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Individual psychoanalytical psychotherapy with perpetrators of sexual abuse

Anne Zachary

Victims of child and other forms of sexual abuse receive increasing attention and resources but it is often difficult to extend the same kind of understanding and possibilities of treatment to their perpetrators. Many of the perpetrators have been victims themselves, which is often a major reason for their having developed in such a way; sometimes the offenders are virtually children themselves (Royal College of Psychiatrists, 1994*b*).

Few places can offer substantial treatment to this group of people and the current trend is for punishment rather than treatment, despite the implementation of the Sex Offender Treatment and Evaluation Project programmes in prisons in recent years (Beckett *et al*, 1994), and the sex offender programmes offered by the probation service. These are short-term behavioural approaches but it is becoming widely accepted, particularly in the forensic field, that only a psychoanalytical understanding and long-term treatment of these psychopathologies can hope to approach a cure, and this by indirect means. Increasingly, particularly following the Royal College of Psychiatrist's inquiry into the problems at Ashworth Hospital (Royal College of Psychiatrists, 1994*a*), the long and established psychoanalytic tradition at the Portman Clinic, which offers psychoanalytic psychotherapy to people with perversion and delinquency, is looked to for both assessment and treatment and also for teaching (Welldon & Van Velsen, 1996).

Range of psychopathology

Sexual abuse arises out of sexual deviations, paraphilias and perversions. Psychoanalysis retains the term perversion for theoretical reasons, stemming from Freud's definition (1905):

> "... psychoanalytical teaching ... shows that it is by no means only at the cost of the so called normal sexual instinct that these symptoms originate ...; they also give expression to instincts which would be described as perverse ... if they could be expressed directly in fantasy and action. Thus symptoms are formed in part at the cost of abnormal sexuality; neuroses are, so to say, the negative of the perversions."

While neurotic symptoms emerge as a result of repression of unacceptable sexual thoughts, perversions occur when there is acting-out of sexual impulses without any thought (see e.g. Gillespie, 1956; McDougall, 1978; Glasser, 1979; Chasseguet-Smirgel, 1985; Stoller, 1986; Limentani, 1989; Zachary, 1997). Perpertrators may abuse children (paedophila or incest), engage in illegal homosexual practices, for example cottaging (soliciting anonymous men in public toilets), look up women's skirts (voyeurism) or touch them (frotteurism), indecently expose themselves (exhibitionism) or indecently assault others, perform acts of sexual violence such as rape (male or female), or work as prostitutes (male or female). Much more recently, it has been recognised that women can also be perpetrators of sexual abuse towards children (Welldon, 1988). This is very difficult for society to come to terms with in view of the universal closeness of mothers to their children but it can happen and probably has much to do with the future development of perversion.

Practical and theoretical considerations

Transference and countertransference are fundamental to a psychoanalytical approach (see Box 1).

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Box 1. Psychoanalytic psychotherapy

The unconscious
The internal world
Mechanisms of defence
Transference
Countertransference
Therapeutic alliance
Interpretation

Specific to the abuser
The meaning of the offence
Re-enactment of previous trauma
Reversal of a state of helplessness
Maintenance of fragile sense of identity
Sexualisation of aggression
Sado-masochistic mode of relating
Core complex (Glasser, 1979)

This concerns the way in which the subject relates to the therapist, based on early experience with parental figures and the responses elicited in the therapist. The neutral setting offered by the therapist is both a powerful stimulus to this interaction and an effective container of the potential for violence and acting-out if the familiar parameters of same time, same place, same therapist are rigorously observed. It is striking how effectively some subjects (carefully determined by assessment) can be contained in treatment surroundings without formal security if these parameters are observed.

In the perverse act an unconscious need to enact a sexual scenario is fulfilled, and morality, authority and rules are defied. This is associated with intense sexual excitement and may be re-enacted in the neutral setting provided by the therapist. Incidents of sexual abuse may be reported with the intention of either shocking or abusing the therapist. The therapist then finds him or herself confronted with a dilemma that is a reflection of the conflict in the individual's mind. Is the therapist going to condone such a cruel act by remaining silent or offering psychological interpretation, or is he or she going to condemn and thus punish the person in one way or another?

The sexual excitement comprises a sexualisation of aggression into sadism. The relationship between the perpetrator and the victim is often sado-masochistic and often this is also the quality of the transference. The countertransference needs to be managed very carefully to avoid being locked into a re-enactment of the symptoms. For example, relief in the therapist if the subject misses sessions or arrives consistently late must be examined and taken up with the person.

The object relations observed in the therapeutic setting are often at a narcissistic level and a blurring of ego boundaries is characteristic of narcissistic states. The perpetrator might claim to 'know' what is expected of him during treatment and behave in such a way as to 'give him or her (the therapist) what they want'. This parallels the claim that many subjects hold in respect of the children they abuse, that is, the perpetrator 'knows' what the other is thinking and feeling. Unlike many other narcissistic character disorders, in the paedophile this dynamic has become intensely sexualised.

Perversion is more than just a symptom or collection of symptoms. Glasser (1979) writes convincingly about the structure of the subject's internal world, demonstrating that the perversions are specific diagnoses. They arise from a particular psychopathology involving the relationship between the perpetrator and the victim which is a representation both of the internal object relationships and of the relationship between the ego and the superego. He uses a concept he calls the "core complex" to describe the circular nature of feelings: a need to merge with the object; a fear of being engulfed by the object; a fear of being annihilated; withdrawal and subsequent feelings of abandonment. This core complex is widely seen in the transference.

McDougall (1978) has done much to help us to see people with these problems as more acceptable by viewing their behaviour as creative. She approaches their problems as a defence against psychic destruction (the need for psychic survival is paramount and is widely accepted as the reason for such psychopathology), and then describes in detail how each aspect of a perversion, each tiny detail of a compulsive sexual scenario serves the purpose of keeping thoughts out of the mind, which avoids any experience of psychic pain.

Assessment

It is essential to test the person's own motivation about treatment. A state of helplessness is often aggravated by a prison sentence and if the only motivation is in either the referrer or the potential therapist, then the therapeutic alliance will fail. Psychotherapy can only ever be voluntary for the same reason and is never formally a condition of sentence. Cooperation within the professional network allows for creative arrangements where, for instance, the probation officer holds the statutory responsibility to ensure that there is treatment as dictated by sentencing and the person chooses

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psychoanalytic psychotherapy. If it should fail, an alternative can then be insisted upon. Dangerousness, both in the community and in the treatment setting (the possibility of concrete re-enactment of the acting-out) needs to be assessed carefully, bearing in mind that most psychotherapy is carried out in an out-patient setting, which is to be recommended in terms of improved efficacy. During assessment the therapist looks for some verbal skill, though this can increase remarkably as treatment is established, and for 'psychological-mindedness' with some capacity to look at the details of the perverse behaviour and ascribe emotional meaning to it. Capacity to receive intepretations and to endure mental conflict and pain, and whether the individual can contain their feelings both within the treatment setting and between sessions (usually once a week) without too much risk of re-offending, are important. This is often to be expected in the early stages and during breaks and, within reason, is responded to sympathetically by the courts when attendance and the therapeutic alliance are strong. There is some understanding of the breakdown of defences that treatment is designed to achieve, and the subsequent risk of a need to offend at times. When assessing the severity of the offences and the safety of others this possibility must be taken into account.

Management and confidentiality

The issue of confidentiality (see Box 2) is a wide one and concerns arise within the community around such perpertrators and their victims in terms of what should be reported, when and by whom. While psychoanalysis demands confidentiality this is often held in a collective sense in institutions for the safety of all and for the increased benefit of the individual. Confidentiality has certain limits. When explored legally these limits are rarely encroached upon and confidentiality is more usually bound by clinical judgement.

Box 2. Important issues arising in therapy

- The complicated matter of disclosure
- The severity of disturbance in perpetrators of sexual abuse, which makes 'treatability' very difficult
- How members of an institution can work together to keep thinking alert and attempt to deal with both disclosure and treatability

For professionals a common worry is that a person in therapy might disclose otherwise unknown information about child sexual abuse, so indicating that a child or children are at risk. The importance of multi-disciplinary communication and support has been emphasised (Williams, 1992) but it is difficult to achieve in a constructive, reflective manner in which thought is kept alive. It is important that the groundwork should have been undertaken before treatment begins so that the multi-disciplinary relationships are in place to protect everyone concerned – perpertrators, children and professionals alike. Agreed policies developed in collaboration with social services and child protection teams are helpful in managing inter-professional issues and ethical dilemmas arising in work with perpetrators and their families and other victims (King & Trowell, 1992).

An example of a developed network exists at the Portman Clinic. The importance of carefully thought-out professional relationships is stressed, as is the need to avoid precipitate action. Impulsive reaction to disclose, whatever the setting, whoever the professional, has to be contained by the organisational structure encompassed by the treatment agency and the policies developed in conjunction with social services. Often, a professional will be faced with a bewildering number of conflicting sets of guidelines. The first imperative when concerned is to discuss the situation with a colleague, usually a senior colleague. Clinical judgement then takes into account fact *versus* fantasy and the risk/actuality of further or ongoing offending *versus* the greater good of society if the perpertrator can continue uninterrupted in treatment. With the setting held firm, interpretation is a very powerful mechanism with which to induce responsibility and/or appropriate help-seeking within the subject. Often, a case will have both a therapist and a clinical manager who will communicate, if necessary, with outside professionals. Where the family constellation is complicated several members of staff might be involved (see Case study) and the relationships which develop between the staff around the family can be studied to understand and enable change in the family dynamics.

Effect on the professional

Management of the countertransference needs careful thought and outside support in the form of

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supervision, personal therapy and team-work with colleagues. In these ways attempts are made to avoid further re-enactment of the trauma within the treatment. Otherwise, the mindlessness of the original abuse operates again, for instance in punitive responses within the treatment or rigid adherence to guidelines and procedures without initial reflection on the role of each professional involved and whether what is being dealt with is fantasy or reality.

Case study

Mr S. came from a large family and had a deprived background. He was abused at the age of eight by a male lodger. Trying to deny this he married early and was proud of his 'ideal' family. A perverse internal structure had been created in order to survive his trauma, and problems arose when he began to feel needy because his wife was preoccupied with the children. This repetition of what it was like to be with his mother led to an urge to repeat his homosexual experience by cottaging.

He came to seek help from the Portman Clinic when this developed further into a frightening urge to act out with his teenage son. He expressed an enormous need which was an indication of the degree of risk, yet expected the clinic to keep his secrets.

Initially, the task was to help him to disclose the risk to his son by telling, in the first instance, his wife. Unfortunately, this happened not in a disclosure of his fantasy but by acting it out one night by going to his sleeping son's room and masturbating him. He then brought his wife to the clinic, both of them in great distress.

In this way he 'forced' his way into treatment and the first stage of this was an active encouragement of his disclosing himself to social services. Meanwhile, his wife was also seen regularly, for support and as the effective parent. The son was subsequently offered an assessment in view of his seeming lack of protest at the assault.

Box 3. Summary of case study

Secrets
Homosexual activity
Fantasy of abusing son
Abuse of son while he slept

Interpretation
Expectation that the clinic would not act on the knowledge of the abuse, as his son had slept, to help the perpetrator keep his secrets

Outcome
The perpetrator reported himself to social services and temporarily moved out of the family home

The dilemma in treatment is that if the perverse structure is addressed it can breakdown, uncovering more severe psychopathology. This can often be what brings a person to seek help. Mr S. was using his cottaging defensively as a means of survival but then found that it extended to a fantasy of incest. When his regular practices were no longer secret he acted out his incest fantasy and then later, made a serious suicide attempt in which his murderousness towards the object (whether primary, for example towards the mother, or transferential, that is towards the therapist) is also apparent.

Mr S. constantly involved the staff team at the clinic in a representation of his perverse internal world, and working together was essential to keep thinking alert. An important interpretation was the expectation that the clinic would 'sleep' in the knowledge of the abuse. In this way it was possible to address the complicated issue of disclosure and the risks involved in uncovering the severe psychopathology of the perpetrator of child abuse in treatment. Not long after treatment began, the perpertrator himself went to social services and temporarily moved out of the family home.

(This case study originally formed part of a series of presentations at the start of the first Royal College of Psychiatrists' multi-section conference on 'Cycles of Abuse' in London, September 1994.)

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Mutiple choice questions

1. The response elicited in the therapist by the perpertrator is:
   a transference
   b countertransference
   c punishment
   d indifference.

2. The following names are particularly associated with perversions:
   a Freud
   b Glasser
   c Jung
   d McDougall.

3. Disclosure of possible ongoing abuse is:
   a mandatory according to laid down policies and not requiring thought
   b the purpose of psychotherapy
   c a matter for the clinical judgement of the therapist in conjunction with colleagues
   d rarely necessary if the groundwork is done before therapy begins.

4. Motivation for therapy:
   a must be present in the perpertrator
   b is reliant on the referrer
   c is built into the court sentence
   d is an essential part of assessment.

5. Personal therapy is:
   a recommended for those working with sexual abusers
   b always twice a week
   c only part of recognised training schemes
   d to be avoided while treatment of an abuser is ongoing.

MCQ answers

1	2	3	4	5
a F	a T	a F	a T	a T
b T	b T	b F	b F	b F
c F	c F	c T	c F	c F
d F	d T	d T	d T	d F

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