

## **Victim or Offender: Stigma, Justice, and the Importance of Critical Thinking in a Complex Forensic Case**

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### **Abstract**

This is a case study about the importance of critical thinking and ethical reasoning in clinical work with stigmatized persons. Our professional ethics tell us that as social workers we have an obligation to social justice. By extension that implies justice itself. By studying a complicated forensic case—that of a young sex offender who also has a substantial history of sexual victimization in childhood and adolescence—I hope to demonstrate that examining our confirmation bias in work with stigmatized clients has more utility than the simple awareness of counter-transference. Given that stigma is ubiquitous, my thesis is that critical thinking and ethical reasoning are essential in work with stigmatized clients. As social workers we cannot eliminate stigma. But we can assist stigmatized clients in coping well and developing resilience that will support them in preventing relapse of the behaviors that led to their stigmatized status. When treatment is approached in that manner, the needs of both society and the client are best served.

*\*Privacy Disclaimer: To protect the confidentiality of the client, identifying information has been disguised and certain details have been concealed.*

## **Prologue**

Charlie committed his offenses just one day after his 18th birthday. During the course of an afternoon he fondled two clothed boys in full public view in two different department stores. Technically, they were clumsy forms of frottage, wherein the offender will grope someone over their clothes in a crowded place like a subway train. Charlie's first target was an eight-year-old boy. He was standing next to his mother when Charlie groped his buttocks. Charlie then went to another store and saw an eight- or nine-year-old boy in the pharmacy department. That boy was testing his blood pressure, seated, his arm in a cuff. Charlie groped the boy's crotch and then asked the shocked child if he would like to go with him to the men's restroom. Charlie saw that he was noticed, and he panicked. Instead of leaving the store, he went into the men's bathroom, where security guards apprehended him.

After Charlie was arrested, the police found surgical gloves, Vaseline, bungee cord straps, and a large, serrated knife in the cab of his truck. Understandably, the police were alarmed. Somehow, the media was alerted and Charlie was on the six o'clock news. From this point forward, Charlie would have no control over his identity. He would be labeled a sex offender.

Before he would be sentenced, neighbors would vandalize his parents' home. He would be denied employment and lose friends and supporters. Travel across state lines would be prohibited. To make matters worse, the paraphernalia found in his truck made him appear like a sadistic, violent offender. I was skeptical that I could help him on a voluntary, outpatient basis. After a relatively long period of engagement, he became one of the most noteworthy clients of my career. I learned a lot from working on his case, and it changed many of my previously held beliefs. Hopefully, I will demonstrate in this paper that a case narrative can yield new practice knowledge.

## **Introduction: The Clinical Context**

In the early 1990s, many of my colleagues were working with trauma survivors, such as adult sexual abuse victims. In his book *Crazy Like Us: The Globalization of the American Psyche*, Ethan Watters (2011) tells us that "if you were an ambitious researcher in psychology or psychiatry during the 1990s, PTSD was where the action was" (p. 72). My colleagues claimed to be seeing more and more clients with disorders along the

dissociative spectrum. It became a mark of clinical distinction to be able to count clients with multiple personality disorder (MPD) among one's cases. Some believed in phenomena like recovered memory, which we now know to be a fallacy.<sup>1</sup> There was, in addition, a voyeuristic quality to their fascination. What seemed to me to be a sudden and popular surge in what was once considered a rare diagnostic syndrome further spurred my skepticism. So, when I had an opportunity to be trained to work on the other side of the street—to treat sex offenders—my curiosity took over where my skepticism left off.

This is a case study about the importance of critical thinking and ethical reasoning in clinical work with stigmatized persons. The subject is a pre-adjudicated sex offender whose individual case challenges conventional assumptions. He does not represent the typical offender who poses a clear threat to the community. At this point the reader might be asking, "why use a sex offender as an example—they aren't a sympathetic population." My reply would be, "why not?" Questioning the use of a sex offender in a case study is tantamount to proving my thesis, which is that people will apply stigma automatically whenever certain language or labels are used. My argument is that, as clinicians, we ought not use stigma or participate in stigmatization.

The dimension of stigma that sex offenders occupy is characterized as "controllability of causes" (Corrigan, 2000, p. 52). In short, many people believe that offenders are able to control their actions despite the fact that a number of them have a diagnosable sexual disorder, impulse control disorder, or are re-enacting their own abusive traumas. Because sex abuse is aberrant and often harmful, most perpetrators—regardless of the facts of their crimes—are seen as dangerous. They are the only class of criminal offender who continue to be punished once their sentence has been concluded (Sample & Bray, 2003, p. 66). The stigma they endure is particularly toxic because the laws governing their management are harsher than those for any other criminal act.

Sex offender-specific therapy (SOST) is cognitive-behavioral, evidence based, and outcome driven (Marshall & Laws, 2003). In many settings it is a manualized form of treatment (Mann, 2009). It evolved as a reaction against psychodynamic approaches to the treatment of sex offenders, which were largely ineffective. In

keeping with the tenets of cognitive-behavioral therapy (CBT), SOST clinicians do not concern themselves with transference or counter-transference. Instead, they use a relapse prevention approach, which is a reasonably scientific and non-judgmental method. However, when Alan Marlatt (1985) developed and promoted the concept of relapse prevention, it was meant to apply to addictive behaviors, not aggressive behaviors that violate the rights of others. Techniques such as motivational interviewing are also utilized, which stress the importance of clinician empathy (Miller, Rollnick, & Moyers, 1998, p. 5). Motivational interviewing was also developed for the treatment of addicts, so SOST needs a stronger foundation on which to claim efficacy.

Research on SOST efficacy is the product of randomized clinical trials (RCTs). Researchers of SOST defend the use of RCTs on the grounds that such research is scientifically sufficient (Seto et al. 2008). Detractors against the use of RCTs include William Marshall, one of the early proponents of utilizing CBT with sexual offenders (Marshall & Marshall, 2007). Within the field, the debate appears to be one of good science versus good clinical work. If applied as designed, SOST is not a harsh or punishing therapy. But SOST in its pure form does sequester behavioral symptoms and does not address the whole person. Underlying dynamic issues become reduced to "triggers." Outside of that framework, the offender's experience is far less relevant to the treatment.

The rate of sex offender recidivism is lower than or equal to that of recidivism for all criminal offenders (Sample & Bray, 2003, pp. 64–66). Yet, the public believes that most offenders will offend again. Risk-assessment instruments have been developed to predict risk based on actuarial factors (Hanson & Bussiere, 1998; Stokes, Berg, Cobbina, Huebner, & Valentine, 2006). Some instruments weigh fixed variables only, such as the age of the victim, the gender of the victim, and the number of victims. Other instruments address both dynamic and fixed measures. Dynamic variables, such as marital status, length of time since the last offense, and response to treatment, are seen by some as important predictors of continued or reduced risk. Overall these actuarial scales are useful for clinicians as well as law enforcement. Many have been rigorously researched and are considered valid and reliable (Witt, 2000). But that may not be enough to reassure society. When science and good clinical

<sup>1</sup> The research of Elizabeth Loftus (1996) has been credited with de-bunking the idea of recovered memory.

work is not enough, society and its agents can employ stigma.

Sex offender specific therapy has been criticized as a “one size fits all approach” (Laws & Ward, 2006). Having facilitated SOST, I would not argue against that perception. Simple approaches to solving complex, systemic social and public health problems may lull communities into a false sense of safety. For the clinician, the challenges are abundant. It is impossible to conduct SOST without also considering the safety of the community. Conversely, for various reasons, some offenders pull for the clinician’s sympathy. Because SOST does not utilize an analysis of counter-transference, it is easy for an inexperienced clinician to fall to one or the other side of the dialectic arc that emphasizes a demand-for-work or overuse of clinician empathy, which Marsha Linehan outlined in her approach to the treatment of borderline personality disorders (1993). As regards SOST, I think there exists an offender-victim dialectic. It is easy to have empathy for victims. Conversely, it is easy to have contempt for perpetrators of sexual abuse. Providers of SOST often struggle with this dichotomy. Most navigate it well. For the clinician working within the SOST context with a client who is both victim and offender, the demands are more challenging. The solution is critical thinking and ethical reasoning.

### Charlie I

Charlie’s parents found a competent, well-respected criminal defense attorney who sent Charlie to my mentor, Dr. White, for an evaluation. The lawyer wanted to know what kind of risk Charlie might present to the community if he were released on bail. If the risks were acceptable, then treatment would be recommended.

Dr. White was puzzled by Charlie’s case. Unlike most “stranger danger” offenses, Charlie’s were crude, public, and verified by witnesses. On the surface, his offenses were negligible when compared to Dr. White’s usual referrals. Charlie had no prior history of sexually deviant behavior and could not articulate any credible fantasies that focused on young boys. Instead, they were vague and impressionistic. If there is such a thing as a “deviant sexual fantasy narrative,” this one was not it. Charlie insisted that he was heterosexual and explained the paraphernalia in a plausible fashion. The knife and bungee cords were for kayaking (he was an accomplished kayaker), and the gloves and Vaseline were for digitally

penetrating his girlfriend. Charlie had a learning disability that made him a literal processor of information. When his health teacher said that preventing HIV transmission involved condoms and certain lubrications, Charlie understood that to mean he needed such protection on his hands, too.

My first session with Charlie was frustrating, despite his superficial cooperation. He appeared on time without his parents. He was dressed casually and was polite and friendly. He was a good-looking, older adolescent, somewhat shorter than average in height, and athletic but stocky. We began by reviewing Dr. White’s report and the discovery material.

“So Charlie,” I asked, “you told Dr. White that you only like girls. If that’s so, what sense do you make out of what you did? Many straight guys discover they like girls by messing around with boys when they are young. That’s usually done in private. You groped two boys in full, public view. You know yourself better than I do. What do you think?”

Charlie shrugged his shoulders, looked at me and flashed a disarmingly open and friendly smile. I asked, “Have you ever fantasized about young boys?” referring to the two fantasies he told Dr. White. Charlie offered the same vague, impressionistic fantasies to me. First, he recalled a dream where he was on a beach watching a boy of nine or 10 playing on the sand. He claimed the dream aroused him but not enough to serve as a masturbation fantasy. The second fantasy was also from a dream, according to Charlie. There may have been a fantasy while awake, but he could not recall the details. When asked how often he masturbated to fantasies involving boys or men, his denial was adamant. Well, adamant for him: “Nope.”

I asked him about his relationship with his girlfriend. How often did they have sex? “Never.” How often do you mess around with each other? “Sometimes.” When you do mess around, what do you do? “Just stuff. You know...”

“No, Charlie—I really don’t know. Is sex difficult for you to discuss?”

“No, I don’t mind talking about it.”

I found him elusive. Yes, he answered my questions, but would not elaborate, even if I made my questions specific or encouraged him to tell me more. After several more rounds of questions, I learned that his girlfriend broke up with him because of his arrest. “I’m sorry to hear that, Charlie—do you miss her? I mean, especially now with everything going on...”

"No, we weren't very serious." Interviewing him was like trying to nail Jell-O to the wall. I made a point of trying to explore what it meant that his offenses occurred only one day after his 18th birthday. That also bore no fruit. "Just bad luck, I guess." I hunkered down for a slog, not yet aware of the prescience of his reply. I doubt that he recognized the implications of his response either.

### Stigma, Briefly

Stigma as a method of social control dates far back. Reference to stigma may be found in "The Procession" chapter near the end of Nathaniel Hawthorne's *The Scarlet Letter*. Hester Prynne was convicted of adultery under Puritan law. She bears a child as the product of a single moment of desire with the revered, local minister. She keeps the identity of her lover a secret in spite of intense pressure to reveal his identity. Part of her sentence involves wearing a scarlet-colored letter "A" on her clothes. In this passage, Hester is in the marketplace following a particularly successful sermon given by her former paramour:

While Hester stood in that tragic circle of ignominy, where the stunning cruelty of her sentence seemed to have fixed her forever, the admirable preacher was looking down from his sacred pulpit upon an audience whose very inmost spirits had yielded to his control. The sainted minister in the church! The woman of the scarlet letter in the marketplace! What imagination would have been irreverent enough to surmise that the same scorching stigma was on them both! (1850/2003, p. 221)

This passage reveals the inherent social violence that stigma confers on individuals. Hester's life, although an isolated one, can contain dignity because she has nothing left to lose. By refusing to reveal her lover's identity, she chooses to retain some control over her life, thereby frustrating the community's effort to shame both her and unknown other person.

Sociologist Erving Goffman defines stigma as a term "used to refer to an attribute that is deeply discrediting"; the stigmatized person "is thus reduced in our minds from a whole and usual person to a tainted and discredited one" (1963, p. 3). As stated in the title of his classic, *Stigma: Notes on the Management of Spoiled Identity* (1963), Goffman describes the various processes

through which society and its agents use stigma to manage the unwanted other.

How stigma is bestowed is based on the historical setting in which it is used. The following passage tells that stigma is a cruel relic of an unenlightened pre-modern era:

With knives and branding irons, the ancient Greeks would slice and burn criminals and traitors to denote their immorality or lack of fitness for regular society. Such a mark was called a "stigma," and an individual bearing a stigma was to be discredited, scorned and avoided...To stigmatize an individual is to *define* in terms of (their) negative attribute...Most researchers of stigma note that the process of stigmatization has a long history and is cross-culturally ubiquitous. (Neuberg, Smith, & Asher, 2003, p. 31)

In this passage, Neuberg, Smith, and Asher tell how the ancient Greeks used physical marks on offenders. Brutal and bodily stigma has no place in the ethos of our contemporary world. In the 21st century, we do not use branding irons or tattoos to communicate stigma. We use information technology. Information about anyone's background is easily available online for free (if one knows where to look) or for a minor fee. We have the Internet to tell us whom we can scorn and discredit.

Writing several decades prior to the emergence of the Internet, Goffman describes how stigma is communicated through various forms of "information control" (1963, pp. 41-104):

Apparently in middle class circles today, the more there is about the individual that deviates in an undesirable direction from what might have been expected to be true of him, the more he is obliged to volunteer information about himself, even though the cost to him of candor may have increased proportionately...Here the right to reticence seem earned only by having nothing to hide. It seems that in order to handle his personal identity it will be necessary for the individual to know whom he owes much information and to whom he owes very little—even though in all cases he may be obliged to refrain from telling an "outright" lie. (p. 64)

This places the offender in a double bind in which they are leveraged to participate in their own stigmatization. They cannot pass a routine

background check; if they reveal their status on a job application, they won't even get to the background check. The offender can be easily known because their identities are recorded on state and federal registration sites on the Internet.

Sex offenders, however, are deviant. They engage in taboo-breaking, criminal behavior that often harms those who are less powerful. The use of stigma against them is to be expected. Societal deviance results from collective social agreement. A pedophile may be secretly deviant, or societally deviant if the community knew about his secret life. If urges are acted upon and he is apprehended, the pedophile (a psychiatric diagnosis) becomes a sex offender. At that point, he is a situational deviant. The criminal act leads to prosecution, conviction, and the application of the label "sex offender." This is acceptable, assuming a just and effective legal system. But what if the prosecution is false and leads to a false conviction? Or, what happens if the prosecution leads to a wrong or unjust, but not false, conviction? The label sticks, even if the person is acquitted or found to be innocent at a later time. Once the situational stigma exists, it becomes the property of society (Falk, 2001, pp. 22, 311–330).

The question I want to address has to do with complexity and justice. As I will describe later in this paper, not all criminal acts are volitional or committed by someone with the intent of exploiting another person or persons. In the introduction, I made reference to the dimension of stigma called controllability of cause. What if someone's aberrant, taboo-breaking behavior could be understood in another, perhaps more humanistic context? Would that mitigate situational stigma or fine-tune it to take into consideration every aspect of the situational context? Or, is stigma such a blunt instrument that contextual factors are irrelevant? Conversely, maybe we have become too civilized with respect to how we stigmatize. While it is true that Internet registries do not maim or physically mark offenders, they do violence to their identity. This includes those who sincerely wish to reform, as well as those who have been reformed. Information on the Internet is permanent.

Because of sex offender registry laws, many sex offenders live under a panoptic gaze.<sup>2</sup> They

never know who knows about them at any given time. Under federal law, all states must maintain an online Internet registry that contains a photograph of the offender, the crime(s) committed, and, often, the offender's home address. These registries are easily accessible to the public because they are intended for public use. In New Jersey, real estate agents are required to inform potential homebuyers if a moderate or high-risk offender lives in the neighborhood. All states require that offenders register with local police on a regular basis, and many states have some form of "supervision for life" that is administered by parole officers. These measures are of dubious utility to the community and hinder the offender's ability to find housing or employment (Levenson, D'Amora, & Hern, 2007).

Offenders committed to preventing recidivism carry the double burden of having to monitor their own (potential) urges and their fear that they might violate some bureaucratic condition of their lifetime parole. People assume that once a sentence has been concluded a criminal offender is allowed to return to his or her previous status, their debt to society paid in full. In principle, it is only fair to offer a second chance. But in practice, all sex offenders, and ex-felons in general, are subject to information control, especially when it comes to background checks and Internet registries (Tewksbury & Lees, 2007). The effect of an invisible scarlet letter truly does violence to the life space of those who "wear" it.

### **The Role of Ethical Reasoning and Critical Thinking**

Social work is a transdisciplinary profession. We study the humanities and the social sciences. Some work settings demand a mastery of legal or medical knowledge. I propose two additional realms of knowledge for clinical social workers. The first requires the study of biomedical ethics.<sup>3</sup> If a counselor, psychologist or clinical social

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different sections of the yard and individual cells. If they saw violations to the no-contact rule, they would remove the inmates to even more solitary seclusion. In the end, many inmates went mad. It seems that not knowing when they were being observed drove them crazy. The power is in the hands of the watcher, not the watched (Semple, 1993).

<sup>3</sup> A paper of this length does not have the scope to adequately address the magnitude of what biomedical ethics can offer clinical social workers. Tom Beauchamp and James Childress offer a comprehensive source in their book, *The Principles of Biomedical Ethics* (2001). Readers simply have to generalize from a medical to a mental health context in order to tap their wisdom.

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<sup>2</sup> The Panopticon was a prison model influenced by philosopher Jeremy Bentham and the Quakers. It was designed to foster meditative self-reflection. Inmates were not permitted contact with each other. They were monitored from a tower built in the center of the prison called the Panopticon. Guards were stationed in the tower at various times, looking at

worker provides a diagnosis or a procedure code they are working in the medical model. Therefore, biomedical ethics can come into play.

Biomedical ethics offers three major models of decision-making: deontology (principles-based), consequential utilitarianism, or virtues. Each model addresses the four principles of biomedical ethics from their unique vantage. Those four principles are: beneficence (do good), non-maleficence (do not harm), respect for autonomy, and justice. Ethical reasoning in clinical social work focuses on deontology or the rules that determine what can't be done and what should be done. But, I argue that ethics can help clinicians decide what can be done in equal or higher contrast to what should not be done. Everything a clinician does has ethical as well as clinical implications. Everything, from what theories we practice to what populations we favor, reflects our ethics. Even our smallest interventions reveal our ethical philosophies.

Most clinical social workers begin their careers as deontologists. The problem with deontology, which assumes that an unwanted outcome can be countenanced if the rules were followed, is that it serves the clinician more than the client. Deontology, in short, is about professional practice risk reduction. Over time and with experience, many clinicians become consequentialists: the rules may be bent or even broken if, in the end, the right outcome ensues. Later in this paper I will suggest another approach social work may want to embrace. For now, I will state that when I began working with Charlie I leaned more towards deontology, but my work with him taught me the value of a consequentialist approach.

Social workers are familiar with the principles of justice and autonomy; however, in biomedical ethics, justice has a broader meaning, as it emphasizes the importance of proportion. In some contexts, proportion refers to the just distribution of healthcare resources, in others it refers to the just treatment of a person. Unlike law, justice in medicine is not blind. Some persons, by virtue of the complexity of their case, deserve care in a higher proportion, as long as the clinician's reasoning is consistent throughout all of her or his casework.

The second school of thought that should be part of clinical training is social psychology, which studies stigma and the phenomena of confirmation bias. Simply, confirmation bias is "the inappropriate bolstering of hypotheses or beliefs whose truth is in question" (Nickerson,

1998, p. 175). On macro (theory) and micro (practice) levels, confirmation bias can facilitate the labeling that drives stigma. Social psychologist Raymond A. Nickerson writes:

The history of science contains many examples of individual scientists tenaciously holding on to favored theories long after the evidence against them had become sufficiently strong to persuade others without the same vested interests to discard them...All of them can be seen as examples of the confirmation bias manifesting itself as an unwillingness to give deserved weight to evidence that tells against a favored view. (1998, p. 195)

When clinicians practice with knowledge of confirmation bias, they are going beyond recognition of their subjective countertransference. They are working with a broader hypothesis that can raise questions as to whether or not stereotypes about certain persons are correct. Confirmation bias theory asks clinicians to consider whether or not their work contains double standards. The challenge for the clinician is how and when to recognize that they ought to examine their work. Reflexivity evolves with experience over time. Oftentimes, good supervision can help a clinician learn to recognize when to think critically. Such awareness can lead to an integration of ethical reasoning and clinical acumen. Sound clinical skills alone are not enough to make for good therapy. If incorporated with the ability to think critically, then good therapy becomes excellent therapy. If I wanted Charlie's treatment to be excellent, I realized that I had to throw the SOST manual out the window. That was my first step towards consequentialism. The next phase of his therapy changed the way I thought about many things. What follows is how I learned to value critical thinking.

## Charlie II

The subsequent few sessions with Charlie were uneventful, unless we were talking about his interest in outdoor sports. Charlie was quite skilled at kayaking, canoeing, and, primarily, mountain biking. He took pride in his capacity for measured, informed risk taking. For example, he was able to handle a 6-ft drop while pedaling his mountain bike at full bearing and land successfully. He had won many awards for his cycling. Prior to his arrest, he was working on getting a sponsor so

that he could compete on a higher level. I enjoyed getting to know that part of Charlie, but I was concerned that I might be colluding with him to avoid the unpleasant topic of his offenses. In an effort to get him to open up more, I suggested that he join one of my offender groups. The members of that group were much older than Charlie. None had young male victims. Like Charlie, some were still under investigation. They formed a very cohesive group of nonjudgmental and accepting men. At 18, Charlie would be the youngest member. I wanted the group to be protective towards him, maybe draw him out.

One evening, after a few group meetings were under his belt, Charlie arrived visibly distressed. He had just met with his attorney. The group feared that Charlie was going to jail. This was an unstated but constant fear that hung over each group member. One of the guys asked him what had happened. Charlie burst into tears and said: "I told him the truth—he said he knew I was hiding something—I just couldn't keep it in any more—so I told him everything." Assuming the worst, I thought that Charlie had just confessed more offenses to his attorney. That would not have been unusual: many offenders have hidden offenses and will shift into a confessional mode under the right conditions. A group member asked Charlie: "What did your lawyer think you were hiding?" With the prompt of a specific question, Charlie revealed to the group that his older brother (by four years) had been repeatedly and aggressively molesting him since his earliest recollections. The abuse involved penetration and was coercive. That was Charlie's secret and he revealed it in tears.

My reaction was immediate. It was an "aha" moment—which, I suspect, is what the experience of shedding confirmation bias must feel like.<sup>4</sup> All of my resistance to believing that dissociation was a common response to sexual abuse evaporated. Everything Charlie said made sense from what I had been told about post-traumatic stress. He was recalling experiences that involved helplessness and horror. He coped by dissociating. I wish I could report that his individual sessions became infused with new energy and that the prosecutor saw Charlie as a victim and chose to investigate

his brother instead. But that's not what happened. The catharsis had a momentary impact on Charlie that allowed him to reveal his truth. Dissociation is a powerfully effective coping mechanism. I knew that I had to change tack from the SOST model I was employing to something more dynamic. It was an ethical decision as much as a clinical one. I chose to see Charlie more as a victim than a perpetrator. This meant that I had to examine my own biases regarding dissociation and reconfigure his treatment plan. It also meant that I would have to be mindful of the offender-victim dialectic. I could give more weight to helping the victim-in-Charlie but not at the expense of minimizing that fact that he also offended. It would be in his best interest not to repeat what got him into this situation in the first place. If his dissociative coping triggered his offense, then addressing his personal history of abuse would be essential. Proportion would need to be the guiding principle, and I did my best to strike a balance between the dual demands of his therapy.

### Critical Thinking In Situ

In retrospect, I realize that my skepticism—my *reverse* confirmation bias—regarding multiple personality disorders (MPD) caused me to reject the phenomenon of dissociation itself and how it could be used as a defensive mechanism or as a coping strategy. Charlie's revelation changed all of that. I saw firsthand that dissociation and its more metaphysical manifestation, MPD, were two very different phenomena. But, his case brought trouble to the way I had been trained to conceptualize and treat sex offenders. I sought out supervision from a psychologist who understood dissociation. He had treated a number of cases similar to Charlie's. He helped me to integrate SOST with an approach that addressed Charlie's PTSD.

Supervision taught me to examine my biases, not my countertransference. For one, I believed that if offenders had an exclusive history of homosexual offenses against minors, they could learn to be attracted to older males—especially if they targeted adolescents with secondary sex characteristics. At that time in my career, I was interested in John Money's theory of "love maps" (1988).<sup>5</sup> Essentially, Money proposed that our

<sup>4</sup> I include this critical incident in Charlie's treatment to illustrate how shedding a confirmation bias might be experientially different from a clinician's experience of countertransference. Typically, clinicians try to induce breakthroughs in their clients, not in themselves. Had I not allowed myself to consider what this new information meant, I would not have been able to offer him a true therapeutic alliance.

<sup>5</sup> My interest in Money's ideas existed prior to the revelations that discredited him. That story, as told in John Colapinto's *As*

patterns of arousal are either “normaphilic” (with love) or “paraphilic” (cleaved from love) (1988, p. 1). Arousal and erotic associations were shaped and conditioned by childhood experiences, both traumatic as well as random and idiosyncratic. I believed that what was learned could be unlearned. I saw arousal as a form of appetite and hypothesized that new appetites could be acquired. Once that was accomplished, I believed they could “become” gay; I wasn’t ignoring the issue of orientation.

To test my hypothesis, I used standard relapse prevention and victim-empathy strategies but integrated a gay-affirming approach into the treatment. I had training in sexual-arousal reconditioning and incorporated homosexual-erotic material into the exercises. Also, I put offenders with male victims together in a separate therapy group from heterosexual offenders. This went against what other specialists did, but I was trying to remove as much homophobic bias as possible from the treatment of male-target offenders.

At that time I believed that homosexual offenders could shed one stigmatized identity for another that at least offered community. Social psychologist Gerhard Falk might say that homosexuality—expressed as gay identity—would reflect simple societal stigma (2001, p. 22). I thought that perhaps some of my clients were trying to avoid societal stigma by passing as heterosexuals. That gave them access to young males. Passing functioned to arrest their psychosexual development. By not acquiring a more age-appropriate sexual appetite, they got stuck in an attraction to minors. Ironically, being apprehended earned them a worse, situational stigma—the form of stigma I assumed they wanted to avoid. In my mind, I reasoned that their stigma could simply be reversed to the societal version, one that could be coped with more easily and reduce the risk of recidivism.

What I failed to grasp was that I was reasoning within the dimension of controllability of causes. When I realized that Charlie was not in control of the causes of his behavior—and of his behavior itself on the day he offended—I began to see the complexity of his case. Charlie didn’t have a shred of homosexual or even pedophilic arousal. My naïve notions regarding sexual orientation withered on the vine when confronted with the power of dissociation.

### Charlie III

Shortly after the group session, I reviewed the discovery material again. I noticed that there was about four hours in between the first and second offenses. I asked Charlie how much time he thought had elapsed between the two incidents. His response was “about a half hour.” That got my attention. If he were dissociating, he would have lost track of time. I asked him again about the fact that his offenses occurred one day after he turned 18—except this time I asked, “What happened in the day or two before you offended?” Charlie answered that he had just learned that his brother had flunked out of college and would be returning home soon to live with the family. He didn’t think he could reveal the incest to his parents, so by offending he functionally—albeit unconsciously—placed himself in a situation where the truth had to come out. He admitted that he was still afraid of the power his brother had over him.

Over time Charlie would tell me everything, but not immediately and not entirely before he was sentenced. He was still using avoidance and dissociation; confessional catharsis only works briefly. What I learned in the short term, though, was enough to build on. His was a tale of neglect and terror. I found some of the details gruesome; I did not want those images in my head. But in the sessions where he would reveal details of his abuse, I practiced how to listen to a war story: sit still, don’t lean backward or forward, avoid any expression of voyeuristic interest or repulsion, and above all just listen and keep eye contact.

I characterize his tale as one of neglect because most of the assaults happened in the home while one or both parents were present. One of Charlie’s early, clear memories was about something he witnessed. He recalled his brother and another boy his brother’s age attempting to insert golf balls into the anus of a four-year-old boy. In supervision, I was taught the importance of pulling for details, the goal being to bring dissociated, emotional memory to the fore, where it could be reprocessed and mastered. I asked Charlie if he was afraid it would happen to him, thinking he was ready to trust me enough to push through his haze and provide more detail. But he couldn’t recall much more, and I was reluctant to press the issue. Another recollection was that his mother entered his bedroom when Chris and he were in flagrante. Nothing was ever said. Later, during a family session, his mother sadly whispered something to the effect that “boys will

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*Nature Made Him: The Boy that was Raised as a Girl* (2000), is a prime example of the dangers of confirmation bias.



be boys.” Charlie would report such recollections only when he was ready and without drama. Typically, he would describe them in a superficial, matter-of-fact manner. He knew that he felt terror but could not recall what terror felt like. “I guess I felt numb,” said Charlie. Like most people with PTSD, he split his emotional memory apart from his factual memory.

I continued to struggle with my biases, however. At times, I was concerned about whether or not I was the right therapist for Charlie. I didn’t believe that I had in me what my colleagues who treated adult survivors of abuse had in them. For one, they felt a unique, singular empathy towards adult survivors of sexual abuse. My beliefs were more neutral and objective. During graduate school, I worked with World War II veterans who had been prisoners of the Germans. That exposure to post-traumatic stress was quite instructive. I easily could have adopted a belief that war-related imprisonment is the worst horror, but the POW camp survivors themselves taught me that there is no hierarchy of horror. While listening to the men describe their experiences in group therapy, I learned that no one category of trauma trumps another. Such beliefs impede healing.

Briefly, I considered dropping his case, but I couldn’t. The issue was Charlie’s age. To me, 18 was still developmentally adolescent. I couldn’t ignore his abuse history and its potential relationship to his offense. His memories were still fresh enough to be credible. As a therapist who worked with perpetrators, I did not doubt that the abuse itself was real. Ultimately, I accepted the challenge to approach his therapy from the perspective that he was a victim who happened to offend reactively to his own history of abuse. Through supervision, I learned his offense functioned as a cry for help. I wanted to give him that help, believing that addressing his own abuse history would reduce or eliminate a powerful relapse trigger.

I was also concerned about Charlie’s brother, Chris. Allegedly, he was a serious repetitive perpetrator. A part of me thought that Chris should be my client, not Charlie. After all, Chris fit the profile of the kind of offender I had been trained to treat. Mostly, though, if I were treating Chris, I wouldn’t have to care as much. Admittedly, I was not allowing for the possibility that Chris too was a victim. But, by then, I had begun to feel protective of Charlie. I saw him as the victim. By allowing the breakthrough that challenged my skepticism and bias regarding dissociation, my experience of Charlie changed. I admired his

willingness to trust, despite his own experiences being abused by an older male.

I conducted some family sessions, sans Chris, but it would be a few years before Charlie’s parents could grasp what had happened. An immediate acceptance that one child harmed another is a lot to expect from parents. Also, the family sessions were just too difficult for Charlie, his mother, and his father. His parents were being asked, in effect, to choose one child over another.

In my individual work with Charlie, I focused on offering him a safe, therapeutic relationship. As our alliance grew, so did my confidence. In reviewing his case in preparation for this paper, I was reminded of a theory from biomedical ethics. Good treatment involves comfort with power. In my experience, even experienced professional social workers seem uncomfortable with the idea that they have power. Yet, for many of our clients, we are primary in their lives. They attribute us with the power to help. Physician and ethicist Howard Brody postulates in his book, *The Healer’s Power* (1993), that physicians ought to feel confident to own their power, share it with the patient, and aim it at the disease together. Many social work readers might think that Brody’s concept is another way to describe the partnership between client and clinician. But I believe Brody is expanding the notion of partnership by acknowledging the power held by the healer.

Perhaps clinical social workers ought to hold the same notion. Confidence and power, when ethically utilized, can be an essential component of a therapeutic relationship. I maintain that without the confidence to acknowledge our power as clinicians, a vacuum is created which makes us vulnerable to confirmation bias. Instead of trusting our own experience, observations, and wisdom, we may depend upon external variables such as zeitgeist and outcome-driven approaches to inform our treatment. This is one way in which our work becomes manualized. As my confidence in working without the manual grew, I think Charlie’s confidence in his own self grew as well.

### A Question of Justice

With work in individual therapy, Charlie was able to establish his own plan for safety, and he overcame his fear of his brother. Meanwhile, his criminal case was stalled. Uncertainty and false hope of avoiding incarceration began to eat away at Charlie. The prosecutor had just lost two highly visible jury trials in which the alleged sex

offenders were acquitted. He was not going to take a loss with Charlie, even though it could have been judicious to at least investigate his brother. There were other victims—albeit older by then—in the neighborhood. Once they learned about Charlie’s offenses, they began vandalizing the family’s home. The police would not respond. Still, no attempt was made to pursue his brother’s alleged crimes. Moreover, there was a realistic possibility that a known offender who had lived in the neighborhood may have victimized Charlie’s brother, but Chris wasn’t talking. If the prosecutor wanted to protect children, how come he did not investigate beyond Charlie? I speculated that the prosecutor wanted a win so much that he failed to recognize his own confirmation bias.

Charlie’s attorney made every attempt possible to mount an aggressive defense. The impact on Charlie was to feel tortured by hope. This compounded his trauma. It became difficult for Charlie to work on past traumatic injury while he was experiencing psychological and emotional trauma as a result of the glacial pace of the justice system. Charlie’s mountain biking became more and more risky. He misjudged a jump, fell, and broke his collarbone. He admitted to a passive death wish and promised to ride more safely. By then, we had developed a solid therapeutic alliance, and our sessions were more about support and coping.<sup>6</sup>

Eventually, Charlie cracked under the pressure. He was caught smoking marijuana with a friend on public, school property. With no other maneuvers (or funds) available, Charlie’s attorney recommended that Charlie accept a plea bargain that assumed exposure to incarceration. The drug charges were dropped, which was a small concession.

I felt helpless and so did his attorney. He admitted to me that Charlie’s case was the most upsetting defense in his career so far. He was a former prosecutor and a father. He understood what was at stake. After sentencing, Charlie was evaluated at a state prison that houses a sex-offender-specific treatment program (SOTP). If Charlie met the criteria of “repetitive and compulsive,” he would be eligible to serve his sentence there, where he would receive treatment.

Admission criteria to the SOTP are simple. Based on the fact that he groped *two* boys in one

afternoon, he was found repetitive. Based on the interviewer’s review of discovery materials, the House-Person-Tree Test, a standard psychological inventory, and an interview, he found Charlie compulsive. Charlie served almost three years at the SOTP, followed by lifetime parole supervision and registration. He was more verbal and alert after his incarceration than I would have predicted. He said that he did listen to everything I tried to teach him about dissociation but just couldn’t express how he was processing the material. He stated that he knew he had used dissociation in the past. After prison, he simply could not employ that strategy any more. He replaced it with stoic resilience.

I continue to see Charlie. I can attest to the fact that he no longer dissociates, which is not always merciful. He feels everything he couldn’t feel before. Charlie has bad luck. Although I believe in the power of the unconscious and its capacity to grant secret, self-defeating wishes, I also believed in randomness. Attempting to locate Charlie’s problems on his subconscious desires—or even conscious ones, for that matter—is something I would have done in my more skeptical days, prior to meeting him, when I believed in controllability of cause. Faulting people like Charlie for having a life of misfortune is an attempt to distance our selves from the horror we feel when we discover how little control we have over that which happens to us.

When compared to offenses perpetrated by fixated or serial offenders, I think Charlie’s were nominal and that his punishment was excessive. I have struggled with the duality Charlie’s case represents. As a clinician with experience treating perpetrators, I believe without reservation that the impact of sexual abuse should not be minimized. I am certain that the two boys he groped were frightened. But, Charlie was caught before worse could happen, and consequently, his victims could be assured that justice would prevail and they would be safe. More harm was done to Charlie than he ever caused to another person. From an ethical standpoint, I do not believe that the principle of justice was served. Justice requires proportion. In my view, the principle of proportion should carry greater weight in complex cases like Charlie’s. By offering him a therapeutic alliance that was accepting, supportive, and positive, I was trying to balance out the injustice he was facing and bring some proportion to his life situation. That exemplifies the way in which clinical and ethical reasoning intertwine. I believe that a just sentence would

<sup>6</sup> Years later, Charlie would tell me that his relationship with me helped correct his damaged relationship with his brother. He called me the “older brother he wished he had had.” Had I stuck to the manual, I doubt that Charlie would have had such a corrective experience.

have allowed Charlie to remain in the community with probation supervision and continue treatment. I would also pose this question: is it even ethical to treat someone like Charlie as a sex offender—legally as well as clinically? I thought not and I did not.

### Conclusion

When I began this case study, I wanted to make the argument that critical thinking and ethical reasoning could actually mitigate stigma. But, the more I read about stigma and its history and the more I reflected on my work with sex offenders, it became clear that stigma as a social force is far more powerful than anything good clinical work can mitigate. A colleague pointed out to me that stigma can be traced back to Biblical times. It then occurred to me that in addition to social control, stigma might also be a collective reflection of fear we believe we cannot manage as individuals. When the courts (the most authoritative body of society) are perceived to respond inadequately to heinous behavior, stigma takes charge. The social impulse to use stigma to manage those who frighten, confuse, or threaten us surpasses whatever technology we have at hand. In a postindustrial and postmodern world, we don't have to brand people or mark them. Information technology can accomplish that for us by keeping people out of the work force or out of our back yards. I would like to state that we create technology whose use is beyond our moral grasp. But, I cannot conclude that until we conclude that the use of stigma itself is wrong.

As a method for informing the treatment of the stigmatized, I proposed that critical thinking and ethical reasoning are as useful as understanding countertransference or following a manual skillfully. As clinicians, we are trained and expected to pay attention to our countertransference when working with people. I contend that such a task is easier than recognizing, acknowledging and addressing confirmation bias. The latter requires that we look at whether or not we are wrong and then ask for supervision. That can be hard to do because it requires us to be aware of feeling dissonant in the first place. That has to be self-generated. In retrospect, the beliefs I held when I began seeing Charlie were naive. I wanted to use my process with this client as an example of how to overcome confirmation bias. Although this may sound very basic to many readers, I hope to convince other clinical social

workers to use ethical reasoning and critical thinking in their therapeutic work with all clients.

Finally, helping to reduce the impact of stigma on clients ought to be of particular concern to social workers. The National Association of Social Workers (NASW) "Code of Ethics" claims "social justice" as one of its principles (2008, "Ethical Principles"). The NASW does not state explicitly that social justice requires proportion, but the principle as written states that social justice efforts should be focused on discrimination, "equality of opportunity and meaningful participation in decision making for all people" (2008, "Ethical Principles"). This implies recognition of proportion, especially with respect to "equality of opportunity and meaningful participation." Few ex-offenders currently enjoy these basic human rights. In addition, NASW's principles also emphasize the "dignity and worth of the person." Specifically, social workers should be "cognizant of their dual responsibility to clients and to the broader society...[and] seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner" (2008, "Ethical Principles"). To me, this sums up our obligation as social workers to the principle of justice. The challenge is to put those words into practice.

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