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SEXUAL DISORDERS (G DWYER, SECTION EDITOR)

Psychological Treatment of the Paraphilias: a Review and an Appraisal of Effectiveness

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Abstract Initially, this paper notes that treatment for the paraphilias has been most thoroughly described and evaluated within the context of treating sex offenders (i.e., child molesters, rapists, and exhibitionists). We note that the literature does not always carefully distinguish "pedophiles" from other child molesters and that rapists are often identified as having a "Not Otherwise Specified" paraphilia. Both these practices appear problematic. We then outline current approaches to the treatment of sex offenders which have typically been seen as relevant to dealing with all types of paraphilias. The historical emergence of sex offender treatment is noted, leading to an outline of current approaches that address known problematic issues by employing established procedures and by delivering treatment in an empirically based manner. We conclude with a description of evaluations of the effectiveness of these treatment approaches which indicate overall positive outcomes.

Keywords Paraphilias · Child molesters · Rapists · Treatment · Good Lives Model · Motivational Interviewing

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Introduction

In this paper, we first consider the meaning attached to the diagnostic and statistical manual of mental disorders (DSM) diagnoses of paraphilias where we note that many clinicians and researchers use these terms without due regard for DSM criteria. We attempt to set this controversy aside by using, where relevant, less precise terms such as "child molester" and "rapist." This allows us to consider problematic sexual behaviors such as rape that do not appear in DSM.

However, the primary focus will be on the provision of treatment for this complex array of disorders where we will begin with a brief historical survey. We then consider the major factors that brought treatment into its modern form, followed by a more detailed account of current treatment and its effects.

The term "paraphilia" covers a range of disorders that are characterized by unusual sexual interests. These disorders are collectively said to involve "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" [1, p. 685] Given the diversity of these problems and their range of harmfulness (e.g., molestation of children, sadistic acts, fetishisms, peeping, and obscene phone calls) as well as their variable incidence, it is perhaps not surprising that some have received extensive attention while others have not. This is particularly true concerning the application of treatment. Accordingly, we will limit our primary focus to those paraphilias (a) that involve the infliction of harm to others and (b) that have received sufficient attention in the treatment literature. This is not to dismiss the importance of other paraphilias to the person so afflicted or to others who may be offended by the behaviors. Clearly, all the paraphilias deserve attention but, to date, the treatment literature is limited on all but a few. Interestingly, however, those paraphilias that have received the least

attention in the treatment literature, when treatment has been implemented—it has in most cases—followed programs developed for the more problematic disorders [2••, 3••]. Whether this is wise or not, the focus of the present paper may provide readers with suggestions for the treatment of the relatively neglected paraphilias. We will focus on the treatment of the following disorders: pedophilia, exhibitionism, and sexual sadism. We will also include the sexual assault of adults (i.e., rape and frotteurism) although rape has not yet been accepted by the architects of the DSM as a paraphilia. Those clinicians working with rapists, and particularly those involved in Sexually Violent Predator (SVP) programs, have adopted the "Not Otherwise Specified" diagnosis for these offenders. We have serious reservations about this practice although we understand the dilemma clinicians face in dealing with rapists.

In what follows, we will outline an overall approach to the treatment with comments about specific disorders where relevant. We will also for the most part set aside concerns about distinctions between commonly used descriptors and the diagnostically correct terms. Our use of less rigorous terminology derives from the characteristic failure of authors to adhere to DSM labels. For example, in reports of treatment programs for men who sexually abuse children, a distinction is rarely made between those who meet criteria for pedophilia and those who do not. When such distinctions are made, the same treatment program is typically applied to all these offenders (including rapists and frotteurs) and there does not appear to be a differential outcome as a result of treatment [4, 5••].

Historical Approaches to Treatment

While there were some descriptions of treatment for various paraphilias prior to the mid-twentieth century [6], modern approaches began in the 1960s, primarily at the Institute of Psychiatry in London (and its associated hospitals, the Maudsley and Bethlem Royal) under the direction of psychiatrists Isaac Marks, Malcolm Gelder, and John Bancroft and the psychologist Stanley Rachman. These initial approaches were limited to attempts to extinguish sexual arousal to the associated deviant interests. While these were reported to be successful, success was defined in limited terms (i.e., changes in arousal responses at phallometric assessments), and it soon became apparent that these deviant interests were associated with a range of other deficits that limited the client's capacity to meet his needs in prosocial ways. Accordingly, treatment was expanded to include an ever increasing range of these (assumed to be related) other problems [7, 8]. Unfortunately these expanded programs were not based on clear evidence of either the existence of these additional problems or their relationship to the risk of recurrence of the problematic behavior. Treatment designers based their decisions to expand the range of targets on their clinical experience or on newly generated research indicating differences between sex offenders and matched comparison groups. As was revealed many years later, many of the features addressed in these early expanded programs were unrelated to the likelihood of relapse and as a result were (or at least should have been) dropped from treatment. We will come back to this issue a bit later.

By the early 1980s, treatment for the paraphilic disorders and associated problematic sexual behaviors had become quite comprehensive targeting, among other issues, sexual interests, associated attitudes, beliefs and other distorted ideas, lack of empathy, inadequate coping, and deficits in various social skills. Such "comprehensive" programs came to be accepted as the standard approach. In 1982, Janice Marques introduced to the sexual offender treatment field, ideas derived from Alan Marlatt's [9] relapse prevention approach to the treatment of addictive behaviors. Marques [10] suggested that the addition of a relapse prevention (RP) component would strengthen treatment, and she persuaded the California Legislature to fund a long-term study of the value of this approach. While RP was immediately received as the new way forward by almost all programs across the USA and elsewhere, evidence on its utility awaited the outcome of Marques' well-designed study. Unfortunately for its enthusiastic practitioners, RP was found to have no effect in reducing subsequent reoffending in a large sample of treated offenders [11]. For some authors [12], these results sounded the death knell of RP, but others [13] claimed that there were valuable elements of RP that should be retained. However, Marques et al.'s results are interpreted; RP has become, at most, a final add-on supplement to the majority of current treatment programs.

In the latter part of the twentieth century, and the early years of the twenty-first century, there emerged three new lines of approach to the treatment of offenders, and as a consequence for most, if not all, paraphilic disorders [2••, 3••]. The first of these was described by Andrews and his colleagues, the details of which are summarized by Bonta and Wormith [14]. As a result of a series of meta-analyses, Andrews discerned three principles that guided effective treatment for all types of offenders, and these principles were confirmed [15] as applying to the treatment of sex offenders. Andrews' three principles were Risk, Need, and Responsivity. Briefly, the Risk Principle indicates that resources should be distributed according to the offenders' level of risk to reoffend: high risk offenders should be given more intensive and extensive treatment while lower risk offenders should receive more limited programs. The Need Principle directs the focus of treatment to those potentially changeable deficits that are known to predict reoffending while the Responsivity Principle addresses the way in which treatment is implemented. When treatment is delivered by warm, empathic, and nonjudgmental therapists who employ social learning principles (e.g., model and reward prosocial attitudes and behaviors) and adjust treatment to the unique

features of each client, then the Responsivity Principle is said to be met.

The second influence that changed approaches to treating sex offenders was Motivational Interviewing (MI) [16•]. This approach is intended to build clients' enthusiasm for and commitment to treatment. This is important because people with deviant sexual interests and behaviors characteristically lack motivation for treatment [17]. MI directs treatment providers to adopt a therapeutic style (e.g., warm, empathic, respectful, collaborative, and encouraging) that will produce a bond between clients and their therapists and result in greater commitment by the clients to the treatment program.

Consistent with these innovations, Ward [18•] introduced to the field of treatment his Good Lives Model (GLM). The GLM proposes that sex offenders seek to satisfy the same needs as do others but, due to skill deficits, they seek to meet these needs in inappropriate ways. Ward suggests that rather than focus exclusively on paraphilics' deficits, treatment should attempt to build skills and instill attitudes that facilitate the attainment of life fulfilling goals. The GLM draws from, and is in harmony with, recent developments in so-called "positive psychology" [19] where the focus is on strengthening the positive features of clients as a way to overcome problems. Clearly, these recent approaches (i.e., MI and the GLM) contrast with earlier claims [20] that sex offenders must be aggressively confronted about their distorted views and problematic behaviors.

Finally, there has been a relatively recent focus on risk assessment [21]. Initially, risk assessments focused on past behavior as a basis for identifying risk to relapse but the historical features that entered these analyses were unchangeable. Fortunately, researchers began to examine features that were, at least potentially, amenable to change and that might also predict future risk. These features were described as "dynamic risks." In the field of sex offending, Hanson and his colleagues [22, 23] identified the dynamic risk factors that allowed treatment providers to focus attention on reducing these problems and on building strengths that would counter these risks.

As a result of these various developments, the treatment of sex offenders, and by implication the treatment of all paraphilic behaviors, was provided with a new agenda. Treatment was to be delivered in a compassionate, warm, and empathic manner, where the client would be treated respectfully and encouraged for movement in the appropriate direction (i.e., follow the MI model). The targets of treatment would include the identified dynamic risk factors and would build clients' strengths and inculcate skills and attitudes that would increase their opportunities to meet a broad range of prosocial needs (i.e., the goals of the GLM). In order to illustrate these recent developments, we will follow the outline of a program we operate in Canadian federal prisons [5••] although we have also applied this approach, with some modifications, to the treatment of community-based adult and juvenile sex offenders.

Current Treatment Programs

Targets of Treatment

As we have shown, research has identified dynamic risk factors that have been shown to predict reoffending (i.e., relapse) and that are potentially modifiable [24]. There are other predictors of reoffending, but these "static" factors are derived from unchangeable features of the offenders' history and as a result cannot enter as a target of treatment.

Dynamic risks come in two forms: (1) stable factors which reflect enduring problems and (2) acute factors that arise in the offender's life prior to the onset of offending. While both these sets of factors may be targets of treatment, the stable factors should all be addressed with the acute factors being somewhat more relevant to posttreatment supervision and support. The stable factors that need to be addressed in treatment include the following: insecure attachments, lack of intimacy, emotional loneliness, poor self-regulation, sexual preoccupation, deviant sexual interests, emotional congruence with children, lack of concern for others, attitudes supportive of sexual offending, and hostility toward women. Some of these features are more relevant to child molesters while others are more often evident in rapists. It appears likely that sexual sadists will have exaggerations of the dynamic factors relevant to rapists although their deviant interests focus more on the exercise of power as well as the humiliation and torture of their victims [25]. To date, researchers have not examined dynamic factors relevant to persons who commit other sex offending behaviors (e.g., exhibiting, frotteurism, voyeurism, or any of the non-offending sexual behaviors such as fetishisms or transvetic fetishisms). In Laws and O'Donohue's [2••, 3••] excellent edited books on sexual deviants, the authors of the chapters appear to assume that the targets of treatment for all these problems should be the same as those relevant to rapists and child molesters. No doubt, the absence of evidence on the risk factors for most of deviant sexual behaviors is what led these authors to make this unfounded assumption.

In addressing the various dynamic risks, treatment providers have developed specific procedures aimed at modifying each of these features. However, the evidence in support of the effectiveness of most of these procedures is, with few exceptions, either not strong or simply absent. Nevertheless, the total package of common procedures has been shown to produce the hoped-for changes [26]. However, it is not just the implementation of procedures to change the targets of treatment that produces effectiveness; the way in which treatment is delivered is the more critical factor in reducing long-term relapses [27].

Treatment Delivery

In the broader clinical literature, there has for many years been a focus on the role of the therapist in the delivery of treatment for various Axis 1 and Axis 2 disorders [28]. There have been three aspects to this research: features of the therapist's style, the therapeutic alliance, and the climate of treatment groups. While the therapeutic alliance (i.e., the relationship between therapist and client) is the key aspect of both individual and group therapy, the quality of this alliance derives from aspects of the therapist's style as does the group climate. Norcross [29] has summarized years of research and has shown that the therapeutic alliance accounts for some 25 to 30 % of the benefits derived from treatment.

Reports from sex offenders indicate that they derive the greatest benefits from therapists who are warm, empathic, nonjudgmental, and supportive [30]. In their extensive examination of the features of therapists that predicted success in sex offender programs, Marshall and his colleagues [31] demonstrated that in excess of 30 % of the beneficial changes were explained by characteristics of the therapist. Treatment providers who were warm, empathic, and are rewarding, and who offered some guidance to the offenders, produced the greatest positive changes. Therapists who took an aggressively confrontational style had negative effects on their clients. Beech and his colleagues [32, 33] examined the group climate in 19 sex offender treatment programs. They found that groups characterized by cohesiveness (all members working together and supporting one another) and expressiveness (all members participating in expressing their views and emotions) were by far the most effective.

In summary, then, it is clear that when therapists working with sex offenders are warm, empathic, nonjudgmental, and rewarding, they not only generate an appropriate group climate, they also maximize the benefits the clients receive from treatment. While cognitive behavior therapy has been the most popular approach to treating sex offenders and other paraphilics, it appears that so long as the appropriate issues are targeted (i.e., dynamic risk factors) and treatment is delivered in a demonstrably effective way, the theoretical orientation of the program contributes little if anything to effectiveness [27].

Effects of Treatment

Unfortunately, there are only few available reports of treatment effectiveness with the non-offending paraphilias [2••, 3••]. With sex offenders, there are now available several meta-analyses of treatment outcome involving over 100 reports and in excess of 30,000 clients [15, 34–36, 37•]. Overall, these reports reveal significant reductions in reoffending over long-term follow-up. Of course, not all programs entering these appraisals were effective but clearly many were. Programs that adhere to the effective features described earlier (i.e., programs that target dynamic risk factors, use appropriate procedures to change these risks, and deliver treatment in a warm, empathic, and rewarding way) appear to be the ones most likely to maximize effectiveness.

The programs we have operated in federal prisons and in a community clinic over the past 40 years have been subjected to independent appraisals. These programs operate as a group therapy and are characterized by the effective features noted above. Our community-based program comparing treated offenders with matched untreated offenders significantly reduced long-term recidivism for nonfamilial child molesters and incest offenders [38]. Our program for exhibitionists [39] has been shown to be effective as has our prison-based treatment approach for rapists and child molesters. For this latter program, we have followed 535 treated sex offenders (nonfamilial child molesters, incest offenders, and rapist) for 8.5 years [40]. Just over 5 % of treated clients re-offended compared with an expected rate (derived from static risk assessment measures) of 23.8 %.

Conclusions

Overall, it is clear that so long as sex offender treatment programs adhere to established principles, their effects will be positive and numerous people who might otherwise be victimized by these men will be saved from suffering at their hands. While it is not so clear that people with other problematic sexual interests will respond to similar treatment programs, the results with sex offenders does encourage optimism about the potential to help them live more satisfying lives.

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Compliance with Ethics Guidelines

Conflict of Interest William L. Marshall and Liam E. Marshall declare that they have no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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