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## **Psychological treatment of problematic sexual interests: cross-country comparison**

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# **Psychological treatment of problematic sexual interests: cross-country comparison**

## *Abstract*

This paper reviews the use of psychotherapeutic approaches to treat individuals who have committed sex crimes and/or have problematic sexual interests (PSI); including types of psychotherapy used, descriptions of preventive and reintegration programs and highlighting specific theoretical controversies. In the second part, experts from Canada, Czech Republic, Russia, United Kingdom, and the United States, who participated in an International Consensus Meeting held in Prague (2017), summarize treatment programs in their countries. The comparison revealed some general findings: each country has variability between its own programs; most countries have different programs for people who are in custody and who are in the community; the state-directed treatment programs are primarily focused on criminal individuals while non-criminal individuals are treated in preventive programs and/or in special clinics or are non-treated; the presence of PSI in patients/clients is acknowledged in most programs, although specific programs exclusively for individuals with PSI rarely exist. Studies on effectiveness are difficult to compare due to methodologic, political and cultural differences. Further communication between more countries to share knowledge about successful treatments and preventive approaches is needed, especially enhanced international collaboration between researchers and clinicians to verify the effectiveness of current clinical and experimental programs.

Keywords: psychotherapy; problematic sexual interest; sexual offence; treatment; cross-cultural; paraphilia

## **Introduction**

Psychotherapeutic and psychosocial interventions are an integral part of treatment for individuals with problematic sexual interests (PSI). Worldwide, they are often used in parallel to biological treatments such as pharmacological agents (Thibaut et al., 2010). Paraphilias are defined as “any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners” (APA, 2013). PSI is a broader term and includes paraphilic disorders as well as non-sexually motivated sex crimes. The majority of international treatment guidelines and health/public care systems are based solely on experiences from the management of men convicted of sexual offences involving women and children. Several theoretical approaches have influenced current treatment programs for individuals convicted of sexual crimes (reviewed in Marshall & Marshall, 2015): 1) Risk, need and responsivity principles (R-N-R principles; Andrews & Bonta, 1998) are often applied. The Risk principle asserts that criminal behavior may be anticipated and treatment should focus on the highest risk offenders. The services should be tailored to match the individual person’s estimated risk of reoffence. The Need Principle highlights the importance of criminogenic needs in the design and delivery of treatment. The Responsivity Principle emphasizes the importance of constructing treatment plans and interventions that match the client’s learning style and abilities; 2) Motivational Interviewing (Miller & Rollnik, 2002) can increase a patient’s motivation and commitment to treatment; especially if it is provided in a warm, empathic, non-judgemental, respectful, and encouraging therapeutic manner; 3) Dynamic risks (Hanson & Harris, 2000) of an individual highlight specific treatment targets (e.g. insecure attachment, problems with intimacy, poor self-regulation, sexual preoccupations, problematic sexual interests, emotional deficits, empathy deficits, attitudes supporting sexual offending and hostility towards women, children or other targeted populations). Treatment programs based on “relapse-prevention”, while still in existence, have become less widely used after they were found to be ineffective (reviewed in Fedoroff & Marshall, 2010). In Canada, where some locations have limited or eliminated the use of relapse prevention approaches, the “Good Lives Model” (GLM) (Ward, 2002) has largely emerged as the replacement.

Historically, many psychotherapeutic approaches were conceptualized as management of paraphilic interests as opposed to treatment. Psychoanalytic approaches began in parallel to the development of behavioral therapies, which were replaced by cognitive-behavioral and modified psychodynamic oriented treatments. Relapse Prevention programs were in turn

replaced by more positive psychology-oriented models like the GLM (Marshall & Marshall, 2015).

The therapeutic approaches of individual and group therapy have been used with individuals experiencing a variety of personal concerns (sexual and non-sexual), with little empirical evidence comparing their efficacy. Some studies have reported no differences (e.g. Looman, Abracen & Di Fazio, 2014).. Group therapy is said to allow individuals to overcome isolation, increase social and communication skills, and facilitate emotional connections. Groups offer the opportunity of positive role modelling, and assists patients to overcome feelings of shame (Frost, Ware & Boer, 2009).

A prominent form of therapy used in Europe and the US in the treatment of individuals convicted of sexual crimes is cognitive behavioral therapy (CBT). This approach aims to change behavior by identifying thoughts and emotions associated with maladaptive and dysfunctional behavior. CBT specifically focuses on decreasing problematic arousal, increasing victim empathy, improving emotional management, better impulse control, addressing cognitive distortions, relapse prevention and family therapy. It uses techniques like covert sensitisation, verbal and masturbatory satiation, imaginal desensitization and biofeedback (Thibaut et al., 2010, 2016). Although the frequency of use of a given technique varies between programs.

Reviews of studies on the efficacy of CBT treatment show a modest reduction of recidivism in adult men (Lösel & Schmucker, 2005) and adolescents (reviewed in Thibaut et al., 2016). However, the durability of the effect seems limited as studies with longer follow-up periods report small or no reduction of recidivism in comparison to control groups of non-treated individuals (Kentworthy, 2004). Nevertheless, the likelihood of recidivism reduces the longer an offender does not recidivate (Hanson et al, 2014). There is little demonstrated therapeutic benefit associated with the insight-oriented therapies (psychoanalytic or psychodynamic) (Thibaut et al., 2016).

The GLM (Ward, 2002) suggests that treatment should aim to build skills and attitudes that facilitate the attainment of life fulfilling goals rather than focus exclusively on deficits. This model has been successfully applied, mostly in North America. Recently, virtual reality was used to test the ability of patients to use coping skills in risky situations (Fromberger et al., 2018). It was suggested that neurobiofeedback mediated by interactive virtual stimuli using a brain/mind–computer interface may be a beneficial intervention (Renaud et al., 2011).

Marshall and Marshall (2012) concluded that as long as appropriate issues are targeted, the theoretical orientation of the program does not contribute much to its effectiveness. The climate of the treatment group (with cohesive, cooperating groups being most effective), therapeutic style (warm, supporting and non-judgemental having better results) and good therapeutic alliance are more important than the theoretical foundation. Furthermore, the motivation for treatment is crucial for efficacy (Gordon & Grubin, 2004) and therefore, it matters if the applied program is voluntary or mandatory (e.g. treatment is often part of a custodial sentence which decreases its efficacy due to the fact that the individuals may have no interest in being there).

The lack of empirically validated etiological theories about PSI and sexual crimes and their relationship to psychotherapeutic approaches is problematic. In addition, attention only to the English-language literature limits access to the full range of therapeutic practices. Treatment developments and demonstrations of effectiveness from other parts of the world should be considered.

### **Reintegration and prevention**

The importance of “important others” (important people in the lives of the individual of interest, such as family or friends) is often highlighted in relation to reintegration and prevention. Their inclusion in treatment programs is promoted to deal with specific problems with social reintegration following a conviction (Brankley, Monson & Seto, 2017). Restoring functional social support networks of individuals through involvement of family, friends and especially romantic partners (if present) greatly decreases the risk of recidivism (Schmucker & Losel, 2015). However, there are also problematic factors (e.g. an avoidant or negative relationship with the patient, low motivation, and difficulties getting to therapy). About half of the institutional, and a majority of the community programs in the US involve a patient’s important others, but this is often limited only to psychoeducation. Less than a third of programs offer other kinds of therapy (McGrath et al., 2010). Occasionally, families and couples might be offered systemic family/couple therapy or perhaps are invited to become involved in support groups. The combination of CBT and family therapy (Multisystemic treatment) has shown promising results in adolescents (Thibaut et al., 2016). The most successful way to address external factors related to reintegration is involvement of concerned others in community-based support programs (like Circles of Support and Accountability, CoSA; reviewed in Azoulay et al., in press).

It has been repeatedly asserted that not all individuals convicted of sexual crimes suffer from paraphilias and not all individuals with paraphilic interests ever commit criminal offences (Thibaut et al., 2010). Psychotherapy intervention vary for the treatment needs of people who have committed offences and those who have not. Fear of arrest, the stigma of being labelled a potential threat to society, fear of receiving a psychiatric diagnoses, and the side-effects of pharmacologic treatments often discourage self-identified non-criminal individuals from seeking treatment from specialists. This is important since population surveys indicate that the prevalence of people with PSI is higher than estimated.

In a representative Canadian sample, Joyal and Carpentier (2016) reported relatively high prevalence of interest in acting on paraphilic interests (e.g. voyeurism: 46.3 %; frotteurism: 26.7 %; sadism: 7.1 %; sex with children: 0.6 %). In the Czech Republic, a representative sample of 24.9 % men reported having preference for non-consensual sexual activities (including voyeurism, toucherism/frotteurism, exhibitionism, stranger rape, immobilization and sadism) (Androvičová et al., 2018). Pedophilic and hebephilic behavioral patterns were acknowledged in 1 % and 4.4 % of a sample, respectively (Klapilová et al., 2017). Despite these facts, preventive/supportive programs for these individuals are rare. The impressive results of preventive projects for self-identified pedo/hebephilic individuals (e.g. Dunkelfeld Project in Germany, Beier et al., 2009) are inspiring. See Knack et al., in this special issue, for more information on primary prevention initiatives underway in Canada and other countries.

### **Specific issues and controversies in the psychotherapy of paraphilias**

The majority of treatment programs are generically designed to treat all individuals convicted of sexual crimes (regardless of the specific diagnoses or criminal behaviors). Programs designed for individuals with a specific paraphilic interest are rare so it is difficult to demonstrate their efficacy for each individual paraphilia or sex crime (Marshall & Marshall, 2015). Nevertheless, some authors advocate for specific treatments for people with paraphilic interest together with the incorporation of specific departments, programs and health/social care systems (Weiss, 2017)..

There are distinct differences in types of sexual crimes, with men who commit rape having different behavioral patterns and cognitive distortions than criminal sexual sadists (in DSM 5, some “rapists” belong to “Other specified paraphilic disorder”, other individuals who commit sexual assault would not be considered for a paraphilic diagnosis ) (Freund, Seto &

Kuban, 1997). Therefore, specialists in some countries work with specific diagnoses such as pathological sexual aggression (Weiss, 2017), biastophilia, or a preferential rape pattern (Freund et al., 1997).

Some authors suggest that pedophilic preference can be understood as a sexual orientation (Seto, 2012). In the SBC, a clear distinction is made between love (orientation) and sexual interest. SBC treatment focusses on changing harmful paraphilic interests but never orientation (Fedoroff, 2018a).

The possibility of changing sexual interest over time (decrease in problematic arousal and increase in normative sexual arousal as measured by psychophysiological indicators) has been described (Muller et al., 2014; for full discussion see Cantor, 2018; Fedoroff, 2018; Cantor & Fedoroff, 2018), which contrasts with currently predominant but not sufficiently scientifically proven views of paraphilias as inborn and immutable (Thibaut et al., 2010; Weiss, 2017; Cantor, 2018). These theoretic presumptions and their application to therapy have recently been a source of many controversies. As scientific research on this topic remains insufficient, conclusions should be regarded with caution, given the possible consequences for therapeutic effectiveness and an individual's belief about the treatability of their paraphilic interest (Todzan et al., 2018).

Studies on the effectiveness of psychotherapeutic approaches have been criticised for their low methodological quality (non-existence of control groups, sample size, different follow up times, recidivism rate being the only measure of efficacy)(Marques et al., 2005; Laws, 1996). In addition, the effectiveness of treatment programs must be considered in the context of the society in which it is applied (e.g. countries differ in availability of programs for criminal/noncriminal individuals, voluntary and mandatory delivery of treatment, stigma accompanying psychiatric diagnoses, and post-treatment policy of treated individuals). As such, the pure effect of psychotherapy is difficult to determine. To optimize treatment steps, it is better to focus on local treatment programs, rather than attempting to demonstrate global treatment effects (Grønnerød et al., 2015).

### **The state of the art in different countries**

The aim of this section is to outline the current state of psychotherapeutic approaches for the management of individuals convicted of sexual crimes, and particularly those with PSI. This paper is based on the views of experts from five countries attending an *International Consensus Meeting: The Assessment and Treatment of People with Problematic Sexual Interests and Behaviors*, held in Prague in 2017. Contributors were asked to address



the following questions: the place of psychotherapy in the treatment programs, the focus on management of paraphilic interest, the voluntariness and accessibility of treatment for criminal/noncriminal individuals, the practical and theoretical orientation of treatment, the presence of preventive and reintegration programs, the contribution, if any, of experts, and studies on the effectiveness of the programs (for summary see Table 1.).

Table 1. Summary chart of factors linked to psychotherapy treatment of individuals with PSI in five countries participating at International Consensus Meeting, 2017, Prague.

	<b>United States</b>	<b>United Kingdom</b>	<b>Canada (SBC<sup>2</sup>)</b>	<b>Czech Republic</b>	<b>Russia</b>
<i><b>Criminal individuals consent for treatment</b></i>	YES (but may experience consequences if refuse treatment)	YES	YES	YES (but part of custodial sentence)	NO
<i><b>Non-criminal individuals with PSI<sup>1</sup> access to therapy</b></i>	YES (but limited)	YES (but limited)	YES	YES (but rarely used)	YES (but rarely used)
<i><b>Group therapy</b></i>	YES	YES	YES	YES	NO (used in a few isolated places)
<i><b>Individual therapy</b></i>	YES	YES	YES	YES	NO (used in a few isolated places )
<i><b>Medication</b></i>	YES (possible)	YES	YES	YES	YES
<i><b>PSI specific treatment</b></i>	YES	NO (combined with other treatments)	NO (combined with other treatments)	YES (specific departments for individuals with paraphilic disorder)	NO
<i><b>Psychotherapy type</b></i>	CBT <sup>3</sup> , GLM <sup>4</sup> , Behavioral	CBT oriented (inc. 3rd wave CBT such as mindfulness)	Modified GLM	CBT, psychodynamic	Diverse practices (hypnosis, authorial approaches)
<i><b>Concerned others involvement</b></i>	YES	Typically NO	YES	In individual cases family therapy	NO (may be used only in private practice)
<i><b>Preventive programs</b></i>	YES (few)	YES	YES	NO	NO
<i><b>Reintegration programs</b></i>	YES	YES	YES	NO	NO
<i><b>Post-treatment policy</b></i>	YES	YES (maintenance packages completed with probation)	YES (on-going with consent)	Out-patient care	Out-patient care
<i><b>Studies on recidivism rate (percentage; follow-up time in years)</b></i>	Hanson, R. K., & Morton-Bourgon (2005): 13.7%; 5 yrs  CASOMB (2008): 3.30%; 5 yrs	Mews, Di Bella & Purver (2017): 10 %; on average 8 yrs	Hanson, R. K., & Morton-Bourgon (2005): 13.7%; 5 yrs  Fedoroff, (2010): < 5%; 15 yrs	Brichcín et al. (1997): 10 %; 10yrs  Weiss (1999): 17.1 %;20 yrs	NO

Notes: <sup>1</sup> Problematic sexual interests; <sup>2</sup> The Sexual Behaviours Clinic; <sup>3</sup> Cognitive behavioural therapy; <sup>4</sup> Good Lives Models

## *United States (US)*

There is evidence that sexual offence recidivism has decreased. However, there were 904,011 registered ‘sex offenders’ in the U.S. in 2018 (*National Center for Missing and Exploited Children*. Accessed 05/30/2018). For example, in the State of Wisconsin, rates of sexual offence recidivism decreased between 1992 and 2010 by 4.2 % (going from 5.8 % to 1.5 %, respectively) (Tartar & Streveler, 2015). Some possible explanations for the decrease include: longer prison sentences, community restrictions, and more intense supervision. However, the fact that similar reductions in recidivism have occurred in countries that have not adopted the same restrictive measures as the US, make these explanations suspect. A further explanation is the possible effect of sexual offender treatment programs in reducing recidivism (Hanson, Bourgon, Helus, Hodgson, 2009). Few states have in-custody sexual offender treatment programs, however, many states require individuals convicted of sexual crimes to participate in outpatient-sexual offender treatment programs as a condition of their probation or parole. In some states (e.g. California), men who have committed sex crimes are required to participate in treatment programs certified by the state, with therapists receiving 36 hours of training specific to the assessment and treatment of these individuals (*California Sexual Offender Management Board*. Accessed 28/02/2019).

The therapeutic process begins with a comprehensive intake assessment that ensures an accurate risk assessment so that treatment planning (including the frequency of treatment sessions) can be arranged. Most programs in the US utilize the R-N-R Model (Andrews & Bonta, 1998). An integral part of treatment is determining whether the individual suffers from a paraphilic disorder whilst considering if there are other factors contributing to sexual misconduct (Ward et al., 2006). As such, client specific strategies are applied as opposed to a “one-size-fits-all” model of treatment (Fanniff & Becker, 2006). The primary therapy modality is CBT. Within the CBT framework, many programs utilize a relapse prevention model. In addition, most program target dynamics risk factors such as criminal attitudes, social skills deficits, victim empathy, emotional regulation, and substance abuse issues. Most programs utilize both individual and group therapy. Those individuals who suffer from a paraphilic disorder often participate in group treatment together with non-paraphilic members. Some programs continue to utilize behavioral interventions (e.g., olfactory aversion therapy, covert sensitization, imaginal desensitization, masturbatory reconditioning, and cognitive restructuring). In rare cases, clients are prescribed medications, but only with the

client's consent and when psychiatrists are trained on the use of medications such as SSRIs or anti-androgen medications (Codispoti, 2008; Khan et al., 2015). In addition, other modes of therapy (e.g, family therapy, substance abuse treatment, sexual compulsivity groups, and social skills training) are included in core sexual offender treatment programs. Although the use of polygraph testing is controversial, in many programs, clients are required to participate in a polygraph exam twice per year and at the outset of therapy they complete a "sexual history" polygraph to assist in therapeutic exploration of the client's reported history of offending.

In addition, individuals who committed sex crimes are required to participate in a systemic intervention model: "The Containment Model" (English, 1998). This is an interdisciplinary strategy that combines elements of treatment, supervision, monitoring, and risk management. Interventions are designed to produce behavioral changes that are supported by modifications in the client's daily lifestyle after returning to communities under some form of mandated supervision. The model is implemented on a case-by-case basis through collaboration of the various stakeholders involved (e.g. a parole agent, a law enforcement officer, inpatient and outpatient treatment providers, a medical doctor, a polygraphist, a conditional release supervisor, and in some cases, a victim advocate, and a responsible family member or friend). Together they form an understanding of the individual's patterns of sexual offending, identifying key risk factors and coordinating services (e.g., treatment, probation, etc.) to interrupt the cycle of reoffence (*California Sexual Offender Management Board*. Accessed 28/02/2019).

Very few programs in the US aim to apply primary prevention strategies to sexual offending. The main perceived obstacle facing clinicians is mandated reporting laws. For example, therapists are required to report individuals to authorities who are suspected, or admit to sexually touching a child, or viewing child pornography. The few existing programs that provide treatment to self-identified non-criminal paraphilic populations must take steps to fully disclose the legal ramifications of entering treatment and making such disclosures. This said, many individuals suffering from paraphilic disorders, who are not in the criminal justice system, still seek professional help. In some cases, these individuals are treated alongside those with sexual offence histories. For many, hearing first-hand about the consequences of arrest and incarceration can be a deterrent to committing crimes and can increase motivation to attain prosocial sexual skills. Despite an increase in self-referred individuals with paraphilic disorders, many are deterred from seeking treatment due to shame, and fear

of detection due to mandated reporting laws (J. Tabachnick, personal communication, February 18, 2019)

### *The Sexual Behaviours Clinic (SBC), Canada*

The SBC is a specialized clinic in the Integrated Forensic Program (IFP) of the Royal Ottawa Mental Health Centre within the University of Ottawa's Department of Psychiatry. While fully integrated within the IFP, which has secure assessment and rehabilitation units, the SBC treatment is intentionally maintained as a completely out-patient, voluntary program. It receives referrals from the courts, lawyers, the Children's Aid Society, probation and parole officers, physicians, and an increasing number of self-referrals (Murphy & Fedoroff, 2017). There are several clinics in Canada devoted to the assessment and treatment of individuals convicted of sexual crimes, most involving in-custody treatment (e.g. in prison). Only about a third of SBC clients are referred for assessment while they are in custody. The SBC is the only clinic that offers treatment to patients who are still before the courts and which routinely offers to continue treatment after individuals complete their probation or parole.

The SBC maintains a strict policy of conducting assessments and treatment only with the full consent of the person being evaluated. Aside from the ethical imperative for this policy, the process of obtaining informed, revocable consent models the importance of consent in the treatment of those convicted of sexual crimes. This is because sex crimes are criminal not because they involve sex but because they involve non-consent. Details of the way the SBC is organized have been described elsewhere (Fedoroff, 2010; Fedoroff, 2016; Fedoroff & Murphy, 2015; Murphy & Fedoroff, 2017; Murphy, Ranger, Stewart, Dwyer & Fedoroff, 2015). The SBC offers a full range of individualized therapies including pharmacotherapy, individual psychotherapy, couple's therapy, family therapy, and group therapy. Group psychotherapy is the most popular and is highly rated by the clients. Therapy is offered to all adults (age 18 and up) who have concerns about their sexual interests or who have been accused of having PSI or behaviors. All costs associated with psychotherapeutic interventions are covered under the provincial health care system and the clients do not have to pay. Patients with disabilities or low incomes are eligible to receive financial assistance to help them get to group sessions. Men and women seeking treatment begin with a complete psychiatric assessment and a full SBC workup that includes a battery of questionnaires, sex hormone profile, voluntary phallometric testing for men (Demidova, Murphy, Dwyer,

Klapilova & Fedoroff, in press) and occasionally, visual reaction time assessment (, and/or a polysomnographic sleep study (Booth, Fedoroff, Curry & Douglass, 2006). Research is currently underway by the SBC team on the use of vaginal photoplethysmography (VPP) for assessment of arousal in forensic female populations (Knack, Murphy, Ranger, Dwyer & Fedoroff, 2015).

The SBC offers several specific groups for its clients: 1. A group for those who wish to change their sexual interests from paraphilic disorders to non-harmful sexual interests, 2. A group for men and women who also suffer from mood and anxiety disorders, 3. A group focussing on people who were themselves sexually abused and those who identify stress as a problem in their lives (e.g. Post Traumatic Stress Disorder), 4. A group designed for friends and family members of SBC patients.

The treatment modality borrows heavily from the GLM but is eclectic and tailored to the specific needs of the client. Details about methods used are explained in Fedoroff (2010) and Murphy, Bradford & Fedoroff (2014). Importantly, none of the therapies offered in the SBC focus on past offences or on whether the person is guilty or innocent (Fedoroff & Marshall, 2014; Fedoroff, 2016). All patients are included in decision making about treatment interventions and the treatments are offered on a “trial basis”. This means that patients are empowered to suggest modifications to their treatment based on how well it is working. To date, there have been no hands-on sexual reoffences against children for men actively seeking treatment in the SBC (Murphy & Fedoroff, 2017; Fedoroff, 2018b).

### ***England and Wales, United Kingdom (UK)***

In the UK, individuals sentenced to custody for a sexual crime may be requested to complete a treatment program as part of their sentence, but this is not a mandated requirement. However, when a sentenced individual remains in the community, they may be required to complete a court ordered treatment program (Sentencing Council, 2014). They may also be released under licence conditions (a set of rules to be followed if a prisoner is released into the community with part of their sentence still to serve), such as participation in a treatment program in the community. Treatment for individuals convicted of sexual crimes in the UK is delivered primarily through Her Majesty’s Prison and Probation Service (HMPPS), rather than via health based routes, and is free of charge. HMPPS offers treatment

to those who are considered medium risk of recidivism or above; low risk individuals do not receive treatment. In order to allocate treatment, a careful analysis is conducted to assess the case-specific treatment needs, and individuals are then allocated to programs. Treatment dose is based on risk and level of need, as opposed to whether clients meet the criteria for a paraphilic disorder, meaning paraphilic and non-paraphilic clients are often part of the same treatment group. Levels of motivation and attitude to treatment are also carefully assessed. Those who are antagonist to treatment are unlikely to be placed.

The most common form of treatment for convicted individuals in the UK are group-based CBT oriented programs, originally developed for criminal individuals. In 2017, *Core Sex Offender Treatment Programs* (SOTP) were replaced by two new programs: *Horizon* (for medium risk individuals) and *Kaizen* (for high to very high risk individuals). They draw on elements of third wave CBT such as mindfulness, and are unique in that they are suitable for individuals who maintain their innocence. Prior to this, an admission of guilt was required for participation in programs. Both programs adopt a strength-based approach, where a focus on the future is pivotal to raising hopes about leading an offence-free life in the community. Participants have the opportunity to practice new skills and participate in activities designed to strengthen success in their lives. There is no requirement to talk about offending. Both programs are group-based, with some one-to-one sessions incorporated (Harman, 2017). They are facilitated by a multi-disciplinary team consisting of specially trained psychologists, prison officers, and facilitators who are managed and supervised by qualified forensic psychologists.

In some cases, clients with a paraphilia need more intense and in-depth work to help manage their interests; such clients are offered access to one-to-one programs based on CBT approaches (*Healthy Sex Program*). These individuals may also be offered pharmacological treatment, administered on a voluntary basis to prisoners in the UK, with the premise that it offers a useful adjunct to psychological therapies. The justification for this is that sexual preoccupation, has been found to be the most prevalent risk factor for reoffending (Hocken, 2014), and is not adequately addressed within psychological treatment programs administered in UK prisons (Winder et al., 2017).

As well as tertiary prevention approaches, targeted initiatives that are focussed on promoting primary and secondary prevention for individuals with concerns about their sexual

interest are on the rise in the UK. Examples include *StopItNow!*, a helpline for self-identified people with pedophilia (StopItNow, 2018), StopSO (2018), who provide a list of specially trained therapists for treatment, the Safer Living Foundation, offering free therapy for individuals concerned they may sexually offend (Safer Living Foundation, 2018) and Freedom Psychology, offering one-to-one therapy with an experienced psychologist to help individuals move towards a rewarding, offence-free life (Freedom Psychology, 2018).

There is currently limited evidence for the effectiveness of the new CBT programs for the treatment of those convicted of sexual crimes in the UK. However, the effectiveness of Core SOTP was recently reported (Mews, Di Bella & Purver, 2017). The sample comprised an experimental group participating in Core SOTP (N = 2,562), and a matched comparison group (N = 13,219). The groups were compared on a range of reoffence outcomes over an average follow-up period of eight years. Results indicated that Core SOTP was associated with little to no changes in sexual reoffending. This finding was not unexpected, as HMPPS continuously reviews the evidence base for treatment, and in 2010 began redeveloping programs in line with current evidence.

### ***Czech Republic (CR)***

Since 1976, the treatment of convicted individuals with paraphilic interests in the CR has been provided in specialized departments within mental health hospitals. Courts sentence these individuals to either outpatient or, in high-risk cases, to inpatient treatment. The treatment is free of charge to the patient and is paid for by general health insurance. Since 1998 there has also been the possibility to participate in a special treatment program during the prison term at a designated facility (Kuřim prison).

The court decides on involuntary treatment on the basis of a psychiatrist's and sexologist's recommendations; the length of treatment and therapeutic mode are also based on their expert opinion. Inpatient treatment is, as a rule, followed by treatment in outpatient sexologic departments served by trained sexologists and/or psychiatrists.

The existence of specialized departments in hospitals that focus exclusively on the therapy of convicted individuals with paraphilic interest is unique. The CR treatment programs were developed exclusively for patients with paraphilic interest (i.e. disorders of sexual interest according to ICD 10) whether criminal or non-criminal; the latter can obtain

treatment voluntarily. Individuals without paraphilias are not offered treatment by the judicial system, but they can ask for sexological or psychological help without a court order.

The treatment begins with a comprehensive sexological and psychological assessment that includes a battery of questionnaires, sex hormone profile, and voluntary penile plethysmography assessment. In sexologic departments, the multi-disciplinary team consists of specially trained psychologists, a doctor-sexologist, and social workers. Treatment programs include a combination of psychotherapy, pharmacotherapy and sociotherapy adjusted to individual cases. Group therapy is essential as it is considered to be the most effective at influencing the attitudes and behavior of a patient (Frost et al., 2009). Psychotherapy is mainly psychodynamic or CBT oriented. The paraphilic behavior is broadly discussed in the patient group, and treatment also includes increasing empathy towards the victim, development of better coping strategies, establishing insight and a sense of responsibility. Couples counselling, family therapy and substance abuse treatment is offered. Voluntary individual treatment for non-offending paraphilias is offered only in ambulatory (out-patient) sexological departments, typically connected with mental hospitals. No specific complex preventive programs are established in the CR (Weiss, 2017).

Several CR recidivism studies support the effectiveness of the comprehensive and specialized paraphilia-oriented approach: Brichcín, Hollý, Kolářský & Tsakalidou (1997) reported 10% recidivism in 316 paraphilic patients in specialized department treatment; Jirků (2014) reported 9.4 % recidivism of people with paraphilias from the special prison ward; Weiss (1999) reported 17.1 % recidivism after 20 years follow-up in 954 patients treated in years 1976-1999, which was significantly lower when compared with an 80% recidivism rate of untreated individuals convicted of sexual crime.

### ***Russia***

Sexual health care in Russia is limited despite the fact that sexology is one of the subspecialties in psychiatry. Only a small number of patients voluntarily seek help from a psychiatrist. Recent changes in the Criminal Code of Russia permits the application of compulsory medical treatment when an individual is diagnosed with pedophilia (Federal Law No. 14, 2012). Other paraphilic disorders are not directly described in the law, and justification for compulsory treatment requires a convincing argument that the person represents a serious public danger and lacks the ability to regulate his/her behavior (is acknowledged as “insane” or having “diminished responsibility”). Therapy for individuals convicted of a sexual crime without a paraphilic disorder is not provided.



Specialized treatment for people with pedophilia was not well developed in Russia when the legislation was enacted. As a result of work done by members that attended the International Consensus Meeting in Prague in 2017, training programs are now being organized, which will be led by colleagues from Canada and Germany that specialize in therapy of those with sexual convictions and paraphilic disorders. These programs will be attended by psychiatrists and sexologists from hospitals and prisons working with such patient with paraphilic sexual interests.

The majority of health professionals in Russia see paraphilias as untreatable and as “difficult to manage” disorders. Within compulsory settings the primary treatment choice is the use of medications, whereas psychotherapy is mainly available only to outpatients (Vvedenskii, Tkachenko & Kamenskov, 2014).

Even in private practice, the psychotherapeutic approach is diverse. Different psychotherapeutic approaches are discussed and applied. Examples include psychoanalytic treatment of individuals convicted of sexual crimes (Program, 2018), hypnosis (Zhitlovskii, 2007), or autosuggestion in supportive therapy (Goland, 1983). The patient is taught techniques relating to relaxation, distraction, and aversion to anomalous targets of sexual interest as well as techniques reinforcing normative sexual interest in adults. Hypnosis, suggestive programming, and modeling are used when the patient is exposed to suggestive thoughts about normal sexual intercourse. Catharsis and regressive techniques are used to address past traumatic experiences (Kocharyan, 2013).

Secondly, authorial approaches are developed, e.g. by the principle of “inverse ontogenesis” (Tkachenko et al., 2014) based on techniques of neurolinguistic programming. The first two steps involve destruction of the patterns of problematic sexual behavior and work within the emotional sphere. The third step involves role-playing (e.g. typical male or female roles) with corrective feedback offered to promote adaptability in society. The fourth step focuses on the development of substitute behavioral patterns in consenting adult sexual relationships. Russian researchers and clinicians are aware of CBT therapy and use of the R-N-R principles but they have not yet been widely applied (Tkachenko & Vvedenskii, 2017). No controlled studies of the effectiveness of psychotherapy have been conducted in Russia.

## **Conclusions**

This paper reviews the use of psychotherapeutic approaches to treat PSI as summarized by experts from Canada, CR, Russia, UK, and the US, who participated in the International Consensus Meeting held in Prague, 2017. The conference revealed that while

there clearly are differences between countries and programs, there are more similarities. In fact, each country has significant variability between its own programs. Each country has different programs for people who are in custody and who are in the community. The state-directed programs in English speaking countries are primarily focused on criminal individuals. Non-criminal individuals are mainly addressed by community based prevention programs and/or in specialized clinics (like the SBC in Canada).

In all countries (except Russia and the SBC in Canada) CBT techniques are involved. The presence of PSI in patients/clients is acknowledged and addressed in most programs, however special departments focusing solely on PSI individuals are unique to the CR. The types of expertise and training of experts differs between countries. The political and cultural differences between countries make comparisons difficult but also provide an opportunity to compare differing treatment approaches.

Participation of more countries in similar discussions and consensus meetings will assist in sharing knowledge about successful treatment approaches, and supporting new preventive and reintegration programs in countries where they are lacking. Continued international collaboration to establish and verify the effectiveness of current and new experimental programs is important. The root of the International Consensus Meeting was the drive to enhance collaboration between researchers and clinicians internationally. Such international collaboration is vital to our combined wish to prevent sexual harm and to enhance healthy, consensual, sexual relationships.

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