Sex offenders, Internet child abuse images and emotional avoidance: The importance of values

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Abstract

There is increasing evidence that people use the Internet to avoid negative emotional states, such as boredom, anxiety, or depression. This may be of increasing relevance for sex offenders. While the primary function of accessing the Internet for sex offenders is to obtain material that aids sexual arousal, the Internet functions to help people address some of the more immediate feelings of distress or dissatisfaction in their lives. For those with a sexual interest in children, once online offenders can then download child pornography and masturbate to such images, providing a highly rewarding or reinforcing context for further avoidance. The intensity of such behavior often has properties that offenders call ‘addictive’, with high levels of activity associated with the avoidance of unpleasant emotional states. The aim of this paper is to address issues that relate to emotional avoidance. Rather than having to exclude access to computers or the Internet, offenders, in the context of making explicit personal values and goals, might be helped to accept negative emotions and commit themselves to generating behavioral goals that will move them towards what they personally value.

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Internet are developing exponentially, along with a reduction in the cost of both hardware and software to the consumer. It is unlikely that there will be a reversal of this trend, and what we face is a pervasive and continuing use of the Internet, however it might evolve, to meet many of our needs. This trend is also likely to be the case for non-western countries, although financial and commercial considerations may limit the speed of growth of domestic use (Castells, 1997).

However, the Internet does not only function to give us goods, but provides a social context for us to meet with others and to exchange information. For many people, such engagement with the Internet community can be beneficial. However for those with a sexual interest in children, accessing parts of that community may result in problematic cognitions and behaviors. However, it would be foolish to suggest that there may not also be some beneficial aspects to Internet use for this particular group. Our major concern in the context of people with a sexual interest in children is the content of the material accessed and the function of the social relationships in propagating behaviors that are ultimately exploitative of children. But the Internet brings with it other concerns. It is not only sex offenders for whom the Internet may be problematic.

Increasingly, we see reference in the literature to ‘Internet Addiction’, reflecting a use of the Internet that is problematic. Earlier research by Kandell (1998) had defined Internet addiction as: an increasing investment of resources on Internet related activities; unpleasant feelings (e.g. anxiety, depression, emptiness) when offline; an increasing tolerance to the effects of being online and denial of the problematic behaviors. Such a perspective characterizes Internet addiction as behavioral and similar in character to other impulse control disorders. Those who meet the criteria are thought to experience social, psychological, and occupational impairment. However, research by Caplan (2002) suggested that the addiction framework suffers from three limitations: (1) it lacks conceptual or theoretical specificity; (2) there is a paucity of empirical research within the addiction paradigm and (3) it fails to account for what people are actually doing online.

Beard and Wolf (2001) were also critical of the term addiction, ‘... this term does not accurately reflect the phenomenon of excessive Internet use. While there are commonalities between excessive Internet use and an addiction, excessive Internet use does not result in all of the symptoms or behaviors associated with a chemical addiction, such as physical withdrawal’ (p 378). This also raises the question as to what it actually is that people are addicted to, ‘Is it the computer? Is it the typing? Is it the information gained? Is it the anonymity? Is it the types of activity in which the individual is engaged? All of these factors may play a role in making the Internet reinforcing’ (p 381).

In the context of child pornography, Quayle and Taylor (2003) examined the explicit role that the content of the material may play in problematic Internet use. Like Caplan (2002), the authors believed that terms, such as excessive, problematic, or maladaptive Internet use, may be more useful that those expressed within the addiction framework. What is also acknowledged in this model is that the escalation of Internet use may be a function not only of the material, but also of the unique role that the Internet may play in meeting other emotional needs. Davis (2001) talked about problematic Internet use as being a distinct pattern of Internet related cognitions and behaviors that result in negative life outcomes, and that such use may be specific or generalized. Using the Internet to meet sexual needs is clearly specific, but there are many aspects of generalized problematic Internet use that are of relevance to the offender population. Generalized problematic Internet use is conceptualized as a multidimensional overuse of the Internet itself, which is not limited to any specific content. Caplan (2002) suggested that ‘they are drawn to the experience of being online, in and of itself, and demonstrate a preference for virtual, rather than face-to-face, communication’ (p 556).

Examples of generalized problematic Internet use cognitions would include obsessive thoughts about the Internet, diminished impulse control in online activities, guilt about online use, and experiencing more positive feelings about oneself when online as compared with when offline. Caplan (2002) designed and piloted a new instrument to operationalize the theoretical construct of generalized problematic Internet use. Of interest to us in relation to Caplan’s study are the seven sub-dimensions that emerged from a factor analysis of their results. These included: mood alteration; perceived social benefits available online; negative outcomes associated with Internet use; compulsive Internet use; excessive amounts of time spent online; withdrawal symptoms when away from the Internet and perceived social control available online. These factors closely corresponded to the findings of Quayle and Taylor (2002) in relation to the psychological functions of child pornography, and may suggest that, for this particular population, it is difficult to differentiate between the effects associated with interaction with the Internet and the function of the material itself.
Morahan-Martin and Schumacher (2000) talked about the Internet as providing an attractive alternative to a mundane or unhappy life. And it has been suggested that what is often achieved through prolonged engagement with the Internet is a change of mood (Kennedy-Souza, 1998). At its most benign, this may be construed as a form of displacement activity, ‘Therefore, for whatever reason the Internet is initially accessed, there is every inducement to end up doing something else that promises to be more interesting or pleasurable… Individuals engage in these alternative activities because they are readily available, attractively presented and appear to be more immediately interesting and gratifying than completing the work originally in hand’ (Hills & Argyle, 2003). It is likely that most of us who use the Internet would identify with this and would readily acknowledge that we use the Internet on occasions to reduce mild negative emotional states, such as boredom. What is more problematic, in the context of excessive or compulsive Internet use for sexual purposes, is the likelihood not only that the individual is using the Internet to change or avoid negative mood states, but that the material accessed is highly reinforcing, particularly as access often culminates in masturbation (Quayle & Taylor, 2002). Of concern is that research in other related areas would suggest that what we will also see is a trend towards a more demographically representative Internet in relation to sexual behavior (McFarlane, Bull, & Rietmeijer, 2002), which may have implications for the sex, age, and ethnic group of individuals presenting for future treatment.

It would, therefore, seem important to address issues that relate not only to content of the material (Internet child abuse images), but also to the function that the Internet may be playing in the client’s life. To adopt a simple ‘abstinence model’ in relation to Internet use may seem intuitively a sensible thing to do, but in fact may serve to perpetuate the problem itself and be easily undermined by uncontrollable access to modern technology. One clinical presentation, which may be of relevance to the issue of compulsive or problematic Internet use, is that of obsessive–compulsive disorder (OCD). It is well established that many people exhibiting OCD have either overt or internal compulsions (covert). OCD is thought to be maintained by the escape from and avoidance of anxiety, which is accomplished by typically overt, and occasionally covert, compulsions. Allowing the person to gradually tolerate more intense levels of anxiety by preventing the completion or initiation of compulsions and allowing the individual to observe that anxiety habituates both within and between exposures has been at the centre of most behavioral treatments (Whittal, Rachman, & McLean, 2002). Within this framework, a study by DeSilva, Menzies, and Shafran (2002) used an exposure model to reduce covert compulsions. Such compulsions were provoked by the clinician, followed by a period of response prevention, when the client was not allowed to follow through on the normal neutralizing thoughts that would reduce their feelings of anxiety. These authors found that there was a rapid and spontaneous decay of both urges and compulsions within 15 min of provocation, which led them to suggest that ‘The challenge for the therapist… is to establish, with the patient, a strategy that will enable the latter to desist from carrying out the compulsion for a relatively short period’.

Intuitively, it would seem appropriate to try and reduce the compulsive element of problematic Internet use by using a similar response prevention model. But as LoPiccolo (1994) has indicated, ‘The emotional valence of the emotions and behaviors involved in a paraphilia is quite the opposite of what the patient experiences in an anxiety or depressive disorder. Sexual desire is a pleasurable emotion, and the approach behaviors motivated by it result in sexual arousal and orgasm, which are intrinsically rewarding… For many paraphilic patients, their deviation is ego-syntonic, and it is only the societal consequences of their behavior which causes them distress’. This comment was not made with respect to the Internet, and while it highlights the problematic nature of this population, it does not address the fact that offending may function as a way of avoiding or changing unpleasant emotional states, rather than only being a means to sexual arousal. Unintentionally, the Internet may be an apparently perfect vehicle for this. Unlike contact offenses, access to the Internet and to preferred content is easily available, can be immediate, and can be controlled. Most Internet users will have their computer in an area that provides privacy, security, and potentially sustained access. The offender can stay online as long as it takes for them to feel better and to secure preferred material or communication.

The literature pertaining to the relationship between affect, emotions, and sex offending has been recently reviewed by Howells, Day, and Wright (2004). They have suggested that “An emerging issue in the field of sex offender theory and treatment is whether emotional and other affective states in perpetrators are functionally important, particularly as antecedents, for offenses. In rehabilitation terms, are affective states criminogenic needs?” (p 180). Within this review, it was noted that there are problems with definition, in that negative affect is used to describe emotions, moods, and feelings. And they questioned whether states, such as boredom or excitement, might be genuinely construed as moods. These authors provided substantial empirical support for the relationship between affect and offending in
relation to studies on anger and sexual arousal, offense pathways studies, and sexual fantasy studies, and concluded that the most convincing evidence for the role of affect as a causal factor in sex offending comes from the offense-process or offense chain studies. In this context, earlier work by Hudson, Ward, and McCormack (1999) described positive and negative affect routes to sexual offending. In their sample of offenders, 37% had evidenced a positive affect chain and 44% a negative affect chain.

However, while Howells et al. (2004) have suggested that it is relatively easy to explain why some emotions such as anger may result in sexual aggression, it is less clear why emotions, such as anxiety and sadness, should elicit deviant sexual behavior. One explanation comes from the work of Marshall and Marshall (2000) which examined affective states and coping behavior. These authors proposed that when in a state of negative affect, sex offenders are more likely to use sexual behaviors as a means of coping than are non-offenders. Sex becomes a way of resolving non-sexual problems which Howells et al. (2004) have suggested is reinforced and learned precisely because it is effective in reducing a state of negative affect. Linked to this is the idea that some states of emotional arousal, such as anger, anxiety and loneliness, may produce situational suppression of empathic responses and affect subsequent decision making processes. In the context of Internet related offenses, a qualitative study by Quayle and Taylor (2002) found that offenders reported increased risk taking during such states and were more likely to tell themselves that the images that they were looking at were unrelated to the abuse of actual children.

A recent study by Middleton, Beech and Mandevill-Norden (2004), examining the psychological profiles of Internet pornography users, based their analysis on the pathways model by Ward and Siegert (2002) of child sexual abuse. This model would suggest several pathways to offending including intimacy deficits, distorted sexual scripts, emotional dysregulation, antisocial cognitions, and multiple dysfunctional mechanisms. Within the sample by Middleton et al. (2004), of the 43 subjects convicted of Internet related offenses, 38% fell within the Intimacy Deficit pathway and 35% within Emotional Dysregulation. The latter group all reported high levels of problems in dealing with negative emotions and both of these groups appeared to use sex as a coping mechanism. These authors felt that the implications of their study with regard to treatment included the importance of a functional analysis of the individual’s offending behavior; a focus within therapy on overcoming intimacy deficits or the acquisition of skills to deal with negative affect; and a focus on increasing victim awareness and empathic responses.

The possible relationship between affect and offending clearly has important implications for treatment. Howells et al. (2004) differentiated between treatment approaches that are based on antecedent-focussed emotion regulation and response-focussed emotion regulation. Cognitive Behavior Therapy might be seen as an example of the former, where offenders are helped to examine the thoughts and contexts that are associated with negative emotions and to generate alternative ways of thinking. However, Marx, Miranda, and Meyerson (1999) suggested that sexually aggressive individuals may also be reinforced through the reduction or removal of aversive stimuli, such as feelings of inadequacy or frustration resulting from life stress, rejection from another individual, lack of control, boredom or avoidance of failed relationships. In this context, relieving tension or other aversive emotional states may function as a negative reinforcer. Cognitive Behavior Therapy, which emphasizes changing the content of cognitions, emotions, and physiological states, may in fact result in further distress as thoughts and feelings are perceived by the individual as being more threatening than otherwise would be the case. Hayes (1994) had suggested that people do not do harm to themselves by being open to their psychological experiences, but do themselves harm when they try not to think, feel and remember. Psychological acceptance is focussed on harnessing the persons capacity for deliberate change to the domains in which this effort is useful, rather than tying them to areas in which it is not. In a similar vein, Polaschek, Ward, and Hudson (1997) proposed that increasing efforts toward emotional awareness and psychological acceptance may be a valuable addition to current treatment approaches.

Until recently, acceptance-based approaches to sexual offenders have been seen as antithetical to current CBT procedures (aimed at controlling or suppressing deviant thoughts). LoPiccolo (1994) lists several factors that have inhibited the development of acceptance-based procedures:

1. paraphilia is a pleasurable disorder, rather than being aversive, as is the case with anxiety or depression
2. paraphilia is ego-syntonic for many patients
3. our innate sex drive implies that deviant thoughts come with a biological imperative to action that cannot be ignored, so deviant thoughts must be suppressed not accepted
4. there is confusion around the issue that ‘acceptance’ implies acceptance of deviant behavior, with attendant harm to innocent victims.
However, sexual deviation can also be a form of self-medication, to ward off anxious, lonely, or depressed feelings. It can result from sexual anxiety and a means to reduce stress. Importantly, from our perspective, LoPiccolo (1994) asserts, ‘In all such cases, the patient typically is not allowing himself to accept the reality of his life situation and his emotional reaction to it. Instead he is displacing his emotional distress onto sexually deviant acting out’. An integration of acceptance procedures with relapse prevention would have the client accept both dysphoric emotions which previously elicited deviant behavior, and also accept the inevitability of deviant thoughts and urges, without having to escape or avoid either types of thoughts or feelings.

The theoretical background to such acceptance procedures is different to that underpinning simple response prevention, and while it is beyond the scope of this paper to examine the relevant literature of this area in detail, a brief overview of the development of this subject is presented here. Clinical behavior analysis is a relatively recent and rapidly growing branch of applied behavior analysis (which focuses on the use of contingency management procedures to treat severely impaired populations such as autism) and emphasises the use of verbally based interventions to treat verbally competent clients who seek treatment for problems such as anxiety, depression, personality disorders, substance abuse, stress disorders, and relationship difficulties.

The seeds of clinical behavior analysis were planted in the writings of Skinner (1953, 1957, 1974), Ferster (1972a, 1972b, 1979), Goldiamond (1974) and Hawkins (1986). Two sets of events have been particularly important to the development of the field. The first is the relatively recent and rapid increase in basic research on verbal behavior. The second set of events that significantly affected the growth and direction of clinical behavior analysis was the development of Kohlenberg and Tsai’s Functional Analytic Psychotherapy (FAP) (Kohlenberg & Tsai, 1991) and Hayes’ Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl, & Wilson, 1999; Hayes & Wilson, 1994). To a large extent, FAP relies on direct contingency shaping of client-related behaviors. However, it incorporates a basic premise of psychodynamic therapies that the best place to observe and modify these behaviors is within the therapeutic session. ACT, on the other hand, stems directly from a radical behavioral perspective on private experience (i.e., thoughts, emotions, and bodily sensations) and recent research on derived stimulus relations. Its aim is to help clients to openly experience both private and public events as they are and without distortion. While ACT may broadly be identified as a cognitive behavior therapy, perhaps surprisingly, its objectives and some of its techniques are similar to those advocated by Eastern psychology, Gestalt therapies, and existential therapies.

Hayes and Wilson (1994) stated that though acceptance is often non-technically defined as a willingness to experience events fully and without defense, its technical definition refers to a willingness to make contact with the automatic and direct stimulus functions of events without acting to control, reduce, eliminate, or otherwise reduce the frequency, occurrence, or impact of such events. Arising out of this radical behavioral perspective, acceptance is seen as a stated goal and refers to the client’s willingness to experience a full range of emotions, thoughts, memories, bodily states, and behavioral predispositions without having to change, escape from, or avoid them. Kohlenberg, Hayes, and Tsai (1993) have suggested that when private behaviors need not be changed, their controlling effects over overt behavior might be reduced considerably, and concern could shift from emotional or cognitive manipulation to overt action. Paul, Marx, and Orsillo (1999) used such an acceptance-based therapy in the successful treatment of a client displaying exhibitionistic behavior. The therapeutic approach was that of Acceptance and Commitment Therapy, the main goals of which were to give the client a counterintuitive method of accepting rather than eliminating troublesome internal events and to focus on long-term adaptive behavior. These authors give the following overview of the therapeutic stages involved with this client:

1. to understand that previous struggles to control their inner experiences have been unsuccessful
2. to see that previous struggles may have made matters worse
3. to help clients delineate between their personal self and their cognitive, emotional and physiological experiences
4. to willingly experience the aversive private events that they had previously avoided to accomplish their previously unreachable goals
5. getting a commitment from the client to change.

In the context of substance abuse (which possibly shares some of the characteristics of problematic Internet use in its relation to poor impulse control) Forsyth, Parker, and Finlay (2002) suggested that the efficacy of treatment strategies may improve where there is an attempt to increase patients’ sense of control over their own responses and the environment, and where intervention decreases attempts to avoid unpleasant emotions. Inevitably, impulsive
behavior is also related to problems of self-control, conceptualized by Gifford (2002), as a conflict between present
and future gratification. Gifford suggested that since humans are a highly visual species, delay of gratification tasks
are particular taxing on self-control when the reward or other consequence may be visible for the individual during the
delay period. For the Internet offender, the presence of the computer may elicit a pre-potent response, while
alternatives that are more abstract, or are not present, are weighed less highly. They argue that ‘When contemplating
this choice problem in abstract, those with self-control problems understand their difficulties, but when faced with a
real choice they cannot muster enough inhibition to deliberate — they simply grab the pre-potent option’ (p 126).
However, these authors suggested that people with better initial self-control are able to employ ‘rule-following’
behavior, involving internal speech, which further facilitates self-control. ‘Use of internal speech shifts the deliber-
ation process to the symbolic level and reduces the saliency of pre-potent stimuli’ (p 127). However, the problem of
self-control may also be resolved by making contact with the harmful long-term effects of immediately reinforced acts
(Kudadjie-Gyamfi & Rachlin, 2002).

How do we convince clients that it is worth engaging with their emotional distress without using the Internet as a
means of avoidance? We are also asking them to forego the immediate pleasure and gratification that comes from
accessing and using child abuse images. One potentially powerful strategy, that lies at the heart of all acceptance-
based treatments, is getting the client to explicitly state their values and to look at how immediate gratification may
inhibit their ability to fulfil those values. Ward (2002) has argued that such a strategy implicitly lies at the heart of all
sex offender treatment programmes, which conceptualize possible good lives for offenders and the necessary internal
and external conditions for living such lives. He says, ‘...individuals are unlikely to refrain from offending if their
lives are characterized by an absence of valued outcomes...one of the reasons individuals commit crimes is that they
are perceived to be rewarding in some ways, a criminal lifestyle represents one way of achieving personal goods...offenders
need to make their own choices and this is guided by a conception of good lives and the belief that it is
possible to achieve different ways of living in the world.’ (p 514).

Ward (2002) went on to discuss the fact that while the role of values in the rehabilitation of offenders has often
been acknowledged, there has been little discussion of the explicit ways in which this should occur. He suggests that
‘...it is necessary for individuals working to rehabilitate offenders to explicitly construct conceptions of good lives
for different offenders and to use these conceptions to shape the behavior change process’ (p 515). Ward used a study
by Maruna (2001) who interviewed offenders desisting from and persisting with lives of crime to illustrate his
argument. The major tasks for offenders attempting to live a crime-free life was to ‘make good’ by working out a
different way to live based on a clear set of personal values and a consistent self-narrative. He suggested that, ‘This
means that therapists attempting to rehabilitate offenders ought to be guided by an awareness of the role that values
and primary human goods play in facilitating well-being’ (p 524). However, values cannot be pre-packaged, and what
is relevant to one offender may be irrelevant for another, ‘The reliance on manual-based interventions in the treatment
of offenders can add to this problem. Because therapists tend to follow standardized procedures, they may fail to
consider the appropriate form of life for a given individual’ (p 526).

Acceptance-based therapies, such as ACT, are values oriented interventions, which focus on valuing as an activity.
Quite literally the client is being asked to ‘value with their feet’, and to begin to experience their life as chosen rather
than imposed. An active part of this is the assessment of client values, where the therapist’s role is to clarify the
direction inherent in what might be fairly concrete valued ends. The therapist also assesses variables controlling the
client’s statements about valued ends, and should attempt to intervene when the responses are based on ‘pliancy
(these might be statements controlled by the presence of the therapist, or by the emotional proximity of others such as
parents, or that may be culturally desirable values). The assessment of values is followed by the generation of goals
and actions that are relevant to those values, and the examination of private events that act as barriers to moving
forward in their life in these areas. Underlying this is the assumption that emotional acceptance is a means to an end,
and putting values into action is that end.

Although coming from a very different perspective, such individual operationalisation of values and goals in the
context of emotional acceptance would seem to have relevance to the critique by Ward (2002) of current Sex Offender
Treatment Programs. With Internet offenders, it would allow an exploration of the function of the Internet in terms of
individual needs, and how far immediate emotional avoidance and gratification reduced the likelihood of the offender
realising his personal values.

Traditionally therapeutic strategies in this area have focused on control skills (for example distraction techniques).
Ward and Brown (2004) have argued that this places an emphasis on negative, or avoidant treatment goals and suggested
that, “The focus is on the reduction of maladaptive behaviors, the elimination of distorted beliefs, the removal of problematic desires, and the modification of offense supportive emotions and attitudes” (p 245). The concern is with “eradicating factors rather than promoting prosocial and personally more satisfying goals”. In the context of exploring personal values, acceptance skills focus instead on encouraging the client to experience private events (emotions, thoughts, bodily sensations) without trying to change them (Lenihan, 1993, 1994). One of the most important acceptance skill is mindfulness, which consists of six specific skills 1) observing, 2) describing, 3) participating spontaneously, 4) being nonjudgmental, 5) being mindful or focusing attention completely and only on one thing at a time, and 6) focusing on what is effective in a given situation. The goal of mindfulness is to develop a life style of participating with awareness. Participating without awareness it is assumed, is a characteristic of impulsive and mood dependent behaviors. Self-conscious observing and describing of one’s own behavior is usually only necessary when a new behavior is being learned or change is necessary. For example, beginner drivers pay close attention to the location of their hands and feet and might mentally check off or rehearse verbally aloud what they are doing, what other cars are doing, and what instructions they should follow as they drive. As skills improve, however, such observing and describing drop out. But if a habitual mistake is made after learning to drive, the driver may have to revert back to observing and describing until a new pattern has been learned.

A part of mindfulness is learning to observe internal and external events without necessarily trying to terminate them when painful, or prolong them when pleasant. Rather than leaving the situation or trying to inhibit the emotion, the individual attends to experience no matter how distressing that attention may be. This focus is based on Eastern psychological approaches to reducing suffering as well as on Western theories of non-reinforced exposure (similar to that used with OCD) as a method of extinguishing automatic avoidance and fear responses. A second mindfulness skill is that of verbally describing events and personal responses. Here, the focus is on learning how to differentiate literal events from thoughts and feelings about those events. Describing requires one to be able to differentiate events, so to speak. This strategy is very similar to the treatment strategies described in ACT therapy.

A third skill is participating. In the context of mindfulness skills, this is entering completely into the activities of the current moment, without separating one’s self from ongoing events and interactions. A good example of mindful participating is the skillful athlete who responds flexibly but smoothly to the demands of the task with alertness and awareness but not with self-consciousness. Nonjudgmental stance requires the individual to take a non-evaluative approach, judging something as neither good nor bad. It does not mean going from a negative judgment to a positive judgment. The position here is not that clients should be more balanced in their judgments but rather that judging should, in most instances be dropped altogether. For example, saying that “every day is a good day” would be the same as saying, “every day is a bad day”. The point may be subtle but it is, nonetheless, a very important one. The idea is that if one can be worthwhile, one can always in the next moment become worthless. From a nonjudgmental stance, a focus on the consequences of behavior and events replaces evaluations of good and bad. A nonjudgmental approach observes painful or destructive events and consequences of events, and might suggest changing behavior or events, but would not necessarily add a label of bad to the behavior and events.

Doing one thing at a time refers to focusing the mind and awareness in the current moment’s activity rather than splitting attention between several activities or between a current activity and thinking about something else. Such one-mindfulness requires control of attention. Like participation described above, one-mindfulness requires for its practice acceptance of the moment since a focus on change, i.e., on a different but changed moment, of necessity interferes with staying in the current moment. Often clients in therapy are distracted by thoughts and images of the past, worries about the future, ruminative thoughts about troubles, or current negative moods. They are sometimes unable to put their troubles away to focus attention on the task at hand. The desire to get out of the current moment or to repair the past is so great that staying in the present is nearly impossible. The focus of one-mindfulness practice is to teach the client how to focus attention on one task or activity at a time, engaging in it with alertness and awareness.

Effectiveness refers to ‘Doing what works’. The focus on effectiveness within mindfulness is directed at balancing the tendency to focus on what is ‘right’ with a corresponding emphasis on doing what is needed to be effective in a particular situation. A central issue for many clients is whether they can indeed trust their own perceptions, judgments and decisions; can they expect their own actions to be correct or ‘right’? Taken to an extreme, an emphasis on principle over outcome can lead to disappointment and alienation of others. Clients often find it much easier to give up being right for being effective when it is viewed as a skillful response rather than as giving up or giving in.

Representing a natural progression from mindfulness skills, distress tolerance skills represent the ability to experience and observe one’s thoughts, emotions and behaviors without evaluation and without attempting to change
or control them. Distress tolerance skills focus on both tolerating and radically accepting reality just as it is in the moment.

The focus in most standard behavior and cognitive therapies on ameliorating distressing emotions and events is balanced by a corresponding emphasis on learning to bear pain skillfully. The automatic inhibition and/or avoidance of painful emotions, situations, thoughts, etc. is viewed as an important component in psychological dysfunction and the prolongation of the very pain one is seeking to avoid. Tolerating distress does not imply giving up or necessarily approving of the situation, but it allows one to cope with pain in the moment to reduce long-term suffering. Indeed, the premise is that tolerance and acceptance of a situation as it is in the moment are prerequisites of any coherent and effective change strategy. Distress tolerance skills are aimed at tolerating distress — rather than impulsively acting to remove the pain without thought of whether the act would lead to more distress in the long run. Four sets of distress tolerance are taught:

1. Distraction skills, which focus on occupying the mind or the body with other sensations, perceptions, thoughts, activities, etc.
2. Self-soothing skills, which focus on comforting and encouraging one’s self until the painful event is lessened or over.
3. Improving the moment, which includes imaginal and cognitive–verbal strategies for changing the meaning of an event until the stress is relieved.
4. Pros and cons, which require one to review the pros of tolerating versus the cons of not tolerating. The skills are taught as ‘crisis survival skills’ and the task is presented much like the task of the individual in prison: if you have to stay in prison for a number of years, it is more adaptive to find a way to tolerate it while there rather than only fight to get out.

A key aspect of this approach is to help clients to recognize in their own lives behavioral goals related to what they value and to help them to commit themselves to these goals. Valuing as described by Hayes et al. (1999) is action of a special kind; it is the kind that cannot be evaluated by the person engaging in it. Values can motivate behavior even in the face of tremendous personal adversity. Valuing is seen as a choice, not a judgment. Acceptance of negative thoughts, memories, and emotions is legitimate and honorable only to the extent that it serves ends that are valued by the client.

Several distinctions need to be made when discussing the issue of values. Among the most important is distinguishing valuing as a feeling versus valuing as an action. These two aspects are often thoroughly confused for the client. The example of valuing a loving relationship is instructive. One’s feelings of love may come and go across time and situations. To behave lovingly (e.g., respectfully, thoughtfully) only when one has feelings of love, and to behave in opposite ways when the opposite feelings emerge would be very likely to have problematic effects on the relationship. Yet, this is precisely the problem we are in when values are confused with feelings, because feelings are not fully under voluntary control and tend to come and go. The cultural context that supports the association between feelings of love and acts of love is the same cultural context that supports the client with agoraphobia staying at home in the presence of high anxiety and the pedophile downloading child pornography in the presence of strong urges. If the client bases living entirely on the absence of emotional or cognitive obstacles, then valued directions cannot be pursued in a committed fashion, because sooner or later the obstacle (e.g. a sexual urge) will be encountered. Valuing as a behavior is always occurring in the client’s life. It cannot be avoided, no matter how shut down and benumbed the client is. Why might this be the case? Because most behavior is purposeful, whether there is an experienced sense of direction or not.

The values assessment process serves a variety of assessment and intervention purposes. First, the client may become aware of long suppressed values. This process is motivational in the sense that the client may find major discrepancies between valued versus current behavior. Second, the process of values assessment can help to highlight a place in the client’s life in which things are ‘better’. A person’s values may not be what someone else thinks they should be, but are always complete within themselves. The assessment of values, goals, actions and barriers can be effected through the completion of a series of structured exercises, using materials developed by Hayes et al. (1999). The values assessment work sheets are reviewed by the therapist and client and then modified in a collaborative fashion. The therapist’s task is to attempt to clarify the direction inherent in what might be fairly concrete valued ends. The therapist should also attempt to assess for other factors that may be influencing the client’s statements about valued ends: the presence of the therapist; cultural factors; immediate family members.
It would be difficult to imagine a client who would have values that were not controlled in part by all of the aforementioned variables. The key is whether the removal of an influence would significantly affect the potency of the value as a source of life direction. This task cannot be completed in one discussion. The issue of “ownership” of a value is likely to resurface time and again. Some of these issues may be addressed by asking the client to talk about the value while imagining the absence of a relevant social consequence. To illustrate, consider a client who forwards the value of being well educated. The therapist may ask if the level of valuing (or the value itself) would change if it had to be enacted anonymously: “Imagine that you had the opportunity to further education, but you could not tell anyone about the degree you achieve. Would you still devote yourself to achieving it?”

The client is asked to generate responses in various life domains. Clients may leave domains empty or generate very superficial answers. Here, the therapist needs to patiently, and in a non-confrontational way, discuss each domain. It often helps to go back earlier in the client’s life and look for examples of wishes and hopes that have disappeared because of negative life events. At other times the therapist may have to assist the client either in generating the directions inherent in specific life goals or, conversely, in generating specific goals from more global directions. The client may also list ends that are not possible. For example, a man may say that he wants to gain custody of children that he has not seen for 10 years. In such instances, the therapist tries to find the underlying value and goals that might be achievable if one were moving in that direction.

The assessment requires the client to focus on developing goals and specifying the actions to be taken to achieve those goals. This is the most applied part of the assessment and the most critical, because it directs the therapy. The work on goals, actions and barriers stands on the foundation of the client’s values. Given the direction specified in each life domain, the client is asked to generate specific goals. A goal is defined as a specific achievement, accomplished in the service of a specific value. The client defines the actions that would be likely to achieve the goal. The therapist and client try to generate acts that can take the form of homework. In some cases they may involve single instances. At other times they may involve a commitment to repeated and regular acts.

Effective behavioral goal setting requires a candid analysis of the barriers the client is likely to encounter that may forestall action. Barriers may involve negative psychological reactions or pressure from outside sources. Negative anticipatory emotions such as fear, anxiety, or shame may also appear. If previous therapy has been successful, the client may be ready to recognize the barriers for what they are, not for what they advertise themselves to be. Part of the values clarification process helps the client identify the barriers to valued action in each domain. As these barriers are discussed the therapist helps the client to examine several issues: what type of barrier is this (Is it negative or private events or an external consequence that conflicts with another value?); if this barrier did indeed present itself, is it something that the client is willing to experience? what aspect of the barrier is most capable of reducing the client’s willingness to experience it? are any of these barriers another form of emotional control or emotional avoidance?

A common problem that may occur at this point is the therapist’s inability to detect goals that are presented as values by the client. For example, the client may say, “I want to be happy”. This sounds like a value, but it is not. Being happy is something you can have or not have, like an object. A value is a direction — a quality of action. By definition, values cannot be achieved and maintained in a static state, they must be lived out. When goals are mistakenly taken as values, the inability to achieve a goal seemingly cancels out the value. A practical way to avoid this confusion is to place any goal or value statement produced by the client, under the following microscope: “What is this in the service of?” or “What would you be able to do if that was accomplished?” Very often this exercise may highlight the hidden value that has not been stated. Some values are really means to an end, in which case they are not values at all. Experiential avoidance is a good example of this.

Marx et al. (1999) suggested that this approach might be used in the context of another group of sexual offenders, rapists, suggesting that ‘instead of an emphasis on changing or controlling psychological events, the emphasis should be on changing the context in which the rapist experiences his deviant thoughts, feelings or sensations’ (p 887). Thoughts, feelings, and emotional arousal, therefore, need not be seen as a reason for behaving in a particular way, and moves the offender away from thinking of such experiences as behavioral imperatives. In the context of making values explicit, the offender is being given the opportunity to learn to tolerate levels of emotional distress without having to escape or avoid them (e.g., through downloading and masturbating to child abuse images) in order to be able to work towards a ‘good life’ which has personal, rather than imposed, relevance. As yet there is little empirical evidence on which to judge the effectiveness of acceptance-based therapies with sex offenders who have downloaded abusive images from the Internet. There is, however, a body of both research and intervention with other clinical populations who engage in emotional avoidance (Jacobson, Christensen, Prince,
Cordova, & Eldridge, 2000; Wilson, Hayes, & Byrd, 2000), and this approach may offer a particularly attractive alternative to existing CBT approaches.

Howells et al. (2004) concluded, “Improving our understanding of the affective dimensions of sex offending is an important task for the future”. In the context of this heterogeneous population, such understanding is likely to be furthered by a framework that helps us understand the function of the behaviors for the individual. This will help us move away from a generic model of treatment that exists in many current sex offender treatment programs to help us focus on what might work for the individual. Middleton (2004), in his review of current treatments for sex offenders, stated that “At the very least the treatment needs to be based on a specific assessment of the individual including the context in which the behavior was developed and sustained. Most human behavior can be understood as meeting needs for the individual and, in order to be effective, treatment will help the individual to meet these needs in a more appropriate manner” (p 110). This does not require us to abandon the substantial body of work that exists in relation to the treatment of sex offenders, but rather return to a model that places an emphasis on the individual and acknowledges that people may behave in ways that are topographically alike but which function in very different ways across individuals. Clearly for some offenders, but not all, accessing images on the Internet may function as a way of avoiding or dealing with difficult emotional states and we need to at least see this as worthy of assessment in the context of providing effective treatment.

References


