CHAPTER 3

ISSUES INVOLVED IN TREATMENT IN A PRISON CONTEXT

3.1 INTRODUCTION

When a person commits a crime and is sent to prison, the offender is not sent to prison to be punished but as punishment (Making Standards Work – An international handbook on good prison practice, 1995). The purposes of imprisonment as pure punishment and revenge are questionable. At the same time, it might also be argued that prison is not a place for punishment but for rehabilitation, as putting offenders in prison, in principle, is similar to putting mentally-disordered persons in a hospital (Kolstad, 1996). Kolstad (1996, p. 323) also argues that in both cases persons will be staying in "total institutions" for many years. He indicates further that while the number of prisons and offenders in prisons are increasing, mental hospitals are being closed down in most Western countries, as mental hospitals are no longer considered reasonable places for long-term stay and the goal is to rehabilitate them so that they can function in communities.

Many sexual offenders are in prison and serving sentences but "are in prison as punishment and not for punishment" (Making Standards Work - An international handbook on good prison practice, 1995, p. 14) as their penalty consists of loss of freedom. The circumstances of their imprisonment should not therefore be used as additional punishment and all adverse effects of imprisonment must be minimized. Sexual offenders are also often sent to prison with the expectation that they will participate in treatment and/or rehabilitation programmes that will prepare them to adjust in society when they are released. Most rehabilitative programmes, however, have shortcomings and limited effectiveness (Clear & Cole, 1994). Clear and Cole are of the opinion that a prison without programmes is unthinkable and that structured activity must be available for prisoners.

Collins English Dictionary (1991, p. 1306) defines *rehabilitate* as "1. to help (a person who is physically or mentally disabled or has just been released from prison) to readapt to society or a new job, as by vocational guidance, retraining, or therapy" and *rehabilitation* as "1. the act or process of rehabilitating". The South African Student's Dictionary (1995, p. 805) defines *rehabilitation* as "things done to give people normal lives and make them part of normal society, especially people coming out of prison". In order to give people normal lives and make them part of normal society, their strengths and behaviour need to be enhanced so that they can lead a meaningful life. Rehabilitative programmes therefore have as their aim the reformation of the offender's behaviour (Clear & Cole, 1994) in order to attend to and focus on personal, social and situational barriers, which hamper effective functioning in society.

Some people argue that imprisonment is so painful in itself that it is reformative and that offenders will change their ways to avoid a repetition of the experience. Others hold that going to prison is not reformative enough and offenders should participate in special programmes in order to rehabilitate. The current political direction in South Africa strongly advocates rehabilitation although some sectors of the community disagree on the emphasis that should be given to rehabilitation programmes and/or the types of programmes that should be offered (Clear & Cole, 1994).

3.2 TREATMENT IN A PRISON CONTEXT

While offenders realize that their sentence is the result of an illegal act and accept being punished, the majority of prisoners accept imprisonment as part of the punishment (Kolstad, 1996). Kolstad points out that studies indicate that imprisonment on its own does not serve any rehabilitative function since even the purposes of imprisonment as pure punishment and revenge are questionable.

Moreover, others question whether rehabilitation and treatment can take place in a prison environment for two reasons (Kolstad, 1996, p. 333):

- Rehabilitation will not be given priority if it takes place in prison where punishment is the main aim. Treatment in prison will always be subordinated to the *stay* in prison

- Inside the total, closed institution, inmates are habituated to existence with such environments, rather than the outside society. Rehabilitation in prison is, therefore, habilitation to the milieus that characterize the total institution, along with the norms, values, and behaviours that characterize prisoners.

To rehabilitate literally means to restore to a normal life or former position (Clear & Cole, 1994) or as Kolstad (1996, p. 332) puts it, teaching the social skills needed to manage in and join the law-abiding society, and to change a self-image or label as "offender" or "criminal" into that of a law–abiding citizen. As all prisoners have been law-abiding citizens at some time in their life, the most important step in their development as offenders is probably the change in their self-image, from perceiving themselves as a "boy" or a "man" to being an "offender" or "criminal". The transformation, therefore, has to be reversed during the rehabilitation process where the purpose is to strengthen/enhance the positive and law-abiding aspects of a person's personality and to make these aspects more visible both to the person and to others in the community (Kolstad, 1996) and to assist the person to lead a law-abiding and meaningful life.

Rehabilitation of offenders who show potential for change is imperative, while protection of the community must remain a continual priority (McGrath, 1991). According to Clear and Cole (1994) and Kolstad (1996), rehabilitative programmes have as their aim the reformation of the offender's behaviour. The researcher agrees with this and maintains that a series of different reactions and treatments must be developed with the emphasis on the consequences of punishment, and on selecting functions or activities for offenders

that serve the goal of rehabilitation.

In the researcher's opinion, offenders are often people with many and varied challenges who face many personal, social and situational barriers, which hamper effective functioning in society. Therapists should therefore foster the individual's personal and social growth, taking the challenges into account and preferably adopt a holistic approach.

Kolstad (1996, p. 333) summarizes the factors necessary for successful rehabilitation as follows:

> *Differentiation*: Rehabilitation has to be tailored to the individual. An individual rehabilitation plan must be developed for every case. Training and support must be adjusted to the needs and resources of every client.
>
> *Assessment of the potential for rehabilitation*: In every case, the realistic potential and goals for rehabilitation must be stated. This requires experience and skill.
>
> *An early start*: Training in social skills has to start as quickly as possible, and planning must start when the offender is arrested or on remand. Good planning and early beginnings prevent a reduction in rehabilitation potential, and accordingly lower the risk of reoffending, as well as save resources.
>
> *Adequate time*: Rehabilitation takes time. It is a lengthy process, both for the client and the staff. Preparation for release must occur over months, and the follow-up should continue for years. Many prisoners have to deal with substance abuse problems, and this underscores the point that rehabilitation will be time consuming and has to start immediately.
>
> *Follow-up*: Follow-up activities may have to be carried on for years. Professional health care and social care have to be provided over a long period and there have to be clear contracts with regard to responsibility and rights. To change internalized ways of thinking and behaving takes time. Changes that include relations and connections to other people are especially difficult to implement. New social networks have to be established in many cases.

Broad-based effort: Assistance and interventions must take place in a wide variety of life-domains: work, residence, drug addiction, family, friends and neighbors.

Location outside institutions: Rehabilitation has to take place mainly outside prisons.

With the current increase in the number of rapists admitted to prison and public outcry to rehabilitate sex offenders, the need to develop a treatment programme for rapists became urgent.

Research shows that there are considerable difficulties in dealing with rapists (or any other sex offenders) in a prison context (Clear & Cole, 1994; Guy, 1991; Marshall et al., 1999; Scutt, 1990). Therapeutic involvement with rapists is often seen as essentially preventative and aimed at instilling a sense of self-worth so that they can rebuild their lives in a constructive and pro-social manner (Marshall et al., 1999) for the benefit of the rapist (sexual offender), the victim, society and the state.

Treatment in a prison is difficult for the following reasons:

- A prison is not the ideal environment for doing behavioural treatment programmes. Therefore Guy (1991) advocates that programmes must be practical and realistic. According to him, constraints must be recognized and dealt with if programmes are to be delivered effectively. Furthermore, a high premium must be placed on continuity from the institution to the community. Programmes should be implemented intensively, seriously and for a reasonable length of time.

- Treatment programmes for sexual offenders are few and scarce (Somander, 1995) and little has been written specifically on sexual offender treatment, particularly prison-based therapies, even in Western and European countries (Frenken, 1999). Scutt (1990) and Somander (1995) indicate that few, if any, studies have been conducted on convicted sexual offenders and give useful indications of what can

be done effectively. Scutt and Somander nevertheless feel that convicted sexual offenders provide a valid group to study.

- The researcher found no treatment programme available in the Department of Correctional Services for rapists and no research on therapeutic interventions with rapists in South African prisons or any other African prison context.

- No guarantees can be given regarding future reoffending (recidivism) unless the rapist/sexual offender is able to control his sexual fantasies and behaviour (Cull, 1992).

- Offenders are often sent to prison in the expectation that they will participate in treatment and/or rehabilitation programmes that will prepare them to readapt to society when they are released. Evans and Gallichio (1991) point out that such expectations, however, need to be balanced against the fact that most researchers agree that sex offenders, especially rapists, cannot be cured, but can learn to control their own offending behaviour and take responsibility for it.

- At the end of any treatment programme or intervention there is no guarantee that it did, in fact, lead to any change or changed behaviour in an offender. This study, therefore aimed to focus on this specific issue, and indicate whether change did take place after a treatment programme was implemented for rapists.

It is recognized that any treatment programme to treat rapists, especially in a prison context, is controversial. Clear and Cole (1994), however, argue that a programmeless prison is unthinkable and that structured activity must be available despite the fact that most rehabilitative programmes have shortcomings and limited effectiveness.

3.3 MANDATES FOR TREATMENT OF PRISONERS IN THE DEPARTMENT OF CORRECTIONAL SERVICES

In terms of the Constitution of South Africa Act 108 of 1996 (Chapter 2, Section 35 (2)(e), p. 17) every sentenced prisoner has the right to "conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment". Taking this mandate into consideration, it is imperative for the Government and the researcher, as a senior official and manager in the Department of Correctional Services, to attend to the needs of sexual offenders where "medical treatment" is seen in the broadest context, thus including physical and psychological treatment.

The Correctional Services Act 111 of 1998 (Chapter 11, section 2) provides as follows:

> The purpose of the correctional system is to contribute to maintaining and protecting a just, peaceful and safe society by -
>
> (a) enforcing sentences of the courts in the manner prescribed by this Act;
>
> (b) detaining all prisoners in safe custody whilst ensuring their human dignity; and
>
> (c) promoting the social responsibility and human development of all prisoners and persons subject to community corrections.

3.4 THE TREATMENT PHILOSOPHY OF THE DEPARTMENT OF CORRECTIONAL SERVICES

It is the policy and philosophy of the Department of Correctional Services to place rehabilitation at the centre of all its activities as a long-term goal of crime prevention and to harness its potential to eliminate recidivism.

Rehabilitation is therefore conceptualized and understood as (Department of Correctional Services internal working document, 2002):

- The creation of an enabling environment where a human rights culture is upheld, reconciliation, forgiveness and healing are facilitated and prisoners are encouraged and assisted to discard negative values, adopt and develop positive ones which are acceptable to society.

- The creation of opportunities, for the acquisition of knowledge and new skills, the development of an attitude of serving with excellence and the achievement of principled relations with others, to prepare the prisoners to return to the society with an improved chance of leading a crime-free life as productive and law-abiding citizens.

- A process that is aimed at helping the prisoner gain insight into his/her offending behaviour and also understand that crime has caused injury to others (including the primary victim/s and the broader community).

The objectives of rehabilitation in the Department of Correctional Services are (Department of Correctional Services internal working document, 2002):

3.1 To encourage prisoners to own the main values as enshrined in the Constitution.

3.2 To make them an asset to society as productive and law-abiding citizens.

3.3 To address the offending behaviour in order to curb re-offending and eliminate recidivism.

Because rehabilitation is a process, a multidisciplinary team of psychologists, social workers, educationists, chaplains and religious care workers offer prisoners opportunities for development and growth by means of various treatment and/or development programmes, which may be short or long. Involvement in treatment or development

programmes has no beginning and no end as the prisoners may attend any programme during the course of their sentence. It is acknowledged that involvement in treatment and/or development programmes does not necessarily transform people back to a state in which they were before entering prison. The process is completed when they are reintegrated successfully into the community.

The rehabilitation model of the Department of Correctional Services has the following intentions:

- Provision of professional services that meet the needs of offenders according to national and international guidelines
- Assisting offenders to develop their full potential in order to live an acceptable lifestyle by creating opportunities
- Provision of services to all offenders who wish to utilize them (offenders have a choice because no treatment or participation in any of the programmes is mandatory)
- Encouraging offenders to participate in programmes for their own benefit (taking into account that they take ultimate responsibility for changing their behaviour)
- Establishing networks with interested community agencies

3.5 NUMBER OF SENTENCED SEXUAL OFFENDERS

One of the main problems in obtaining statistics regarding rapists is that sexual offenders are not classified into specific categories. The Department of Correctional Services only distinguishes between three main crime categories, namely sexual, aggressive or economic. Sexual offenders therefore include all prisoners found guilty of rape, incest, child abuse, exhibitionism, indecent assault and sodomy. The same problem regarding crime categories still existed in the Department of Correctional Services in 2001.

On investigation the researcher determined from the Department of Correctional Services statistics that the total percentage of sentenced sexual offenders had increased since 1993.

Table 3.1 Percentage of sexual offenders, 1993-1996

Percentage of sexual offenders, 1993-1996	
Year	**Percentage of sexual offenders**
31 March 1993	8.06
31 March 1994	8.22
31 March 1995	10.3
31 March 1996	10.3

Source: Bergh (1997)

The sexual offenders referred to in table 3.1 represent only those that had been convicted of sexual offences (e.g., rape, voyeurism, indecent assault) while the remaining percentage of offenders (not indicated in this table) had been convicted of either economic (e.g., fraud, theft, robbery) or aggressive crimes (e.g., murder, armed robbery).

Table 3.2 presents the number of prisoners in custody according to the three crime categories from 1995 to 2001. The statistics also indicate a marked increase annually for sexual offenders.

Table 3.2 Number of prisoners in custody, 1995-2001

Year	Number of prisoners in custody, 1995-2001				
	Sexual	**Economic**	**Aggressive**	**Narcotics**	**Other**
1995	8 078	35 488	34 811	3 458	5 472
1996	9 477	36 060	37 927	3 571	3 191
1997	10 624	38 657	41 328	4 053	4 157
1998	11 495	34 768	41 718	3 724	4 118
1999	11 937	35 540	44 090	3 671	5 269
2000	12 859	37 523	49 315	3 620	6 439
2001	13 783	36 943	53 024	3 494	7 444

Source: Management Information System, DCS

Table 3.3 presents the percentage of sexual offenders versus other crime categories from 1993 to 2001 and the results indicate a serious increase in incarcerated sexual offenders.

Table 3.3 Frequencies and percentage of sexual offenders versus other crime categories, 1993-2001

Average for period	All crime categories	Percentage of sexual offenders
Average for 1993	Number not available	8.1 %
Average for 1994	Number not available	8.2 %
Average for 1995	87 307	9.2 %
Average for 1996	90 226	10.6 %
Average for 1997	98 819	10.7 %
Average for 1998	95 823	12.0 %
Average for 1999	100 507	11.9 %
Average for 2000	109 756	11.7 %
Average for 2001	114 688	12.0 %

The statistics in tables 3.1, 3.2 and 3.3 confirm that even though there was an increase in the prisoner population, there was also a rise in the number of sexual offenders (including rapists) from 8.1% in 1993 to 12% in 2001.

3.6 AVAILABLE HUMAN RESOURCES IN THE DEPARTMENT OF CORRECTIONAL SERVICES

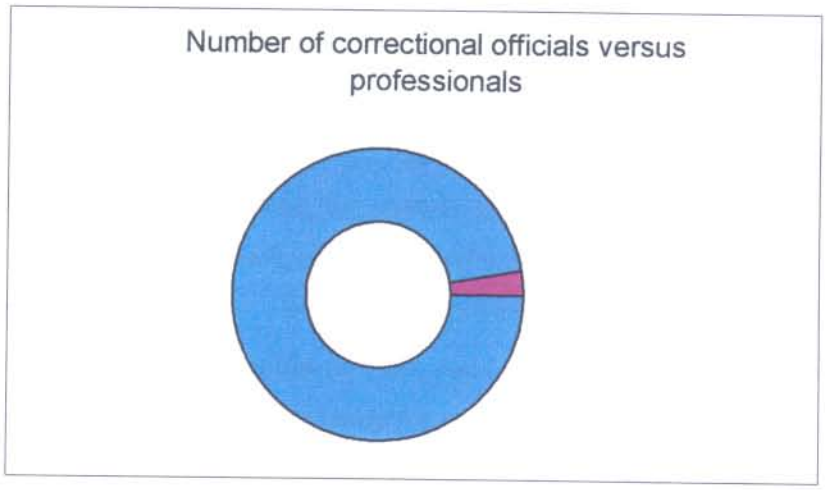
On investigation, the researcher established that 32 000 correctional officers were employed in 250 management areas/prisons countrywide to work with all prisoners. In 2001 only 873 (2.7%) of these correctional officers were professionals (social workers,

educationists, psychologists, chaplains and religious care workers) who rendered developmental, treatment and/or support programmes to prisoners.
The 873 professionals consisted of the following personnel:

Social workers	477	(1. 5% of available personnel)
Educationists	318	(1% of available personnel)
Psychologists	44	(0.14% of available personnel)
Chaplains	34	(0.10% of available personnel) assisted by
	1 991	external religious care workers

From the above statistics and chart 3.1 it can be assumed that with the limited professional resources, treatment is available only when and where human resources are available. The shortage of professionals to render treatment programmes also indicates that many incarcerated sexual offenders, including rapists, will therefore not be exposed to a treatment programme during their sentence. This situation is not uncommon in other countries. Somander (1995) points out that there is no possibility of providing treatment for all the prisoners who have been sentenced for a sexual offence at the moment in any case.

Chart 3.1 **Number of correctional officials versus professionals in the Department of Correctional Services, 2001**



Blue: correctional officials

Red: professional personnel (social workers, psychologists, educationists, chaplains and religious care workers)

3.7 AVAILABILITY OF TREATMENT PROCEDURES FOR SEXUAL OFFENDERS IN THE DEPARTMENT OF CORRECTIONAL SERVICES

As Director of Psychological Services, the researcher was aware that the treatment of sexual offenders, such as child molesters or rapists, included a variety of treatment techniques, rendered primarily by psychologists and/or social workers and not simplistically related to the offence. Considering that a number of problem areas are common to all prisoners, including sexual offenders, treatment in prison is aimed mainly at improving social skills, sex education, anger management and cognitive restructuring. As far as the researcher was aware, no research had yet been done in the Department of Correctional Services on the efficacy of treatment programmes or whether any change had, indeed, taken place as a result of exposure to treatment programmes.

3.8 MOTIVATION AND NEED FOR DEVELOPING A TREATMENT PROGRAMME FOR INCARCERATED RAPISTS

The Constitution of the Republic of South Africa Act 108 of 1996 and the Correctional Services Act 111 of 1998 mandate the treatment of prisoners, including rapists. This motivated the researcher to develop, implement and evaluate the results of a specially designed treatment programme for rapists in a South African prison context. The rationale for the development of a South African treatment programme for rapists was that there was no treatment programme available for convicted rapists in South Africa. Available treatment programmes in other parts of the world were not suitable for rapists in South Africa as they did not provide for problems with illiteracy, language differences, infrastructure and availability of resources, which do not exist in other Western countries.

3.9 RATIONALE FOR USING A SPECIFIC PROGRAMME STRUCTURE AND CONTENT

The researcher examined different theoretical perspectives on rape but did not include them as they fall outside the scope of this study. The purpose of consulting them was to determine the most common factors, aspects and/or patterns that needed to be covered in a treatment programme for rapists. The following aspects of rape and rapists were seen to be important:

- rape is an atrocious and brutal act and violent crime, which involves not only physical harm but also emotional and physical injury (Lisdak & Roth, 1990)
- male dominance and power as opposed to female submission (Lisdak & Roth, 1990)
- rapists' underlying feelings of insecurity about their masculinity (Lisdak & Roth, 1990)
- defective socializing processes (Haralambos & Heald, 1983)
- rape is an interpersonal crime (Amir, 1971; Broadhurst & Maller, 1990)

- different social meanings and values for different cultures e.g. the difference between rape-prone and rape-free cultures (Broadhurst & Maller, 1990; Haralambos & Heald, 1983; Lottes, 1988; Sanday, 1981)
- endorsement of violence in patriarchal societies (Brownmiller, 1975; Burt, 1980; Herman, 1990; Sanday 1981)
- the conceptualization that communities live in a rape culture (Scutt, 1990; Vogelman, 1990)
- a universal devaluation of women and children (Finkelhor, 1986; Sanday, 1981)

In addition, in order to develop the treatment programme, the researcher obtained the following two programmes:

- The Maintaining Change Programme, a relapse prevention manual for adult male perpetrators of child sexual abuse, by H. Eldridge. Although the author retains copyright of the entire manual, the Faithfull Foundation allows purchasers to photocopy and use the entire manual with their own clients or patients.

- The Anger Management Programme that is utilized in correctional facilities in England, was obtained from their Head Office.

Both these programmes were not suitable for South African correctional facilities, however, as they were designed for prisoners with an extensive educational background (at least Grade 12, fluency in English and literate) because many of the modules involve self-study, writing and reading.

The literature review only provided outlines and limited information regarding other available treatment programmes from Canada and America. The researcher found that although researchers often indicated the aspects investigated and results obtained, they rarely indicated what their programmes looked like and what their manuals contained. However, it was clear that the programmes available required offenders to have a certain

level of education, and be literate, which would create serious difficulties in South African prisons if no adjustments were made.

The researcher also discovered that countries differ in their prevailing psychotherapeutic frames of reference. Frenken (1999) indicates that Britain, the northern, Dutch-speaking part of Belgium and The Netherlands have a reasonably long cognitive/behavioural tradition, while in France, Switzerland, Austria, Italy, Spain and Scandinavia, the psychodynamic tradition prevails and Germany follows a more eclectic approach.

Marshall et al. (1999), Marshall and Eccles (1991) and Somander (1995) maintain that cognitive behavioural programmes with sex offenders seem to have the best long-term results. Prendergast (1991) and Somander (1995), however, argue that psychotherapy alone does not work to produce safe, healthy and, above all, happy individuals. Somander (1995) also argues that the overriding treatment for sexual offenders should be psychotherapy, which includes psychoanalytically focused treatment as well as behaviour modification and cognitive therapy. This implies that a combination of modalities is necessary.

Prendergast (1991) adopted a holistic approach to deal with the whole person, namely body, mind and social being of the offender. For him, the holistic approach includes group psychotherapy, sex education, social skills training, anger management, relapse prevention, vocational education, substance abuse training and aftercare. Somander (1995) and Marshall et al. (1999) also followed a similar holistic approach.

Marshall and Eccles (1991) found that programmes with sex offenders produce the best long-term results when they include components of relapse prevention and where there is an emphasis on relationships rather than sexual problems. Guy (1991) noted that the most success is achieved with structured programmes where each of the offender's major problem areas is addressed.

Marshall et al. (1999) focus on self-esteem, cognitive distortions, empathy, intimacy or loneliness, attachment styles and sexual and non-sexual fantasies and preferences and relapse prevention, which they consider offence- specific. They utilize other specialists to do anger management, living without violence, parenting skills and cognitive skills (including problem solving), which they consider offence-related. They also emphasize taking of responsibility, stating clearly that one of the implications of accepting responsibility for having committed a sexual offence is that the behaviour of the offender must be integrated with the offender's self-concept.

Based on the above research, the researcher decided to structure a treatment programme to focus on specific components that were identified by international experts. Accordingly, the researcher adopted a holistic and modular approach in developing a treatment programme for convicted rapists and furthermore combined cognitive inputs with a psychodynamic approach in line with the Kia Marama Programme for sexual offenders (Neilson, 1990). The different components would be dealt with in a modular manner, thereby including aspects such as attitudes and behaviour, thinking skills, self-esteem, developing social skills, education regarding own sexuality, alcohol and substance abuse, taking responsibility for one's own behaviour, anger and stress management and victim empathy. Cull (1992), Marshall et al. (1999), Prendergast (1991), Somander (1995) and Steen (1995) also found this approach valuable for sexual offenders.

The researcher structured the treatment programme in the following manner:

Module 1: Cognitive restructuring

This module consists mainly of the "Steps to Excellence for Personal Success" (S.T.E.P.S., 1997), which is a new and simplified version of the Investment in Excellence Programme (IIE). The IIE is a non-traditional education curriculum that teaches skills that release individual and/or group potential by changing old habits, attitudes and beliefs, thereby bringing about lasting change. The IIE

programme was piloted in 1996 and since 2000 has been presented successfully to more than 8 900 prisoners and 7 450 correctional officials. The results of the IIE programme were very positive as it improved self-image, self-confidence, self-knowledge, feelings of self-worth, insight and motivation, increased self-discipline, which led to acceptance of circumstances, increased tolerance, changed attitude and outlook on life, changed thinking and perceptions and changed communication. The researcher anticipated that the offenders would benefit from the newer version, S.T.E.P.S. programme, because it is a simplified version and does not require people to be literate in order to utilize the material.

Module 2: Interpersonal and social skills

This module deals with self-awareness, building trust and exploring emotions to train the rapists in the skills necessary to be assertive, express their feelings, overcome anxiety, improve communication and enhance their self-esteem. Self-awareness helps people become aware of their own personal style of interacting with their environment and with others. With an awareness of how they behave, think and feel, they have a choice to continue as before or do things differently. Self-esteem as a focus area is seen as an important part of adaptive functioning (Marshall et al., 1999). Sexual offenders very often have low self-esteem (Marshall & Hambley, 1996). Creating a particular therapeutic context that enhances a sense of self-worth is therefore an essential first step in the process (Marshall, 1996) because it influences the way self-thoughts are organized and what aspect of the self will be the most salient in particular circumstances. Marshall (1996) states further that enhancing the self-esteem of sex offenders has several benefits as it facilitates their effective treatment, reduces risk factors, lowers the chances of experiencing emotional distress and negative affect, enables them not to easily give up adherence to a preventive programme and prevents them from blaming others for their failures.

Many offenders never had opportunities to interact with others in a healthy safe environment therefore this module was designed to teach them what many non-offenders take for granted, such as the capacity to recognize what they want and to know how to go about getting it appropriately and without risk to others. In this module they also learn to solve conflicts effectively, to be rewarding and supportive of one another, how to develop intimacy and improve their communication skills and emotional expressive capabilities. Sexual offenders have a greater feeling of loneliness than other members of the community and may therefore seek out feelings of closeness through sex even to the extent of forcing sexual interactions with victims (Marshall & Hambley, 1996).

Module 3: Anger management

Cull (1992) indicates that many offences are the result of inappropriate expression of anger. To suppress one's anger is as potentially damaging as is the expression, verbally and/or physically, of aggression because angry people often vent their feelings inappropriately and irrationally. This module helps the offender to understand the basis of his anger and to employ appropriate means of self-expression prior to the anger being overwhelming and out of control. Conflict resolution skills are rehearsed in role-play while opportunities to implement these new skills are presented throughout the treatment programme as well as the process of living in a prison environment.

Module 4: Sex education

This module covers aspects such as differences between men and women, violence against women and HIV/AIDS. The focus is on a range of acceptable behaviours, modification of inappropriate sexual attitudes, gender sensitivity and understanding the full variety of needs which sex typically meets.

Module 5: Recreation

The module engages participants in mutually enjoyable activities, hobbies and/or leisure pursuits.

Module 6: Substance abuse

This module deals with problems with alcohol and drugs, life skills, et cetera. The alcohol and drug awareness module indicates the part played by alcohol and/or drugs in committing the offence and how it affects a person's lifestyle. The model on human sexuality discusses attitudes and beliefs. An offender may typically attempt to justify his behaviour by distorting his beliefs about the events leading to the offence, about his perception of women and of his victim's part in the offence. These cognitive distortions are challenged and the offender's assumption of responsibility for his behaviour is the goal. Issues relating to gender roles and attitudes towards women are also covered.

Module 7: Victim empathy

This module focuses on the training of rapists to develop empathy for their victims and/or potential victims. Mayer (1988 as in Mackinnon & Njaa, 1995, p. 22 as well as Marshall et al., 1999) indicated that sex offenders are lacking in empathetic responses. The latter also argued that the fact that sexual offenders have difficulties in empathizing with others might be linked to general problems in social competence. Therefore, the rapists were also helped to confront the trauma suffered by victims. This module's focus is to bring home to the rapists the full implications of their behaviour upon their victims. The long- and short-term consequences are spelt out in order to replace the focus from themselves to others.

Sexual offenders often misperceive their victim's behaviour and that is why victim empathy was included in the programme. Rapists often claim that their victim led them on and simply changed her mind either at the last minute or after the fact (Marshall et al., 1999). What is clear is that sexual offenders misperceive/misread women's cues, therefore they perceive the women as not being distressed when the victim does not respond or see it as enjoyment of sexual assault, or it matches their fantasies. In this research it was considered an important aspect in the treatment process, as therapists have to be constantly providing feedback to these clients about the inappropriateness of their attitudes and perceptions (Marshall et al., 1999).

Module 8: Stress management

The aim is to reduce the amount of stress in their lives and teach them how to deal effectively with stress they cannot avoid. This module focuses on how the body is affected by stress and what to do to lessen the degree of stress and its negative effect. A variety of relaxation skills are taught, with the participants being encouraged to practise and focus on those that suit them best.

Module 9: Relapse prevention

This module assists them to identify high-risk situations and teaches them how to avoid these and strategies for coping effectively if and when they do occur. The Report of the Working Group Sex Offender Treatment Review (1990) as well as Marshall and Eccles (1991) indicate that the most promising approaches are those that include relapse prevention components.

3.10 CONCLUSION

The increasing number of convicted rapists and the public outcry for rehabilitation programmes for rapists emphasized an urgent need to develop a treatment programme for

rapists, as no treatment programme for rapists is available in the Department of Correctional Services yet. As rehabilitation and treatment both deal with a process, it fell directly within the scope of this research, which also deals with human processes.

It is acknowledged that treatment programmes to rehabilitate or treat rapists especially in a prison context are controversial and might have shortcomings and/or limited effectiveness. However, the aim of this study was to bring about change and to rehabilitate rapists to assist them to lead law-abiding lives in the community after release from prison. Various treatment approaches have shown some success with sexual offenders (Report of the Working Group Sex Offender Treatment Review, 1990). Most research found that treatment programmes for sexual offenders that include a combination of cognitive and psychotherapy modalities and follow a holistic approach have the most success (Marshall et al., 1999; Marshall & Eccles, 1991; Prendergast, 1991; Somander, 1995). The researcher used these research findings to develop a treatment programme for rapists in a unique South African prison environment according to a modular approach. Therapeutic involvement with the rapists was therefore seen as essentially preventative, to bring about change and instil a sense of self-worth so that they can rebuild their lives in a constructive and socially acceptable manner (Marshall et al., 1999) for the benefit of themselves, the victims, society and the government.

Expectations regarding the effectiveness and success of the treatment programme need to be balanced against the fact that most researchers agree that sex offenders, especially rapists, cannot be cured, but can learn to control and take responsibility for their own offending behaviour (Cull, 1992; Evans & Gallichio, 1991; Report of the Working Group Sex Offender Treatment Review, 1990).

This study was new and had never been done in South Africa before. It was an attempt to try and solve specific problems not only in correctional facilities, but also in the community and other institutions that have non-incarcerated persons with similar problems.