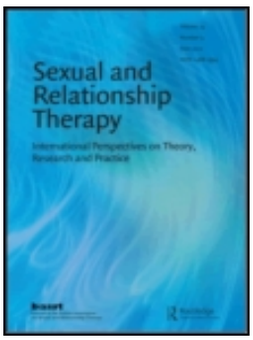

Routledge
Taylor & Francis Group

Sexual and Marital Therapy

ISSN: 0267-4653 (Print) (Online) Journal homepage: http://tandfonline.com/loi/csmt19

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To cite this article: Anthony Bateman MRCPsych & Eric F. Mendelson MRCPsych (1989) Sexual Offences: Help for the forgotten victims, Sexual and Marital Therapy, 4:1, 5-10, DOI: 10.1080/02674658908407868

To link to this article: http://dx.doi.org/10.1080/02674658908407868

LEADING COMMENTS

Sexual Offences: help for the forgotten victims

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Introduction

In recent years a healthy and welcome interest in helping victims of sexual offences has been mounting. However, in our enthusiasm to help the direct victim of sexual offences we could easily forget the needs of the two other parties involved in the traumatic incidence: the partner of the victim and the offender. Some of them need help as much, and in some cases even more, than the direct victim. These two comments highlight the needs of these two groups and describe some positive and practical attempts to meet these needs.

Helping the Partners of Rape Victims

Ever since Burgess & Holmstrom (1974) described the rape trauma syndrome, a great deal of attention has been given to the psychological and behavioural reactions of women who have been raped (Rose, 1986). They reported that the victim initially suffers from feelings of humiliation and anxiety, somatic complaints, sleep disturbance, nightmares, fear, suspicion and anxiety, and that this is followed by a later phase of depression, guilt, self-blame, sexual problems and social dysfunction. The majority of victims are thought to recover within 3–4 months of the rape although some may continue to be distressed for longer (Sutherland & Scherl, 1970). Recent studies (e.g. Mezey & Taylor, 1988) have confirmed these earlier findings.

In contrast very little attention has been paid to the effect of rape on the victim's partner and how his reaction may interfere with the successful adaptation to what has happened on the part of the victim. Approximately 50% of rape victims have a partner or are living with their family although only 15–20% are married. Silverman (1978) felt that male partners and family members of rape victims are subject to the same misunderstanding, prejudices and mythologies surrounding rape as the general public and may secretly feel, for example, that 'nice girls are not raped' or that 'she must have asked for it'. Clearly any expression of these beliefs, if

only indirectly, will serve to heighten the victim's own sense of guilt and personal responsibility. This may result in difficulties in the emotional relationship of the couple at a time when support, empathy and understanding are needed. Bateman (1986) described a characteristic psychological and behavioural syndrome in the partners of rape victims. Initially there is a phase of anger invariably directed towards the rapist, lasting 5–7 days. This is followed by a protective phase in which avoidance activity occurs. For example, the partners may fortify their house with locks, irrespective of where the rape took place, accompany the victim everywhere or insist on them 'reporting in' at pre-arranged times; they avoid TV programmes which contain scenes of violence or sexual activity and some men scan newspapers and magazines to remove any mention of rape before the victim sees it. This phase is, at first, accompanied by marked anxiety, tension and restlessness but after a few months a depressive phase emerges associated with guilt and sexual difficulties and it is often the partner who avoids sexual contact rather than the victim. In some cases the partner may be so identified with the rapist that he fears that he will become like the rapist if he has sexual intercourse with his wife or girlfriend.

Clearly these responses in the partner will interfere with the successful rehabilitation of the victim and the involvement of partners is therefore essential. Interestingly, consideration of the reaction of a partner as a possible variable when studying the outcome of treatment for the victims of a sexual assault is rare.

In this country the majority of work with rape victims is carried out by untrained volunteers who work within a supportive network of a victim support scheme, often in conjunction with the police. Initially the helper needs to educate and advise the partner about the emotional and behavioural reactions he may suffer from, as well as those the victim will experience.

The helper must also be knowledgeable about police procedure and legal proceedings in order to support the partner and help him not to feel as powerless and useless as he often does. Knowledge of these matters will assist the partner in helping the victim overcome her difficulties and forewarn him of his own potential reactions especially those which prevent the victim regaining an autonomous life. Most importantly the helper, more often a woman, needs to be aware of her own reactions to the responses of the partner especially as many men will appear to control and dominate the victim's life by becoming over-protective. This may too easily provoke hostility in the helper who may view it as further evidence of the domination of men over women rather than understanding that it results from the man's struggle to overcome his own distress, hurt and humiliation. If the helper can understand this she will be able to allow the partner to ventilate his feelings and assist him in reducing the conflicts that have been stirred up by the rape. Only if he begins to place them within the context of his own life will he be able to help his girlfriend or wife to do the same. Often both victim and partner will need to be seen together in an attempt to facilitate a joint understanding of the problems they are facing.

It is often not appreciated that the partners of rape victims may need treatment in their own right and not solely as an adjunct to the treatment of the victim. A number of partners remain seriously troubled many months after the rape. They

become profoundly worried about their identity as men, shun their male friends, avoid sexual contact with their partner and withdraw from regular social interaction. These individuals may need more intensive psychoanalytic psychotherapy if they are to begin to understand what it means for them that their partner has been raped.

ANTHONY BATEMAN

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Sex Offenders—anyone to help?

Following on the greater concern for victims of sexual assaults, there is now an increasing interest in helping the offenders. An enthusiasm which is mostly welcome, but not universally. Some, such as Glasser (1988), raise questions as to whether they are significantly different from other offenders and justify a greater degree of help, which will distract limited resources away from those with mental illness or from other criminals with equally distressing psycho-social problems. But West (1987), argues that sex offenders are deserving, as they tend to feel there is something wrong with them, unlike ordinary criminals, and that many have urges which most of their fellow citizens do not have to bear or struggle against. Yet the problem remains suprisingly small, albeit that a proportion is unreported; in England and Wales sexual offences amount to less than 1% of recorded crime (Home Office, 1987). Whatever the ultimate merits, at the very least, treatment helps to assure the courts and society that something positive is being done, and serves offenders by allowing them to deal with their guilt by the penance of having to attend.

The United States has been at the forefront of developing pioneering and varied approaches to treatment, using individual and group therapies, including major components of self-help, based in the community, residential units, prisons and psychiatric hospitals. The Dutch also have a humanitarian system, with a 'confidential Doctor service' where suspected cases can be investigated, treatment arranged and whenever possible prosecution avoided. A working party of the Howard League (1985) have produced a succinct review of these facilities. Clinical experience indicates that latterly there has been a decline in the use of inpatient care

in managing these offenders. Certainly, in Britain there has now to be evidence of a prominent mental illness, or psychopathic personality disorder in a very disturbed but obviously well motivated individual, for this care to be offered instead of a custodial sentence.

Although it is not known whether a group or individual approach is a more efficient treatment, current fashion is in favour of the former. For over 3 years the writer and colleagues have been running a treatment service in the community based on group therapy (Mendelson *et al.*, 1988). The project employs the main and widely accepted principles of treatment, but in a highly structured manner. The weekly sessions last 90 min and follow a programme of six, which continuously repeat enabling frequent entry and discharge points. Members are expected to attend for two or three treatment cycles and longer if considered necessary.

The first session focuses on the potential ruinous consequences for the offenders, in order to enhance perception of deterrent factors and recruit motivation for the work ahead. Lengthy prison sentences, beatings from the other inmates and animosity from their local communities are some of the horrors elicited from members. The second and third groups concentrate on the many possible adverse effects on the victims. Two sessions are needed as guilt is often a powerful block to them appreciating the harm and accepting full responsibility. In the fourth session, behaviour and fantasies which led them ino sexual offences are explored so that they can gain a better understanding of the factors involved, such as how masturbation to deviant fantasies and unacceptable pornography only reinforces their undesirable urges. With this greater insight, the fifth group discusses strategies and psychological techniques for reducing and resisting temptation. Here there are only two specialist concepts. Covert sensitization: the rehearsal of deterrent scenes in fantasy, which when re-enacted serve as an aversive stimulus and negate expected gratification—especially important at moments of temptation. For example, an offender will stop himself by imagining his own particular nightmare, be it the disgrace of another court appearance or facing an angry mob of inmates. Secondly, orgasmic reconditioning: the gradual shaping of deviant inclinations into those of a more appropriate nature, through approximating masturbation with images of acceptable partners.

Pornography can be useful in helping individuals progress to fantasies of appropriate sex with adults. The final group of the cycle is spent on social rehabilitation, learning the skills to attract and maintain an adult partner, as well as the development of alternative sources of pleasure through hobbies and other leisure pursuits.

Group work is not suitable for everybody, and even those who agree to it may need individual help as well. Other approaches should also be considered. Libidinal suppressants can be useful (Berlin & Meinicke, 1981), particularly in the few offenders who have very powerful urges which either cause them great distress or fear that their reserves of willpower will not hold out. If these drugs are given together with other therapies, after improvement, a phased withdrawal can be begun. Psychodynamic interventions will also have a place in the armamentarium (Cox, 1979). Where the offence has been committed within a family then it may be

judicious to provide help to all, using a programme of family therapy (Furniss *et al.*, 1984).

Evaluation of treatment is extremely difficult in this field, requiring carefully matched controls and follow up over a lengthy period. While we await a study which can address these issues and tell us whether these programmes are any more successful in reducing recidivism than the disappointing results from therapeutic interventions aimed at other offenders, it seems parsimonious to direct our attempts at those likely to re-offend. Unfortunately, but understandably, therapists tend to select those who will be rewarding to work with, often married men who, in association with marital frustrations, abuse the children. But as West (1987) concludes, "The typical sex offender appears in court once only and never again". Follow-up studies indicate that single men, particularly offenders against boys, and those with poor social functioning are at greater risk (Fitch, 1962).

Furthermore, the likelihood of reconviction dramatically rises with the number of previous sexual offences (Phillpotts & Lancucki, 1979). Therefore, those unappealing, isolated, single, men who lack verbal or social skills, often of dull intelligence, resentful, and with past offences—are those at greatest risk of offending, and surely deserve to be a priority for treatment programmes.

In the planning of treatment it has to be noted that many will become dependant. Moreover, in these vulnerable individuals discharge may herald reoffending, therefore treatment will need to have a mutually acceptable end point. Finally, and as a testament to the rewarding nature of this group work, the writer has observed that the therapists develop a striking attachment to their work and can rarely be prized away!

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