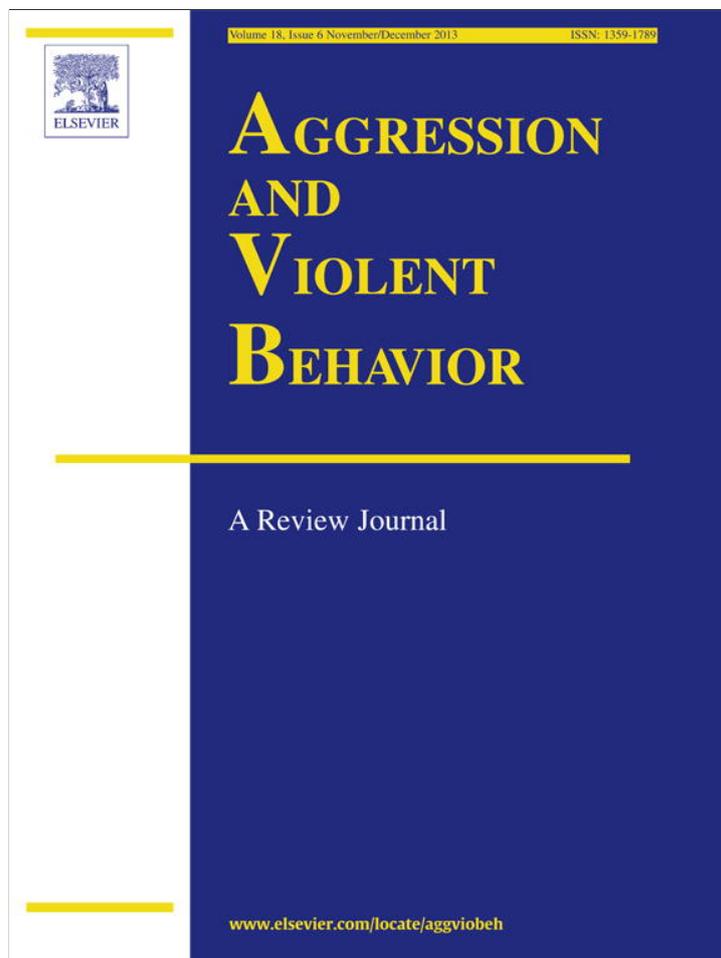


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## Aggression and Violent Behavior



## Clinical relationships with forensic clients: A three-dimensional model

L. Chudzik<sup>a,b,\*</sup>, F. Aschieri<sup>c</sup><sup>a</sup> Centre Psychothérapique de l'Orme Alençon, France<sup>b</sup> EA 2114, Université de Tours, France<sup>c</sup> Università Cattolica del Sacro Cuore, European Center for Therapeutic Assessment, Italy

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## ABSTRACT

This paper considers the clinical relationship with clients in mandatory treatment. In several countries, clients found guilty of committing a sexual or violent offense (often resulting in a jail sentence) are obliged by law to meet a psychotherapist. This mandatory treatment occurs both during the time in jail and in the community. The clinical relationship with these clients is a complex process involving the therapist, the client, and the courts. In this paper we describe some common factors that can facilitate or hinder the therapist's work in this situation.

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\* Corresponding author at: Centre Psychothérapique de l'Orme Alençon, France.  
E-mail address: lionel.chudzik@univ-tours.fr (L. Chudzik).

## 1. Introduction

The clinical relationship with violent offenders involves ethical and deontological considerations, legal philosophy, professional and personal values, and technical practices which have been discussed in depth elsewhere (Bush, Connell, & Denney, 2006; Ward & Birgden, 2009). The most frequently raised issues in the literature include how to define clear boundaries between forensic assessment and treatment (American Psychological Association, 2013; Greenberg & Shuman, 1997), how to manage the therapist's dual obligation as the offender's therapist and as the organization's consultant (Birgden & Perlin, 2009), how to differentiate between therapy and punishment (see Glaser, 2009; Prescott & Levenson, 2010; Ward, 2010; Ward & Salmon, 2009), and how to choose between a risk-management and a strength-based approach (see Marshall, Marshall, Serran, & O'Brien, 2011; Ward, 2007).

These contributions on mandatory therapy help conceptualize our practice, particularly establishing clear boundaries for our involvement, yet leaving somehow less explored the dynamics of the relationship within those boundaries, and how to prevent, on a single case basis, professional malpractice. This paper will focus on the relational dynamic in mandatory treatments. We highlight some practical indications about how to establish and manage the clinical relationship in mandatory treatments.

## 2. Clinical relationship and psychotherapy

Research on non-forensic psychotherapy processes includes studies on the features of the client/therapist relationship. The Task Force on Evidence-Based Therapy Relationships, coordinated by Norcross (2011), recently carried out an empirically-based review of what many influential psychotherapists have long known, namely that the main elements underlying the effectiveness of the psychotherapy relationship are: a positive alliance in individual psychotherapy (and cohesion in group therapy), empathy, and collecting client feedback (Norcross & Wampold, 2011). Goal consensus, collaboration, and positive outlook are thus important elements for the effectiveness of any kind of psychotherapeutic relationship. The Task Force also describes practices that should be avoided, such as confrontations, negative processes (e.g., blaming, critical, or hostile comments), assumptions (assuming to know the client's perception of relationship satisfaction or treatment success), therapist-centricity and rigidity. At this point of our profession's development, the relationship with the client can be seen as the keystone of an arch: it is not the whole arch, but the part that holds it up.

The recommendations regarding the clinical relationship with forensic clients have been quite different and traditionally based on the risks inherent to treating these clients.

Mandatory treatment clients have for a long time been viewed through a psychopathy prism. That is, they have been described as manipulative (Bursten, 1973), trying to control the therapist (Yochelson & Samenow, 1977), untrustworthy (Andrews & Bonta, 2010), and unwilling and needing a structured intervention (Hollin, 2005).

In contrast, some authors have recently taken a different view, promoting greater collaboration and a more open relationship with these clients. Ward (2002) reconceptualized the goal of treating offenders in the Good Lives Model, stating that: "every rehabilitation program presupposes conceptions of possible good lives for offenders and, associated with this, an understanding of the necessary internal and external conditions for living such lives" (p.513). Marshall et al. (2011) carried out a thorough literature review of the clinical relationship with offenders undergoing treatment, with roughly the same results as the Task Force on Evidence-Based Therapy Relationships. The authors found that "the therapist is key to producing changes" (p.75). Marshall et al. (2003) and Marshall et al. (2005) observed that therapists working with sex offenders should be warm, empathic, rewarding,

and directive. Ross, Polascheck, and Ward (2008) have shown all the principal parts of an effective therapeutic alliance with offenders, in line with the proposals of Marshall et al. (2003, 2005). Mann, Ginsburg, and Weekes (2008) also argued for more collaborative work in offender treatment and developed a motivational interviewing style (Miller & Rollnick, 2013) that could be applied to work with offenders.

### 2.1. The bi-dimensional model (BDM)

The roots of the disagreement found in literature about how to relate to criminal clients can be traced back to a dilemma clearly stated by Monahan (1980), characterizing what we call the bi-dimensional model (BDM). This author led a Task Force created by the American Psychological Association to develop guidelines for psychologists working in the criminal justice system. He addressed the core problem of working in this field by asking "Who is the client?" Among the twelve ethical questions that Monahan (1980) posed in this work, the first, "Questions of Loyalty," (p.5) seems to be the most relevant to our topic. In Questions of Loyalty, Monahan looked first at the dilemma faced by therapists when considering to whom they owe loyalty, due to "the impression that they are constrained to a multiple choice answer, with the alternatives being (a) the 'system' (or 'society') and (b) the offender" (p.5). To overcome this dilemma, Monahan argued that this question requires an "essay answer" (p.5). He observed that the therapist should be "the agent of the individual." In other words, the therapist should give priority to the client, but that this ideal should be reconsidered when the client poses a risk to society.

The dilemma depicted by Monahan and Ward is clearly visible in the work of Blackburn (2002, Fig. 1). This author addressed the problem of how to manage the clinical work in terms of an individualist versus a collectivist position. The individualist position assumes that the therapist should give exclusive attention to the client (the offender), leaving aside the influence on the relationship that would accompany the notion of a coercive treatment. The collectivist position is that therapists give priority to the demands of community safety implied in the courts' referral to treatment and see their role as that of social agent.

Each of these positions carries some risks. Blackburn (2002) points out that the individualist position sidesteps the moral obligation of protecting society, while the collectivist position disregards the welfare of the individual and the moral obligation of looking after the client. Blackburn concludes with the same "essay answer" as Monahan: coercive treatment should only be applied in specific situations involving the risk of sexual or non-sexual violence, and the therapist has to find a balance between the two obligations. This stance has been adopted by all ethical codes that we know of, and we largely concur with it.

Recently, Ward (2013) stressed that the difficulties for forensic psychologist and for psychologist working in mandatory treatment are to cope with two different ethical codes that should guide the therapists' behaviors. On the one hand, therapists should adhere to the Justice System principles (e.g., equity of the guilt, protection of society). On the other hand, therapists should endorse the mental health ethical

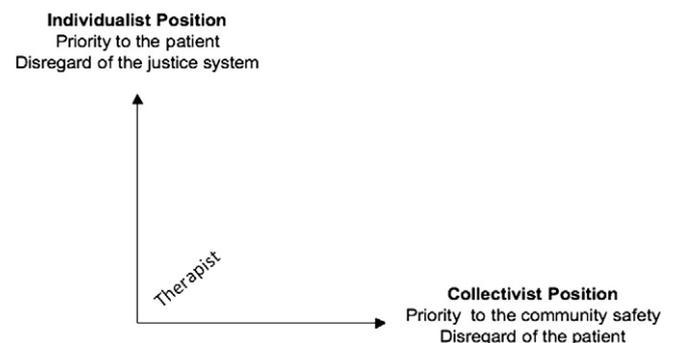


Fig. 1. The therapist dual obligation in the bi-dimensional model.

guidelines (e.g., enhance individual well being). Such ethical codes are incommensurably different and according to the author nor a superordinate more general universal code nor hybrid version of such codes can solve the problem of multiple commitment for clinicians in this field. Ward underlines the consequences of this kind of conflict on the therapists: “this [dual obligation] is likely to result in a fractured professional identity, unethical practice, and possibly a loss of personal integrity” (p. 98–99). Ward suggests to overcome this conflict seeking for “overlapping moral beliefs relating to the problem in question” (p. 98) in any given situation that calls for a reconciliation between different ethical codes.

The point we wish to stress is that in mandatory treatment the different views of the client endorsed by the therapists and the type of obligations therapists feel under have a profound influence on the way in which they “construct” offenders. Both Monahan (1980) and Blackburn (2002) fail to specify that endorsing an individualistic or a collectivistic position in therapy, prior to meeting the clients, will inevitably affect the presentation. This, in turn, has an influence on the way therapists perceive their relationship with their clients and strongly affects their goals, their view of the possibilities for change and of the client's involvement in the therapy process. In other words, the implicit assumptions underlying the individualistic and the collectivistic positions can have a deep impact on therapists' practical approach to clients. Within an individualistic position, clients may react to therapists' lack of interest in the crime by steering clear of the crime-connected processes. This, in turn, may confirm the therapists' view of clients as being like “normal” clients. In fact, within an individualistic framework, the therapists may be overly naïve because they see themselves as treating “usual clients,” just as in their everyday practice, thus denying the process through which the clients were referred, and missing an important opportunity to explore how deeply the clients' life history has been marked by the justice system and the fact that those clients have committed one or more crimes.

On the other hand, within a collectivistic position therapists may be over-skeptical, and they may react coldly because they see themselves as treating “delinquents,” forgetting that those people are also their clients. This can result in an escalation of provocative and negative reactions, seen, in turn, as proof of the client's lack of engagement in therapy or their dangerousness. In these cases, therapists called in by the courts to treat the offender may view themselves as part of the criminal justice system (Glaser, 2009) as prescribed within forensic assessments (Greenberg & Shuman, 1997). However, when clinicians attend to this role as therapists they fail to give clients the chance to be someone other than an offender, and they run the risk of dealing with the sessions as “parts” of the sentence and the punishment.

In both situations we, as therapists, are dealing with an incomplete person; in the first case, we miss the fact that the reasons for which we actually meet our clients are connected to the crime; while in the second case we miss clients' motivations for change, overshadowed by the crime.

Another criticism is that the bi-dimensional model is based on general principles and faces the issue of who the client is at a general level. However, all therapists have experienced problems with specific clients or failed to establish a positive relationship for different reasons (fear of recidivism, shocked by a revelation, etc.), and in many cases general rules are hard to apply. Likewise, all therapists have experienced lapses or deontological difficulties with certain clients. The first principle of the ethical code of the Association for the Treatment of Sexual Abusers (Association for the Treatment of Sexual Abusers, 2001) is that: “Members will not allow personal feelings related to a client's crimes or behavior to interfere with professional judgment and objectivity. When a therapist cannot offer the highest quality of professional service to a client for any reason, he or she will make a proper referral.” Personal feelings can be difficult to detect, identify, and manage during a session. For some therapists who work in remote areas, a “proper referral” could be very difficult in practice. In other words, we can adopt and pursue

ethical values and professional guidelines, and we can have a clear idea about the goal of our therapy, but still fail to build up a therapeutic relationship with a client in real, everyday practice. For example, a therapist who adopts a strength-based, collaborative approach may meet a new client who arouses feelings of disgust and anger to the point of compromising treatment. Alternatively, the therapist may take a risk-need approach using a standardized manual, and take some liberties with the manual because he/she thinks that this particular client is not a real offender, thereby no longer pursuing the primary goal. To sum up, in its extremes, what we call the bi-dimensional model seems to lead to a dilemma of change for psychotherapists.

In systems theory, Papp (1983) described a dilemma of change as the dynamic between a desired state and the costs involved in attaining to it (Fantini, Aschieri, & Bertrando, 2013). The dilemma in this case is about our core professional identity: we have to choose between losing our therapist identity (embracing a collectivist position) or losing our sense of social utility (embracing an individualistic position). The desired state of both living up to our professional identity and protecting society seems unattainable, and the fulfillment of each single aim implies the cost of falling short on the other. To continue the family therapy analogy, dilemmas for families, according to Papp, are often between maintaining one family member “ill” to protect the family's status quo, and allowing the identified patient to heal, at the risk of losing the family's homeostasis. Papp stresses how important it is, when families are entrapped in a dilemma of change, to heal the symptom in the identified patient while addressing it within the family system. The aim for therapists who work in mandatory settings would then become to treat the symptom (here, the client), without losing the family (here, the society); and treat the family (here, the society), without overlooking the symptom (here, the client). We believe that attaining to this dual obligation requires a more articulated view of the system within which mandatory therapy takes place, as we will propose in the three-dimensional model (TDM) for mandatory treatment.

### 3. A three-dimensional model (TDM)

Our aim is to offer practitioners a new model based on systemic and narrative principles for conceptualizing the therapist–client relationship.

One way to consider a system is to look at how it emerges. The system that interests us now requires two conditions. The first is the encounter between an individual who becomes an offender and an individual who becomes a victim. The second is the encounter made public by the victim bringing a charge. Three parties are involved in the trial: the criminal justice system (or society), the victim, and the accused (Fig. 2). During the trial, the “story” not only of the offense, but also of the offender is created. The accused may or may not assume the identity of offender before the sentence. In both cases, the identity of

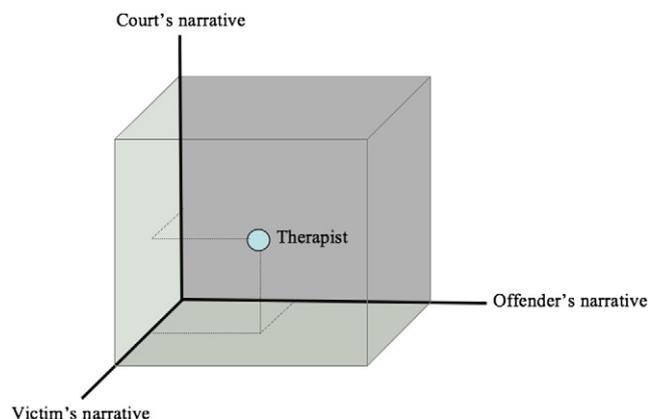


Fig. 2. The three-dimensional model.

the offender is created from evidence provided by family members, employers, experts (often psychologists), and friends, each part of the offender's life and personality, but within the context of the crime. When this happens, the identity of the accused coalesces in a social and legal narrative in which the offender's role assumes a relevant position. As seen, the system is already established prior to the therapist's intervention, and crystallizes during the trial.

The "story" concept comes from the work of the fathers of narrative therapy, [White and Epston \(1990\)](#). These therapists consider the patient's difficulties as the product of a story. This story defines the role assigned to the patient and the meanings of his life events. When a family comes to a therapist, the members generally tell a story saturated by the problem. The patient is viewed only through the problem and he himself becomes the problem, and the problem becomes an identity ([Aschieri, Fantini, & Bertrando, 2012](#)). We propose to look at a court of justice with this concept. A court works as a family seeking help for one of its members. During the adjudication process, each protagonist (the victim, the offender, and the justice system) develops a story saturated by the offense. At the end, the conviction gives to the author of the offense the identity of the offender. Then, justice asks the therapist to change the offender. It is at this point that psychotherapists in mandatory settings appear on the scene. This offender identity is saturated by the offense and, often, by all the personal representations of a man who is able to commit the offenses that he does. During psychotherapy sessions, therapists contend with three main narratives inherent to the system with which they work: the victim's, the court's and the offender's narratives can be thought of as three axes within a tridimensional space (the system created by the offense, the trial, and the sentence) with the therapists' goal being maintaining awareness of which narrative they are leaning toward during the treatment ([Fig. 2](#)).

Therapists run into five specific risks when they enter into this system. The first two risks occur when they enter the system with no explicit awareness of the system, or of the pre-existing narrative. The other three risks occur when they are in the system and they adopt one partial narrative, developed by one of the parts of the system (justice, victim or accused), as the true one.

We will examine each risk, focusing on how to identify it and become aware of the process, how to understand it, and how to cope with it. We will illustrate each risk with brief, real-life clinical cases involving experienced therapists (some of the cases are from our own practice). They illustrate the therapeutic impasses in which even therapists who routinely work in mandatory treatments might find themselves. All the cases show the usefulness of the TDM. This is not to say that victims and legal officers always think or act in the same way. Rather, the clinical examples reveal stereotypes on which we base our perceptions.

#### 4. First step: entering the system – the shock/detachment reactions

When working in this type of system, the way the therapist deals with the pre-established background and narratives about the client will influence the clinical relationship. We believe that the therapist runs into two contrasting risks: either being shocked by the facts of the case or remaining completely detached from them. These two risks are based on the fact that the therapist has no awareness either of the justice system or of the victim's or the offender's narratives.

##### 4.1. Shock

The therapist may feel shocked by the specific nature of the offense or the way it is told, and may be unable to process it or absorb any further information. All of a sudden, the therapists are overwhelmed by the emotional impact of the narratives that emerge from their clients' reports, and by the weight of the emotions that feature the system. In such a state, reflecting on one's own position from each narrative is

hindered by the shock of dealing with such narratives. This process ([Fig. 3](#)) can be illustrated by the following case examples:

**Case 1.** The first time the therapist met Charlie he was in jail. The medical staff had asked urgently for an assessment of the risk of suicide, describing him as being very depressed. The therapist knew nothing about him and thought only about the suicide risk factors. The first minutes of the meeting were very difficult; Charlie said nothing, looking at the desk, his face inscrutable and showing no emotion. The therapist asked him whether he knew why he was asked to meet him. After a long silence, without moving, he looked the therapist in the eyes for the first time and answered: "I killed my brother."

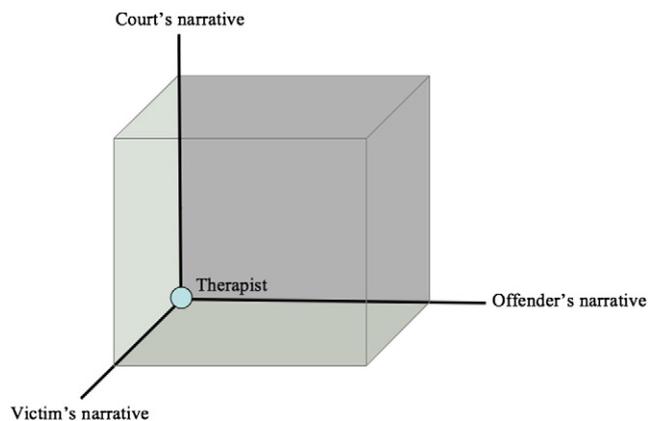
**Case 2.** Karl was a 40 year old man. The therapist met him in a community services department after a six-year jail sentence for the rape of two elderly women (aged about seventy). His probation officer referred him to the therapist because Karl had attended an "ineffective" therapy with a colleague in the past. Karl told the new therapist, in their first session, that the previous psychotherapist was very harsh with him and not helpful. "The meetings were all the same," he said. "She asked me again and again to describe the events and to explain why I did it, but I don't know myself." After the session, the therapist phoned to the previous therapist (with Karl's permission) who said that it was the first time she had encountered this type of client, and she could not understand and find a way to help that man. She was pleased that a new therapist was taking over the case.

These two cases illustrate how, even as therapists, we can be caught off guard and flummoxed by our feelings. The therapist was so shocked by Charlie's revelation that he, too, become silent and dealt with the situation by asking questions about suicidal factors, without talking about what Charlie had just said. Karl's therapist was so shocked by the age of his victims that she could not view the situation objectively and constantly asked about the events, and not about Karl as a person.

##### 4.1.1. Recognizing shock

Shock is characterized by a strong feeling of helplessness and powerlessness. It is like being awakened abruptly by an unexpected event. During the interview, the therapist cannot find a way out of this state; it is impossible to be objective and not to fixate on what has just been said. It is difficult to find words, the mind goes blank and the therapist may become tactless. Everything the therapist says revolves around the offense, or, by contrast, he/she continues as if nothing has happened. This state may last a short time, or continue over several sessions, or throughout the treatment.

The first and stronger emotion of shock is the horrified surprise that occurs when the therapist is not prepared for what is said by the client. The therapist experiences a "mini" trauma, with symptoms similar to



**Fig. 3.** Graphic representation of the shock reaction in the TDM.

those of post-traumatic stress disorder, namely the mind going blank, repetition, and difficulty concentrating. The therapists' shame about their own fragility and vulnerability is the second indicator of being in a state of shock. In fact, the therapists often attempts to overcome these sensations by trying to hide their surprise, hoping that the client is unaware of their reaction. In our experience, the process of hiding the shock reaction experienced by the clinician increases the feeling of paralysis and vulnerability.

#### 4.1.2. Coping with shock

The best way we have found to avoid this situation is to be as well informed as possible about the patient before the first meeting. If we are not familiar with a type of offense (for example sexual abuse of an elderly person) we can do some research beforehand. This will help avoid the risk of being surprised by the revelation.

The greatest difficulty with this kind of reaction is how to cope with it during a session. In our experience, the best way to cope is to follow the advice of Yalom (2009), namely to focus on the process more than on the content, by reformulating what had happened in the session rather than on what had been said. For example, in the case of Charlie one way to cope with the shock could have been to say: "I'm sorry, I didn't know. I can understand now why it is so difficult to be here with me. How do you feel about this situation?"

#### 4.2. Detachment

The opposite extreme of reacting with shock is detachment. It works as a defensive indifference to the clinical relationship. The therapists do not connect with any of the narratives inherent to treating mandatory offenders and hence remain emotionally uninvolved and outside the system in which the therapeutic process should take place (Fig. 4).

**Case 3.** Paul was serving a prison sentence for the sexual abuse of an eight-year-old boy. He was a repeat offender, with six known victims of the same age and sex. Just before his release, he had asked for an appointment with a physician. He explained that he was worried about his ability to have sex and asked for medication to help him. The physician prescribed Viagra. A short time after his release, he offended again (without using the medication). At the trial, the physician said: "I am a physician, I treat the individual not the criminal and I don't want to know anything about why they are in jail."

The physician's reasoning is faulty; it suggests that it is not possible to consider a person as an individual if we know that he is in jail for a serious offense. Moreover, it does not take into account the system in which the patient is living.

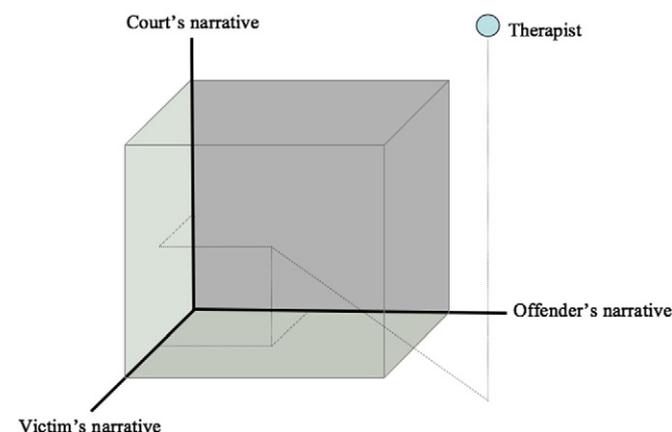


Fig. 4. Graphic representation of the detachment reaction in the TDM.

#### 4.2.1. Recognizing detachment

Detachment is characterized by lack of awareness of the system and the offense. The therapist completely ignores the courts' purpose and system, and the client's criminal record. The client is seen as typical of those encountered in a traditional medical or therapy setting. The therapist often acts on a specific aspect without considering the whole picture and the whole person, thus ignoring the offense and the legal system.

This situation can be found among professionals who do not work regularly with forensic clients, and know nothing about the legal procedure. Experienced therapists, with no information other than what the client tells them, could unconsciously adopt this attitude assuming that treating the Axis I disorder may directly decrease the risk of recidivism, and ignoring the other factors that may have lead to the offense. Also, the *Association for the Treatment of Sexual Abusers (2001)* pointed out that priority must be given to treating Axis 1 disorders for deontological reasons. We agree with this position, but depression or psychotic disorders can coexist with pedophile fantasies, anger disorders, and other processes that may lead to legal consequences if acted out.

Detachment can also be encountered when therapists adopt this position deliberately and willingly. Their argument follows a pseudo-humanist line, namely the importance of treating the client without considering the judicial demands and constraints (see the physician in Case 3).

#### 4.2.2. Coping with detachment

If we observe colleagues adopting this position, the best thing to do is to tell them about the TDM to promote a more complete appreciation of the tangle of narrations that need to be taken into account when working in this context. We do this with young psychologists and colleagues in one-to-one supervision and it seems to work well. If not due to a lack of experience, this position could be interpreted as a defensive one. If therapists notice their own lack of interest, boredom, or absence of external information, they have to ask themselves why this is happening. Supervisors and colleagues are important in understanding this process. It could also be an opportunity to discuss it directly with the patient. How did the patient feel during the session? What does the patient think about the treatment? These kinds of discussion are often an opportunity to give a new direction to the treatment.

### 5. Second step: within the system

Once introduced into the system, the therapist has to consider the narratives of each party: the victim, the criminal justice system and the offender and the way they influence the clinical relationship. We can see it as a three-dimensional system (Fig. 2), in which the identification with the narrative of each single position is supported by several factors. In fact, we can share and understand the victims' distress and pain, the court's concern and duty to protect society, and the offender's desire to uphold his own version of the facts. Each of these positions can bring to mind stories of ourselves as victims, judges, or aggressors. The risk for the therapist working in compulsory treatment settings is that of endorsing one of the other positions present at the onset of the system and adhering solely to its inherent narrative. These endorsements work as an identification with the stereotypical figures of the three positions. When these identifications are too strong, the psychotherapist thinks and acts in the session as a stereotypical judge, victim or offender, losing his psychotherapist's role. In our view, this TDM has some links with Karpman (1968), which examines the interplay between the roles of victim, persecutor and rescuer. In Karpman's view these three roles compose a "dramatic triangle" in which the characters involved in the relationship switch – at different points in time – among the position of the victim, of the persecutor, and of the rescuer. Through involvement in mandatory treatment, the therapist is vulnerable to internalizing the triangle shaped by justice, victim and offender, and can switch among those positions. Our goal with this model is to help the clinicians to acknowledge these positions in their own attitude and to help them to keep in mind that

they are not the judge, the victim or the offender, but the therapist whose expertise uses the three “claimed” realities within the relationship to promote clients' self awareness and change.

### 5.1. Identification with the victim's narrative

In this case, the therapist sees the client through the eyes of the victim and endorses the victim's narrative on the client. Identification with the victim occurs when the therapist is too personally or emotionally involved in the suffering and rage experienced by the victim (Fig. 5). There can be many reasons: the therapist may have been a victim him- or herself, or have a family member with the same characteristics as the victim (e.g., a son or daughter of the same age and sex). Here, the clinician empathizes with a stereotypical victim, or the victim that he has been or he could be. In this situation, the therapist loses his/her professional identity and behaves and thinks as a lay person, with no other guidelines than his/her own intuitive belief.

This position prevents us from seeing the client as a person, but rather as an incarnation of what Baumeister (1996) called the myth of Pure Evil. Baumeister warns that when we reflect and act under the influence of this myth, the offense is seen as intentional and motivated by pleasure, and the offender is seen as a non-human monster. Offense and offender become confused and the whole client's identity is defined by the crime. The therapist stops listening and starts to view the client as an enemy.

**Case 4.** Paul had been sentenced for committing a sexual offense with an adolescent. Just after the guilt sentence he became depressed and was hospitalized following a suicide attempt. During a session, the unit psychologist told him: “You are a monster, you are a pedophile, and you have nothing to do here.” He understandably refused to see her again throughout his stay in hospital.

**Case 5.** George was 36 years old, and was condemned to two years of suspended sentence for beating his wife and baby (who suffered shaken baby syndrome). During therapy sessions, he wore colored floral shirts, spoke very loudly and without inhibition. When talking about the reasons why he beat his wife, he said that he was upset with her since she had just started a new job. She started to ask him to take care of the house and of the baby. The therapist felt upset when he said that rather than coping with these duties he called the social workers asking them to cook and to take care of his son because he could not do it, despite the fact that he was unemployed at the time. The therapist became aware of his feeling of anger and disdain when he ended the session after quarter of an hour, thinking of having spent more than 45 min with him.

#### 5.1.1. Recognizing identification with the victim's narrative

When the therapist adheres to the victim's narrative, the sessions tend to have an inquisitorial style, with more closed questions than

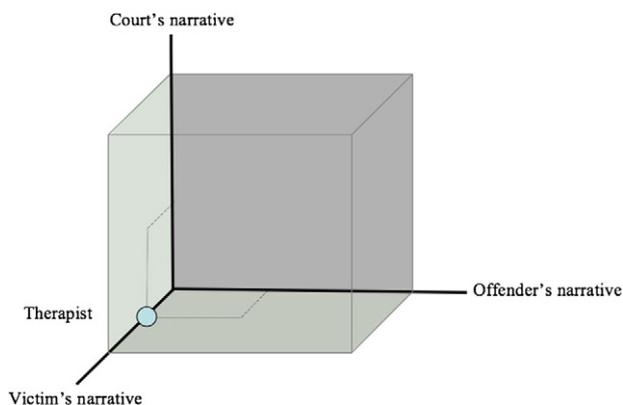


Fig. 5. Graphic representation of the identification with the victim's narrative in the TDM.

usual; the therapist tends to keep distance from the client, and may or may not be overtly harsh with him. The therapist can also communicate disdain and mistreat the client in a subtle way (e.g., leaving the patient in the waiting room for a long time; administering a number of redundant psychological tests; canceling sessions without a proper explanation), using the rationale that, because of what client has done he can tolerate such inconvenience. Or, the clinician can dedicate insufficient time to the client's therapy (short meetings, not giving the client a chance to say a word in a group therapy). Sometimes, the therapist's goal is to push the client to admit the damage he has caused the victim. However, the common point is the feelings of disgust, anger, or rejection.

Also, pessimism about the probability of change may cause the recidivism risk to be over-estimated. The therapist believes that treating the client is impossible and that the only thing that can be done is to try to prevent a further crime. In our experience, the therapist has been compromised by feelings of disgust, rejection, and aggression, and sometimes revenge. The predominant state for both the therapist and the patients is anger: the therapist feels anger because of his identification with the victim's narrative, the patient feels anger because the therapist does not listen or cannot understand his perspective.

#### 5.1.2. Coping with identification with the victim's narrative

In these situations, the Association for the Treatment of Sexual Abusers (2001) code of ethics recommends referring the case to a colleague. When possible, this is probably the best solution. While making the referral, the therapist should discuss his or her reasons with the client. However, in some circumstances it is not possible to make a proper referral (no psychotherapist available in the area, other therapists do not want this kind of client, psychotherapist obliged by the institution to work with the client, etc.).

When a referral is not possible, to help the therapist to avoid the exclusive identification with the victim, it is useful to carry out a detailed personality assessment prior to the beginning of treatment. For example, right after the first session with George (Case 5), the therapist thought he had a hypomanic mood disorder on the basis of his disconstraint, lack of inhibition and extroversion. Later on, in the assessment process the therapist administered him the Psychopathy Check List-Revised (Hare, 2003). To his surprise, his score was 28, which is the European cut-off score for psychopathy. As soon as the therapist realized this, he felt renewed curiosity about George. He realized that his quick “lay-person” diagnosis of him as “manic” was driven by his identification with what he thought George's wife might have felt. This process was enhanced by the recent birth of the therapist's second child, and by the efforts he was taking at that time to help his wife in the household duties. His emotional identification with the victim's narrative prevented him from seeing George's deeper psychological functioning, namely his emotional behavior, and his lack of emotional reactivity. In the feedback session with him, they started to talk about how much it was difficult for George to feel emotions (including empathy for his son) and how much he used people without being even aware of it. After this feedback the therapist felt the sessions becoming interesting for him. In this case, the assessment instrument traditionally used by forensic psychologists helped the therapist to change the “lenses” through which he was seeing the client, interpreting his actions, and responding to them. We believe that therapists can use as many instruments as they need to, while maintaining the same confidentiality rules that apply with other traditional clinical assessment tools in psychotherapy (Loving, 2002).

#### 5.2. Identification with the court's narrative

In this position, the therapist adheres to the social justice narrative about offenders (Fig. 6). The court – as a representative of society – serves to punish the offenders for their crimes, while at the same time attempting to rehabilitate them. In the BDM, this position coincides with the purely collectivistic position of the therapist. Psychotherapy is associated with an extension of the punishment/rehabilitation system,

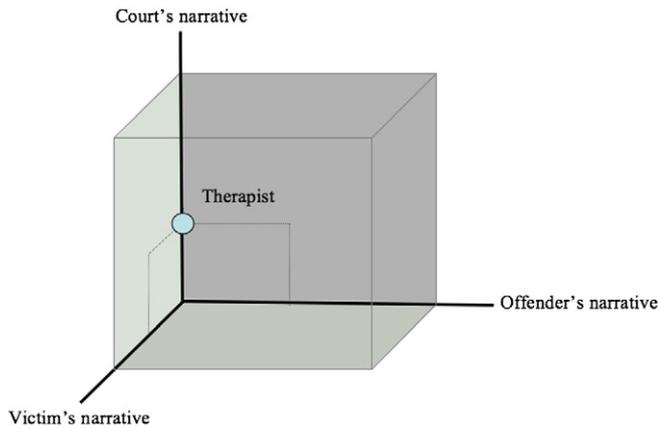


Fig. 6. Graphic representation of the identification with the Court's narrative in the TDM.

and therapists can shift to control rather than treat the offender. This position is often fuelled by concern for discovering the “truth,” a need to control the client, or to anticipate future crime. The therapist may want to take advantage of his position to discover new elements of the crime, as well as not yet persecuted crimes. From this position, the goals of intervention thus become the assessment and control of risk. The difference between identification with the victim and with the court is that the latter stems from a desire for protection and fear of recidivism, whereas the former stems from feelings of distress and anger. The therapist's fears of recidivism and probing the risks may lead offenders to accept the story that they are “ontologically” dangerous and their only goal in treatment is to learn to control themselves. We believe that this is a risk of all treatments based on what Ward, Vess, Collie, and Gannon (2006) called “avoidance goals.” In these treatments, there is a risk of inadvertently teaching the offender to cover up by adopting a kind of social varnish. Adapting to social rules is necessary but not sufficient (Ward, 2002). When working with aggressors, therapists have to define the goals of the treatments and select the techniques also on the basis of the psychological meaning that the crime/offense had for the client.

In our experience, therapists' identification with the courts is the most frequent orientation. We can understand this approach considering that the legal department asks us to do what we can to prevent recidivism, and this is the first goal of our treatment (Chudzik, 2009). However, while we share the same final goal with the courts, we do not have the same means for reaching it. For the therapist, there is a great risk of confusing *control* and *psychotherapy*.

**Case 6.** Michael was a 60-year-old man living in the community after having served a 15-year prison sentence for pedophilia. One day the patient started to talk about a little boy living downstairs in the building where he lived, and the therapist started to worry about a possible new victim. On this basis, the therapist suggested weekly sessions, and the client agreed. During several of the following sessions, out of fear, the therapist asked about the boy and kept checking all the acute risk factors suggested by the literature such as the number of times he met the boy, his emotional states, his eventual sexual fantasies at this period, and his social support. However, the sessions became harsh and Michael started to act unwilling and withdrawn.

**Case 7.** Jack is referred to the therapist after having beaten his wife and having been sentenced for mandatory treatment on anger management. Shortly after the therapy started, he was involved in a divorce proceeding initiated by the wife. After the trial, Jack claimed with his therapist to have lost “everything” he previously owned (house, car, child custody). At the time he was sleeping in a friend's house, and because of the depression he started to suffer, he also lost his job. The therapist witnessed how the depression was turned progressively into anger against the former wife to a point that the therapist started to

worry about a possible act of violence against her. This possibility froze him. The sessions progressively focused on convincing Jack about the inappropriateness of his anger and about the need to decrease its level also by taking medications. And after a phone call to the probation agent, the therapist realized that the probation agent was doing exactly the same, namely trying to reduce the risk of Jack acting out violently on his ex wife. The therapist was not trying to treat Jack, but rather to control his behavior just as the probation officer was already doing.

#### 5.2.1. Recognizing identification with the court's narrative

One way for the psychotherapist to identify this situation is to focus on the feeling of fear. Despite being a natural reaction, fear – and fear of recidivism in particular – may be a warning sign that the therapist is adhering primarily to the justice system narrative. Fear could indicate the possible recidivism as well as worries about the possible damage to the therapist's reputation in case of diffusion by the media of the recidivism news. In this context, the assessment prior to the treatment turns into an inadvertently long period in which the therapist cannot find a way to allay his own fears. The client often picks up the implicit request for reassurance from the therapist, and adapts either by covering up his own inner struggles or by using the therapist's fears as a way to not engage in the treatment. The therapist can be seen as implicitly conveying that the client is “really” only a criminal, hence mirroring the justice's narrative about them.

#### 5.2.2. Coping with identification with the court's narrative

Fear is a natural alarm system, and we often start to react before becoming aware of the threat. If fear is the reason underlying identification with the courts, we should examine the threat. The first thing for us to do is to assess its plausibility and imminence. Here, assessment dynamic tools, such as the STABLE- and ACUTE-2007 (Hanson, Harris, Scott, & Helmus, 2007) are useful. Such tools provide some guidelines to help clinicians assess the acute risk of recidivism, as we described in the case of Michael, above. Optimally, these tools should be used also with several colleagues. The other way of coping with this position is to talk to a specialized colleague for support, which will help us to assess the reality of the threat and how to cope with it.

It is clear that when danger appears imminent, the psychotherapist must alert the appropriate services. However, identification with the courts could lead the therapist to try to manage the situation alone. In fact, when the perceived risk of recidivism increases, the therapists can feel it as a shortcoming of their own therapy, and be unwilling to let it be known to the probation officer although they do not have the courts' means of control.

Second, as therapists in this kind of setting we have to keep in mind this question: does the therapist treat or control? As therapists, we cannot do both because we do not have effective means for control.

In the case of Michael, when the therapist realized that the sessions were becoming aimless, except for his desire to calm his fear, he realized that the therapy was protecting neither the boy nor society. The therapist finally chose to share his concerns with Michael and explained why he had those feelings. The therapist pointed out how the actual situation with the little boy was very close to the previous situations involving past victims, and he told Michael that he needed to be aware of it. After checking with the probation agent that there were efficient social controls, the therapist worked with Michael on his past modus operandi and the close affective relationship that he built with his previous victim.

#### 5.3. Identification with the offender's narrative

The identification with the offender illustrates the individualist position described by Blackburn (2002). The therapist develops a close relationship with his/her client to the extent of forgetting the criminal

justice system (Fig. 7). By empathizing with the client, the therapist shares some of the sense of blaming the law, the sentence, or the victim. The offense is frequently seen through extenuating circumstances whereby the victim is more or less responsible. Or, as described by Meloy (1988), the therapist may identify with and admire the client when describing the offense.

There are many reasons why a therapist identifies with the offender. The first is a result of our training. As observed by Meloy (1988), there is an implicit message in the training of all mental health professionals, which is we can rely on what our client says. Whatever the underlying theoretical perspective, the traditional client–therapist relationship is based on warmth, closeness, empathy and care. This creates a psychological setting that fosters compassion and exclusivity. The psychotherapeutic relationship could lead the therapist to forget the demands of the system, and sometimes the reason why he is working with the patient. The risk here is of supporting criminogenic thinking, and of forgetting or underestimating the recidivism risk. The second reason stems from the therapist's personality. Borrowing Karpman (1968), some therapists see themselves as rescuers. They tend to protect their clients (seen as victims) against mistreatment by society and the law (in this case, the persecutors). This is a kind of naïve idealism and could explain certain conflicts between medical staff and legal professionals, each viewing the patient from a different angle and defending their own position. The third reason why a therapist may adopt this position is related to the client. The therapist has to keep in mind that manipulation or malevolent seduction may occur.

**Case 8.** Alfred was sentenced with 15 years in jail for having tortured and raped his former wife and her lover. His mandatory psychotherapist was fascinated by him. Alfred had a violent childhood spent with an abusive, alcoholic uncle, and never knew either his mother or his father. Later, he spent his adolescence in the street, without a home and without protection, and during that period he had his first experiences with drugs and prostitution. The therapist felt compassion for Alfred's past experiences and at the same time was fascinated by the thrilling episodes he reported. Hence, a big part of the treatment was devoted to the recollection of this story. This pattern terminated the day Alfred arrived at the office completely overwhelmed. He revealed that he had met a new girlfriend some months before, and that he had learned the day before that she was drug addict and that she had stolen his money and prostituted herself while dating him. The psychotherapist during the session did a lot to contain Alfred's despair over what he felt as a betrayal by her. The next week, the probation agent called the therapist to say that Alfred was back in jail for new murder attempt against this woman.

**Case 9.** Andrew was a friendly 36-year-old man who had kept the same job for 10 years and was liked by his colleagues. When he was twenty, he entered into what was to be a three-year relationship with a woman. Although they were in love, they increasingly argued about leisure time and the management of their life as a couple to the point that they decided to separate. After they broke up, he felt very bad. Sharing the same group of friends, they often ended up spending time together with these friends. Each time Andrew started a new relationship, the former girlfriend called him with “excuses” (helping with car, moving furniture, etc.). Over time, all the new girlfriends finally asked him to choose between them and the former girlfriend. One day, 10 years after they broke up, they had sex and he started to think that a new love affair was possible. The day after, she said that she just needed affection, and that she did not want a new relationship with him. They argued a lot, he got overwhelmed by anger, and stabbed her with a knife seven times. The first therapist he met after the sentence was convinced that the aggression was due to the woman's hysterical personality, and that Andrew was by no means responsible for the aggression.

### 5.3.1. Recognizing identification with the offender's narrative

The feeling of an exclusive, close, and intimate relationship with the offender is the core element of the identification with him/her. The therapist feels more competent than anyone else in understanding the offender. The therapist enjoys their sessions together, and starts believing to be the only person who really understands and can help the client. The offense is minimized or seen as a thing of the past, prior to meeting the therapist. Treatment is often ended prematurely by the therapist who shares the client's view that everything is now fine and that there is no longer any need of treatment. This relationship is often comparable to a “honeymoon period” in an intimate relationship, impairing the therapist's necessary ability to look dispassionately at the overall person of the client.

### 5.3.2. Coping with identification with the offender's narrative

There can be several reasons for this identification. It happens that frequently the traumatic past of these clients fascinates therapists and increases their voyeuristic stance (Schafer, 1954). Attracted by the client's past, therapists can forget to explore current struggles, or underestimate the risk of acting upon those in the present.

Another common reason is manipulation. At the end of his book, Hare (1993) wrote a survival guide, and more recently Harris and Rice (2006) produced a number of guidelines to deal with it. We believe that the best way to deal with this position is to prevent it by thorough training in relevant topics such as psychopathy (Hare, 1993) and manipulation. Second, also included in Hare's survival guide, the therapist should gather collateral information, such as the legal file, by contacting the probation officer or the previous therapist. The therapist should remain alert to all possible opinions. The therapists have to be open to contradictory impressions beyond their own. In our experience, we have often avoided falling into this identification trap by listening carefully to what other professionals told us about the patient. Lastly, self-doubt is a valuable aid for coping with this situation; the therapist should listen to any information that differs from his/her own view, and be receptive to any relevant feedback. In case of disagreement, we never try to convince our collaborators, but we do try to understand why they have a different view of the same person and we accept, as a first stance, that we may be the ones who are wrong.

## 6. Clinical use

Using the TDM to view complex mandatory treatment cases will help us overcome the dilemma raised by the BDM. The TDM does not frame the clinical issue within an impossible choice (i.e., owing loyalty to the aggressor/client or to the society/victim?), but within a clearly identifiable system, providing an understanding of some well-defined

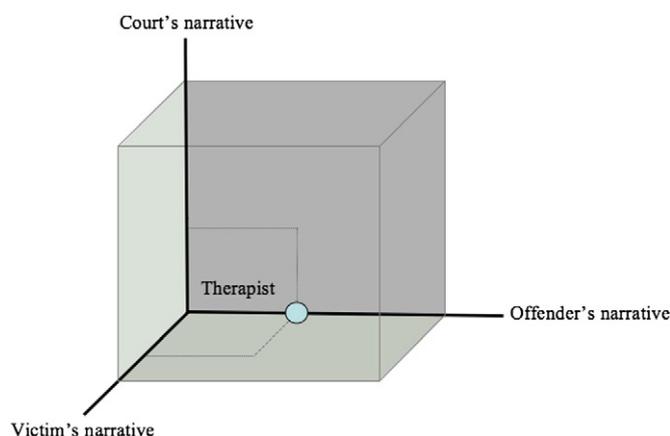


Fig. 7. Graphic representation of the identification with the Offender's narrative in the TDM.

risks. The five positions described above can be pitfalls for the clinical relationship because each involves the therapist's loss of perspective and appropriate boundaries. Each position thus poses a risk for the therapeutic process, whatever the therapeutic orientation.

A second advantage of the three-dimensional model is that it describes a micro-level process. In other words, it describes what could happen during a session. We no longer have to choose between an individualist and a collectivist approach, at a general, macro level. The model concerns the client–therapy relationship and can be used to assess our position with our clients, increasing therapists' self awareness and reflexivity.

Third, it is important to stress that our position in this system changes from one client to another. We believe that all therapists are liable to adopt all the positions, even if they are more attracted by one than another, and that we must not feel immune to assuming an unexpected one in given situations or with given clients.

Similarly, it is clear that over time we may change our position with the same client. For example, we may begin treatment identifying with the offender and then realize his/her dangerous potential. We may then react by identifying with the courts. In this example, the fear of recidivism may counteract the intensity of our initial identification with the offender.

To conclude, for therapy to be effective, we must be aware of our potential to identify with the court, victim or offender. According to Miller and Rollnick's (2013) theory of resistance, resistance is a relational process that arises from a dissonance in the clinical relationship. A therapist who identifies with the victim could unconsciously create this resistance in the client by confrontation and by making the client resist the “offender” identity that the therapist tries to impose on him. Here, resistance works as a vicious circle: therapists engenders resistance and misinterprets it as a characteristic of the clients, without being aware of promoting the resistance with their own behavior.

## 7. Conclusion

We presented an alternative model to the well-known bi-dimensional model described by Monahan (1980). After interpreting the challenge posed by the BDM under the light of the systemic concept of dilemma of change, we examined the trial process as a narrative construction of identity. We proposed a three-dimensional model which offers the possibility of identifying five common pitfalls that occur in the clinical relationship when working in mandatory treatment setting. Such pitfalls include shock, detachment, identification with the narratives of the victim, the court and the offender. We have suggested a number of ways of identifying, understanding and coping with each of these pitfalls.

Mandatory treatment with forensic clients is a challenging task. The justice system asks us, as therapists, to decrease the recidivism risk, and we cannot ignore or deny this demand. However, in our three-dimensional model, we can seriously adopt this goal, without adopting the justice narrative. If we accept the idea that a court confers a narrative identity to the offender; that a victim has his own narrative about the offender; and that the offender himself, coping with the entire process, develops his own account, which often involves resistance to the pressure of the other narratives, we can work with the offender collaboratively. Here, collaboration means involving the offender in the building of a new narrative. At each moment of the therapy, we run the risk of assuming the position of a victim or of the court or of the offender. In each of these cases, we lose our therapist identity and, we think, our effectiveness. We have to enter into the system with the acknowledgment of the offense(s), but keeping in mind that we do not yet know the person who committed it. We think that our work, to decrease recidivism, begins with discovering the person under the offender. Collaborative style and decreased recidivism risk here are compatible.

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