Women who sexually offend against children: the role of care and compassion in their experiences and their treatment

Amanda Barton 2011

Thesis Overview

Volume 1

Volume 1 contains two documents. Both documents focus on women who sexually offend against children. The aim of this volume is to forward our thinking and understanding of some of the issues facing this group of offenders. It is hoped that the information presented will stimulate advances in our treatment of this group of women.

The first document is a theoretical review of the literature considering whether a therapeutic approach, Compassionate Mind Training (CMT), could be successfully applied to females who sexually offend against children. CMT aims to develop a person's self-caring and compassionate mentality. It is argued that CMT could be used to tackle certain existing psychological difficulties. Three core psychological problems – (a) attachment disorder, (b) shame, and (c) low self-esteem - commonly found in the female sex offender populations are considered in detail. A discussion of the application of CMT for bringing about changes in these dimensions of psychological highlights the potential utility of CMT. The contribution that this could make in enabling this client group to better access more standard treatment approaches aimed at reducing their offending behaviour is considered. It is suggested that adopting CMT would improve the effectiveness of offence-based intervention techniques and in some cases allow women to access such programmes when their psychological difficulties would previously have prevented this.

The second document reports upon the Interpretative Phenomenological Analysis (IPA) of a small number of semi-structured interviews with females who sexually offend against children. The analysis focuses on the way in which these participants make sense of their early relationships, specifically their experiences of care and compassion, and the means by which they understand and make sense of their experiences. One cluster of themes is presented: 'expectations of parents' roles'. The women's stories are interpreted and the similarities and differences between the women's experiences are discussed. Two further clusters of themes; 'what is compassion' and 'the impact my past had on my present' were revealed but are not discussed in this paper. Ultimately the themes represent the shared difficulties these women had in their upbringings. This paper demonstrates how much we can

learn from these women's stories. It is hoped that the data can inform treatment approaches and stimulate further research in this area.

Volume 2

Volume 2 contains five case practice reports. The first is an essay on two psychological models and their application to clients. The second is a service related project conducted in a child and family setting. The third is a single case design study completed in a home for adults with learning disabilities. The fourth is a case study on the treatment of depression in an older adults service. The fifth is an abstract summarising a presentation given on a patient from a low secure ward.

Dedication

To my Dad.

Acknowledgements

Thank you to my supervisor, Professor Anthony Beech, for his ideas and to Professor Paul Gilbert for meeting with me to discuss Compassionate Mind Training.

Thank you to the Lucy Faithful Foundation, especially Sherry Ashworth, for their help in finding participants and for their support to myself and to the participants during the research.

Thank you to the participants themselves who despite their involvement with our criminal justice system have been victims themselves.

And, thank you to Ben, and now William and Toby, for following me around the country during the course of my training.

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Abstract

This paper considers whether a new therapeutic approach, Compassionate Mind Training (CMT), could be successfully applied to females who sexually offend against children. CMT aims to develop a person's self-caring and compassionate mentality. It is argued that CMT could be used to tackle certain existing psychological difficulties. The significance of three core psychological problems – (a) attachment disorder, (b) shame, and (c) low self-esteem - commonly found in the female sex offender populations are considered. The potential of CMT for bringing about changes in these dimensions of psychological need is highlighted. Plus, the contribution that this could make in enabling this client group to better access more standard treatment approaches aimed at reducing their offending behaviour is considered. It is suggested that adopting CMT would improve the effectiveness of offence-based intervention techniques and in some cases allow women to access such programmes when their psychological difficulties would previously have prevented this.

Keywords: compassionate mind training; treatment; sexual offend(ing); children; women; female

1. Introduction

Sexual offending was once thought of as a male crime. It is now acknowledged that females also commit sexual offences and with that they pose a significant risk of causing psychological harm to their victims (Beech, Parrett, Ward, Fisher, 2008). These offenders do not form a homogeneous group; however the evidence suggests that there are some similarities in the upbringings of these women (Matthews, Mathews & Speltz, 1991). Where this is the case, these women may share psychological difficulties which can be treated. The aim of this paper is to review the available literature to establish whether, and to what extent, common psychological problems exist and to identify the kind of interventions that might be

beneficial. Particular emphasis is placed on the review of Compassionate Mind Training (CMT) as a potential approach for working with these psychological problems.

This review is structured by starting with an account of the current situation for women convicted of a sexual offence against a child. Current treatment provision is briefly described. Section 2 reviews the literature on what we know about women who sexually offend against children in terms of their social, educational and psychiatric background, and their lives as children including their key relationships. Section 3 comprises a discussion around what the author considers to be three psychological difficulties likely to arise from the typical backgrounds that some of these offenders share. Section 4 reviews CMT as an approach in general and section 5 reviews CMT as a therapy which could target each of the 3 psychological difficulties previously discussed. Finally section 6 reviews some of the theoretical difficulties with the ideas put forward in this paper.

1.1 Statistics and Current Treatment Provision

In 1998 Grubin assessed that females were responsible for less than 1% of the sex offences committed in the UK. This figure appears to have risen marginally. In a telephone survey conducted in the USA, 1481 women were asked about their sexual victimisation experiences and 1% reported female perpetrators (Finkelhor, Hotaling, Lewis, & Smith, 1990). In Arkansas, USA, in 2002 there were 1644 registered sex offenders, 2.4% of whom were women (Vandiver & Walker, 2002). This also tallies with data from the English and Welsh Prisons where around 1% of the sex offenders in prison are female (data from National Offender Management Service, UK, 2007). However the last 30 years has seen an increase in the incidence and prevalence of males and females convicted of sexual offences. The number of female sex offenders appears to be rising as society becomes more open to idea that females do commit sexual offences and as victims become able to disclose abuse by women. Whilst the increase in male offenders has led to a growing recognition of the specialist treatment needs of the male client population, the treatment needs of women have been largely left to individual therapists who are sometimes allocated to female offenders. The Lucy Faithfull Foundation has been commissioned to develop an assessment and treatment programme for the Prison Service. However, standard treatment is not yet currently offered to

female sex offenders in UK prisons, and provision of individual therapists is sporadic. Where it exists it is often supplied through charities or private organisations.

Treatment programmes designed for male offenders were first developed in the 1990s, e.g., the Sex Offender Treatment Programme used within the Prison Service in England and Wales (Thornton & Hogue, 1993). The Carter review outlined a major restructuring to create the National Offender Management Service and in anticipation of this development, male sex offender work undertaken in both the Probation and Prison Services has been updated and aligned (Sex offender strategy for the National Probation Service, Sept 2004). Nathan and Ward (2001) state that while female sex offenders have features in common with male sex offenders, they also have some needs that are quite different. The National Probation Service now funds a charitable organisation, The Lucy Faithful Foundation, to provide a specialist assessment, intervention and support service for female sex offenders in custody and in the community.

2. Histories of women who sexually offend against children

This part of the paper reviews some of the literature available on the backgrounds of women who go on to sexually offend against children. In order to consider possible treatments for these women it is important to understand what we can about these women's stories. The first section describes what is known about their social, educational and psychiatric background and the possible links to sexual offending. The second section describes what is known about their upbringings. Attention is given to their own experience of abuse, to their relationships with key care-givers and to the impact their upbringing might have had on their psychological well-being. The third section considers where the research has gone with this information and reviews the main typologies that have been compiled to date.

2.1 Social, educational and psychiatric backgrounds

Although there is not a single pathway to offending, a number of commonalities exist in the lives and upbringings of women who sexually offend against children. Grayston and De Luca (1999) found that they typically come from low socio-economic groups. They are often poorly educated and frequently unemployed (Nathan et al., 2002). Tardiff et al. (2005) found

over two-thirds living on welfare benefits. Amongst this group there is a trend for abusive mothers to have their first child at a younger age than mothers who do not abuse their children (Saradjian, 1996). These factors suggest a picture of a group living in social disadvantage and facing difficulties which may contribute to feelings of powerlessness (Ford, 2006).

Forty-eight percent have a history of psychiatric diagnosis and treatment (O'Connor, 1987). Although most offenders are not highly disturbed or psychotic when abusing Faller (1987) many experience long term difficulties with self-harm, emotional distress, depression and anxiety (Eldridge & Saradjian 2000). Green and Kaplan (1994) found that female sex offenders had a mean of 3.6 personality disorders each and were most likely to have a diagnosis of avoidant or dependent personality disorder. In their study, all had post traumatic stress disorder symptoms, attributable to physical or sexual victimisation in their past. Faller (1995) found 50% abused substances although they were not necessarily using drugs or alcohol at the time of their offending. Given the extent of emotional, psychiatric and personality disorder and suffering, it is perhaps unsurprising that these women look for ways of coping with their distressed feelings. It is suggested that the abusing is a way of coping with feelings of anger, fear or loneliness. Matthews (1993) hypothesised that sexual abuse is an expression of anger, disappointment, sadness and low self-esteem.

2.2 Upbringing

There are extremely high rates of sexual abuse in the backgrounds of women who go on to sexually offend against children with studies estimating between 80 and 100% prevalence rates (e.g. Travin, Cullen & Protter (1990), Matthews, Mathews & Speltz (1991) & Stanley & Goddard (2002)). Travin et al. (1990) observed that this experience had often been ignored or minimised by their caregivers and the abused women were often blamed.

Women who sexually abused young children reported that their own sexual abuse began at a very young age and in half the cases continued into adulthood (Saradjian, 2000). Women who went on to abuse children were more likely to have been physically abused themselves than women who did not go on to abuse children, and, with the exception of very serious injuries, these women did not receive appropriate treatment for them.

Saradjian (1996) suggested that a major difference between female abusers and non-offenders was the greater amount of emotional abuse and neglect in their lives. More recently, Bifulco (2008) suggests that the mediating factors in the intergenerational transmission of sexual abuse are recurrent depression and the mother's vulnerability factors. However, whether good, caring parenting alone can protect women from going on to sexually offend is not established. It is also unclear whether it is simply that better educated, or more intelligent, women may avoid being discovered, or if discovered their cases may be dealt with informally and therefore never enter the statistics.

Aside from being victims of sexual abuse, women who sexually offend against children are often raised in chaotic environments. Craissati, McClurg and Browne (2002) found that sexual offenders commonly reported an 'affectionless control' style of parenting. Physical and sexual abuse are more likely to occur when there is a home life characterised by poor parental relationships and where there is a history of parental aggression, alcohol abuse and criminality (Weeks & Widom, 1998). Freel (1995) found that two thirds were in care during their early years, and Green and Kaplan (1994) in their study, observed that only 4 out of 11 had intact families. In another study Harper (1993) found that all abusing mothers had been in care at some point in their childhood.

Where these women remained with their parents, they report poor relationships with them describing their parents as "cold", "rejecting", and "unloving", (Saradjian, 1996). Allen (1991) found that these women described their mothers as critical. Green and Kaplan (1994) found primary carers were described negatively and as predominately abusive. Craissati, McClurg, and Browne (2002) found that family backgrounds of sexual offenders are typified by neglect, violence and disruption. Saradjian (1996) went on to note that peer relationships are often superficial or nonexistent and these women lack the social skills to form such relationships. Saradjian (1996) describes these women as having a poor self-concept and low self-esteem. They lack power and control in most aspects of their lives and hold overwhelmingly negative views of themselves. "These views remain unchallenged by positive peer relationships so women expect nothing better and try to gain control over their lives in any way they can" (Saradjian, 1996).

In a recent study by Beech, Parrett, Ward and Fisher (2008) female offenders talked about the powerful influence of their past experiences on their abusive behaviour, for example, previous experience of aversive attachment relationships, a failure to acquire adequate parenting skills, or learning that sex has little intrinsic value.

2.3 Typologies of Female Offending

Researchers are beginning to create typologies that will allow them to characterise specific types of female sex offenders. This information is also useful for the treatment of these women as it provides therapists with specific information that will assist them in making effective therapy and case management decisions. A number of models exist, for example Faller's (1987) five case types, and Finkelhor and Araji's (1986) four factor theory of male offending. Matthews (1989) model however is based soley on her experience of working with female sexual offenders and brings together: the type of abuse perpetrated, the perceptions the women hold about their victims, the involvement of co-offenders, and the psychological similarities and differences of the women themselves.

Matthews (1989) suggests that there are three main types of female offender: (1) 'Teacher / Lover' abuser who does not believe that her behaviour is wrong in fact, she frequently sees the child as her partner and the sexual behaviour as a positive experience for both individuals; (2) 'Predisposed Offender' is a woman who acts alone while offending and who generally abused her own family members. The majority of these women were sexually abused themselves at a very young age. (3) 'Male-Coerced' offender is a woman who is passive and feels powerless in interpersonal relationships. She endorses a traditional lifestyle where the husband is the breadwinner and in control of the family. Generally, she will have been coerced into the sexual abuse by her husband or partner. She fears abandonment and violence if she did not participate in the abuse. It appears that this group comprise a large percentage of the overall population of female child molesters.

More recently Beech, Parrett, Ward and Fisher (2008) identified a number of common schemas held by female offenders. In this model, a schema is defined as a structure containing beliefs or attitudes that follow a similar theme or pattern. These develop as a result

of trying to make sense of early life experiences and contain fundamental assumptions about an individual and their relationship with others and the world (Mann & Beech, 2003). Beech, Parrett, Ward and Fisher (2008) found that four of the five schemas suggested by Ward (Ward, 2000; Ward & Keenan, 1999) to underlie male sexual offenders' cognitions could be clearly identified in women, these were: Uncontrollability, Dangerous world, Children as sexual objects, and Nature of harm. Entitlement, the final implicit theory (IT), commonly found in males, was not identified in any participants in the sample. Looking at combinations of schemas also demonstrated that for some women sexual motivation existed alongside fear of violence, for others only fear of violence was present and for others sexual motivation alongside further cognitive schemas existed.

Matthews (1989), and Beech, Parrett, Ward and Fisher (2008) support evidence collated by Vandiver (2006) that a group of women sexually offend as a result of coercion by a male co-perpetrator. Working with women offenders, especially those who have co-offended in a male-coerced context, is different from working with male offenders. Male offenders have often experienced sexual victimisation as children. However, as adults they are rarely victims of a man who is also their co-offender. In the case of women, it is more common to have been abused as a child and also abused within an adult relationship. It may be necessary to recognise and help them survive their own victim experience before they can begin to fully empathise with the child they have abused (Matthews, 1993).

Johansson-Love and Fremouw (2006) stress the need for further development of typologies for female sex offenders. It may be that the shared psychological difficulties arising from their upbringings also form a typology, although it is not the intention of this paper to set out to identify typologies. However, Nathan and Ward (2001) highlight the need in treatment to identify the psychological phenomena linked with sexual offending and it may be on these grounds that women's treatment needs are best considered.

3. Psychological difficulties likely to arise from such an upbringing: Attachment difficulties, Shame, Low Self-esteem.

While no woman shares the exact same upbringing or experiences, the literature indicates that women who go on to sexually offend against children often share similar experiences of poor relationships with others, particularly their primary caretakers, abuse, or growing up in chaotic environments. While there is no certainty that these experiences will result in psychological problems in later life, the risk of this occurring is increased. Nathan and Ward (2001) highlight the need in treatment to identify the psychological phenomena linked with sexual offending. This section separately considers the argument that certain background factors lead to particular psychological problems. Section 3.1 considers how a difficulty in forming secure attachments may emerge in the women's lives given the experiences they had when growing up. The link between compassion and attachment is drawn out. The relationship between attachment problems and sexual offending is described. The implications of an attachment problem for engaging in therapy are considered as is the relationship between attachment and neurophysiology. Section 3.2 and 3.3 reviews the experience of shame and low self-esteem respectively and the relevance of these to treatment success.

*3.1.1 **3.1 Attachment** Compassion and Attachment*

According to Bowlby (1969/1982) humans are born with a repertoire of behaviours that assure their closeness to others that will guide their development and assist in reducing their distress. Bowlby viewed the attachment system one that is activated by perceived threats and causes people to seek security from others. This system fosters emotional stability, the formation of positive attitudes toward relationships and in turn better care-giving to others. When a person's attachment figures are not available or supportive, strategies of affect regulation other that attaining closeness to others are sort. These tend to be characterised by avoidance and anxiety (Gillath, et al., 2005) Attachment styles are initially formed during early interactions with primary caregivers therefore a solid care-giving system is likely to prove invaluable in an infants chance of developing into a successful, self-assured, happy adult. The ability to help others has been shown to be a consequence of having witnessed and benefited from good care-giving from a persons own attachment figures (Collins & Feeney, 2000; Kunce & Shaver, 1994). Securely attached people's interactions tend to foster empathic

compassion and reduce distress in others (Hazen & Shaver, 1987). Insecurely attached people may be less able to feel empathy and compassion to another person. An anxious person may find that they become emotionally overwhelmed by someone's distress and over-inflate their own worries and their perception of the other person's difficulties. Although they notice the person's distress, their difficulties in differentiating their own and the other person's distress may prevent them from reacting with compassionate altruistic care. An avoidant person however may feel so uncomfortable with closeness that their compassionate responses are inhibited and they fail to respond with compassionate altruism.

In a series of experiments activation of attachment security, achieved for example by asking people to recall personal memories of supportive care, strengthened compassion and inhibited personal distress in reaction to others' distress (Mukulincer et al., 1999, 2001). This relationship between the security of our attachment and our ability to be compassionate to others is paramount in parenting our children. It explains why some people struggle with compassion in later life. These are the people who have likely been parented by insecurely attached care-givers. When the child experiences distress the care-giver was unable to respond in a truly altruistic and compassionate way. This was demonstrated in an experiment where mothers were asked to leave their children alone in a room and then to return (Crowell & Feldman, 1991). Securely attached mothers were observed to prepare their children better for the separation and also to comfort them better on their return. Insecure avoidant mothers showed little distress, whilst insecure anxious mothers were very agitated and found it difficult to leave the room. This is an example of personal distress interfering with giving effective compassion to others.

Some infants are not able to organise their attachment behaviour according to a coherent pattern. These infants are classified as disorganised in their attachment. This is demonstrated in a confusing lack of orientation in interactions, or in unpredictable responses to separation-reunion situations. Infant attachment disorganisation is often observed as switching between approach and avoidance attitudes towards the care-giver. Disorganised attachment is thought to result from instances where the care-giver is both an infant's source of compassion and also a source of threat. A care-giver may act differently on separate occasions for a variety of their own reasons, e.g. they may have suffered a recent trauma (Liotti, 2004), or they may have a

disrupted attachment system of their own. When the care-giver responds to the infant's distress in an angry way, the infant's distress is heightened however there is no-one else for the infant to turn to, this leads to fright without solution (Liotti, 2004). The infant therefore has no single strategy to deal with its distress. Disorganisations in attachment follow.

3.1.2 Linking attachment difficulties to sexual offending

The research suggests that a significant number of women who sexually offend against children will have been the victim of sexual abuse when they were children (Matthews, Mathews & Speltz, 1991). It is also likely that they will have: suffered physical, emotional and/or neglectful abuse (Carlson et al., 1989; Van Ijzendoorn et al., 1999); been in care, had parents who were emotionally unavailable having suffered losses of their own (Ainsworth & Eichberg, 1991; Main & Hesse, 1990); been brought up in a chaotic environment, and had a frightening relationship with their parents (Main & Hesse, 1990). Given these events it is unlikely that they will have formed a close relationship with a caring adult.

In his theory of attachment, Bowlby (1969, 1975, 1980) proposes that difficulties in the patterns of early interactions between a child and their carer can be played out in adult

relationship difficulties. Usually a child's early interactions provide a foundation for people to learn about social relationships and develop an understanding about how the social world works. This understanding, or model of the world, then guides our thoughts, feelings, and behaviour in close relationships throughout our lives. When the early patterns of interaction are unrepresentative of the general world these children grow up unable to fully understand the world and other people.

A number of problems in cognitive functioning exist in many sexual offenders for example; levels of inadequacy, distorted intimacy balance (feeling that emotional intimacy is easier with children than adults), aggressive thinking, callous/unemotional traits and emotional loneliness (Beech, Fisher, & Beckett, 1999). According to Ward and Siegert (2002), the primary cause of such interpersonal functioning problems is insecure attachment in childhood and subsequent adult attachment problems (Ward, Hudson, & Marshall, 1996). As such, a number of researchers have suggested that difficulties in attachment form the starting point

for a pathway into offending (e.g., Bifulco, 2008). Indeed, a history of poor attachment has been widely noted in sexual offenders' histories (Becker, 1998; Browne & Herbert, 1997; Marshall, Serran, & Cortoni, 2000).

Marshall (1989) describes a theory in which an insecure pattern of attachment leads to difficulties establishing intimate adult relationships. This may lead offenders to have difficulties in forming relationships with age appropriate adults (Marshall, Serran, & Cortoni, 2000) . Fonagy and Target (1997) describe how poor attachments lead to a lack of a sense of personal responsibility and limited empathy that allows people to see others as objects. This enables them to develop distorted views around unacceptable behaviour (Fonagy, 1999). Burk and Burkhart (2003) outline a relationship between disorganized attachment, where the individual has had to cope with a frightened or frightening caregiver, such that they have not developed or adequately internalized self-regulatory skills. Together these factors contribute to the pursuit of intimacy through inappropriate sexual behaviour. Eldridge and Saradjian (2000) state that needs for attachment are then met through offending.

3.1.3 Difficulties of working with attachment problems

Clients with attachment difficulties present a problem to therapists. Their style of attachment can impact on the quality of the relationship they form with their therapist (Meyer & Pilkonis, 2002). Lee (2005a) reports that clients often understand the logic of what is being said to them in therapy, but they struggle to take it on board. When they are with the therapist their threat system is activated and they construe statements as threatening. (This struggle can be understood as a fear of compassion and is discussed further in section 6.1.) In turn they remain highly self-critical and the therapist struggles to form a good working relationship with them. Forming a good working alliance with patients has been shown to be a consistent, though modest, predictor of outcome in psychotherapy (Hersoug, Høglend, Monsen & Havik, 2001). Therefore, in order to form a good working alliance, patients with attachment problems are usually involved in traditional psychotherapy approaches, which allow for therapy taking place over a long period of time. A long term therapy approach is also appropriate for working with attachment disorders as adult attachment style encompasses a relatively enduring set of characteristics (Young, Klosko, & Weisharr, 2003). Therefore changing attachment style is as fundamental as changing the way a person is and likely to be a

slow process. Ultimately, therapies still depend upon clients changing their beliefs, ways of thinking and their behaviour. When therapy raises these issues the threat-system is activated and self-critical thoughts begin. The client therapist relationship is endangered as is any progress made so far. The treatment needs of this group are complex and long term and existing psychological problems need to be tackled before any offence specific work can successfully take place.

3.1.4 Neurophysiology and attachment

People with poor attachment patterns tend to have lower levels of certain neurohormones such as peptides, oxytocin, vasopressin and opiates (Beech & Mitchell, 2005; Carter, 1998; Depue et al., 2005; Panksepp, 1998; Uväns-Morberg, 1998; Young, 2002). These neurohormones are associated with a positive affect system that is particularly linked to social signals of affiliation and care. When humans experience care and affection that create warmth this affect system is started up and the neurohormones are produced. These hormones are known to have a calming effect on people, they can alter pain thresholds, and they are linked to better immune and digestive system functioning (Gilbert, 2006). There is increasing evidence that oxytocin is linked to social support, regulates stress-hormones, and buffers stress; those with lower oxytocin having higher stress responsiveness (Heinrichs, et al., 2003).

Oxytocin is particularly implicated in the development of the mother and infant attachment process. The density of oxytocin receptors rises rapidly around the time of birth which is linked to an increase in maternal behaviour (Beech & Mitchell, 2005). An increase in oxytocin is also observed around the birth in the subsequent nursing period in various animal species (Keverne & Kendrick, 1994).

The positive affect system is developed in the first years of life where a parent provides reassurance and soothing (Gerhardt, 2004). In doing so the care-giver creates experiences and emotional memories of safeness, and enables infants (and later children) to understand and feel safe with their own emotions (Leahy, 2005; Schore, 1994). Such emotional memories, with their neurophysiological mediators, may then become available in times of stress (Brewin, 2006).

People who have poor attachments resulting from poor experiences of care, affection and warmth have more limited opportunity to produce oxytocin and opiates. A lack of such hormones means that it is harder for the person to physiologically express warmth, calm, and affection to others. Increased stress levels in turn activate alternative affect systems such as the threat system making them more sensitive to threat and less emotionally regulated. While soothing and affiliation lowers stress and cortisol, shame, negative evaluation and criticism by others is now known to be one of the most powerful elicitors of cortisol stress responses (Dickerson et al., 2004). It is now believed that parental neglect and abuse may fail to help the positive affect systems mature, and indeed abuse and neglect can cause problems in brain maturation (Gerhardt, 2004; Schore, 2001).

3.2. Shame

Clinicians frequently describe the intensity of shame that female sex offenders exhibit early in therapy, for example Matthews (1993) describes "feelings of intense 'shame' and stigmatisation", and Eldridge and Saradjian (2000) talk about the personal crises in which a woman finds herself when being assessed for being a perpetrator of child sexual abuse. Shame is a very important component in inhibiting women's disclosures. In turn this stands in the way of women accepting therapy. A lack of disclosure prevents clinicians from working fully on the offending behaviour. Shame also stands in the way of a woman's ability to receive help for any abuse that she may have suffered and access the help being offered to her as she will ultimately blame herself for the abuse.

The effects of shame and guilt on treatment success have been studied by a number of researchers. Travin, Cullen and Protter (1990) for example, observed that many sex offender treatment programmes for men have high dropout rates as they overwhelm clients with shame and guilt. This is particularly true of some approaches which use aggressive confrontation to promote early offense disclosures in a group setting which reduce client confidence and fail to model empathy (Marshall, Serran & Cortoni, 2000). It is also problematic in programmes which do not adopt the model that all behaviour is 'explainable', if not excusable, when viewed within the context of a person's life (Eldridge and Saradjian, 2000).

Some differences between men and women appear to exist in the experience of guilt and shame. It has been found that women move out of guilt and shame more slowly than men (Matthews, 1993), thereby prolonging the period before they give themselves permission to heal. Women's anger towards themselves tends to be more deeply entrenched and although they typically develop empathy for their victims earlier in therapy than men, they maintain their feelings of shame for their abusive behaviour (Matthews, 1993). Therefore, it may be particularly pertinent that feelings of shame and guilt are addressed early on with female offenders.

Shame can be viewed as a form of self-criticism or self-devaluation. When we feel shame we experience attacking thoughts and feelings. Such feelings are a key component of most psychopathologies, most obviously depression in which feelings of worthlessness and self-devaluation are central. Kohut (1971, 1977) argued that our early experiences influence our ability to cope with shame later in life. He argued that people could internalise an ability to be self-reassuring and soothing when things go wrong, or that they would act out their frustration at themselves in self-hatred.

Wheton (2000) referred to our ability to reassure ourselves by focusing on our positives as 'resilience'. Bowlby (1980) and Kohut (1971) believed that warmth and affection in early relationships and appropriate parental responses in childhood, such as caring and non-shaming responses in times of failure and disappointment, would lead children to adopt such self-reassuring responses.

3.3. Low Self Esteem

Self-esteem reflects a person's overall evaluation of his or her own worth. Low self esteem is perhaps a secondary pathology to the intense experiences of shame[1] and the impact on attachments stemming from emotionally abusive relationships. However, it is intrinsically linked to our capacity to deal with psychological challenges and to our well-being. As such it is included in this review for consideration of its own accord. One of the most persistent

[1] Shame can be considered to be an emotion and therefore a component of self-esteem. Given the importance of shame as an experience for female sex offenders, shame and self-esteem are considered separately for the purpose of this paper.

effects of long term victimisation, such as these women experience, is lowered self-esteem. Herman (1992) attributes lowered self-esteem to internalised beliefs of the perpetrator and self-blame for the victimisation. Raising self-esteem in offenders is rarely viewed as a priority as prevention of re-offending is the main purpose of therapy. However, many clinicians refer to the importance of raising self-esteem and the positive impact that this can have on assisting progress in other areas of therapy (e.g. Saradjian, 1996).

4. Compassionate Mind Training

Gilbert (2006) has developed a form of therapy called Compassionate Mind Training (CMT) which aims to develop the person's ability to access a self-caring and compassionate mentality. CMT was developed as a form of therapy for people who are highly self-critical. CMT starts from the premise that when things go wrong for people they feel afraid of other people's reactions. They expect to be rejected by others and to feel ashamed. Whilst most of us can access a self-caring and compassionate mentality that is soothing to us, some people find it hard to limit such self-attacks. As a result they spiral into self-criticism and become unable to soothe and reassure themselves. Compassionate Mind Training refers to specific exercises designed to improve compassion generating skills. CMT has developed out of Compassion Focused Therapy (CFT) which refers to the underpinning theory of applying a model of compassion to therapy.

A key element of CFT is related to the observation that individuals prone to high levels of shame and self-criticism can find it very difficult to generate feelings of contentment, safeness or warmth in their relationships with others (Gilbert, 2009). An approach to this problem is via the evolved functions that underpin some of these feelings and styles or social relating (Gilbert 1989, 2005, 2007, 2009). Research suggests that there are three types of emotional regulation systems that enable us to feel reassured, safe, content and to register warmth (Depue, 2005): threat and protection systems; drive, resource-seeking and excitement systems; and contentment, soothing and safeness systems. The interaction of these systems is shown in Figure 1.

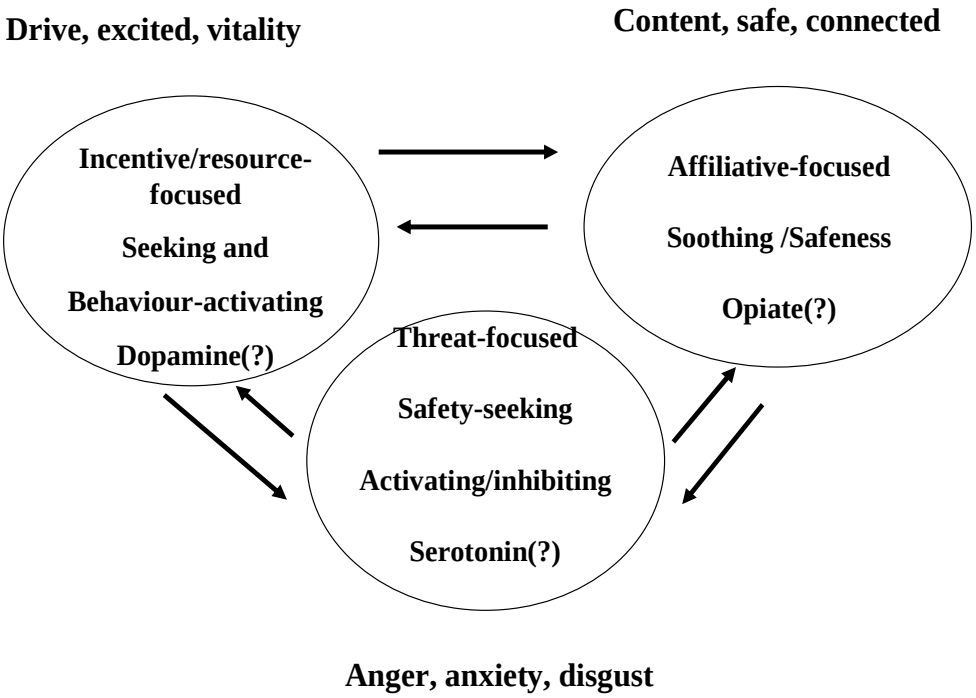

Figure 1. Affect regulation systems. From Gilbert (2005)

All living things have evolved a threat-detection and protection system (Gilbert, 2009). The human system works by focusing our attention to threats and signalling these through our feelings such as anxiety or anger. These feelings alert us to take action and protect ourselves. Behaviourally our responses are observed as fight, flight or submission (Marks1987; Gilbert 2001). The system is especially sensitive to keeping us safe and is therefore easily conditioned (Rosen, 1998). This makes it particularly vulnerable to psychopathology (Gilbert, 2009).

The drive and excitement system focuses our attention towards things we need and want, such as food and alliances, and is about generating positive feelings. This system could be activated by the use of drugs such as cocaine. The third system, contentment, soothing and social safeness also produces positive emotions but it is associated with a sense of peacefulness and well-being. The system is linked to the opiates that mediate the positive feelings. This contentment system has been developed with the evolution of attachment behaviour (Gilbert 2009). Caring behaviour demonstrated by parents has been shown to have

a soothing effect on the child's physiology. Caring behaviour stimulates this system, it leads to the production of opiates in the person being cared for and this can soothe over-arousal and threat distress. In turn this moderates the instinctive fight / flight response of the threat-distress system. CFT seeks to mirror this effect by improving or increasing the experience of care and the production of opiates in turn reducing the emotional distress and behavioural fight/ flight response of the threat –distress system.

CMT helps the person access self-soothing and reassurance via emotional memories of others who have been soothing and reassuring to them in the past. Where these experiences are missing, CMT helps the individual develop self compassion through a number of techniques, for example, the use of imagery, cueing warmth, compassionate re-evaluating, and through exercises such as compassionate perspective taking, meditating, and letter writing. The aim of CMT is to help the client replace the negative emotions, for example, self-anger or contempt, with more positive emotions such as self-kindness and warmth. CMT was developed as a way of enhancing other psychological interventions, not as a replacement for those treatments. As such, it may have the potential to help a proportion of the female sex offending population reach a stage where they are able to access therapies directed at their offending behaviour.

A number of links have been established between self-critical thinking and psychopathological difficulties. Gilbert and Irons (2004) found a strong inverse relationship of self-criticism with abilities to focus on self-reassuring thoughts, and self-reassurance was associated with lower depression scores. Neff (2003a, 2003b) found that a lack of self-compassion was associated with increased vulnerability to a number of indicators of psychopathology. Gilbert, Baldwin, Irons, Baccus, and Clark (2006) found that self-criticism was associated with difficulties in generating images and feelings of self-compassion. Lehman and Rodin (1989) found that bulimic and non-bulimic people did not differ in regard to using food for nurturing, but bulimics were significantly less able to self-nurture in non-food ways. CFT would help clients to replace the self-criticism with self-kindness (Gilbert, 2009). It would do this using specific skills and techniques to enable the client to build up an internal compassionate relationship with themselves to replace the self-critical one.

4.1. Current CMT applications and success

Some of the elements of CMT appear in existing therapeutic approaches which have already shown the importance of helping people develop inner compassion and self-soothing abilities for example, in Dialectical Behaviour Therapy (Linehan, 1993; Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). McKay and Fanning (1992) developed a cognitive programme for people with low self-esteem. They view self-compassion as a key antidote to self-criticism. In mindfulness training for depression, compassion is believed to emerge naturally from its practice and has been shown to be beneficial to clients (Segal, Williams, & Teasdale, 2002). In some forms of mindfulness training, loving-kindness mediations are added to standard procedures in a more overt attempt to develop compassion (Shapiro, Astin, Bishop, & Cordova, 2005; Allen & Knight, 2005).

To date, published outcome studies focus on clients with generic difficulties including depression and anxiety. Gilbert and Procter (2006) found positive results using CMT with six patients attending a cognitive–behavioural-based day centre for chronic difficulties. The patients completed 12 two-hour sessions in CMT and showed significant reductions in depression, anxiety, self-criticism, shame, inferiority and submissive behaviour. There was also a significant increase in the participants' ability to self-soothe and focus on feelings of warmth and reassurance for the self.

In a pilot study by Gilbert and Irons (2004) a group of self-critical clients from a depression support group were encouraged to keep a diary monitoring their self-attacking and self soothing thoughts and images. As a group, they were given training in self-soothing and self-compassion which included work on building compassionate images. Although there were only 9 participants, a "significant improvement in the reported ability to self-soothe" was noted (Gilbert and Irons, 2004, pp. 512).

CMT has been accepted and applied widely across clinical settings. Clinicians report anecdotal success using CMT to help clients with a range of difficulties including paranoid psychosis (Gilbert & Mayhew, submitted), eating disorders (Goss 2007, unpublished), personality disorders (Welford, unpublished), post-traumatic stress disorder (Lee, unpublished, Townend, unpublished), and with new mothers (Cree, unpublished).

5. Compassionate Mind Training Applied to Attachment, Shame and Low Self-Esteem

A main consideration of this paper is that CMT could be of value in helping to prepare women for the treatment they need to target reducing their risk of reoffending. The author considers that CMT is a useful technique for tackling some of the pre-existing psychological problems that female sex offenders present with. These are taken in order: attachment difficulties, shame, and low self-esteem. A theoretical explanation of how CMT would address these problems is provided.

5.1 Working with Attachment Difficulties

It was suggested that people with poor attachments work their way through life using ineffective affect systems (see Section 3.2). Their affect systems produce too much cortisol and not enough oxytocin and opiates. If this could be altered then the person would begin to feel better in mood and self-image and more able to relate to people around them. Some researchers believe that it is possible to develop one of the positive affect system later in life by teaching people how to self-soothe.

CMT is based on the hypothesis that compassion is a trainable mental skill. When we experience compassion, greater activity is observed in the left prefrontal part of the brain, which contains the neural network linked to empathy and maternal love (Davidson, 2005). Davidson studied a group of Buddhist monks who are able to generate “pure compassion” during meditation. While they meditated he used MRI scans to observe their brain activity. The monk’s brains showed that the left prefrontal cortex was swamped with activity and makes stronger connections between thoughts and feelings. It also showed a dampening of activity in the right prefrontal area, which is connected to negative moods. It would seem plausible that if monks can be taught to develop their ability to meditate and to increase their brain function in certain areas, then offenders might be able to learn to use this part of the brain more selectively too and that they could be taught to ‘switch on’ this brain activity on a frequent basis. As the person feels better in mood and self image, so it becomes easier to be self-compassionate and generate feelings of warmth.

5.2 Working with Shame

Typical approaches to tackling problems with shame involve teaching the person to re-evaluate their self-criticisms by focusing on positives and reducing their black and white polarised thinking (Beck et al., 1979). Gilbert et al. (2004) suggest that whilst this may work with people who basically like themselves and who use their criticism to improve themselves, those who have come to hate themselves may struggle to adopt such a new thinking style. It is plausible that a proportion of female sex offenders will have come to hate themselves for their crimes, if not before treatment, then during the early stages when they come to realise the implications of their actions.

In CMT, clients are taught how to replace shame-based thoughts with alternative healthy thoughts. Based on the idea that self-reassuring and developing affiliative relationships operate through systems that evolved for affiliative and affectionate-attachment, there may be value in adopting a CMT approach in which people are helped to develop inner warmth and compassion for the self as a counter affective response to self-disgust and hatred (Gilbert 2000).

5.3 Working with Low Self-Esteem

Women's self-esteem is likely to be improved by attending therapy and forming a relationship with a therapist who can provide a genuine empathic relationship and show unconditional positive regard towards the women. Helping the woman to make sense of her own history, particularly her victimisation and perpetrating behaviour, can also act to raise self-esteem in this context. The key components of self-esteem encompass beliefs (for example, "I am competent/incompetent"), emotions (for example, joy/sadness) and is reflected in behaviour (for example, assertiveness/timidity). Self-esteem is therefore undoubtedly addressed indirectly in traditional approaches to working with sex offenders. For example, Cognitive Behavioural Therapy is based on the theory that what people think affects how they feel which can alter what they do. As therapy progresses and people learn to understand the relationship between thoughts, feelings and behaviour, and gain control over challenging these dimensions, so their confidence in themselves and control over their lives improves and, with that, their feelings of self-worth, or self-esteem, also improve.

However, this group of offenders may find it hard to access this type of therapy. Whelton and Greenberg (2005) have shown that the most pathological aspects of people with low self-esteem incorporate high levels of self-criticism, especially anger or criticism which is directed towards themselves. It has been demonstrated that such people find it hard to feel reassured by cognitive tasks and behavioural experiments (Lee, 2005b) which are key features of Cognitive Behavioural Treatment programmes. Rector et al. (2000) suggest that highly self-critical people may do less well with standard CBT.

Psychodynamic therapists also recognise that low self-esteem underpinned by self-directed criticism and self-persecution can be particularly distressing and pervasive (Scharffee et al., 2003). Given the likely prevalence of shame and self-criticism in female sex offenders, therapies that specifically focus on this element may be especially useful for some clients. Compassionate mind training (CMT) evolved from working with high shame and self-critical people (Gilbert, 1992, 1997, 2000; Gilbert & Irons, 2005) and may prove useful as a preliminary approach to raise self-esteem and enable women to better access the help being offered to them.

6. Unanswered questions

Whilst CMT is proposed as a positive, and useful, adjunct for working with female sex offenders it is important to note that it may benefit some women more than others. Therefore, the clinician's initial assessment will still be paramount in treatment planning. There are also a small number of theoretical questions or observations of interest, addressed briefly below.

6.1 Can we help people with attachment disorders overcome their fear of self-compassion?

Rockliff et al., (2008) used measures of heart rate variability and cortisol to distinguishes between those who had higher mean scores of self-criticism, self-coldness, anxious attachment and psychopathologies, from those who had higher mean scores of self-compassion, self-reassurance, and ability to depend on others and experience close relationships. Those with anxious attachments were negatively associated with changes in heart rate variability and compassionate focused imagery (CFI) experience. This suggests that anxious attachers may find CFI more threatening. This evidence fits with clinical observations that for some people, focusing on self-compassion is difficult, unfamiliar,

threatening and can feel unsafe (Gilbert, 2007; Gilbert & Irons; Gilbert et al. 2006). Some clients who have experienced harsh backgrounds may struggle to access their soothing and social safeness systems and it has been suggested that this might be due to a lack of positive emotional memories (Gilbert, 2009). For others, compassion may be feared because they feel they do not deserve compassion, it triggers sadness, or it is frightening to let others feel close (Gilbert & Procter, 2006). The interactions between the function of self-criticism and the fear of self-compassion may involve negative beliefs about the self such as 'I'm unlovable' to fear of gaining something which could be taken away from them later. They may perceive self-kindness as being unnecessary. Engaging in such explorations may account for considerable amount of time in therapy but will be paramount to the success of the process (Gilbert 2009).

6.2 Is the oxytocin producing system permanently damaged?

Studies suggest that children who are neglected until later into their childhoods produce low levels of oxytocin in response to pleasant stimuli (Wismer Fries, Ziegler, Kurain, Jacoris & Pollack, 2005) and in response to the need to reduce corticosteroid levels (Meinschmidt & Heim 2007). What is unclear at this stage is whether, with enough practice, the systems can be 'repaired' and can begin to produce 'good enough' levels of oxytocin, or whether the system has been irreparably damaged. Early research has shown that an oxytocin nasal spray can increase trust in humans (Kosfield, Heinrichs, Zak, Fischbacher & Fehr, 2005). It would be useful to consider the clinical use of oxytocin. Could it be used early in therapy to help develop a therapeutic relationship? Would it allow an individual to engage to the extent that they could begin useful treatment into their offending behaviour?

6.3 CMT: what does self-reassuring actually consist of?

CMT does not provide a quick and easy adjunct to existing therapeutic approaches. Gilbert and Irons (pp. 47, 2004) say "we suspect that self-reassuring is itself a complex process with different components such as the ability to remind oneself of one's positives, past successes, and abilities, the capacity to tolerate disappointment and feeling vulnerable, and the ability to have compassion for the self". Different forms of reassuring may be about encouragement and 'geeing oneself up, or energising, whilst others may be about soothing and calming oneself down'. Clearly the clinician and client will need to work closely to identify how the different types or forms can reassure. Its very nature as a tool of self-discovery makes it a

potentially long therapeutic approach, though seemingly a credible and hopeful treatment approach.

7. Conclusions

This paper set out to consider whether a new therapeutic approach, Compassionate Mind Training (CMT), could be successfully applied to females who sexually offend against children. It has been argued that CMT could be used to tackle certain existing psychological difficulties thereby allowing them to go on to successfully engage in treatment aimed at reducing their offending behaviour. It may be that many women may need individual therapy aimed at their individual psychological needs prior to their being able to participate successfully in treatment for their offending. If this 'pre-treatment' can be provided then the chances of a treatment group or a standardised programme working may be greatly enhanced.

The literature makes it clear that female sexual offenders against children do not form a homogenous group. This presents a challenge to treatment providers as existing models of treatment developed with male sexual offenders are standardised group based approaches and it appears that this may not successfully be mirrored with female offenders. Any group based intervention programme for females will need to be careful to take into account the differences between the women. Although a number of helpful typologies have been developed which differentiate between women on their offending type and consequently their psychological similarities, there are still difficulties inherent in assuming these women share the same treatment needs.

This article has concentrated on three core psychological difficulties that may present themselves in some women who sexually offend against children – attachment difficulties, shame and self-esteem. However, there are likely to be a range of psychological problems faced by these women that space did not permit consideration of in this review, e.g., self-harm, depression, post-traumatic stress disorder, eating disorders etc. It is likely that disorders other than the ones discussed in this article may present difficulties to women that need to be treated prior to their tackling their offending behaviour and that CMT may prove a useful approach in doing this. Further research is needed to establish this.

CMT has not yet been trialled with women who sexually offend against children, so it is clear that research is needed to trial the potential effectiveness of this approach before consideration can be given to incorporating the approach into other models of treatment and the development of assessment procedures to determine which women would benefit from a CMT approach.

Ultimately, whilst treatment to tackle a woman's underlying psychological needs is desirable, and morally right, the overall purpose of therapy - to prevent re-offending - must not be lost sight of. Further research is therefore needed to establish which areas of psychological need stand in the way of women being successfully able to engage in treatment addressing their offending behaviour.

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The Experience of Care and Compassion in Early Relationships in the Upbringing of Women who Commit Sexual Offences against Children

Abstract

This paper reports upon the Interpretative Phenomenological Analysis (IPA) of a small number of semi-structured interviews with females who sexually offend against children. The analysis focuses on the way in which these participants make sense of their early relationships, specifically their experiences of care and compassion, and the means by which they understand and make sense of their experiences. One cluster of themes is presented: 'expectations of parents' roles'. The women's stories are interpreted and the similarities and differences between the women's experiences are discussed. Two further clusters of themes; 'what is compassion' and 'the impact my past had on my present' were revealed. These are discussed but are not analysed in this paper. Ultimately the themes represent the shared difficulties these women had in their upbringings. This paper demonstrates how much we can learn from these women's stories. It is hoped that the data can inform treatment approaches and stimulate further research in this area.

Keywords: care and compassion; sex(ual) offen(ces); women; children; upbringing; relationships

Introduction

Sexual offending was once assumed a male crime but it is increasingly obvious that females are involved too. Intuitively professionals have felt that there are differences in the nature of the involvement, the precipitating factors, and consequently the treatment needs of these women. Eldridge and Saradjian (2000) made the observation that to reduce reoffending treatment for female sex offenders must address the women's background experiences and the impact these will have had on their attitudes, beliefs and goals. However, given the small number of female sexual offenders and professionals working with them, detailed knowledge

of the background experiences of these women is still sparse and more information is needed to inform treatment approaches.

In a study looking at factors that influence reconviction rates in female nonsexual offenders, Clark & Howden-Windall (2000) found comparable predictive factors for reconviction amongst males and females such as previous offence history, early onset of offending, or previous sentences. However, they found that for female offenders, familial factors such as problematic home life when growing up and lack of continuity of care were highly predictive of reconviction. It is plausible that these factors would be paralleled in the female sexual offending group.

O'Connor (1987) describes some of the motives given by females who sexually offend and demonstrates that they may have a host of motives that underlie their behaviour. They appear to have a more complex emotional underlying element to them than is suggested by some of the research with male offenders. Typologies of female sex-offenders are starting to appear. Most recently Vandiver and Kercher (2004) analysed a sample of women offenders, including those who had abused adult victims, and identified six different offender types. Each typology indicates different motives or needs consequently suggesting different aims or approaches to treatment. For example, women who have offended under coercion from others may have different needs to those who have abused independently (Ford, 2008). The former may need to develop their ability to assertively resist such coercion, increase their self-esteem and develop skills to form new relationships, while women who have offended alone may need to address offending-related beliefs, such as that their victim was like an adult partner who wished for the sexual contact, in the case of women who have abused adolescents (Ford, 2006).

Probably the most striking difference between male and female offenders is that female offenders are much more likely to abuse alongside another person (usually male) whilst men seldom offend with another person (Mathews, 1989; Wolfe, 1985; Johansson-Love & Fremouw, 2006; Vandiver, 2006). When women do participate in the abuse with another person, they generally play an adjunctive, rather than primary initiating role. Usually, women who abuse with a man are doing so in order to please their partner, frequently out of fear (Jennings, 1993). A characteristic of female sex offenders in general appears to be their dependency on, or rejection by, males (Mathews 1989). These women have a low level of

self-esteem and are dependent on men not only for their survival but for their sense of self as well (Eldridge & Saradjian, 2000). Such a dependence on co-offending suggests that the relationships surrounding the offending are highly significant to women. We know that the relationships formed as adults are largely governed by our earlier experiences. One avenue of investigation must be to consider what types of co-offending relationships these women form and what background factors in their lives lead to their seeking out, or falling into, such relationships.

Many female sexual offenders experienced sexual abuse as children (e.g., Lewis & Stanley, 2000; Matthews et al., 1991; Saradjian, 1996; Tardif *et al.*, 2005, & Travin et al., 1990). We know that survivors of abuse struggle to modulate their emotional arousal (van der Kolk, 1988). It is as if memories of the abuse constantly invade consciousness and the anger or sadness that these memories produce penetrate the current issues and cannot be kept separate. Past abuse experiences are also likely to have impacted on the women's developing sexuality and potentially contributed to beliefs about abuse and the harm caused, originally to themselves and now to their victims (Ford, 2008). Where abuse took place within the family home, the child is less likely to have been able to develop secure attachment patterns. Without such attachments, she will have been unable to obtain appropriate care and thus comfort for the difficult emotions brought about by the abuse.

The aim of this study is to consider in depth just one aspect of the lives of a group of six women who have gone on to sexually offend against children, their experience of care and compassion in their early relationships. In order to get a feel for those experiences that may have precipitated some difficulties or abnormalities in their lives so as to further our understanding of those factors that lead women into sexual offending and to help lay the basis for further research into treatment approaches for women who sexually offend.

Method

Sample

Six women were identified by therapists working at the Lucy Faithful Foundation, a charitable organisation that provides therapeutic input to people who have committed, or are at risk of committing, a sexual offence.

The principal inclusion criteria were:

a) Adult female
b) At least one (spent) conviction for a sexual offence against a child
c) Known or suspected to have an attachment disorder or problematic relationships, resulting from poor childhood relationships
d) Currently receiving therapeutic input from a therapist employed by The Lucy Faithful Foundation or by the National Probation Service

The principal exclusion criteria was:

Participants all spoke English as their first language (as there was not an interpreter available for this project).

The identified women were approached by their therapists and asked if they would be willing to participate in the research. They were read a copy of the participant information (see appendix 1). The therapist answered any questions they had concerning their involvement. All 6 of the women approached agreed to participate. All of the women were interviewed by the lead researcher who ensured that they fully understood the nature of the research and that they were still willing to continue before the interviews commenced. Sampling was considered 'selective', i.e., based upon choosing individuals who typify certain conceptually based types. The types chosen were not intended necessarily to match their overall prevalence in the population.

Participant Background Information

Two of the women had offences of multiple child abuse carrying prison sentences of 8 years. Two women had offences of sexual assault, in both cases consisting of having entered into a relationship with a teenage boy under the age of 16. These women each received community orders of 3 years. The remaining two women were convicted of interfamilial child abuse and received community sentences of 2 and 3 years respectively. Four of the women carried out their offences with a male co-offender (their partner). Five of the women were victims of domestic violence at the time of their offence. At the time of this interview four women had completed or almost completed treatment. One woman was midway through treatment, and one woman was just beginning treatment. (This information is summarised in Appendix 3).

Interviews

Participants completed a semi-structured interview, as set out in Appendix 2, with the researcher. This took between 20 and 105 minutes. All interviews were audio-recorded and transcribed verbatim. The interview comprised two sections.

The first section concentrated on the subject's upbringing, family background, relationship with their main caregiver, and the type of emotional memories they had of their childhood. The second part of the interview looked at the participant's past experience of both comfort and self-soothing and how they use sources of soothing today. The purpose of the interview was to determine what people can tell us about how they make sense of their early experiences and to help us to understand the extent and quality of their experiences of care, affection and 'soothing'. However, the secondary aim of the interview was to allow the women to tell their own stories. It was anticipated that the interviews might open up discussion of emotive life events and it was felt important that the interview could capture the depth and complexity of the women's situations, feelings and explanations.

IPA

This is a qualitative study analysed according to the principles of Interpretative Phenomenological Analysis (IPA) (Smith, Osborn, & Jarman, 1999). IPA is a relatively recent qualitative approach developed specifically within psychology. It is concerned with trying to understand lived experience and with how participants themselves make sense of

their experiences. Using IPA means trying to unravel people's inner life experiences (Willig, 2001) without a predetermined hypothesis to test (Smith, 2003). It involves focusing on the meaning to events by the participants but also the researcher interpreting and then imposing an understanding of the meaning given to those events by participants. As such IPA has the potential to uncover constructs that have not been previously developed by either theorists or researchers.

IPA was considered appropriate for this research as there has not been a previous study of care and compassion in the lives of female sex offenders. We are therefore at the starting point of trying to understand the experience of care and compassion for these women. It was envisaged that the women may struggle to give an account of how their particular experience of care and compassion has influenced their lives and therefore IPA was considered an appropriate methodology to try to structure an understanding around the data. It was hoped that IPA would enable us to try to understand the experience of proceeding down a particular life trajectory.

IPA Procedure

Each interview transcript was read several times and then notes were made in the left hand margin on anything that stood out or appeared significant. The right hand margin was then used to transform, or interpret, initial notes and ideas into more specific themes or phrases. This stage utilises the researcher's own conceptions which are required to make sense of the data through a process of interpretation. Caution is essential at this point so that the connection between the participant's own words and the researcher's interpretations is not lost (Eatough & Smith, 2006). Lastly the data is further reduced by establishing connections between the preliminary themes and clustering them appropriately. These clusters are given a label which describes the conceptual nature of the those themes.

Reliability and Validity

Subjectivity presents a problem for traditional methods of assessing a study's quality. For example, evaluating reliability is based on the assumption that the researcher is objective and disengaged from the analytic process (Henwood & Pigeon, 1992). An alternative approach,

‘the criterion of persuasiveness’, taken by Elliott, Fischer, & Rennie, (1999) and Smith (1996) is applied by inspecting the interpretations of the data and ensuring these are grounded in examples. This approach has been applied to this paper; interpretations are illustrated by extracts from the data set with the aim of allowing readers to assess the persuasiveness of the analysis for themselves.

Results

Three clusters of themes arising from the interviews were identified. The first cluster was labelled 'What is Compassion?' This draws on information about the women's understanding, attitudes towards and experience of compassion. The cluster is listed first because the primary aim of this research was to investigate the meaning of compassion for this group of women. However, the data for this cluster was so thin, and often missing that it was not possible to analyse this properly. This theme is discussed in detail in the discussion section. Please see Appendix 3 for further details of the preliminary analysis including tables of clusters and themes.

A second cluster was identified in the data and labelled 'The impact my past has had on the present'. Again the data was limited and thin, with little insight or rationale provided by the women for how their past might have impacted on their current position. Please see Appendix 3 for further details of the preliminary analysis including tables of clusters and themes.

The third cluster was labelled 'Expectation of parent's role'. This explores the women's experience of the roles their parents took in their relationship with them and their interpretation of these roles. This was the area that the women most readily discussed and appeared to offer the most data. This cluster was analysed and was found toencapsulates 4 themes; 'Mother isn't what she should be', 'I had a different relationship with my dad than my peers', 'I was provided for so I was happy', and 'A parent's role is to control the household'. The individual themes are discussed in detail.

Cluster 3 - Expectations of Parents Roles

In trying to establish some of the experiences that participants had in their relationship with their parents it became clear that they largely accepted the roles that their parents had taken in their upbringing and were matter-of-fact in the retelling of their histories. Throughout this cluster of themes the participants made a variety of remarks which implied that they considered that a parent's role is one of material provider; few of the women made reference to emotional needs, parents as companions, people to confide in, people to learn from, or people who showed unconditional love.

'Mother isn't what she should be'

The women were asked to talk about their relationships with their main care-givers, usually their parents. When asked about their mothers, several of the participants talked about feeling distant from their mothers. Their remarks suggested that there was an ambivalence in their feelings towards their mothers.

> ***Researcher***: Can you tell me about your relationship with your mother?
> ***Julie***: My mum left when I was three, but I don't remember her leaving. But I do remember, and she thinks I don't, that until I was about 9 she kept appearing in the house at night, but only to sleep with my dad and disappear but not to see me.

Clearly, Julie had almost no direct relationship with her mother who was mostly absent from Julie's childhood. However, despite Julie's ambivalent tone when she speaks about her mother, it is most likely that she is covering up feelings of hurt, abandonment and confusion. Julie perceives that her mother chose to maintain a relationship with her father whilst refusing to see her. This is likely to have caused Julie to question why her mother did this, and to wonder what it was about herself that her mother was avoiding. When Julie compares her relationship with that of her friends, she will have been unlikely to find anyone else living with the same situation. Her relationship with her mother is not what it should be.

As a teenager Julie began to see her mother again, but the relationship continued to be confusing, providing Julie with few answers and maintaining the feelings of hurt.

When Julie questioned her mother about not coming to see her...

> ***Julie***: My mum swears blind that I always saw her. But I just saw her when she came by with a pram and said this is my son but I don't want you having anything to do with him. And I thought, way to show you love me hey.

And, when Julie told her mother that her father had been abusing her...

> ***Julie***: But she [Mother] didn't think he'd [Father] do that to me. To this day she still doesn't believe that he hurt me as much as he hurt her. To her it's "don't be daft".

Clearly, Julie does not receive any emotional support, comfort, or understanding from her mother which she could have craved so deeply.

A number of the women spoke as if there was little understanding between them and their mothers. They appeared surprised by some of the questions posed which they found difficult to answer.

> ***Researcher***: What kind of things did you like to do with your mum?
> ***Sue***: Never did naught with my mum really, she was just there.
>
> ***Researcher***: How has your mum coped with what has been going on in the last year? [arrest, court case, sentencing, and taking in Sue's 4 young children]
> ***Sue***: Well she doesn't talk about stuff.

When talking about being looked after, after having a minor accident...

> ***Martha***: The best thing was, is that she'd [Mother] say when you fall off the wall and you break your leg, don't come running to me.
>
> ***Researcher***: Do you think she [Mother] understands you?
> ***Sue***: No, not really.

It seems as though there is an emotional gap between the women and their mothers, as if their mother is not quite what she should be. There is also an acknowledgement that their mother is not someone to be relied upon for emotional support when they need it.

> ***Julie***: Around the time I was arrested, the first thing my husband told me [that] my mum did when she found out was to say "Great, how am I supposed to hold my head up around the community now?" Nothing to do with how's she's coping.

There is also a sense of the mother as a negative figure, of someone who admonishes, and an inevitability about the ongoing nature of this experience. Throughout the interview Sue describes periods of angst throughout her adolescence where her mother would withdraw her love and physical and emotional contact -for example, in a discussion about what it is like to feel sorry for ourselves:

> ***Researcher***: Is there anything you can do to help yourself manage those feelings?
> ***Sue***: No, I just go and see my mum then she reminds me that it's all my own fault.

Toni recalls some difficulties in her relationship with her mother.

> ***Toni:*** Mum had responsibility for looking after us all, she did everything as Dad was out working. We didn't get on at all though. We used to argue about everything. It didn't feel very nice. There were more horrible moments than nice ones. She definitely favoured the boys over me.
> ***Researcher:*** Do you remember any periods of closeness with your mum?
> ***Toni:*** I suppose there must have been, but I don't remember.

Toni also talks about how she was sexually abused by her father as a young child. Years later her mother found out about the abuse but Toni says her mother did not believe that it really happened and will not talk about it any further. Toni expresses no surprise about this and is accepting of her mother's position:

> ***Toni:*** Mum has been told [about the abuse] but doesn't want to believe it. She's had it hard herself. I don't think she had a great relationship with my Dad at first anyway. She rings me sometimes to see how I am and we do go shopping now.

Such a gulf between the experience these women had of their mothers and that of an emotional and psychologically available, providing mother appears to have left a feeling of sadness with these women. They present as people who know that they have missed out on

something but who are not sure what it is or how it has impacted on the people they have become. This was particularly true for Sue who was only just beginning treatment.

'I had a different relationship with my dad than my peers had with theirs'

The women in this sample mostly spoke regretfully about the relationships that they had with their fathers. They recognised a difference between their relationships and those of their peers. In many ways they appeared more aware of the problems with their fathers than the problems with their mothers. Although only one woman made the direct claim that she felt her negative relationship with her father had directly impacted on her going on to offend, several women describe the relationship in a way that appears worrying if not wholly inappropriate. The divergence from the notion of an ideal father figure, part of whose role is to provide care and compassion, is clear.

Martha's initial account of her relationship with her father began positively. She recalled happy and fun times spent with him. She went on to describe their relationship:

> ***Martha***: We were more like brother and sister than father and daughter.

Martha describes an affectionate father, who would take her to the pub or cinema when she was a teenager and acted like a brother or a friend. He was someone she felt she could confide in. Martha describes this as a positive experience. However, shortly after getting married, Martha's husband became violent toward her. After confiding in her father, he approached her husband to try to reason with him. This was unsuccessful but her father and husband struck up a relationship and began to see each other frequently.

> ***Martha***: He [dad] said that he felt more like his dad than his father-in-law.
> ***Researcher***: How did you feel about their relationship?
> ***Martha***: Well torn between the two of them. But I stayed for 13 years, but then I just left, I couldn't take anymore. I got a divorce from him on cruelty.

Martha's father developing a relationship with her abusive husband certainly poses questions about the impact it might have had on Martha. Would it have been interpreted, albeit unconsciously as a betrayal of Martha, or as a validation of the husband's abuse? What message does this give to Martha? Would she have interpreted this relationship as implying that she should accept the abuse she was suffering and remain in the relationship? She stated earlier that her father was her main confidante, so who else would she have turned to for

emotional support had she wished to end the relationship? Although Martha does not verbalise such turmoil, it is not unreasonable to suggest that it did exist and would have caused her considerable distress. Although Martha was aware that her relationship with her father was different from that of her peers, it is not clear that she saw aspects of the relationship as inappropriate and damaging to her. Martha appeared to view the relationship as caring, perhaps in a different sense than an outsider might view the situation.

In contrast, Sue did not know her father's identity and says her mother did not have any partners whilst she was growing up. There were no other significant male figures in her life, for example a teacher, sports leader, grandfather or uncle. Sue acknowledges that she was different from her peer group in this respect. However, Sue describes that as a teenager she learned to use men; she would go to pubs, and almost always go home with a man.

> ***Researcher***: Looking back, how were you feeling when you hooked up with a man in the pub and you knew you would be going home with him?
> ***Sue***: I felt cared for.

Like Martha, Sue puts an interpretation onto care and comfort that is skewed from that which an outsider might consider accurate.

Meg lived with her mother, father and elder sister yet also experienced a lack of a father figure.

> ***Researcher***: Can you tell me a bit more about your relationship with your dad?
> ***Meg***: Well I didn't really have a relationship with him. My dad would just ignore me. If I was upset I would always go to my mum, never my dad as I don't think he could handle those emotions. When I was growing up, I always had the feeling that my sister was the favourite one with my dad. When I left home, I didn't hear from him from one week to the next. I think if my dad had treated me a lot better, then I wouldn't have made some of the decisions that I did about the males I chose as partners. Because, I think what I was doing was looking for the love through my partners that I wasn't getting through my dad.

Meg describes a similar pattern of behaviour to Sue, that she would go to bars and always want to go home with a man who she would interpret as providing her with care and comfort.

However, Meg is the only woman who offers the link between her relationship with her father and her subsequent behaviour. Meg acknowledges that what she thought she was experiencing as care and comfort was masking the actual pain she was feeling about her poor relationship with her father. She later stated that it was not real care that she experienced from the men she went home with; instead, she now feels that they took advantage of her as much as she did of them.

Toni describes an ideal relationship with her father in a warm tone of voice.

> ***Toni:*** He was very affectionate towards me. I was his favourite. I was the real Daddy's girl and special. He was always very nice to me.

Later when asked about whether she had ever suffered any sexual abuse, she admitted that her father had sexually abused her over a number of years. The abuse ended when she was 10 and she feels this was because she was becoming more aware of right and wrong and her father became afraid that she would tell someone. Toni's warm and affectionate memories of her father are surprising and seem incompatible with the history of abuse, yet Toni appears to have, at least on the surface, reconciled the extremes.

> ***Toni:*** It's [the abuse] done and dusted as far as I'm concerned, it's under the carpet now and not talked about.

Although Toni interprets the abuse as something that happened a long time ago and that has no bearing on the present, it is harder to reach the same conclusion as an outsider. This is especially true when her history of abusing seven of her own children over a long period of time is considered. Whether her relationship with her father has impacted on her perception of right and wrong, of the meaning of harm, and of empathy for others could be questioned.

Julie suffered sexual, emotional, physical and psychological abuse from her father for as long as she can remember. She recalls no positive interactions with her father involving any kindness towards her. Julie also suffered emotional, physical and psychological abuse from her grandfather, uncle and brother and grandmother who shared the same home. It was only when she was 13 that she realised how abnormal things were.

> ***Researcher***: At what stage in your childhood did you realise that you weren't in a normal family environment?
> ***Julie***: Early on, but it wasn't until I was 13 that I realised to what extent it wasn't normal.

Clearly Julie grew up with no experience of a normal relationship with a father figure (or a mother figure). It is perhaps surprising that she is now able to reflect on her childhood experience, to try to understand how it impacted on her and to look forward to her future.

'I was provided for so I was happy'

Few of the women in this sample could give an example of, or explain how, an early relationship had been loving or caring. Although they stated that things had been positive, they did this mostly by recounting events or activities they had taken part in, gifts they had been given, or treats they had received. Further questioning did not reveal any examples of parenting that demonstrate a sense that the child was loved unconditionally for whom they were. For example, there were no reports of kind words or phrases, being shown forgiveness, or being given something demonstrating that they were seen as having individual needs. Questions were mostly met with blank expressions or with difficulty in remembering:

Chloe, describing her mother:

> **Chloe**: a loving caring mother…
> **Researcher**: How did she show that?
> **Chloe**: [Pause]
> **Researcher**: How did she show you she cared?
> **Chloe**: [Pause…] Don't know.

Martha, describing her childhood:

> ***Martha***: It was ok…
> ***Researcher***: Were you happy in your home?
> ***Martha***: Yes
> ***Researcher***: What helped you to be happy at home?
> ***Martha***: Well, I always got a dinner.
> ***Researcher***: What other things made you happy at home?
> ***Martha***: (pause) I'm not sure.

Sue, describing her childhood:

> ***Researcher***: Were you happy growing up?
> ***Sue:*** Yes. I went to dancing classes, and gymnastics and swimming.

Toni, describing herself as being provided for at home:

> ***Toni:*** We had everything we needed. It was a bit basic and I would have liked more fashionable clothes when I was a teenager. But we were always well fed and had clean clothes.

However, Toni was the only woman to articulate a view that something had been missing in her relationship with her parents which should have been there. She describes a time when she was bullied at school when she could have done with her parents' support.

Toni: It was difficult because things got bad when I went to secondary school. I had a lot of trouble with the other girls. I could have done with someone to talk to about it, they might have been able to help. But, I wasn't getting on that well with my parents and there wasn't anyone else to turn to.

'A parent's role is to control the household'

Questions on physical affection were overwhelmingly met with confusion, few examples, bizarre examples, or no previous consideration that a lack of affection might be unusual. It is acknowledged that people who go on to lead fulfilling, contented, non-offending lives differ in their experience of and disposition towards physical affection. However, this group of women appear to have been particularly deprived of the experience.

Chloe describes her childhood positively but struggled to pinpoint experiences of affection or care.

> ***Researcher***: What sort of person was she? [Mother]
> ***Chloe***: A kind loving mother
> ***Researcher***: How did she show you that?
> ***Chloe***: Erm… (long pause)… it's hard for me to describe
> ***Researcher***: It is quite a difficult question. Can you think of any ways that she might have shown you that she loved you… or that she was caring for you?
> ***Chloe***: … (long pause)

Chloe then began an anecdote about how she had once disobeyed her mother and that her mother had been very angry and grounded her when she returned home.

Later in the interview:

> ***Researcher***: Do you remember getting many hugs or kisses from your parents – some parents are more affectionate that others – what were yours like?
> ***Chloe***: I used to give my dad a kiss on the cheek when I was going to bed or when he was dropping us off at school.
> ***Researcher***: What about your mum?
> ***Chloe***: … (long pause)
> ***Researcher***: Your aunty?
> ***Chloe***: Not much from my aunty.

There appears to have been a lack of physical affection in Chloe's upbringing. Although physical affection and love are not synonymous, Chloe appeared confused about how she was shown care and compassion as a child and what the researcher might be expecting as a response to these questions. Her response to how her mother had been caring, which was answered with an anecdote about how she had got into trouble, does show that her mother was involved. It also shows a degree of concern for her whereabouts and actions but is so far removed from being told she was loved, praised, given a kiss, or held.

Martha appeared to understand the nature of the question she was being asked, although she did not show much insight into why she was not shown much affection and what she thought about this. This was surprising, as Martha showed considerable insight in other areas of the interview and had clearly spent a lot of time working through her past and her offending, both alone and in therapy.

> ***Researcher***: How did your mum go about showing you affection or showing that she cared for you?
> ***Martha***: Well she didn't really; she didn't give us cuddles or anything, cos, I don't know, I don't know why that was…
> ***Researcher***: Were there other ways she showed you that she cared?
> ***Martha***: She was in charge.

It is possible that either Martha has not previously recognised there to have been anything missing in her childhood, or that the implications of considering that there had been a lack of care or compassion would be too painful.

> ***Martha***: [As an adult] I never wanted anyone fussing around me or cuddling me all the time. Even if my ex husband used to cuddle me I'd say get off and I felt uncomfortable. I don't know why, it was just uncomfortable.

It is interesting that the patterns of affection that began in Martha's childhood were carried forward into her marital relationships. It could be questioned whether this forms an avenue into inappropriate ways of looking to fulfil sexual relationships: seeking physical closeness or fulfilment without showing or wanting affection or intimacy.
Sue also describes a lack of positive physical affection:

> ***Researcher***: How does she [Mother] show you that she cares for you?
> ***Sue***: I don't know.
> ***Researcher***: Some mums are affectionate and give lots of hugs and kisses, but others are more reserved..
> ***Sue***: She's not like that.
> ***Researcher***: She's more reserved?
> ***Sue***: Yes.
> ***Researcher***: How else did she show you she cared?
> ***Sue***: ... [pause] Well... she kept us in line.
> ***Researcher***: She made sure you behaved properly?
> ***Sue***: Yes.

Toni describes her relationship with her father as being affectionate, but that her mother was more reserved.

> ***Toni:*** Mum wasn't an affectionate person. She's not like that, even now. Even like at Christmas when everyone has had a drink and is hugging each other she doesn't join in.
> ***Researcher:*** Does she have other ways of showing you that she cares?
> ***Toni:*** She rings me up and we go shopping sometimes.

Julie also describes a lack of positive physical affection:

> ***Researcher***: Can you recall any moments of kindness from your parents?
> ***Julie***: When they were nice to you, they wanted something doing.
> ***Julie***: I will always hate my birthday. It will either be that I'd get lots of gifts and then within 3 days they'd all be given to other people or I'd get lots of gifts and my dad would kick off or then they'd be putting pressure on me saying you owe us for them. It was always everything they did to me. I had to repay them ten times more so it got to the stage where I didn't know whether I was coming or going.
> ***Researcher***: Can you think of any moments of kindness, without conditions attached?
> ***Julie***: [No] Without conditions… only from my husband, but at the time I didn't realise they were without conditions. At the time I was just thinking that they were all like my dad and everyone else.

Amongst the group there was a feeling that parents were very much in charge of providing discipline. Parenting strategies were generally strict. Physical punishment was alluded to; however, it was most commonly referred to as a threat from parents rather than something that happened (except in Julie's case). This group experienced strict parenting from both parents. There was a feeling of suspiciousness or fear from the women surrounding their relationships with their parents which sometimes felt uncomfortable.

> ***Meg***: I wouldn't feel comfortable in going to ask anything or tell him [Dad] anything, it was just the way he was, stern or something. I always felt as though I'd get told off instead of getting the help I wanted.
> ***Martha***: My relationship with my mum was fine, as mothers and daughters go. She was too strict with me, that was the only problem.

Discussion

Three clusters of themes have been identified; What is Compassion? The impact my past had on my present, and Expectation of parents roles. Cluster 1, What is Compassion was not analysed in great depth but it is still of interest to the project. What is interesting is that many of the women were unable to give a meaningful explanation to questions about compassion; what it is, how one might experience it, what situations you might need it in, what it might feel like or give and experiences from their own lives about times that they had experienced compassion. These questions were met by blank expressions, "don't knows" odd or bizarre examples, or answers that reflected a superficial understanding of compassion. All of the women were asked questions which included the terms 'compassion', 'comfort' and 'soothing'. The following examples are given as a general flavour of the response given but also cover most of the comments given to these questions.

Only one woman gave an answer to the question; What is compassion?

> **Researcher:** What is compassion?
>
> **Toni:** It's about being nice to people if someone dies.

Although Toni's answer indicates that she has some idea of what compassion is about, her answer is very specific and she was not able of willing to elaborate. It is possible that the women lacked a vocabulary to define the word, but it seemed more likely that there were merely unfamiliar with the word as their general use of vocabulary appeared very competent. This implies that the word compassion was simply not used very much in the lives.

> **Researcher:** What is compassion?
>
> **Julie:** I don't know
>
> **Researcher:** What situations do people need comforting in?
>
> **Julie:** Hmm. Bereavement, and miscarriage. I had a miscarriage and I didn't grieve over her. Probably other situations which get at you emotionally, but mainly bereavement and miscarriage.
>
> **Researcher:** What situations do you think you would need comfort in as a child?

Julie: Maybe if you fall and hurt your knees.

Researcher: How about if you think specifically about your own childhood; what situations do you think you were or you should have been comforted in?

Julie: (No response.)

Researcher: Can you think of any situations?

Julie: Well I used to get annoyed when I got picked last for sports teams.

Although Julie was not able to give an explanation for compassion, she does have an idea of some situations that people need comfort in. What is interesting is the shallowness of her answer. Julie has suffered a lifetime of abuse and hardships and yet she does not draw the link between these and the need for comfort. One consideration could be that she did not want to talk about painful issues from her past, but this was not evident in her body language or facial expression which appeared relaxed and she appeared engaged and concentrating on the conversation. At other stages in the interview Julie spoke at length about her hardships which makes it more likely that she simply struggled to make the connection to her experiences and the need for comfort.

When asked about comforting, some of the women were more able to give examples of what they did to comfort themselves. However, some of their answers implied that not all the women had healthy strategies for helping themselves.

Researcher: Do you have any ideas about how people comfort themselves?

Meg: Well I know some people turn to drink. But that can cause problems

Researcher: How about any positive ways of comforting?

Meg: I don't know really. Maybe retail therapy.

Researcher: How do you go about comforting yourself?

Chloe: Well I read of do crosswords

Researcher: How does that change the way you are feeling?

Chloe: I don't really know, I guess I just don't think of what the problem was anymore.

For Chloe, comforting was very much described as distraction techniques. She went on to describe other ways of distracting herself from her worries. However, these techniques all appeared to be short lived and she would return to the original worry or state of mind after she finished her activity.

Researcher: Who would you go to seek comfort?

Martha: Oh no one, I would just watch tv and eat ice cream

Researcher: What about when you have had a boyfriend; would you go to him for comfort?

Martha: No, I would never do that.

Researcher: Can you say why not?

Martha: I don't know, I just never would.

Martha's does not attempt to explain her adamant approach to not seeking comfort from others. However, in other parts of the interview, Martha describes life-long difficulties in her relationships with men in which there are no apparent examples of compassion.

It is apparent from these examples that the women struggled to articulate examples of care and compassion in their lives. One explanation is that this is due to a lack of emotional memories for such events. If this is the case, it also explains why they are unable to give good examples or show an understanding of the meaning of these experiences as adults. It is also relevant for why they found it so hard to articulate how their past had had an impact on the person they are now.

An alternative explanation might be that the woman were reacting in a fearful way to these questions. Some of the women expressed considerable guilt for the crimes they had committed and it might be that they felt they did not deserve compassion. Some of the women had experienced a considerable amount of loss, for example having their children taken away from them. It could be hypothesised that they would feel frightened to let people feel close to them for fear of losing people again. This might show itself in a women who appears emotionally blocked or unavailable.

One cluster of themes had a good amount of available data and those findings have been described and explored. These were labelled 'Expectation of parent's role' encapsulating four themes; 'Mother isn't what she should be', 'I had a different relationship with my dad than my peers', 'I was provided for so I was happy', and 'A parent's role is to control the household'. These concerned women's experiences of the roles that their parents took in their relationship with them and these women's interpretations of these roles.

The women discussed how their relationships with their parents differed from the norm, and whilst some sadness was expressed, the tone was mostly ambivalent. Worryingly, the research suggests that people who experience such relationships are likely to be affected in a number of ways. For example, lacking an emotionally available mother is known to be a risk factor for future developmental problems. A number of studies have looked at the impact of psychologically unavailable mothers and found disturbing results. Egeland et al. (1981, 1984), compared characteristics of children who have suffered different forms of maltreatment. They found that although children from physically abusive, verbally abusive, and neglectful homes were all likely to suffer, those with 'psychologically unavailable' mothers were found to be the most disturbed. In another study comparing the impact of parenting on boys and girls, Wolfe et al. (1984) found that the mother was particularly important in determining the child's later adjustment.

A number of these women also had absent fathers, or difficult relationships with their fathers. Dunn et al., (1998) reported evidence for children growing up in single-parent families suggesting that there are higher levels of problems and poorer prosocial behaviour reported than amongst children in a two-parent household. In their study, single parenthood remained a

risk indicator even when account was also taken of negativity in family relationships, maternal age, education level, depressive symptomatology, history of previous live-in relationships, mothers' support networks, and the family's current financial and housing circumstances.

Historically, fathers have been viewed or presented in a variety of different images to describe the script that they have been seen to be fulfilling. Over time there have been major changes in what society views as desirable male parenting. In Britain we are currently undergoing a renewed wave of interest in the notion of the father as a nurturant participant - somebody who plays an active role in the day-to-day care and bringing up of children (Lamb, 1996). This attitude might be based on what we now know about the impact of growing up without a father. On average, children raised without fathers are more likely to show signs of psychological maladjustment, to have difficulties at school, to drop out of school early, to be represented in the statistics on delinquency and unconventional social behaviour, and they seem to have difficulty establishing and maintaining intimate relationships, particularly heterosexual relationships once they move into adulthood (Lamb, 1996).

Studies on attachment show that most babies formed attachments to both of their parents, even in traditional families in which their mothers stayed at home with their child and dads went away to work,. What these studies have further shown is that those attachment relationships to both parents have a significant impact on children's development although, not surprisingly, the relationship with the party who spends more time with the child tends to be more influential. Nevertheless, children who have positive and secure attachments to both of their parents seem to do better overall than children whose relationship with one parent is less secure (Harper & McLanahan, 2004). Likewise, children who have two insecure relationships are most disadvantaged. These studies underscore that, right from the beginning, the attachments or relationships that the infant establishes are extremely significant and important. They also stress that the factors that make for secure attachments to mothers are the same as the factors that make for secure attachments to fathers.

Children form secure relationships with people who are sensitive, warm, caring and involved, regardless of the gender of that person. Most of the women in this sample did have their father

present even if he did not take on a nurturing role. However, warmth and involvement were certainly limited in the case of most of the women.

All the women in this sample began to meet men and became sexually active at a young age. Half of this sample were pregnant by age 17. Four of the women went on to have 4 children, one had 6 children, 1 had 7 children and 1 had 9 children. Evolutionary models suggest that early onset of father absence places daughters at special risk for early sexual activity and adolescent pregnancy. Specifically, evolutionary psychologists have hypothesised that the developmental pathways underlying variation in daughters reproductive strategies are especially sensitive to the father's role in the family and the mothers' sexual attitudes and behaviour in early childhood (Draper et al., 1982). Consistent with Hetherington's (1972) work on the effects of early father absence on personality development in adolescent daughters, the evolutionary model suggests that girls detect and internally encode information about parental reproductive strategies during approximately the first 5 years of life as a basis for calibrating the development of motivational systems, which make certain types of sexual behaviour more or less likely in adolescence. The model thus posits a direct effect of quality of early paternal investment (e.g., father presence vs. absence, quality of paternal care giving, father-mother relationships) on early onset of sexual and reproductive behaviour.

Some researchers have questioned that the quality of the relationship with the father can have such an impact on the child. In a study by Harper et al. (2004) a longitudinal event-history analysis was conducted to demonstrate that a sizable portion of the risk that appeared to be due to fathers' absence *could* be argued to be attributable to other factors, such as teen motherhood, low parent education, racial inequalities, poverty, and adolescents in father-absent households. However, even when such allowances were made children growing up without a father or with a poor paternal relationship still faced elevated incarceration risks.

Saradjian (1996) suggested that a major difference between female abusers and non-offenders was the greater amount of emotional abuse and neglect in their lives. Theme 2, 'I was provided for so I was happy', demonstrated how positive emotional support was lacking in many of the women's lives. Theme 4, 'A parent's role is to control the household', also illustrates that the women's perceptions of being cared for centre around their being told what

to do rather than being cared for in an emotional way. It could be argued that a lack of emotional support, care and affection would lead to loneliness, emptiness and feelings of anger or fear. Such feelings may exist in those that go on to sexually offend. For example, Matthews (1993) hypothesised that sexual offending can be understood as an expression of anger, disappointment, sadness and low self-esteem.

Simons et al., (1991) found that mothers' 'harsh parenting', though not necessarily abusive, was predictive of their later treating their own children severely. This applied more strongly than the relationship between fathers' harsh parenting and the offsprings' subsequent severe parenting.

Further Discussion

Methodological problems

Inherent in retrospective designs- asking people to reflect on things that happened a long time ago – are difficulties associated with the quality of a person's memory and ability to recall events. Sudman and Bradburn (1982) noted that "people have difficulty recalling the time period in which events occurred, the frequency of events, and their reactions". There is also the impact the passage of time can have on influencing a person's interpretation of events. This was notable in a number of the accounts where the women appeared to have idolised aspects of their childhood, or parents, especially where the explanations did not appear to match the events described. The impact appeared to be stronger when women were talking about parent's who had passed away. This added an additional complexity to interpreting the women's stories. Saradjian (1996) has noted this effect: "If there is inconsistency it does not always mean the woman is deliberately lying. It may be that the woman has idealised and denied her experiences so much to herself that she is actually describing what she believes to be the truth."

Domestic Violence

As adults, five of the six women interviewed began relationships with men who became violent towards them early in the relationships. It was outside the scope of the interview to address this theme thoroughly, but it could be argued that an immature ability to understand

the nature of self-care, and to have understood how the experience of being comforted and cared for in an appropriate way, may have contributed to these women staying with their partners. The causes of domestic violence and the nature of the women involved in these relationships is multi-faceted but there is little research in the area of women's ability to self-soothe. This may prove an interesting avenue of exploration and a potential pathway through which help can be offered to women coming out of these relationships.

Reflections

When I reflect on the process of conducting this research I keep coming back to how difficult a group of participants these women were to assess. They each raised so many issues requiring care and skill to be shown by the interviewer whilst gathering the information required for this project. I wonder if the skill and experience of the interviewer could impact on the quality of the information collected. It would also have been useful to have another clinician present to observe the non-verbal behaviour which may have proved relevant to the findings drawn on why the participants could not respond more fully to questions on their understanding of compassion. On reflection I wonder if an experienced clinician with experience in using CFT might have elicited a greater quantity or quality of data. As a second year Clinical Psychologist Trainee, I felt able to engage the participants, look after their needs and gather the information to questions or areas of interest that were pre-prepared, but perhaps was somewhat inexperienced in probing areas where participants were reticent to answer questions or appeared unable to answer them. Of course, it remains in line with theory that the areas participants felt unable to engage in discussing are likely the result of a number of possible psychological processes and further questioning would not have yielded more information but this is an uncertain area. If I were to conduct this research again, I would like to see the women with a skilled clinician participating in the interviewer role.

Conclusions

This investigation has drawn together the childhood experiences of care and compassion in the lives of six women who have subsequently gone on to sexually offend. The accounts of the women interviewed for this study showed that they shared the experience of a difficult and challenging upbringing, with significant relationship difficulties in their past. This study

highlights the importance of early relationship experiences in sculpting the people involved and the actions, or crimes, that they go on to commit. The aim of this study was to further our understanding of the relationships experienced by women who go on to sexually offend. Whilst this was a small study, there appear to be significant similarities in the interpretations that the women place on their life experiences. For example, many viewed their mothers as being different to what they should have been, felt that they had different relationships with their fathers than their peer group did, and had clear views that their parents' roles were those of house-hold controllers or disciplinarians rather than moral guides, supporters, comforters or friends. For many of the women, the links between their experiences and their actions were unclear, particularly those who had not yet completed any treatment. It is hoped that research of this nature will further our understanding of the past experiences of women who sexually offend against children, thereby providing clinicians with a better basis upon which to plan treatment. It is also hoped that such research will inform services of some of the key elements important in protecting children at risk from going on to offend as adults.

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Executive Summary

This work was stimulated by the desire to consider alternative approaches in the treatment of women who sexually offend against children. It was felt these women might share some similarities in their own upbringings which might have contributed to some of the problems they face today. It was thought that these women may not have experienced optimal parenting themselves and may have missed out on some forms of emotional experience – care and compassion - which most of us take for granted. It was considered that this might impact on their own abilities to care for themselves, their children and ultimately to resist offending.

In trying to establish some of the experiences that participants had in their relationship with their parents it became clear that they largely accepted the roles that their parents had taken in their upbringing and were matter-of-fact in the retelling of their histories. The participants made a variety of remarks which implied that they considered that a parent's role is one of material provider; few of the women made reference to emotional needs, parents as companions, people to confide in, people to learn from, or people who showed them unconditional love.

The results showed four areas in which most participants shared similar experiences or similar evaluations of areas of their lives.

Most of the women expressed feeling ambivalent towards their mothers. For some of the women there were experiences of abandonment and subsequent confusion. Emotional support, comfort and understanding were generally lacking. The women presented a picture of a mother figure who 'wasn't as she should be'. The effects of an emotionally and psychologically unavailable mother appear to have left a feeling of sadness with the women. They present as people who know that they have missed out on something but who are not sure what it is or how it has impacted on the people they have become.

Most of the women talked of having 'different relationships with their fathers' than their peer groups had. For a number this was due to their being sexually abused by their fathers. For others this was about distant, non-existent or inappropriate relationships. Only one women,

who had been in therapy for approximately a year, described her poor relationship with her father as a contributory factor in her going on to sexually offend herself. Most of the women spoke regretfully about their relationships with their fathers, however there was not a clear sense of what they felt they had missed out on. Again there was no explicit mention of their missing out on care, compassion, unconditional love or general emotional support.

For many women material provision was central. There was a clear feeling that their childhood happiness was determined by their parents ability to provide for them in terms of food and activities. When asked how parents showed they cared, a typical answer would include… "because they always gave me dinner" or "I went to dance classes". Some women were not able to articulate how their parents showed they cared. None of the women mentioned physical affection, kind words or encouragement.

Whilst there was a sense of little physical affection, there was a sense that a 'parent's role is to control the household'. Parenting strategies were generally strict and physical punishment was alluded to however it was most commonly referred to as a threat. Generally there was a feeling of suspiciousness or fear expressed by the women about their parents.

This work also considers a treatment approach called Compassionate Mind Training (CMT). CMT aims to help a person to develop their ability to care for themselves and to show themselves and others compassion. The review considers how these women might benefit from aspects of this therapy. It is considered that CMT could be used to tackle certain existing psychological difficulties faced by these women, for example attachment difficulties, shame and self-esteem. It is thought that the women would then be in a better position to access standard treatment approaches.

This paper demonstrates how much we can learn from these women's stories. It is hoped that the data can inform treatment approaches and stimulate further research in this area.

Appendix 1

Participant Information Sheet

Study title: Self-Comforting

You are invited to participate in a research project looking at people's experiences of being comforted and comforting themselves. This is a small study that is just focusing on people who have been convicted of committing sexual offences. We are hoping to develop new ways of helping people in your position.

The purpose of the study is to find out what sort of experiences you have had of being cared for by others, both as a child and as an adult. You will also be asked about how you look after yourself emotionally and the things you do to relax. The researcher will **not** be asking you any questions about your offending. The researcher is interested in how your upbringing has influenced how you experience looking after yourself and how others have looked after you.

You do not have to take part. Participation is optional and will not influence any help you are currently receiving.

The interview should take between one and two hours. The interview will be recorded onto an audio recording device. The researcher will then transcribe the interview so that the researcher can look at your answers in detail.

Should any unforeseen problems arise with the continuation of this research project, you will be kept informed.

Your interview will be kept anonymous at all times and you will not be named as having participated in the project. Some comments you make may be quoted in the final report, however your name will not appear anywhere on the documentation. You are also free to terminate the interview at any point.

I do hope that you will consider this an interesting and worthwhile project and that you will consider participating.

Appendix 2

Semi-Structured Interview

Part 1

Upbringing / Environment / Relationships

Tell me about where you grew up? (What sort of house, community…)

Who did you live with? (What did they do, what were they like..)

Was it a safe environment? Did you feel secure?

How did you view your position in the family? (Were you valued / understood / comfortable / cherished / loved / happy / connected to others / cared about)

Who took the most responsibility for looking after you?(Who was your main care giver)

Tell me about your relationship with them?

Tell me about your relationship with _____ (other main child in house, other significant adults)

Relationship with Main Confident

Who would you go to when you were sad or worried (if different person from already mentioned)? Tell me about your relationship with them?

What kinds of problems would you take to them?

Can you give an example?

How did 'x' respond? (What did they say? What did they do? What was their manner - calm / panicked…)

What did you think about their response at the time?

How did it make you feel? (Cared for? Understood? Calm? Anxious?)

Did you feel you could count on them?

To what extent did you feel they understood you? (Empathised with you? Appreciated you the way you were?)

What do you think about it now?

Can you give another example of a time when you went to this person because you were sad or worried? (Repeat follow-up questions)

Part 2

Ability to Self-Comfort

Sometimes there are occasions when we are not able to, or don't want to share a problem - perhaps something that goes wrong or something that makes us angry with someone else. Can you describe a time that this happened to you?

How did you handle the situation?

What did you do to calm down or resolve the problem? (Problem solving / self-talk / self-comforting?)

How good are you at calming yourself down compared to other people you know?

What occasions have there been when you have felt sorry for yourself?

Have you tried to comfort yourself? (If yes: How have you gone about this? Was there anything difficult about comforting yourself?)

(If no: how do you think someone would go about comforting themselves? What would this involve? Why might it be difficult?)

Do you think it's important that we can comfort ourselves? (Why?)

Looking back at your childhood, do you think others comforted you as often as you think you needed?

Comforting Today

In what situations generally do you believe that people deserve to be comforted?

In what situations do you find you need comfort now?

When there are difficulties in your life, who would you go to now for comfort? (Describe this relationship, what does this person do to help you?)

What does that experience feel like? (Happy / warm / embarrassed / ashamed)

Appendix 3

Results

Table 1: Clusters and Themes

Clusters	**Themes**
What is Compassion?	You have compassion for people who are upset Compassion is about being sorry for people Compassion is not something relevant to my life
The impact my past has had on my present	A bad relationship with my dad led me to make poor choices of partners for myself
Expectation of parent's role	Mother isn't what she should be
	I had a different relationship with my dad than my peers
	I was provided for so I was happy
	A parent's role is to control the household

Appendix 5

Participant Background Information

Table 2: Participant Background Information

	Offence	**Sentence**	**Male Co-offender**	**Received Treatment for 1 yr +**	**Victim of Domestic Violence**
Chloe*	Multiple child abuse	8 years prison	Yes – husband	Yes	Yes
Martha*	Multiple child abuse	8 years prison	Yes – husband	Yes	Yes
Julie*	Sexual assault (relationship with a 13 year old boy)	3years community order	No	Yes	No
Sue*	Sexual assault (relationship with a 14 year old boy)	3years community order	No	No (Has just begun treatment, had received 1 session at time of interview.)	Yes
Meg*	Child Abuse (intrafamilial)	3 years community order	Yes – husband	Yes	Yes
Toni*	Child Abuse (intrafamilial)	2 years probation treatment order	Yes – partner	No (Midway through 1 year programme)	Yes

*The women's names have been changed.