based treatments and sexual offence focused work, which might have contributed to the lengthy periods of detention in secure services. In line with Marshall and Moulden (2006) and Prochaska and DiClemente (1983), the preparation programme seemed to have been helpful to the participants in this regard; fears were allayed or managed, shame was addressed by helping to separate a group member’s identity from their offending behaviours. Attending to experiences of shame and fear preceding treatment might support engagement and risk reduction. The long-stay secure hospital men in this study were either re-engaging with group SOT or embarking on this intervention for the first time and the narratives of past therapy are not known. The follow-up data would suggest that engagement with group SOT was one of a number of factors that contributed to positive care pathway progressions. For change to occur and be meaningful an individual has to want to change (internal motivation), and there is evidence that participants moved from a position of treatment as coercive (e.g. Glaser, 2010) towards treatment as being ‘therapeutic’ (Prescott and Levenson, 2010). Whilst it would be naïve to conclude that desirable responding may not be present for *some* aspects of *some* participants’ communication of their experiences, it is unlikely that this is a fair or accurate sole interpretation of the themes presented here, not least because the quality of engagement would have been integrated into professional risk-based decisions about care pathway progression and management.

Peer support and challenges, and facilitator qualities such as support and acceptance were valued by participants in the experience of engagement and the therapeutic process, consistent with previous research (Clarke et al., 2013; Conner et al., 2011; Drapeau et al., 2005; Grady & Brodersen, 2008; Garrett et al., 2003; Wakeling et al., 2005; Walji et al., 2013). Sharing experiences in a group had the benefit of participants feeling less isolated, more understood, and better about themselves (Clarke et al., 2013), and offered an opportunity for interpersonal dynamics which themselves become part of the learning process, and are unlikely to be replicated in individual therapy. It is likely that the therapeutic relationship and climate in terms of facilitating change helped participants to make a transition from initial negativity to positive sense of self (Beech and Fordham, 1997). It seems that a well-managed group setting can provide therapeutic benefits for a secure hospital population, where the complexity of symptomatology often results in debates as to how offence-focused work might be tolerated by clients.

The aspects of programme delivery that supported engagement, learning and consolidation included a range of visual and experiential techniques and programme delivery in two cycles with additional one-to-one support. This links with research on learning styles whereby individuals who experience trauma in early life may as a result have neuro-processing difficulties making it difficult to engage with the standard approach of treatment (language-based ‘talking therapies’: Creedon, 2004; Hocken & Daniels, 2013). This is likely to be a relevant consideration in working with people in secure hospitals, and might help to overcome therapy interfering behaviours. For example, the use of an audio case study (as a pseudo-additional group member whose life experiences were ‘played’ at the beginning of each new module) enabled participants to relate to and connect with the character that resulted in increased comfort in sharing their own experiences. This reflects neuropsychological research into the power of storytelling and ‘transportation’ and the associated impact on memory and changing beliefs (Green & Brock, 2000). An additionally valued component of programme design was having small group sizes; increased responsivity for this high-need, high-complexity population, whilst being resource intensive, seems desirable and could account (at least in part) for the positive transition through the programme and beyond.

**Limitations**

Firstly, the sample size is small and limited to a forensic psychiatric population in medium secure care in the UK which has implications for generalisation. Factors which are likely to have influenced interpretation of data include the multiple roles held by the lead author as researcher, co-author and facilitator of the SOT programme. Although measures were taken to address these limitations through the research team, they will invariably have had some impact on interpretation of themes. Perhaps more critical to data quality is the influence of these multiple roles on participant responses, who were aware of these multiple roles. It is also important to highlight that there might have been extrinsic factors influencing the perspectives of the participants based on the status of their detention and having to rely on professional opinion to progress through the system. By conducting the interviews after end-of-programme reports had been disclosed, and reiterating anonymity and separation from clinical progress, this aimed to keep the likelihood of positive bias to a minimum however remains a noteworthy possibility. Lastly, the evaluation only explored the views of those who completed the entire programme and not any non-completers who would have had their own (perhaps different) experience of the pre and initial stages of SOT.

**Implications and Recommendations**

The complexity of working with individuals with mental disorder who have been detained in prison or secure care for lengthy periods of time suggests that smaller groups with supporting individual sessions, and highly responsive content and delivery style make for positive therapeutic experience. Skilled therapists are imperative to offer the necessary support to clients and facilitate complex peer dynamics, supporting the importance of therapist selection, training and ongoing supervision. Preparation programmes seem to serve a number of functions including increasing intrinsic motivation and building group cohesion that perhaps contribute to the generation of a safe space within which to sit with experiences of shame and overcome fear that might have contributed to initial negativity about group SOT engagement.

There is value in further exploration of group members’ experiences of treatment of sexual offending, especially in relation to the under-studied populations of forensic psychiatric settings. Particular directions for research may include further understanding the role of shame and fear as barriers to treatment and the duality of treatment as being coercive and therapeutic. Not only will this develop understanding of how to support individuals pre-treatment but may also help with understanding why some individuals do not start treatment or disengage partway through. Exploring individual experiences of after-care (both inside and outside hospital) could also be a sensible direction for further studies, particularly in the context of the application of learning and evaluation of the support they receive or perceive to be required.

Recommendations for strategies to potentially enhance engagement (subject to further exploration) include: develop pre-programme materials and offer individual preparation sessions which include the same responsive, interactive, empathic approach highlighted from group experiences; work in conjunction with previous group members to draw on their unique insight into what might make a difference to promote meaningful engagement; extend the therapeutic process beyond the group room, for example training ward staff to support people on a programme and developing a peer support programme; give consideration to the name of the programme to reduce the risk of confidentiality breaches; reflect more broadly on the language used in both academia and clinical settings - the label of ‘sex offender’ carries stigma and undermines the process of separating offending behaviours from an individuals’ identity, which is critical in addressing shame and fear, enhancing a positive sense of self and therefore promoting desistance.

In summary it seems that having a preparation programme, a responsive interactive delivery style, and a supportive therapeutic climate impacted on the experience of engagement for participants in the SOT and were valued in facilitating the transition throughout the programme. This supports the need for increased flexibility and responsivity in working with a forensic psychiatric population.

**References**

Andrews, D. A., & Bonta, J. (2003). *The Psychology of Criminal Conduct (3rd ed.).* Cincinnati, OH: Anderson

Beech, A., & Fordham, A. S. (1997) Therapeutic climate of sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment,* 9, 219-223*.*

Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology.* 3(2), 77-101.

Clarke, C., Tapp, J., Lord, A., & Moore, E, (2013). Group-work for offender patients on sex offending in a high security hospital: Investigating aspects of impact via qualitative analysis. *Journal of Sexual Aggression.* 19, 50-65

Coffey, M. (2006). Researching service user views in forensic mental health: A literature review. *Journal of Forensic Psychiatry & Psychology,* 17, 73-107.

Collins, E., Brown, J., and Lennings, C. (2010). Qualitative Review of Community Treatment With Sex Offenders: Perspective of the Offender and The Expert. *Psychiatry, Psychology and the Law*. 17, 290 -303.

Colton, M., Roberts, S., & Vanstone, M. (2009). Child sexual abusers’ views on treatment: A study of convicted and imprisoned adult male offenders. *Journal of Child Sexual Abuse: Research, Treatment & Program Innovations for victims, survivors, and offenders.* 18, 320-333

Connor, D. P., Cope, H., & Tewksbury, R. (2011). Incarcerated sex offenders’ perceptions of prison sex offender treatment. *Justice, Policy Journal.*8

Creeden, K. (2004). Integrating trauma and attachment research into the treatment of sexually abusive youth. In M. C. Calder (Ed.), *Children and Young People Who Sexually Abuse: New Theory, Research, and Practice Developments*. Lyme Regis, Dorset: Russell House Publishing.

Day, A. (1999). Sexual offender views about treatment: A Client survey. *Journal of Child Sexual Abuse.* 8, 93-103.

Drapeau, M., Korner, A., Granger, L., Brunet, L., & Caspar, F. (2005). What sex abusers say about their treatment: Results from a qualitative study on paedophiles in treatment at a Canadian penitentary clinic. *Journal of Child Sexual Abuse.* 14, 91-115.

Drapeau, M., Korner, C. A.,Brunet, L. & Granger, L. (2004). Treatment at La Macaza Clinic: A qualitative study of the sexual offenders’ perspective. *Canadian Journal of Criminology and Criminal Justice.*  46, 27-44.

Fernandez, Y. (2006). Focusing on the positive and avoiding the negativity in sexual offender treatment. In Marshall, W., Fernandez, Y., Marshall, L., &Serran, G (eds). Sexual offender treatment: Controversial issues. John Wiley & Sons ltd: West Sussex.

Gausel, N., and Thørrisen, M. M. (2014). A theoretical model of multiple stigma: ostracized for being an inmate with intellectual disabilities. *Journal of Scandinavian Studies in Criminology and Crime Prevention*, *15*(1), 89-95.

Garrett, T., Oliver, C., Wilcox, D. T., and Middleton, D. (2003). Who cares? The views of sexual offenders about the group treatment they receive. *Sexual Abuse: a journal of research and treatment.* 15 (4).

Garrett, T., & Thomas-Peter, B. (2009). Interventions with sex offenders with mental Illness. in Beech, A., Leam, C., and Browne, K. (eds) Assessment and Treatment of Sex offenders. Wiley-Blackwell:Oxford

Geary, J., Lambie, I., and Seymour, F. (2011). Consumer perspectives of New Zealand community treatment programmes for sexually abusive youth. *Journal of Sexual Aggression.* 17, 181-195.

Glaser, B. (2010). Sex offender programmes: New technology coping with old ethics. Journal of Sexual Aggression. 16, 261-274.

Grady, M. D., & Brodersen, M. (2008). In their voices: Perspectives of incarcerated sex offenders on their treatment experiences. *Sexual Addiction & Compulsivity.* 15, 320-345.

Green, M., & Brock, T. (2000). The role of transportation in the persuasiveness of public narratives. *Journal of Personality and Social Psychology*. 79, 701-721.

Gronholm, P. C., Thornicroft, G., Laurens, K. R., & Evans-Lacko, S. (2017). Mental health-related stigma and pathways to care for people at risk of psychotic disorders or experiencing first-episode psychosis: a systematic review. *Psychological Medicine*, 1-13.

Haaven, J.L., & Coleman, E. M. (2001). Treatment of the developmentally disabled sex offender. In Laws, D., Hudson, S., & Ward, T. (eds), Remaking Relapse Prevention with Sex Offenders. California: Sage.

Hanson, R. K., & Harris, A. J. R. (2000). Where should we intervene? Dynamic predictors of sexual offence recidivism. *Criminal Justice and Behaviour,* 27, 6-35.

Hanson, R. K., & Morton-Bourgon, K. (2004). *Predictors of sexual recidivism: An updated meta-analysis.* Ottawa: Public Works and Government Services Canada.

Hocken, K., and Daniels, M. (2013). Working with trauma and learning styles in sex offending. Presentation: ATSA: Chicago.

Jones, L. (2009). Working with sex offenders with personality disorder diagnoses. In Beech, A., Leam, C., and Browne, K. (eds) Assessment and Treatment of Sex offenders. Wiley-Blackwell:Oxford

Laws, D., R., Hudson, S., & Ward, T. (2000). The original model of relapse prevention with sex offenders: Promises unfulfilled. In Laws, D., Hudson, S., & Ward, T. (eds), Remaking Relapse Prevention with Sex Offenders. California: Sage.

Levenson, J., Prescott, D., and Jumper, S. (2014). A Consumer Satisfaction Survey of Civilly Committed Sex Offenders in Illinois. *International Journal of Offender Therapy and Comparative Criminology.* 58, 474-495

Losel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology, 1,* 117-146.

Mann, R., & Shingler, J. (2006). Schema-driven cognition in sexual offenders: Theory, assessment, and treatment. In Marshall, W., Fernandez, Y., Marshall, L., &Serran, G (eds). Sexual offender treatment: Controversial issues. John Wiley & Sons ltd: West Sussex.

Mann, R. E., and Marshall, W. L (2009). Advances in the Treatment of Adult Incarcerated Sex Offenders in Beech, A., Leam, C., and Browne, K. (eds) Assessment and Treatment of Sex offenders. Wiley-Blackwell:Oxford

Marshall, W. L., Marshall, L. E., Serran, G. A., & O’Brien, M. D. (2009). Self-esteem, shame, cognitive distortions and empathy in sexual offenders: their integration and treatment implications. *Psychology, Crime & Law, 15, 217-234.*

Marshall, L., & Moulden, H. (2006). Preparatory programs for sexual offenders. In Marshall, W., Fernandez, Y., Marshall, L., &Serran, G (eds). Sexual offender treatment: Controversial issues. John Wiley & Sons ltd: West Sussex.

Marques, J. K., Wiederanders, M., Day, D. M., Nelson, C., & Van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California’s sex offender treatment and evaluation project (SOTEP). *Sexual Abuse: A Journal of Research, Treatment, and Evaluation, 17,* 79-107.

McAlinden, A. (2005). The use of ‘shame’ with sexual offenders. *British Journal of Criminology. 45, 373-394*

Orlinsky, D. E., Grawe, K., Parks, B. K. (1994). Process and outcome in psychotherapy—Nocheinmal. In A. E. Bergin & S. L. Garfield (Eds.), *Hand- book of psychotherapy and behavior change* (4th ed., pp. 270–378). New York, NY: Wiley.

Prescott, D., and Levenson, J. (2010). Sex offender treatment is not punishment. *Journal of Sexual Aggression. 1-11.*

Prochaska, J. and DiClemente, C. (1983) Stages and processes of self-change in smoking: toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 5, 390–395.*

Walji, I., Simpson, J., & Weatherhead, S. (2013). Experiences of engaging in psychotherapeutic interventions for sexual offending behaviours: A meta-synthesis. *Journal of Sexual Aggression.*

Ward, T. (2010). Punishment or therapy? The ethics of sexual offending treatment. *Journal of Sexual Aggression. 16, 286-295.*

Ward, T., & Fisher, D. (2006). New Ideas in the treatment of sexual offenders. In Marshall, W., Fernandez, Y., Marshall, L., &Serran, G (eds). Sexual offender treatment: Controversial issues. John Wiley & Sons ltd: West Sussex.

Wakeling, H. C., Webster, S, D., and Mann, R. (2005). Sexual offenders’ treatment experience: a qualitative and quantitative investigation. *Journal of sexual aggression.* 11 (2), 171-186.

Williams, D. J. (2004). Sexual offenders’ perceptions of correctional therapy: What can we learn? *Sexual Addiction & Compulsion.* 11, 145-162.