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Commentary OMICS International

The Importance of the Therapeutic Alliance When Working with Sexual Offenders

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Abstract

While there is general agreement in the literature regarding the importance of the therapeutic alliance in psychological interventions with people, the forensic context raises some unique challenges. This paper will discuss the significance of the therapeutic alliance in interventions with offenders, especially sexual offenders and the impact on treatment efficacy and change. Therapist characteristics will also be reviewed as well as some of the obstacles and challenges present in a correctional setting, which can impact on the therapeutic alliance. Lastly, the role of transference and countertransference is also considered.

Keywords: Sex offenders; Therapeutic alliance; Therapeutic relationship; Transference; Countertransference

Commentary

The importance of the therapeutic alliance when working with sexual offenders

The therapeutic alliance (TA) is a fundamental component of the therapeutic process. Over the past few decades the importance of therapist characteristics including the TA has been emphasised in the literature [1]. Despite the TA being identified as essential within therapeutic interventions, it appears that therapists' understanding of the TA remains unclear as does an understanding of how to develop an effective TA particularly with sexual offenders [2]. This appears to be further complicated when working with offenders generally, but sexual offenders more specifically. It is the aim of this paper to revisit the conceptualisation of the TA and how it may manifest practically, especially for those working with sexual offenders. The importance of the TA for treatment engagement and outcome, client change, as well as the therapist characteristics which enhance the TA will be considered. A review of the potential obstacles to therapists working with offenders, such as system factors, common approaches to offenders, dual roles and confusion about effective therapist qualities will follow. Finally, the importance of transference and countertransference within the therapeutic relationship will also be discussed, which is seldom considered with the forensic population. Please note that the term therapist and psychologist will be used interchangeably throughout this paper.

Therapeutic alliance

TA's origins were psychodynamic in nature, first mentioned by Freud [3] in his work examining transference and countertransference as significant aspects for process and change in psychoanalysis. TA remained rooted in psychodynamic theory until further work, which has since been expanded upon and is currently conceptualised as the relationship between the therapist and the client. Rogers [4] then highlighted the importance of the patient's experience of therapist empathy and the concept of alliance as a core feature of effective intervention. Later on, Bordin [5] defined the alliance as having "three features: an agreement on goals, an assignment of the task or a series of tasks, and the development of bonds". More specifically, tasks or specific activities "that need to be undertaken to facilitate change in psychological therapy; goal, the aspect of the alliance that most centrally relates to achieving therapeutic change; and bond, the development of trust and an ability to negotiate within the therapeutic relationship" [6].

Rogers [4] suggested that warmth, empathy and genuineness on the part of the therapist are both necessary and sufficient qualities within a therapeutic context. Yalom [7] suggested that the relationship between the therapist and the client generates a "healing power", which without renders the therapeutic relationship useless. A strong TA facilitates feelings of safety and trust, both of which are necessary for therapeutic change [8]. Thus developing a collaborative working relationship with a client is paramount and this is particularly relevant for unmotivated or resistant clients, such as offenders.

The TA can be further conceptualised as the interpersonal factors of a relationship between a psychologist and a client. These factors entail empathy, warmth, positive regard, directiveness and respect. While some researchers have suggested that the TA is more reflective of therapist variables, the client does not come into therapy as a 'blank slate'-they bring their own personalities, experiences, expectations and motivations which necessarily impacts on therapy and the TA [9].

The issue of how to define the TA is a difficult one because each theory tends to have a different definition of what constitutes the TA [9]. For example, in a review of the literature regarding process variables in the treatment of sexual offenders, Marshall et al. [10] suggest that the TA is a product of the therapist's style and the offender's perception of the therapist. Martin et al. [11] suggest that the TA refers to the collaborative nature of the working alliance, the emotional connection between the client and the therapist, and their agreed goals for treatment. For the purpose of this paper TA will be defined as a collaborative, dyadic relationship between both the therapist and the client that facilitates positive change for the client.

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Impact of the therapeutic alliance on treatment outcome

It would appear that the TA within a correctional setting is understood and enacted differently to the TA in a clinical setting such as a mental health centre or private clinic – although this should not be the case. Several reasons for this difference between mental health and correctional facilities may exist including; the mandated/coercive nature of client-therapist contact; dual relationships of care for psychologists; mode of treatment delivery being primarily group-based; and the significant power imbalance between an offender and their psychologist [6]. These factors can impact on the development of a TA between the psychologist and the offender.

Research consistently finds that the therapeutic relationship accounts for a significant portion of variance in treatment efficacy [12]. A positive TA has generally been associated with better therapeutic outcomes in non-offender as well as offender populations [11,13,14]. With sexual offenders, therapist characteristics (e.g., warmth, non-confrontational approach, empathy), as well as offender characteristics (e.g., hostility) affect the TA [10,15,16]-this will be discussed later in the paper. A significant negative relationship was found between risk for sexual recidivism and offenders' perceived therapeutic bond formation with their therapist, particularly females [17], and sexual offenders who have a positive perception of group leaders are more likely to be engaged in treatment [18].

A few meta-analyses have found moderate effect sizes between the TA and outcome. For example, Horvath and Symonds [19] found an average effect size of 0.26 and Martin et al. [11] found 0.22. Norcross [20] found that the use of specific techniques accounted for only 15% of treatment-induced changes whereas the TA accounted for 30%. A review of the TA literature has found a moderate and consistent relationship between the TA and therapeutic outcomes with an effect size of 0.275 [11,21,22]. Furthermore, given that group therapy tends to be the primary modality used with sexual offenders, group cohesiveness and climate is dependent on the therapist providing an environment for these factors to develop. Research has found that the highest functioning and most effective groups were the most “cohesive” groups, which tended to have supportive therapists who were non-confrontational [12].

The TA also has an impact on treatment attrition rates. Sexual offenders who drop-out of treatment often have a higher recidivism rate compared to those who refuse treatment altogether [23]. Furthermore, offenders may not be as motivated as other clients by the very nature of being mandated to receive treatment. However, the severity of a client's symptoms and pathology (or resistance) does not necessarily have a strong impact on the development of a positive alliance [8]. Therefore, the developmental of alliance and severity of symptoms appear relatively independent. This finding is optimistic as it suggests a possibility that an effective alliance could compensate for the severity of the client's symptoms.

A topic often overlooked within offender rehabilitation is the clients' perception and opinions regarding interventions. Client perceptions of treatment and the TA are equally as important as the TA itself and in fact studies have consistently found that therapists' perception of their work is not accurate and that it was the client's estimate of therapist features that correlated with treatment outcome [8,24]. A consistent observation tends to be the client's subjective evaluation of the therapeutic relationship, rather than the therapist's actual behaviour, which has the most impact on therapy outcome [8]. Sexual offenders judge the role of the therapist to be critical to any benefits derived from treatment with effective therapists being described as honest, respectful, caring, non-critical and non-judgemental [25,26]. Due to the sensitive and highly personal nature of their problems, sexual offenders need to be able to self-disclose without feeling rejected or judged-they need to feel accepted regardless of their offending behaviour. Therefore, one could argue that the TA is even more pertinent in a correctional setting in order to motivate offenders to engage, particularly for sexual offenders.

Therapeutic alliance as a variable in client change

An essential purpose of the TA is to facilitate client change by enhancing therapeutic engagement and collaboration with the client and by fostering a safe environment for change to take place [27]. Research points to the TA being one of the most important variables in client change particularly with sexual offenders [25,28]. Marshall et al. [10] have examined how therapist's behaviours within groups correlate with treatment changes-they found that therapist displays of empathy, warmth, being directive and rewarding contribute to treatment change [26]. Drapeau [25] found that offenders report that their therapist was the most important factor in their treatment, with some indicating that the therapist was the only factor which influenced them to change and others suggesting that the effects of treatment resulted primarily from their relationship with the therapist as opposed to specific program components.

Rogers [4] initially hypothesised that the therapist is not the author of change per se, as much as a witness of its emergence. By providing an honest, accepting and understanding therapeutic relationship with the client, the therapist creates the conditions whereby change can occur [29]. Indirectly, it would seem that Rogers [4] was suggesting that a sense of not being accepted can inhibit change in clients. It is when a person experiences acceptance that change is facilitated and this can be accomplished through an effective TA.

A key factor in treatment efficacy with offenders as per the Risk-Needs-Responsivity model is that of responsivity [30,31]. This idea holds that treatment interventions for offenders should be delivered in a way which optimises the acquisition of anti-offending, pro-social skills, and should invite the offender to be motivated to engage in therapy and ultimately, change. Responsivity within the offender rehabilitation literature is primarily concerned with therapist and therapy features [32]. Too often however, offender rehabilitation research and practice ignores the role of the therapeutic interaction effects in impacting on client self-concept [33].

People are most likely to make changes and maintain them when they have a sense of agency, self-efficacy, and feel acceptance [29,34,35]. In this sense, collaboration (as opposed to confrontation) is seen as imperative when working with sexual offenders. Collaboration builds on rapport and facilitates trust in the therapeutic relationship. In other words, the therapeutic process is focused on a mutual understanding, not on the therapist being ‘right’. This means that the responsibility for change still remains with the offender. TA is also directly applicable to the responsivity principle as it requires the therapist's ability to be able to alter their approach and style to match the client's needs. Dowden and Andrews [36] suggest that unless therapists possess the skills necessary for responsivity such as warmth, empathy, and respectfulness, treatment benefits diminish.

Burnett (2004) as cited in Flynn [37] suggests that in order to assist with the successful reintegration of offenders, individual counselling needs to be conducted in such a way where the therapeutic

relationship becomes a safe place for personal history to be revealed and where conflicting feelings and thoughts can be explored and discussed. This allows for clients to reflect critically on personal factors, which otherwise can obstruct desistance. Meaningful interventions occur when clients feel valued and engaged in the supervision process and the therapeutic relationship works with them to reinforce positive action and explore ambivalence. This approach also encourages clients to solve their own problems by providing advice, guidance and collaboratively exploring the normative process, which facilitates change [38].

Rex [38] describes how the probationers she interviewed in her study reported that their supervising officers had helped them maintain their decision not to reoffend and this appeared to be linked to the encouragement and support they received. Recidivists at the "turning point" might need active encouragement in order to maintain that behaviour. In fact, evidence suggests that offenders in the community are willing to accept guidance about their behaviour, even if it is quite directive as long as the therapeutic relationship is perceived as being supportive [38]. Rex [38] points out that one point that emerged clearly in her study was the difficulties the offenders found in maintaining the decision to abandon crime. This was why they emphasised the importance of feeling engaged and fully supported by the service providers in the community. When both parties, the offenders and the service provider, viewed the working relationship as functional, prosocial behaviour was maintained.

Treatment for sexual offenders is predominately delivered in a group format, with the TA being an imperative component of this. The importance of leadership in producing cohesiveness, appropriate group norms and the installation of hope for the future are of utmost importance in running effective groups and inoculating responsivity in group members [32]. The most effective changes occur in clients who experience a group treatment program that is cohesive, well organised and well led, encouraging the open expression of feelings, producing a sense of group responsibility and instilling a sense of hope in group members [32]. Another study found that men who had undertaken a sexual offender treatment program in a group that was described as cohesive, and where the members showed involvement and commitment to the group, as well as showing concern and friendship for each other, were more likely to change in therapy compared to groups where this was not the case [32].

Beech and Mann [39] argue that in many ways sexual offenders are qualitatively different from general psychotherapy clients, so the need for the TA is even more vital. Sexual offenders usually enter treatment under duress and coercion so the level of engagement may initially be less than optimal. In addition, the stigma and vilification experienced by sexual offenders is unlike any other negative reactions to other types of offenders, so in treatment, they may be extremely sensitive to labelling, hostility or a lack of empathy in therapists [39]. In addition, the prisoner culture appears to have an effect on the reluctance of sexual offenders to be open about their behaviours and experiences, as sexual offenders are usually targeted within the prison setting. In other words, if the prison culture further reinforces sexual offenders to be closed off regarding their prior behaviours and experiences to optimise their survival in prison, then the TA is all the more essential in procuring effective communication. If therapists fail to take these factors into account and do not respond to them appropriately, then treatment effects are significantly reduced, if not entirely eliminated.

Therapist factors which contribute to the therapeutic alliance

The factors which contribute to an effective TA entail two domains, one professional and one personal. Personal factors include things such as empathy, warmth, and genuineness whereas professional factors can be considered those aspects that can be trainable, such as skills like directiveness and rewardingness [9]. Warmth, empathy, rewardingness and directiveness have repeatedly been found to be important features influencing change whereas harsh confrontation by the therapist is negatively correlated to change [12]. Ward et al. [32] cite some important factors to TA from Marshall et al. [10], who list the following features as essential when working with sexual offenders; empathy; genuineness; warmth; resourcefulness; supportiveness; self-disclosure; an ability to ask open ended questions; to be rewarding; to use appropriate humour; to be attentive; confident; emotionally responsive; trustworthy; and to instil positive expectations on the part of the client. Some of these therapist features will be considered now, as well as some of the potential misunderstandings of these qualities by therapists working in a correctional setting.

Empathy

Empathy involves seeing the world through the other person's eyes, thinking about things as the other person would and feeling things as the other person would. Empathy should provide the basis for clients to be heard and understood, and in turn, clients may be more likely to honestly share their experiences in depth [26].

Empathy within the therapeutic relationship, especially with sexual offenders, can be tricky to develop and/or maintain. Therapists may feel resentment, fear or anger at the client for their offences, their presentation or their lack of apparent motivation. These factors can often make it quite difficult to take the time to hear what the client is saying and to empathise with them. Empathy is one of the first principles of motivational interviewing and is considered vital to understanding someone's situation [40]. Through expressing empathy, clients may feel that they are being heard and may feel comfortable to open up and discuss their offending.

Experiencing empathy towards sexual offenders does not mean that the therapist approves of the offending behaviour. There appears to be a general fear amongst therapists working with offenders that if they demonstrate any degree of empathy or compassion, it would be inappropriate or would be somehow minimising their offending behaviour. This should not be the case. Empathy in this sense refers to listening to what the client is saying and attempting to understand what it would feel like for them to experience that. For example, if a client recalls a traumatic experience in childhood and links this back to their offending behaviour, an empathic response would be to validate the client's feelings and attempt to ascertain why they have made the connection between that event and their offending behaviour. Unfortunately, however with an example like this often the response by correctional therapists is to explain this as "excuse making" or minimising [26]. Once these labels are attached to what the client is saying, it is quite difficult for the psychologist to experience empathy.

Empathy is not something that can be forced or faked as there are other elements that are associated with it such as non-verbal cues, body language, etc. Empathy is often mistaken or used synonymously with sympathy. The two are quite different. Empathy refers to someone's ability to relate to how an individual is feeling. Sympathy on the other hand is feeling sorry for someone. When working with

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clients, particularly forensic clients, sympathy may be unhelpful in the sense that it does little to support their autonomy [41].

Warmth

Warmth refers to friendliness and approachability. Warmth in the therapeutic context refers to displays of acceptance, care and support which encourage clients to examine their problematic behaviour. When someone is open with us and inviting, they are easy to talk to. Without warmth, the interaction may seem detached or void of a connection. Therapist warmth has been found to be predictive of positive therapeutic outcome and positive client ratings [26]. However again, when working with sexual offenders, therapists can confuse warmth for "poor boundaries", or worry that displaying warmth may be misconstrued as such. Warmth refers to the ability to display kindness and compassion. This is not the same as displaying affection, dismissing offending behaviour, colluding with offenders or having an unhealthy attachment to them. Perhaps a concern for some therapists is that by displaying warmth, this may be mistaken for being 'too soft' or collusive with clients. The risk is that therapists who are overly compassionate may not challenge or set firm boundaries and may encourage a sexual offender's biased, exculpatory and self-protective views of his behaviour [42]. Displaying warmth does not refer to having poor physical boundaries with clients, such as touching or hugging. Warmth can be expressed in many ways, non-verbally (i.e., tone of voice, eye contact, facial expressions) as well as interpersonally, through working collaboratively with the offender and being mindful of the language used with and towards offenders.

Rewardedness

Rewardedness refers to the therapist being encouraging, reinforcing statements, and recognising and praising client effort and progress. This serves to increase client efficacy, enhances a positive experience of treatment and reduces aggression and resistance [12]. The recommendation is that initially, small client progress should be reinforced and rewarded but as time goes on; reinforcement should be intermittent as difficulty increases. Being able to reinforce changes and gains requires effective listening skills. Therapist support is demonstrated by rewarding positive client progress as evidenced through encouragement, supportive statements and the recognition of client effort. These things increase the client's self-efficacy and at the same time reduce client resistance [40].

Many therapists believe that they are listening, when they are merely hearing. Effective listening involves entering each interaction with undivided, unbiased attention, non-defensive curiosity and appreciation [41]. Effective listening also requires a demonstration to the offender that the therapist is listening and asking for feedback as to how accurate their listening is. Furthermore, effective listening is not the same as agreeing, advising, persuading, arguing, sympathising or consoling. Good listening often involves reflecting back statements and the purpose is two-fold allowing; the therapist to accurately identify and understand what the offender is saying, thus the offender feeling heard, validated and understood which can encourage further communication; and providing the therapist an opportunity to model effective listening skills.

Directiveness

Confrontation with offenders has historically been the dominant approach, especially when working with sexual offenders [10]. Confrontation with anyone is likely to lead to either withdrawal or resistance. Directiveness can sometimes be misunderstood as being dominant and directing clients on what to do. However, directiveness in this sense refers to the ability of the therapist to assist the client, it refers to guidance. Offering suggestions or alternatives and encouraging the client to make their decisions as well as encouraging clients to practice skills outside of sessions. This should be used with flexibility however and only once the TA has been established [10]. If this is used too prematurely, therapists may risk a rupture or a negative reaction from the client.

Unique obstacles in developing a therapeutic alliance with sexual offenders

Working with offenders generally and sexual offenders specifically, can create unique challenges for the therapist for a host of reasons, including; environmental/system factors (correctional policies, legislation, rules); attitudes towards sexual offenders (manipulative, denial); and role conflict and confusion (confidentiality, boundaries). This section will now explore some of the more common obstacles for therapists working with sexual offenders within a correctional setting.

System factors

System factors are defined here as those factors outside the control of the client, therapist and the program management. Correctional policies and legislative rules are an example of system factors. For example, mandatory or coerced-voluntary treatment can make therapy seem punitive and as 'part of the system' [9]. Understandably for psychologists working within correctional settings there are more challenges with clients being less motivated, more hostile and more resistant to therapeutic intervention. So the question is how do psychologists deal with these adverse therapeutic issues? What hypotheses do therapists develop to account for these behaviours or more generally, what psychological theories do therapists approach clients with? The answers to these questions appear unexplored in the literature and therefore remain unknown.

The essence of the TA is noted as collaboration, suggesting that the client's sense of autonomy and agency may be a necessary condition for the formation of a TA [9]. Obviously, autonomy is quite limited in prison and often treatment is coerced or mandated, which can adversely impact on the development of the TA [43]. Policies often have offenders commencing treatment towards the end of their sentences, in the lead up to release on parole. This is often many years after the commission of the offence, which may lead offenders to no longer agree on goals which may have been relevant around the time they committed the offences.

Therapists are also susceptible to the negative impact of system factors on their ability to form an effective TA with offenders. For example, system policies often dictate a therapist's caseload, access to supervision and/or professional development and training [9]. Furthermore, the system often determines who will be entered into a program, regardless of the offender's needs or suitability which can place a strain on the therapists and undermine therapist's clinical decision making.

Common 'approaches' to offenders

Some research has suggested that one of the best ways to approach clients within the correctional environment, particularly those with psychopathic or personality disordered traits is by detaching [9]. However, it is questionable as to whether a "detached" approach to

therapeutic work with any type of client is useful or can nurture the TA. It is possible to engage with hostile or resistant clients and de-escalate their presentation through the use of motivational interviewing [40]. The process may take a little longer and may be taxing on the psychologist however it is arguably achievable. It is difficult to continue being frustrated or hostile toward someone who is calm, supportive and someone who is listening to what you are saying, even those with personality disorders.

In motivational interviewing, resistance is seen not as a feature of the individual but rather a result of interactions with the environment, which can and do fluctuate [40,44]. Perhaps instead of seeing someone as resistant, the therapist should attempt to analyse why this behaviour is present and the function it is serving, such as the avoidance of shame and a need to 'save face'. Resistance is not pathology but is often in response to an environmental or situational factor(s)-it is also influenced by the therapist's behaviour [26]. When listening to clients who express resistance there is usually an element of truth to be found in what they are saying. If the therapist is able to identify this and demonstrate empathic understanding, then this facilitates a more open and receptive dialogue between the therapist and the offender. Resistance is usually a sign that the client is not feeling heard or wants the therapist to back off.

Confrontation unfortunately, continues to be a common approach to working with offenders, especially sexual offenders [10,26]. Because sexual offender treatment tends to be involuntary, client resistance often prompts therapists to adopt a paternalistic, condescending or confrontational approach [45]. This is the one therapist feature that has continuously been shown to impede progress and in fact can be harmful to clients [9,10,12]. A confrontational style is often displayed as aggressive, critical, undermining, hostile and/or sarcastic. Studies demonstrate that clients who find their therapist confrontational tend to either discredit or forcefully challenge the therapist and fail to make changes [46]. Hudson [47] found that sexual offenders reported that when their therapist was confrontational they simply learned what to say rather than engage in a meaningful manner. Unfortunately, what this means is that any intrinsic changes have most likely not been made therefore, the efficacy of a program or intervention has potentially been undermined and lost.

Any relationship evokes an affective element and the TA is no different. If clients feel safe with their therapist and feel able to express their emotions and thoughts, then therapy is likely to be effective. Research has found that some of the most significant changes occur when emotions are accessed [48]. If a client cannot acknowledge or reflect on their emotional states then it can be more difficult to understand or modify them [9]. Therapists are consistently found to exert a significant impact upon clients' motivation for change and the subsequent outcomes [29].

Dual roles for psychologists

A challenge often facing many correctional psychologists is the dual role that therapists within correctional facilities have and the ethical dilemmas that they often face. On the one hand they are responsible to provide services to the client (offender) while on the other they are to answer to the correctional facility. Therapists are often required to combine roles, some of which are incompatible with the TA, which can cause role confusion [9]. This can also cause confusion for the clients about how they should behave and what the boundaries and limitations are. For example, therapists may appear to be apparently available to help clients, yet they are also often expected to disclose information to others within the system and in some cases this may also result in punishment or other ramifications to the client. Marshall and Serran [49] have found that in the absence of trust a TA is difficult to establish.

Confusion about effective therapist qualities

Some of the personal factors involved in the TA, such as warmth and empathy should not compromise a therapist's accountability to a correctional department. If an accurate understanding of these concepts is present, then there should be little difficulty with demonstrating empathy, warmth and positive regard whilst working with a client. Again the emphasis is on the misunderstanding of what these concepts are, how they are demonstrated and how they may be interpreted by others which is what seems to create the reluctance for therapists to engage with offenders in an effective and meaningful manner. Displaying and feeling empathy towards clients is not the same as colluding with and minimising their offending behaviour. Displaying warmth is not the same as violating boundaries (whether that be physical, sexual or emotional). Exercising directiveness is not the same as being inflexible, rigid, confrontational, hostile, and dominating the interaction with the client. Rewardedness is not the same as offering indirect praise for non-specific things, belittling the client with patronising comments or avoiding work on the pertinent issues. Positive regard is not the same as dismissing outstanding issues, approving of offending behaviour or not taking treatment seriously.

Working with sexual offenders

As mentioned, despite consistent findings in the literature regarding the importance of the TA in work with clients, including (maybe even especially?) sexual offenders, it is concerning that there continues to be a lack of implementation and/or a poor conceptual and practical understanding of these factors. It seems as though correctional therapists feel that should they enact these qualities in their work with clients, then their professionalism and boundaries may be called into question [50]. In addition, certain labels readily attached to offenders, such as "manipulative" or "personality disordered" can lead to negative reactions and interactions with offenders, hindering the development of a TA [9,26]. Labels such as "manipulative" or "personality disorder" can; reduce the personal responsibility for the therapist by feeling that it is the 'offender's problem' only; hinder the development of a TA through therapists responding negatively towards the offender; and risk therapists labelling offender behaviour instead of completing a functional analysis of the problem behaviour.

A unique challenge for correctional therapists, usually as law-abiding members of society, is that they are often faced with needing to build a positive therapeutic relationship with someone who has committed an offensive act. Therefore, the therapeutic relationship within the forensic setting is in a constant state of flux between this splitting and reintegration. It becomes a delicate balance of seeing the client beyond their offending behaviour, yet also being able to address the issues that led to the offending behaviour in the first place. Perhaps this is where the role of clinical supervision becomes imperative for correctional psychologist. Self-reflection is essential for therapists in order for them to continue to improve and to be aware of their own biases, which can and do impact on the therapeutic relationship and therefore the development of the TA.

When working with sexual offenders it is particularly important for therapists to be mindful of the social stigma attached to sexual offending and those who perpetrate this type of behaviour. It is not an

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understatement to say that sexual offenders probably face the most significant degree of social exclusion and prejudice compared to other types of offenders [51]. While one cannot dismiss or minimise sexual offending behaviour, in order to be able to access the precursors and maintainers of such behaviour, therapists need to better understand these people and the function of their presenting behaviours. This level of understanding requires perspective taking, empathy, and an open-mind, all of which are linked to the above-mentioned qualities required for an effective TA. The absence of these factors makes this task particularly difficult, if not impossible.

Whenever two people are engaged in a dialogue of any sort, there is a dynamic created and this applies directly to the TA. Correctional therapists often associate any negative reactions or responses in therapy as "the offender's problem" or "a reflection of the offender". This minimises the responsibility the therapist takes for their contribution to the therapeutic interaction and does not allow for an opportunity for therapists to self-reflect. This can be particularly damaging and harmful to the therapeutic relationship and the client, who in this case is an offender. No matter how professional or well-maintained the therapeutic framework and boundaries are, therapy is "an interpersonal process whereby the person of the therapist intrudes in more or less subtle ways . . . when the patient responds to the therapist, the therapist is almost certainly implicated" [52]. This also requires the therapist to be aware of issues such as transference and countertransference which may influence the therapeutic relationship.

Transference and countertransference

The issue of transference and countertransference in therapeutic work with sexual offenders is often overlooked, if considered at all. These terms are often associated with Freud [3] and psychodynamic theory and most therapists appear to shy away from this altogether, especially within the forensic arena. However, these two processes which occur in all therapeutic relationships have significant implications for therapeutic outcome [53]. Psychodynamic theory suggests that attachment schemas tend to be reactivated in psychotherapy and then displayed in the interactions with the therapist [25,53]. Therapy is then considered an opportunity through which the offender can acquire new object representations as well as ways of interacting.

Transference has been described as a manifestation of core relationships, usually dating back to childhood [52]. More specifically, transference has been described as "the patient's experience of the therapist that is shaped by the patient's own psychological structures and past and involves displacement, onto the therapist, of feelings, attitudes, and behaviour belonging rightfully in earlier significant relationships" [54]. Transference allows for the therapeutic relationship to locate damage and provide an opportunity through transference to repair it or reframe it. Transference can be positive (e.g., the therapist is seen as 'all-knowing') or negative (e.g., the therapist is seen as overly critical). Transference often creates opportunities for the therapist to access emotion-rich experiences which have been linked to greater change in therapy. For example, if an offender requires assistance with intimacy deficits, as is often the case with sexual offenders, using the therapeutic relationship as an anchor for this seems logical, particularly if there is transference present. Furthermore, once transference is present, the therapist's awareness and appropriate reaction to the transference, allows for the opportunity for the transference to be dealt with appropriately and therapeutically, and for the problematic features of it to be resolved [53].

No matter how 'professional' or 'neutral' a therapist attempts to be, therapy is an interpersonal process whereby the personal characteristics of the therapist manifest in more or less subtle ways. This may be through tone of voice, facial expressions, mode of dress, or body posture, just to name a few. Furthermore, it would appear that therapists can be oblivious or dismissive of their own contribution in this regard. Cognitive-behavioural therapies (CBT) can dismiss transference and the importance of the role of the therapist in influencing change [8,10]. Thus given that CBT tends to be the dominant approach to offender rehabilitation, it is not surprising that little attention and training is focused on the impact and importance of transference and countertransference with offenders.

Transference and countertransference is part of the basic human "meaning-making process that flows from the need to comprehend, understand, predict, and make sense of events" [53]. In other words, transference as well as countertransference are not inherently pathological even though their roots have been examined within a psychopathological framework [3,55]. Thus, therapists should not conceptualise transference and/or countertransference as pathological, which may lead to underappreciating its roots, basic mechanisms and functions and ubiquity in social relations [53].

Acknowledging transference or countertransference is often avoided in therapeutic contact with offenders. There may be a variety of reasons for this such as being unfamiliar with recognising transference or countertransference, misunderstanding transference and countertransference, avoiding self-reflection, having a weak TA, or fearing an exploration of transference and countertransference. Therapy is an interpersonal process and whatever the client says within that framework is in part a function of the therapist, as much as the person being addressed (or perhaps more accurately of the client's construction and perception of the therapist).

Countertransference in particular seems to be a phenomenon which therapists avoid acknowledging or processing, as if by mere avoidance of the topic this will mean that countertransference will not occur. Countertransference requires the ability for therapists to be insightful, self-reflective and honest. Countertransference is defined as reactions evoked by the client but based on the therapist's unresolved issues [56]. This may be conscious or unconscious and in response to transference or other client attributes. Like transference, countertransference can be either positive (e.g., overly supportive and friendly) or negative (e.g., inappropriately withdrawn or critical) [56].

Often, when working with offenders, the general attitude appears to be that any issues arising within the therapeutic context are solely that of the offender. This view is inaccurate and hinders therapeutic progress. For example, when working with sexual offenders, the therapist may have polarised views of the offender, where at one pole they may see the offender as a victim and the other they may focus on him as an offender and obscure more central issues and feelings [57]. The reluctance that therapists have regarding the acknowledgement and acceptance of countertransference appears to reflect a significant deficit in self-reflection and a strong element of self-protection. In order for therapists to self-reflect, they need to be aware of the 'baggage' that accompanies them into the therapeutic relationship. Objectivity cannot exist in its purity as we are all people made up of histories and experiences and this shapes our world-view. Clients fall somewhere within each therapists' world-view and for some therapists, this world-view conceptualises offenders as negative, manipulative, and unchanging. Entering a therapeutic setting with these preconceived notions, which are often not always overt, can

significantly impact on therapeutic progress as well as the formation of the alliance. In the absence of self-reflection, the therapist can miss the opportunity to explore the significance of countertransference in the TA and the impact that this can have on therapeutic outcome.

Countertransference should not be viewed as an impediment to effective therapy but in order for it to be utilised to its potential, therapists need to be aware of their own countertransference. More so than transference, countertransference can become problematic if it is acted out through in-session behaviours [56]. For example, a recent study found that while a negative transference from clients did not lead to negative countertransference in therapists, negative emotional expressions from therapists did lead to negative transference in clients [56]. Countertransference also impacts and influences the style adopted with offenders as well as the focus. A negative countertransference can seriously jeopardise the development of a TA while an overly positive one can lead to a therapist failing to address factors related to offending behaviour [58].

The therapist's unawareness of countertransference, whether it is positive or negative, tends to reduce the ability for the therapists to assess the client's transference [59]. As professionals, therapists need to be aware of their own reasons or contributors behind the therapeutic decisions they make, as ignoring this paves the way for careless or reactive decisions which may not be in the client's best interest. This may arguably be even more pertinent within a correctional setting as the decisions made can have profound effects on the client's life and ongoing management.

Conclusion

The aforementioned issues have serious implications for treatment. Ideally therapists need to be selected on their ability to employ and demonstrate these effective therapist characteristics as an absence of these qualities seriously impacts treatment efficacy. Therapist flexibility is essential and conducive to effective therapy. Furthermore, flexibility allows for the ease of expression and as discussed above, emotional expressiveness is of the utmost importance in therapy as this facilitates change [12]. This requires the therapist to be able to invoke a safe environment within therapy to allow for such emotional expressiveness. Focusing only on procedure and content while ignoring group process and the role of the TA is counter-productive and in fact, potentially harmful to clients.

Training for therapists working with sexual offenders is imperative, in as much as making therapists aware of the importance of the therapeutic relationship in therapy. Clinical supervision also becomes essential in order for psychologists to discuss and reflect upon these factors. As discussed throughout this article, the importance of a TA cannot be understated. This is especially relevant within the forensic arena, given the influence of the legal system. Issues of transference, countertransference, and the TA need to be at the forefront of training and need to be made of utmost importance when working with clients. The ignorance of such factors will most surely undermine the efficacy of any therapeutic intervention. Therapy is a two-way street and involves a dynamic between at least two people (more in group). With this dynamic, a relationship is formed which requires effort in order to be maintained and strengthened. With an effective TA, the potential for therapeutic gain and change to be made is maximised.

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