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Paradoxical and double-bind communication in treatment for people who sexually offend

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Abstract *At its most fundamental structural level, treatment for people who sexually offend has inherently paradoxical elements. These involve questions about efficacy, the balance of community safety and client autonomy and responsibility for meaningful change. These elements can create further forms of paradoxical and double-bind communication within the treatment experience itself. This paper explores this communication and its potentially harmful effects on clients, therapy and community safety, particularly in light of the schemas, implicit theories and cognitive deficits exhibited by people with histories of sexually offending behaviour. It is intended to suggest topics for consideration in solving clinical dilemmas and preventing harm to therapeutic relationships.*

Keywords *Civil commitment; communication; paradoxical; sexual offender; treatment*

Introduction

Treatment of people who sexually abuse continues to draw considerable controversy from a number of directions. The high-stakes nature of treatment programmes lends itself to unclear, and even paradoxical, double-binding demands on clients. In effect, clients can find themselves unable to meet one requirement without violating another. A paradox often occurs early in treatment when therapists fail to recognise where their clients are on the behavioural change continuum, particularly expecting them to be more ready for change than they actually are.

This paper explores how paradoxical and double-bind communication occurs in treatment for people who have offended sexually, and offers ideas for ameliorating its effects. Professionals can prevent many problems in treatment by understanding this communication, especially as the clients of sexual behaviour treatment programmes often enter treatment with psychological factors that make meaningful participation difficult. These factors include cognitive rigidity, stage of change and the clients' implicit theories about the world. Each of these factors alone presents a challenge; the paradoxical elements inherent in many treatment programmes can create unnecessary mismatches in the therapeutic process.

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The resulting mismatch of clients and therapy risks leading clients to mistrust their providers and therapists to give up on their patients. When treatment is mandated by the legal system—as is frequently the case with people who have sexually offended—this failure can put clients back into prison. Clients often enter treatment with certain distorted perceptions of the world, which may enable offending patterns and become barriers to treatment. It is vital that practitioners recognise potential aggravating factors and guide clients to a better understanding of their behaviour and its affects. In the context of treatment for people with sexual behaviour problems, examples of double-bind communications appear on an alarmingly regular basis. There is a dearth of study on the long-term effects of such communication on clients attempting to build healthier lives for themselves.

Background

In an influential paper, Ward and Stewart (2003, p. 353) state:

> The treatment of sexual offenders raises a number of profound ethical questions. The understandable community concern with reducing risk and minimizing harm, together with a managerial culture within corrections, has put the whole issue of public safety at the forefront of rehabilitation policy... In addition, the perception that sex offenders deserve punishment and not consideration for their welfare has resulted in a reluctance to implement more constructive treatment models... Intervention with sex offenders is not, therefore, a simple matter of implementing the best behavior change technology and leaving political and social debate to politicians and policymakers.

More recently, Glaser (2010) has proposed that the current state of treatment for people who sexually offend is inherently punitive. Glaser extends the concerns of Ward and Stewart (above) and states clearly that treatment programmes for clients with sexual offence histories cannot serve the “two masters” of community and client interests (p. 262). Although Glaser’s arguments have met with varying levels of disagreement (Prescott & Levenson, 2010; Ward, 2010), the fact that these discussions exist demonstrates the controversies that are endemic in treatment for people who have sexually offended. The broader question at the front lines of treatment, however, may be that if professionals cannot agree on the apparent “two masters” paradox, what must our clients make of this?

Beyond the role of treatment providers, there are real and ongoing controversies over whether or not treatment for people with sexual behaviour problems is effective. In autumn 2010, debate about the efficacy and potential harm caused by such treatment was at the forefront of the biannual conference of the International Association for the Treatment of Sexual Offenders (Hanson, 2010; Marshall & Marshall, 2010; Rice, 2010). When respected experts disagree on whether or not effective treatment for this client population exists, professionals naturally must wonder about the promise and limits of treatment and personal change.

These paradoxical aspects of treatment for people who have sexually offended are not merely the concern of professionals. In the absence of other factors, the frameworks in which many treatment programmes exist raise not only moral and ethical concerns; they create confusing and potentially harmful messages that undermine genuine personal change on the part of treatment participants. These messages and their context are deserving of exploration in their own right.

Paradoxical and double-bind communication

Watzlawick, Bavelas, and Jackson (1967) describe several implicitly contradictory messages within families. Many involve injunctions demanding specific behaviour that by its very nature can only be spontaneous (p. 199). Dubbed the "be spontaneous paradox", examples from couples and families entering treatment include:

> You ought to love me.
> I want you to dominate me.
> You should enjoy playing with the children, just like other fathers.
> Don't be so obedient.
> You know you are free to go, dear; don't worry if I start crying. (p. 200)

Each of these statements is inherently paradoxical, containing the imperative voice and/or a value statement. If the receiver behaves in a spontaneous fashion, he is not following the other's instructions. If he follows the instructions, he cannot be spontaneous. The husband who follows his wife's instruction to dominate her is explicitly obeying her.

In isolation, these messages can seem harmless and even amusing, much like the pages in books and manuals that say: "This page left intentionally blank". Even the most loving parents encourage their children by saying: "just be yourself". However, within relationships marked by the power of one person over another, intense emotion and the inability of the receiver to exit the situation, these persistent messages can create a truly problematic double-bind for client and therapist alike.

The idea that paradoxical and double-bind communication is pathogenic is not new (Bateson, Jackson, Haley, & Weakland, 1956). Although there is only scant literature to test the role of paradoxical communication in the aetiology of mental illness statistically, there is a rich literature of attempts to use paradoxical communication therapeutically (Weeks & L'Abate, 1982). Recent reviews attest to its durability (Gibney, 2006).

The paradox of change

Prochaska and his colleagues have described a transtheoretical model of change that has received widespread attention in the psychotherapy literature (DiClemente & Prochaska, 1998; Prochaska, 1999; Prochaska & DiClemente, 1992), as well as the treatment literature regarding people with sexual behaviour problems (Marshall, Marshall, Fernandez, Malcolm, & Moulden, 2008). Of importance to this paper is that the transtheoretical model posits that people proceed through five stages of change: precontemplation, contemplation, preparation, action and maintenance of change. Although these stages are ideally sequential it very often happens that people, including people with sexual behaviour problems, vary in their readiness, willingness and ability to change across time.

The relevance of this to treatment for people who have sexually offended is not always apparent to those working directly with them. Many, if not most, programmes approach such clients as if they are in the preparation stage of change, despite the fact that they are very often in the precontemplation or contemplation stages (Mann, 2009; Marshall et al., 2008). This can create a challenging and paradoxical situation for clients, who feel that they cannot progress meaningfully in treatment without first becoming ready, willing and able. At the same time, circumstances often make dropping out of treatment equally untenable (e.g. in some jurisdictions, dropping out results in additional prison time).

This paradoxical introduction to therapy within the legal system can come to effective resolution under the right circumstances through the use of preparatory programmes and programmes for those who deny their offences (Cullen & Wilson, 2003; Marshall et al., 2008; Marshall, Thornton, Marshall, Fernandez, & Mann, 2001). However, it is easy to overlook the fact that psychotherapy clients generally do not see entering treatment and engaging in change as a straightforward process, as evidenced by dropout rates across settings (e.g. Wierzbicki & Pekarik, 1993). Meta-analyses highlight the contributions of cognitive–behavioural interventions and the principles of risk, need and responsivity to reducing the likelihood of future sexual crime. However, factors such as the therapeutic relationship (a vital component in general psychotherapy) have received very little attention in the treatment literature regarding sexual offending (Andrews & Bonta, 2010; Hanson, Bourgon, Helmus, & Hodgson, 2009; Hanson, Gordon, Harris, Marques, Murphy, Quinsey, & Seto, 2002; Hubble, Duncan, & Miller, 1999). In fact, it is only in the past several years that researchers have examined factors related to attrition and called for consideration of them as markers for programme improvement (Beyko & Wong, 2005).

Perhaps the single most important factor in treatment is the client and his or her willingness to change. Bem (1972) called attention to the fact that how clients perceive themselves throughout the change process is critical to the success of treatment efforts, and that people develop and come to "know" their attitudes by observing their behaviour and concluding what attitudes must have caused them. His research demonstrated that people are often more convinced by what they hear themselves say than by what others say to them. Similarly, Ryan and Deci (2000) note that motivation to change often starts extrinsically (e.g. a concerned relative or the legal system), and becomes intrinsic over time. Clients, hopefully, engage in change because it is interesting and satisfying in itself. Deci and Ryan (2002) contend that there are three psychological needs that motivate people to initiate behaviour, and are essential for psychological health and wellbeing. They argue that these needs are universal, innate and psychological, and include the need for competence, the need for autonomy and the need for relatedness (Deci & Ryan, 2002). Treatment providers seeking to enable clients to attain these goals will probably have a greater chance of successful outcome.

These are crucial considerations in the treatment of people who sexually offend. It is common for outside stakeholders, the lay public and clients themselves to view treatment programmes as being entirely responsible for client change. In this mindset, treatment is something that therapists do "to" their clients. The discussion above illustrates that although providing a sound treatment programme is the responsibility of clinicians, the ultimate responsibility for change lies with the client. However, lack of clarity about the role of the client and the role of the therapist can itself be confusing and paradoxical to clients.

Aggravating factors

Cognitive distortions have held a central role in traditional theories regarding thinking errors and people who have sexually offended. However, recent reviews have called into question the idea of cognitive distortions and their role within treatment (e.g. Marshall, Marshall, & Ware, 2009). The current literature regarding treatment for people with sexual behaviour problems has highlighted the importance not just of pro-offending attitudes and beliefs, but of the schemas that underlie them. For example, Polaschek and Ward (2002) have proposed that rapists hold five schemas, or implicit theories, that contribute to an explanation of their behaviour. These include: women are unknowable/dangerous; women are sex objects; male

sex drive is uncontrollable; all men are entitled to sex (entitlement); and others are dangerous and hostile (dangerous world). In a subsequent analysis of rapists, Polaschek and Gannon (2004) found strong evidence to support these constructs.

Similarly, Ward and Keenan (1999) outlined five common implicit theories among child molesters. These include children as sexual objects, entitlement, dangerous world, uncontrollability and nature of harm (e.g. that sex with children is either not harmful or can be beneficial). As with the implicit theories of rapists, these go beyond being mere permission-giving self-statements and function as a lens through which the offending client views the world. It is noteworthy that these implicit theories derive in large part from client self-report rather than observation by outsiders.

The presence of these implicit theories beg the following questions: if these are among the lenses through which people with sexual behaviour problems view their world, in what ways does professional communication with them support or challenge these implicit theories? In what ways do the contexts in which treatment occurs support or challenge their implicit theories? For example, let us say that a client complains passionately about a seemingly frivolous aspect of the treatment programme. His female therapist responds confrontationally that this complaint reflects an ongoing sense of entitlement. Despite the therapist's accuracy, the client may view this as ongoing evidence of a dangerous world, that his female therapist is unknowable and deceptive and that he is therefore entitled to behave as he sees fit, as he sees no other way out of his situation. Alternatively, if the therapist responds warmly, explores the complaint and asks the client: "what part of our discussion today might reflect some aspects of your attitudes and beliefs when you were offending?", the response may be very different.

Understanding these implicit theories takes on additional significance for those treating people with a history of sexual offending when one considers the cognitive rigidity of these and other people who engage in criminal behaviour in general. In their meta-analysis of 39 studies involving 4589 participants, Morgan and Lilienfeld (2000) found that antisocial groups performed 0.62 standard deviations worse on tests of executive functioning than comparison groups, a moderate to large effect size. Schlank (2006) has produced similar findings among a group of civil commitment centre residents in Minnesota.

In the above situation, the client (who may be contemplating or preparing for a deeper level of personal investment in change, as per the transtheoretical model) may well lack the cognitive flexibility that the therapist requires in the conversation, resulting in a mismatch of treatment adherence to the responsivity principle (Andrews & Bonta, 2010). The context of the discussion, which takes place with a therapist who holds great power over the client, becomes a high-stakes matter for the client, who probably entered treatment with a wide array of offence-related schemas. Given the client's cognitive rigidity, it is unlikely that the client will view this conversation as helpful, and will probably use it as confirmatory evidence of his worldview.

The above is also an example of how what might seem as straightforward communication to the therapist becomes a double-bind to the client. The client has one rigid psychological state and the therapist has another. Further, it is likely that the therapist's approach to the dialogue with the client is, in one way or another, influenced by an unseen but implicit third party to the discussion—the social and legislative community that often sets the stage on which such communication takes place. The high stakes and strong emotions create a situation that might appear tenable to outsiders, but not to the client. These are key ingredients in a double-bind. In his current psychological circumstances, he is unable to draw upon the cognitive flexibility needed to resolve his situation.

Double-bind communication in treatment for people with sexual behaviour problems

Just as the original developers of the double-bind literature did not intend to blame the parents of disturbed children (Gibney, 2006), the purpose of exploring this communication is not to condemn clinicians, but rather to highlight the often untenable situations in which they find themselves with their clients. The examples below come from the authors' experiences working in inpatient settings, community supervision and from media accounts. Some double-binds appear verbatim, while most are implied. As Watzlawick observed (1968), most double-binds take considerable time to appear fully within human communication. It may be most helpful to consider the existence of the double-binds and paradoxes as reflective of the broader legal and cultural frameworks in which programmes function (i.e. the aforementioned unseen and implicit third party). What becomes clear in the examples below, drawn from clinical practice, is that clients do not enter treatment with the same style of thinking or cognitive schemas that their therapists have.

You need to be more motivated to change

Although expressed only occasionally in this way, its sentiment is a hallmark of many programmes. Internal motivation can only happen spontaneously within a person and not at the direction of a professional. On its own, this bind echoes the classic joke that it only takes one psychologist to change a light bulb, but the light bulb has to want to change. The difference here, however, is that the client's future hangs in the balance, and he or she cannot escape this bind. A solution to this dilemma is to use motivational enhancement techniques to elicit and explore the client's internal reasons for change rather than argue the case for change.

Please be honest and straightforward with us; evidence that you do not agree with us will be understood as resistance

Moyers, Miller, and Rollnick (1998) have quipped that when clients agree with their therapists it means that they have good insight, but that when clients disagree with their therapists it means they are in denial. Although stated humorously, there is an element of truth in this. In traditional psychotherapy, resistance is expected as clients work through ambivalence and (sometimes painfully) come to realise that they must embrace the process of personal change. However, in treatment for people with sexual behaviour problems, disagreeing with one's therapist often comes with considerable costs. Therapists, like others, do not like being contradicted. Professionals can be at their best when they view client disagreement as an opportunity for exploration of the issues and clarification of values.

It is our job to point out your thinking errors. However, it is not acceptable to observe when we are using thinking errors

An individual civilly committed because of his sexual offending history, upon hearing the governor of that state speaking to the media, was overheard to say: "I didn't know his thinking was so polarised". It is not surprising that clients will watch their therapists and others in authority closely. Unfortunately, therapists can easily take it personally when their clients notice their imperfect thought patterns. Discomfort at this unusual interaction is natural. Setting limits on it defensively can provoke distrust and an unnecessary sense of inequity. A more helpful way around this paradox can be to acknowledge that thinking errors occur

naturally, and that the aim of treatment is not to eliminate them but to adjust them in a healthy direction whenever possible.

You need to express emotions in treatment. However, if you do so in a way that others do not like, we may call that a problem with emotional regulation. However, if you are overly constricted, that is not acceptable either

Treatment providers are not always clear on what makes adequate treatment participation, and different therapists have different styles. In the authors' experience, many clients have tailored their treatment participation to meet the style of their therapists rather than vice versa. Their motivation for doing so has had more to do with their desire to progress than with any definable treatment need. Within institutions, clients themselves can be quite clear about the most effective ways to interact with specific clinicians. Therapists can be more helpful by focusing on emotional expression that meets the needs of the client and his peers rather than the preferences of the therapist.

Although the literature remains unclear on this matter, it would appear that the nature of client participation in treatment may tell us something about how well they "get" treatment and how well that translates into greater functionality in the community. In one study (Looman, Abracen, Serin, & Marquis, 2005), treatment participants with high scores on a measure of antisociality [Psychopathy Checklist-Revised (PCL-R); Hare, 2003] typically re-offended at rates higher than those with low scores. However, it is of interest that those treatment participants with high PCL-R scores and lower scores on measures of treatment behaviour recidivated at the same rate as low scorers on the PCL-R. This suggests that the highly antisocial participants who engaged in the treatment process and showed a degree of resistance were the ones who ultimately demonstrated greater success in the community.

We expect you to demonstrate meaningful and consistent behavioural change within a highly controlled environment

For people who have sexually offended and are housed in inpatient and prison settings, this is a familiar dilemma. In many ways, demonstrating rule compliance can be easier in a confined setting (e.g. the absence of conduct reports) than in the community. Release into the community can be extremely challenging and potentially exacerbate dynamic risk factors (e.g. social isolation). However, demonstrating prosocial decision-making in an environment in which few decisions occur independently can mean that the positive behavioural changes demonstrated are themselves highly artificial because of the environment in which they take place. For example, many civil commitment programmes in the United States do not allow clients to enter one another's rooms. Additionally, one civil commitment programme has moved to ban all CDs, DVDs and VHS tapes because, in very large part, the programme could not afford the staff to review them for pornographic content. In another programme, the director considered a lifetime ban on owning a television in the facility for clients found to possess pornography. Under these circumstances, it is virtually impossible to demonstrate the kind of good decision-making that would be required in the community.

On one hand, discussion of the choices one makes is an expectation of any treatment programme. On the other hand, many programmes go to extremes to limit the choices a client actually can make, even when the programme describes its therapeutic environment as collaborative. Like many other examples, programme administrators can easily defend these decisions in the legal system and the public eye. However, it is important for professionals to take into account that clients very often take a different view. While many observers may

consider this grist for the therapeutic mill, it can also become a dilemma for therapists attempting to justify these policies at the same time as they listen to their clients' frustrations and doubts about the motives underlying the programme. Inpatient programmes can help to resolve these issues through close attention to whatever counter-therapeutic elements may exist in their security policies.

You need to participate fully in treatment regimens that we professionals cannot agree on ourselves

This is the message that people with sexual behaviour problems receive when they read media portrayals of treatment controversies regarding sexual offending (Marshall & Marshall, 2010). One way out of this bind may be to remember that while there is no shortage of controversies in the field of treatment options for sexually problematic behaviour, professionals may want to remember that actual completion of treatment does appear to correlate with reduced future sexual crime. It may be that successful treatment is where participants not only complete meaningfully, but also view themselves as having completed. This seemingly small distinction may be related to the "desistance scripts" of reformed criminals (Maruna, 2001).

Treatment makes some people who offend worse; it is important that you participate

There is a commonly believed perspective in the field that treatment increases the likelihood of recidivism for some people who have sexually offended. Based on results obtained in two influential studies (Rice, Harris, & Cormier, 1992; Seto & Barbaree, 1999), but ultimately refuted by others (e.g. Barbaree, 2005; Doren & Yates, 2008), this perspective continues to affect opportunities for treatment participation and completion for clients with high scores on the PCL-R. Therapists can make treatment more helpful to clients by ensuring that it incorporates personally meaningful goals (Yates, Prescott, & Ward, 2010).

Treatment and treatment planning is a collaborative process. However, we remain the final arbiters of your treatment plan and completion of treatment goals

Although the balance of collaboration and clinical assessment of need and progress can seem straightforward to highly trained professionals, this balance easily appears as a cynical power-play to clients. Often connected to the implicit theories of entitlement and dangerous world noted above, people who have sexually offended very often do not view the balance of therapeutic factors as the brilliant choreography that professionals do. Recently, the sexual abuse literature has included studies of "user satisfaction" for treatment participants (e.g. Levenson & Macgowan, 2004; Levenson & Prescott, 2009; Levenson, Prescott, & D'Amora, 2010); however, practical experience suggests that even clients in higher stages of treatment see such endeavours—in which true collaboration is illusory—as cynical. A more helpful way forward may be to explore the benefits and liabilities of treatment participation for each client.

Seriously exploring your life and questioning your actions is a part of treatment; seriously questioning your treatment programme may be viewed as resistance and failure to progress

Observers from Haley (1986) to Toch (2008) have discussed the power tactics and dynamics of institutions. It can be very easy for therapists offering services to people with sexual behaviour problems to minimise the power they hold over clients, despite their intentions (Zimbardo, 2008). Just as questioning the fairness of one's world is a hallmark of adolescence

(Jenkins, 2006), therapists can be more effective when they view these challenges to their authority as an indicator of a potential for change and not simply hostility.

It is vital that you form a therapeutic relationship with us; however, your mistakes will be called "boundary crossings and violations" and sanctioned accordingly

Human relationships can be difficult to define even for the healthiest people. However, clients in treatment face an entirely new set of challenges. While people with histories of sexual offending frequently experience confusion and difficulty in relationships (e.g. Wilson, 1999), and treatment will hopefully ameliorate this, treatment providers learn early on to be on the lookout for manipulation by clients (e.g. Salter, 2004). This can quickly become untenable: the client with a history of poor relationships is directed to form healthy relationships. The stakes are high, as mistakes are intolerable. Further, a truly healthy relationship is spontaneous by nature. One cannot force themself into a relationship. However, the cost of not doing so can be very high for treatment participants. Therapists can help clients to overcome this dilemma by helping clients to learn about relationships rather than holding them accountable for what they do not know or cannot yet do.

You must discuss your complete sexual history with little regard for the possible legal consequences of disclosure

Many treatment programmes require full disclosure of one's sexual history. In many cases, polygraph examinations are used to verify this history. However, provision of adequate legal advice to prevent further prosecution rarely occurs. Anecdotal accounts of situations in which clients who disclosed past crimes believing they were immune from further prosecution were subsequently charged have circulated among professionals (C. Steen, personal communication, 30 December 2010). Here the double-bind is particularly clear: adequate protection from self-incrimination may be insufficient to make treatment progress. In some cases, protecting one's rights (including by declining a polygraph examination) may be grounds for termination from treatment. Given that in some situations termination can result in a return to prison, this is a challenging situation indeed, particularly in the absence of research demonstrating that full disclosure is necessary for successful treatment. Further still, in treatment programmes that expect spontaneous participation in treatment groups an emotional utterance of one's past actions can be downright dangerous.

Treatment is about becoming a new person. However, the community will always regard you as a "sexual offender"

Many professionals are well acquainted with this dilemma, and yet it is rarely an explicit component in treatment programmes or their manuals. This dilemma about one's identity, particularly for those exploring their implicit theories about the world, is crucial to address. This is particularly the case given the emotional sequelae of community reintegration for people who offend and public alike. Further, with many jurisdictions' push towards community notification and registration, people who have sexually offended can no longer escape this dilemma.

"How do you release somebody after building them up as monsters?"

Although not spoken in a treatment session, these words from the former medical director of a civil commitment programme summarise the concerns of many observers of treatment for people with sexual behaviour problems (Oaks, 2008). He was referring to the political nature in which many civil commitment programmes exist. Media accounts of tragic cases have, in many US states, contributed to the existence of civil commitment beyond the expiration of a criminal sentence in prison, ostensibly for treatment purposes. When policymakers and the public view people who have sexually offended as monsters (Sample & Kadleck, 2006), it becomes increasingly challenging to return them to the community. However, the fundamental basis underlying civil commitment laws is that to remain legal and constitutional, residents of civil commitment centres must have the possibility of release. Programmes find themselves in the untenable position of being criticised by stakeholders when they release clients, as well as when they do not. This situation becomes all the more impossible by the fact that these programmes rely upon government funding. In order to ensure a revenue stream, they must be ready to argue that their clientele is so dangerous as to require the often expensive and unpleasant conditions of a secured facility at the same time as they argue that some of their clients can remain safe if released into the community. Although this may be factually correct in specific cases, nuanced messages have a short life in the media and among politicians, who often prefer more polarised messaging.

The effect of this and related discourse about people who have sexually offended can be dramatic to those working in programmes. In this case, the clientele of Minnesota's civil commitment programme have been encouraged to create healthier and more adaptive lives for themselves while no one has been fully discharged to the community in the nearly 17 years of the programme's existence (Demko, 2009). Although outsiders may observe that the law allows for indefinite confinement and residents of commitment centres should therefore focus more upon a good life than on obtaining liberty, this is experienced much more often than not by clients in treatment as the language of politicians and not therapists. By most human standards, a life worth living involves liberty.

There is no cure for sexual offending

"No-cure" language has surfaced in many areas of treatment for people with sexual behaviour problems. However, it has been confusing to client and therapist alike. Research indicates that it is possible to change one's behaviour, even when one has a proclivity towards crime. Ultimately, sexual offending is a behaviour. At a time when there is debate around the inclusion of certain "sexual disorders" in the DSM-V, the medical-model implications of no-cure language becomes even more confusing. On one hand, treatment programmes advocate for long-term behavioural change. On the other hand, clients learn that they cannot be cured. This has serious implications for one's motivations to enter a treatment programme. Treatment programmes can provide relief to clients and communities alike by abandoning this analogy and using more precise language.

"The focus of the program is not completion. It is consistent demonstration of behavioral change" (Oaks, 2008)

This quotation from a letter from an administrator to a civilly committed sexual offender (whose release is dependent upon treatment progress) directly illustrates double-bind communication. With rare exceptions, release to the community is the most important goal

for anyone deprived of their liberties. While consistent demonstration of behavioural change is certainly a vital component of a treatment programme, advising a client away from the direction of programme completion puts the client into an untenable, inescapable and high-stakes situation. Professionals may be more helpful by simply advising clients that although programme completion is a goal shared by all, consistent demonstration of behavioural change is a vital component within it, and suggesting that the client focus more attention on the latter.

Maximum treatment benefit

In a recent and provocative op-ed ("opposite the editorial") piece, Pake (2010) declared: "There is no such thing as success in (sexual offender) treatment". To many, the only true measure of treatment success is confirmation, upon death, that the offender never engaged in another sexually abusive act. However, the practices of risk assessment and community risk management necessarily involve a degree of probability and outcome that assumes that some people pose an acceptable degree of risk to the extent that they might be allowed back into the community. For people participating in institutionally based programming, there is probably a point at which they have learned all that they can learn, and have changed all that they are capable of changing. Some programmes refer to this as the client having reached "maximum treatment benefit". However, as much as some (e.g. clients and their counsel, courts, bureaucrats) may wish to equate this term with successful treatment completion (and an implicit recommendation for release), that may not actually be what programme staff intended to say.

Discussion

Treatment programmes experience enormous pressure to reduce the likelihood of future sexual abuse. Often, these programmes find themselves operating in circumstances where their work is poorly understood (such as when others perceive them as solely responsible for client change) or without adequate knowledge of their clientele (e.g. understanding sexual abuse as an inevitably repetitive pattern for which there is no cure). In the absence of a clear mission or policies, many professionals feel a responsibility for their client's future behaviour.

Against this backdrop, clients enter treatment in varying stages of readiness and ability to change. They frequently possess cognitive schemas that make them suspicious of treatment providers and are less cognitively flexible than other mental health clients. It is all too easy for them to experience their treatment programmes as paradoxical and double-binding. They perceive contradictory messages such as those described above and—most importantly—find themselves in a high-stakes situation in which not complying with one or more expectation of treatment can result in a return to prison.

Treatment providers therefore have an obligation to understand how clients understand their communication. As Beech and Fordham (1997) have observed, people with sexual behaviour problems often rate their therapists as less helpful than therapists believe themselves to be. Further, treatment providers can help to remedy paradoxical situations by recognising and discussing them openly with clients as well as working to resolve them. Often, this can take the form of a double-sided reflection, such as: "On the one hand you experience this expectation, and on the other hand that expectation seems at cross purposes". Similarly, therapeutic approaches aimed at eliciting the client's internal motivations for change can help to resolve these dilemmas for client and therapist alike. If treatment

programmes are to balance the needs of their communities and clients, a recognition of clients' potential double-binds is essential.

Conclusion

The field of treatment for people with sexual behaviour problems remains controversial across many dimensions. It is vital that professionals consider what is known and unknown in society's attempts to reduce the harm of sexual abuse. Communication regarding expectations and probable outcomes is a necessary component of a helpful dialogue between professionals and the community. Given the stakes involved, it is crucial that our field turns a critical eye to the nature of its communication with our clients, with ourselves and with other stakeholders in the community safety endeavour.

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