ARTICLE KINDLY WRITTEN FOR StopSO

Written in 2017. Put online April 2018

Shame and Sexual Offending

By Dr Andrew Smith

The following article will briefly explore notions of shame and guilt, before discussing shame issues in relation to working with individuals who have committed a sexual offence, particularly against a child. Therapists' own shame issues are discussed with regard to working with sex offenders, with reference to 'vicarious traumatisation'. The challenges of therapists overcoming their own shame responses in order to move clients from a debilitating right-brain state of shame to an enabling left-brain state of guilt are depicted, a transition theorised to more likely promote rehabilitative change. In order to illustrate points I will use qualitative research data from male sex offenders and probation officers interviewed (Smith, 2009), data which is also relevant to psychotherapists working with sex offenders.

Shame and sex offending Shame and related forms - embarrassment, disgust and stigma – can be viewed, positively, as regulating anti-social behaviour. Shame, for instance, has been utilised restoratively, through 're-integrative shaming', whereby an offender meets his victim to learn about the harmful consequences of his actions. However, for this or any other form of rehabilitation to be effective, Maruna argues that an offender must develop a 'redemptive script' of his life through therapy, where his essential 'good self' is developed or re-established (Maruna, 2001), a rehabilitative journey also conceptualised as transitioning from shame to guilt.

Such a distinct dualism between shame and guilt can be viewed as a social construction, an arbitrary narrative of particular professional discourses. However, the therapeutic journey from shame to guilt can provide a conceptualised framework for working with sex offenders who experience high levels of shame, and there is research evidence indicating rehabilitative benefits of helping clients escape a shame-saturated identity.

Many sex offenders have deep-seated attachment problems and have experienced trauma and abuse. DeYoung (2015) relates chronic shame to such dysfunction and lack of adequate attunement by care givers. Taking a psychoanalytical and neuro-scientific perspective, Shore (2012) posits how good enough parenting inculcates a positive 'ego ideal', hardwiring the message that *I should give myself a bad time if I fall short, but not that bad a time* (a functional left-brain guilt response). However, pre-rational shame impulses are predominantly located in the right brain hemisphere. If shame is linked to early developmental problems, the offender will be unable to engage with a rational consideration of guilt, until the early attachment and trauma wounds are tended to by a therapist, providing consistent emotional attunement and regulation missed out by the client in childhood. Once this is achieved, then the following left-brain, strengths-based cognitive-behavioural rehabilitative goals can be worked towards, although the treatment pathway for each individual will be different:

- *Meeting social, emotional and sexual needs in pro-social rather than anti-social ways*
- *Enhancing emotional regulation*

- *Restructuring cognitive distortions (if motivated)*
- *Raising awareness of consequences of offending (if motivated)*
- *Encouraging a safe, but satisfying sexual fantasy life*
- *Safety planning.*

Many sex offenders do not only have to cope with subconscious, right-brain shame, but also left-brain conscious awareness of the pariah status of having a sexual conviction, compounding deep lying shame schemas. The shame of sexual offending becomes their 'master status' or 'extended identity', where the offence becomes the person.

> *… No; it's with you until you bloody die. You know the hate you feel for yourself. Well the disgust … you wake up it's there. (Offender 1)*

Instinctive disgust about sexual abuse of children is magnified by the mass media search for attention-grabbing headlines, trading in pantomimic good and evil archetypes within a risk-averse society that demands protection from its folk devils, be it terrorist or sex offender, independent of the objective risk of sexual re-offending.

Female sex offenders can suffer from an additional source of shame, with their sexual offending activating collective unconscious archetypes of 'loving mother' and 'terrible mother'. The loving mother is idealised: the 'terrible' one split off, and projected onto the demonised other, a purging process rendering female sex offenders as particular repositories of shame.

Issues of shame for therapists

When working with victims of sexual abuse, the potential for 'vicarious traumatisation' is significant. Pearlman and Saakvitne (1995) posit that although there is some overlap with 'burnout', vicarious traumatisation is not simply emotional exhaustion or a consequence of the gap between clinical aspirations and the often emotionally-draining reality of everyday clinical work, as in 'compassion fatigue'. Unlike transference and countertransference, vicarious traumatisation is not connected to a specific client or relationship. It occurs cumulatively across time and place and, in addition to classic trauma symptomology, can result in disruption to the therapist's sense of identity, world view and spirituality, triggering the therapist's shame about indifference or even hostile feelings towards clients. Pearlman and Saakvitne describe graphically the impact on therapists of constant engagement with the cruelty, depravity and on-going harmful consequences of sexual abuse.

> '*Vicarious traumatisation can leave the therapist serious, cynical, sad. He may develop an increased sensitivity to violence, or be prone to bouts of grief and despair for humanity. It can affect his ability to live fully, to love, to work to play, to create*' (Pearlman and Saakvitne, 1995, p. 281).

For practitioners working with sex offenders, engagement is more problematic as the perpetrator can often also be a victim of sexual abuse and other traumas.

The majority of victims of sexual abuse do not go on to sexually abuse others although the evidence from my clinical practice is that many sex offenders have suffered sexual abuse. In addition to being sexually abused, many perpetrators who I have worked with have been exposed to a set of interlinked, highly stressful abusive life experiences, including experiencing and witnessing violence.

If one is to provide holistic therapy to sex offenders then this must include, as Shore argues above, addressing right-brain victim issues related to attachment, trauma and shame problems, enabling the offender to eventually engage in left-brain cognitive-behavioural work, more typical of orthodox sex offender rehabilitation programmes. This requires the forming of a therapeutic alliance based on the three 'core conditions' of unconditional regard, congruence and empathy.

As already discussed, such close engagement with the lives of victims, and empathising with abuse experiences, can lead to vicarious traumatisation. However, fear of getting too close to offenders' accounts of sexual abuse can result in the practitioner becoming additionally emotionally conflicted, concerned about the overlap between empathy and collusion.

> *… it's almost trying to think the unthinkable … trying to put yourselves (in the offender shoes) … and then of course if you do start thinking that, you know the slippage things about standards and morals almost … but yeah, I think … the tendency for any suggestion of any sort of collusion is guarded against … you know that I don't nod in the wrong place.* (Probation Officer 6)

If the therapist has not worked through personal experiences of abuse and disempowerment, this may compound the sense of emotional conflictedness, with a potential for punitive or punishing practice to ensue, resulting in a shame reaction on the part of the worker. Working with offenders who deny and minimise their sexual offending, a common phenomenon, can lead to workers feeling deskilled, leading to cynicism and moral outrage.

> *I think it's on the detail that people try to wriggle away, or minimise their offending, so I suppose it's about being able to be dispassionate so you know that any revulsion you might feel, you've got to get beyond that.* (Probation Officer 5)

Such hostile feelings towards clients can undermine the therapist's ego ideal, again producing a shame response.

Providing therapy to sex offenders often entails dealing with the here-and-now distress of not being able to have contact with their children, because of (usually necessary) child protection issues, and rejection by family and friends. Some individuals who have committed a sexual offence do go on to build a constructive, non-offending lifestyle, although the road is often hard, and some offenders remain on the outside of society, looking in. Ongoing therapeutic engagement with the colossal negative impact on a person's life of committing a sexual offence, can be attritional, an additional source of vicarious traumatisation.

Another source of therapist shame can be intrusive sexual thoughts about abusive sexual material disclosed by the client. Erotic transference between therapist and client is a well-documented issue, with sexual transference and counter-transference issues being fairly routinely discussed in supervision. However, experiencing voyeuristic interest in deviant sexual acts or such acts triggering arousal in the therapist can be particularly shame-inducing.

If the client sexually re-offends whilst on the practitioner's watch, catastrophic thoughts can arise in the therapist's mind about professional censure, or being named and shamed. When I train therapists for StopSO (Specialist Treatment Organisation for the Perpetrators and Survivors of Sexual Offences), the most anxiety-inducing topic is "what would happen if a client offended?" As with suicide or any other form of harm, there can of course never be any guarantees, even after all good practice guidelines have been adhered to (a discussion of which is outside the scope of this article). However, the prospect of suffering public shame if a client commits a sexual offence against a child, is perhaps greater with this client group than with any other.

> *I know my other colleagues feel like this, you think 'Oh my God, they are going to come and look at my stuff' (records).* (Probation officer 11)

For the clients I work with, the most damning conferred identity is that of 'paedo', and many professionals who work with sex offenders fear shame by association. A process of feared moral contamination and pollution can be at work, through contact with this demonised client group.

Conclusion

In order to work effectively with sex offenders, therapists need to have worked through their own personal shame issues, often through their own therapy. They also need to be able to acknowledge, understand and share vicarious traumatisation symptomology with a supervisor who understands this phenomenon and the particular potential shame issues attendant on working with sex offenders. Good supervision can hopefully enable therapists

to keep perspective, leading to a healthy work-life balance, avoiding the dual therapeutic evils of over or under emotional involvements with clients. For many sex offenders who are suffering from early attachment and trauma problems, it will be necessary to address right-brain shame issues through the healing qualities of the therapeutic relationship over time, before addressing left-brain cognitive restructuring.

References

DeYoung , P. A. (2015) *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach.* New York, London: Routledge, Taylor and Francis Group.

Maruna, S. (2001) *Making Good: How Ex-convicts Reform and Rebuild their Lives.* Washington: American Psychological Association.

Pearlman, L.A. and Saakvitne, K.W. (1995) *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. New York and London: W.W. Norton and Company.

Shore, A. (2012) *The Science of the Art of Psychotherapy*. New York: Norton.

Smith, A. (2009) *Sex Offenders and the Probation Officers who Supervise them: How Relevant are Strengths-based Approaches?* Doctoral thesis for Cardiff University School of Social Sciences. Online. Available HTTP: http://orca.cf.ac.uk/55909/1/U584448.pdf (accessed 24 Aug 2016).

DR ANDREW SMITH BIOGRAPHY

Dr Andrew Smith has worked in the area of sex offending for 13 years. He has been awarded a PhD on strengths-based approaches to sex offending, and is a regular contributor to journals and books. His book - *Counselling Male Sexual Offenders: A Strengths-focused Approach* - is a forthcoming publication from Routledge. He is a qualified probation officer and counsellor, and now works as an independent consultant.