Treating Sexual Offenders

An Integrated Approach

William L. Marshall • Liam E. Marshall
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Preface

This book describes the treatment program for sexual offenders that we have developed over the past 36 years. Our research and clinical activities are seamless endeavors with each informing the other. The questions we have asked in research have always arisen in our clinical work, and our clinical work has then incorporated what others and we have empirically discerned.

For the purposes of this book, we will restrict our focus to the consideration of adult males who sexually offend, and within these offenders we will describe the issues surrounding men who rape adult females, men who molest children, and men who expose their genitals to unwilling adult females. Within these categories we will also discuss sexual sadists. There are, of course, many other types of sexual offenders (e.g., voyeurs, frotteurs, obscene phone-callers, necrophiles, and those who have sex with nonhuman animals); and there are young males (Barbaree, Marshall, & Hudson, 1993; Ryan & Lane, 1997) and women (Hunter & Mathews, 1997; Schwartz & Cellini, 1995) who also sexually offend. Data emerging over the past 15 years, in particular, are rapidly expanding our knowledge of juvenile (and even child) sexual offenders (Johnson, 1998; Task Force on Juvenile Sexual Offenders and Their Victims, 1996), and these data seem to indicate sufficiently different issues with these young offenders in that they require their own specialized approach to treatment (Miranda & Davis, 2002; Worling, 1998). At present, the small number of women who are identified as sexual offenders has limited our capacity to formulate soundly based treatment and assessment programs with these offenders. Whether anything we know about the characteristics of adult male sexual offenders, or their treatment, is transferable to juveniles or women who sexually offend remains open, but we are confident that continued research will reveal numerous unique features of female and juvenile sexual offenders.

The development of our approach occurred in the context of both a prison-based program as well as a community-based program. While our work in recent years has been exclusively in Canadian federal

prisons, we operated the local community program from 1969 until the workload in prisons became too much, so our colleague Dr. Tony Eccles took over the community operation in 1992. We have also worked in earlier days in a psychiatric inpatient and outpatient setting where we ran a sexual offenders program. What we describe in this book is, in our experience, equally applicable to a prison setting, a psychiatric setting, or an outpatient community-based clinic. In an outpatient clinic, far more exhibitionists will be seen than in prison, and there will likely be more frotteurs. However, our experience suggests that the program described in this book is equally applicable to these offenders and, indeed, we consider frotteurs to be essentially the same as rapists.

In our prison settings there are numerous other programs available that compliment our sexual offenders program. For example, Correctional Service of Canada provides programs such as Reasoning and Rehabilitation, Substance Abuse, Anger Management, and Parenting Skills. Reasoning and Rehabilitation aims at modifying antisocial attitudes, developing impulse-control, and enhancing effective coping skills. Were these programs not available, we would have to provide them for many of our clients. Interested readers are referred to the following appropriate resources: Reasoning and Rehabilitation (Ross, 1995), Anger Management (Hughes, 1993), Substance Abuse (Lightfoot, 1993), Parenting Skills (Carpentier, 1995).

We have made three evaluations of the long-term effectiveness of our programs, and these are described in chapter 3 under the section "Evidence of Effectiveness." At this point we simply want to note that each of these evaluations (two for our outpatient program and one for our prison program) demonstrated a clear benefit for treatment.

The scope of this book covers what we believe to be the essential features of effective treatment for sexual offenders wherever such treatment is conducted. Our intention is to illustrate to clinicians the therapeutic style, procedural aspects, and treatment targets that are necessary to effectively change these often difficult clients. Because various aspects of our program differ from the established cognitive behavioral/relapse prevention approach, we also hope this book will provide an incentive for others to try some aspects of our approach or to conduct research that will confirm or deny the value of other features of our program.

Acknowledgments

First, we wish to acknowledge the efforts of two special people. Allana Lukacz did a wonderful and careful job of searching through our files and the official records to generate our outcome data. Allana was naïve about sexual offenders and thus had no expectations of what the data might mean. She applied herself to the task with diligence and objectivity. Jean Webber's tireless and patient work typing this manuscript and proofreading for grammatical errors represented a profoundly appreciated effort. The number of hours Jean spent re-reading the manuscript and making seemingly endless changes without ever complaining or tiring reflects her remarkable character. We are deeply indebted to these two wonderful women.

Next, we want to acknowledge the contributions to our thinking by many colleagues; in particular, we would like to mention Gene Abel, Howard Barbaree, and Tony Ward whose influences on the entire field have been outstanding. Also, the past members of our staff and the many students who have worked with us have shaped our approach to working with these difficult clients.

Our publisher, Taylor & Francis, and the series editor, Michel Hersen, are due thanks for inviting us to write this book and for supporting and encouraging us throughout. In particular, contacts with Dana Bliss of Routledge/Taylor & Francis provided excellent guidance when it was needed.

Finally, we owe a debt to our many clients over the years whose courage in facing and overcoming their problems continues to earn our admiration. We learn much about ourselves by doing this work, so we thank our clients for helping us become more self-aware and hopefully better citizens.

CHAPTER 1

Description of Disorder

INTRODUCTION

With the emergence of sexual offending into the domain of public discourse, in the 1980s in particular, many people asked why these offenses were suddenly occurring at such an apparently rapidly accelerating rate. Some members of the public and the media questioned whether this was a real phenomenon or just the result of some overly zealous investigators prompted into action by the growing women's movement. Others suggested that perhaps sexual offending had increased in parallel with the social changes initiated in the late 1960s and 1970s around all issues of sexuality. Perhaps, some suggested, it was the result of relaxed rules governing the availability of pornography or the increasing explicitness of sex in films, television, and advertising. Numerous accounts of human sexuality, however, have pointed to the occurrence of rape and child molestation throughout recorded time (Forsyth, 1993; Foucault, 1978; Licht, 1932; Taylor, 1954). Greek mythology describes how the god Zeus raped many maidens often by disguising himself in some way (Servi, 1997). Disguised as a swan Zeus seduced the beautiful Leda and sired Helen, Castor, and Pollux. The infamous Marquis de Sade described, in his 18th century novels, practices that are clearly sadistic, and he was imprisoned for several years for administering cantharides (a supposed aphrodisiac) to unwitting prostitutes so that he could engage in various sexual acts with them. Baron Gilles de Rais, who fought valiantly beside Jeanne d'Arc in the 15th century, is said to have sexually molested and even murdered countless children. He was eventually hanged and burned after confessing to his crimes. By the late 19th century several authors had described an array of sexual practices, some of which are today seen as offenses (Krafft-Ebing, 1886; Moll, 1893).

Among the reports of sexual assaults made from the 1970s on, as well as in many social surveys, victims were speaking of offenses that occurred

many years earlier. When these victims were asked why they waited so long to report the assaults, they identified various reasons, such as their assumption they would not be believed, their view that the investigative and prosecutorial process would involve attacks on them and their behaviors, as well as their belief that family, friends, and even lovers would hold them responsible and reject them. Russell (1984) reported that of the cases identified in her random sample of San Francisco residents, only 2% of incest victims and 6% of the child victims of nonfamilial offenders had reported the offense to the authorities. Even more recent data reveal that sexual offending remains remarkably underreported. For example, Henry and McMahon (2000) found that 91% of cases of child sexual abuse had gone unreported, and Kilpatrick (1996) showed that 56% of women who were sexually assaulted as adults failed to report the crime. Whatever reasons silenced these victims at the time of the abuse, their reports, once confirmed, indicated two things very clearly: Sexual abuse is not a recent phenomenon, and the contemporaneous social climate serves to facilitate or inhibit reports of sexual abuse. It is now accepted that sexual abuse, in all its forms, has been an ongoing problem in all societies for all time. Changes to laws, and to the processes of investigation and prosecution of sexual abuse, appear to have made it more likely that nowadays these offenses will be reported and dealt with more effectively, although additional improvements in these processes are needed to make victims feel supported and not feel blamed when they bring forward an accusation.

FREQUENCY OF SEXUAL OFFENSES

Despite the above noted changes, it is difficult to estimate the frequency of sexual assaults, and it is all but impossible to estimate the number of offenders within any given society at any particular time. Epidemiological studies, like those done with most Axis 1 and Axis 2 disorders, are very unlikely to elicit reports from offenders that they are abusing. What such studies can do is elicit reports from victims about their abuse, although even here there are problems. It is no doubt difficult, given the continuing stigma attached to having mental illness, for people to report in surveys that they are suffering from depression, schizophrenia, or anxiety disorders. It is, however, likely to be far more difficult for most victims of sexual offending to indicate this within the context of an objective scientific survey. In fact, most published surveys of the incidence of sexual victimization have been less elegant than is demanded in an appropriate epidemiological study. Most such surveys have not attempted to obtain a demographically representative sample, and even where they have, there are no doubt many victims who would not divulge the facts of their abuse

in such a survey; many other victims might refuse to participate at all; and perhaps other individuals might, in an attention-seeking ploy, falsely report being abused.

Indeed, the issue of possible false accusations presents an unresolved problem to investigators, prosecutors, and researchers. For example, nearly half of all reported cases of child sexual abuse in the United Kingdom have been deemed "unsubstantiated" by the investigative process (Westat, 1987), but this does not mean that an offense did not take place; it simply means the investigators could not formulate a case that they believed could be pursued to prosecution. While it is difficult to believe that half of all reported cases of child sexual abuse represent false accusations, there seems to be no doubt that some, but hopefully few, reports are untrue. One aspect of the truth or falsity of accusations of sexual abuse concerns the so-called "recovered memories" of abuse. This issue has been quite divisive with those (e.g., Fredrickson, 1992; Terr, 1994) who believe that certain therapeutic processes can uncover memories of abuse that have long been forgotten, pitted against those (e.g., Kaminer, 1992; Loftus & Ketchum, 1994) who point to evidence from memory research that belies the basis of these putative recovered memories. Both sides of this debate appear intractable and tend in our view to overstate their case (see comprehensive reviews in Lynn & McConkey, 1998). Aside from the problem of "recovered memories," there is at present no way to tell which accusations are true or false other than by the gathering of credible evidence, its presentation in court, and the rendering of a judicial decision. Not surprisingly, this process can be fallible, as we have seen from recent cases where convictions were subsequently overturned. However, our view is that by far the majority of reports of sexual abuse, particularly those where the accuser is willing to endure the investigation and trial, are true reports.

Peters, Wyatt, and Finkelhor (1986) reviewed research on the prevalence of child sexual abuse and reported that between 6% and 62% of females and between 3% and 31% of males had been sexually abused as a child. These reported ranges are so broad as to be all but meaningless, although the reviewers suggest that the discrepancies are likely due to methodological features of the studies (e.g., different definitions of abuse, differing samples, questioning format). In considering the 1986 Peters et al. report, Conte (1991) rather surprisingly says that "even if one takes only the lowest estimates, it is clear that sexual abuse of children is a common experience of childhood" (p. 17). It is a bit hard to see how 6% or 3% can be construed as reflecting "a common experience." Canadian national surveys, funded by a government commission, revealed that up to one-third of males and more that 50% of females reported being

sexually abused as a child, with most of these assaults occurring before the victim had reached age 12 (Bagley, 1991).

In their examination of female college students in the United States, Koss, Gidycz, and Wisniewski (1987) found that 15% of these women said they had been raped and a further 12% said that they had thwarted an attempted rape. Russell (1984) interviewed a representative sample of Californian women and found that 44% reported having been raped. An international survey, reported by van Dijk and Mayhew (1992), revealed somewhat variable data, but across all countries (European, Asian, and North and South Pacific nations) the rates of rape were worrisomely high. In reviewing reports of the incidence of the sexual assault of adult females, Koss (1992) estimated that the true rate of rape was 6 to 10 times higher than the official records would indicate. Her estimate is consistent with the remarks of other researchers (Russell, 1984) and is based on the observation that very few women who indicate in surveys that they were raped, ever reported the offense. Marshall and Barrett (1990) extracted the number of rapes from the official records in Canada during the full year 1988. Taking a conservative stance, they then multiplied this rate by four, which produced an estimate of 75,000 adult female victims of rape for that year. This estimate, if even close to the true rate, reveals a frequency of rape that is startling: It indicates that a rape occurs in Canada every 7 minutes.

Very little has been reported about the rates of exhibitionism, but Rooth (1973) observed that this was by far the most commonly reported sexual crime. In addition, DiVasto, Kaufman, Jackson et al. (1984) noted that 30% of adult women reported that a male had illegally exposed his genitalia to them. Using an anonymous survey, Person, Terestman, Myers et al. (1989) reported that 4% of male university students said they had exposed themselves to an unwilling observer.

Person et al.'s (1989) report indicates another source of information on the rates of sexual crimes; that is, anonymous surveys asking whether the respondents themselves had committed such offenses. Employing a representative sample of U.S. citizens, Laumann, Gagnon, Michael, and Michaels (1994) found that 2.8% of adult males and 1.5% of adult females indicated that they had forced someone to have sex. Similarly in Ageton's (1983) U.S. sample of male adolescents, 10% of these young males said they had forced a female into having genital contact with them. Herman (1990) reported that between 4% and 17% of adult males indicated they had molested a child, and other researchers have found that approximately 15% of males reveal some likelihood of having sex with a child (Malamuth, 1989; McConaghy, Zamir, & Manicavasagar, 1993).

Clinicians working with sexual offenders have also provided evidence on the extent of sexual abuse. Abel, Becker, Mittelman et al. (1987)

obtained a certificate of confidentiality from U.S. law enforcement officials that guaranteed the reports of Abel's clinical subjects would not be subject to seizure by authorities. Under these conditions, many of Abel et al.'s sexual offending clients reported having committed numerous offenses additional to those for which they had been charged. The 232 offenders against children admitted to 55,250 attempts at child molestation, of which 38,727 were successfully completed; the 126 rapists reported having 882 victims; and 142 exhibitionists had exposed on 71,696 occasions. Studies using polygraphy (which, it must be said, has dubious scientific status) have similarly reported rates of offending that are far in excess of those recorded in the official records (Ahlmeyer, Heil, McKee, & English, 2000; Heil, Ahlmeyer, & Simons, 2003).

EFFECTS ON VICTIMS

The effects of sexual abuse on victims can be extensive, long lasting, and profoundly damaging to various aspects of the person's life. It is clear, however, that not all victims of sexual abuse suffer such major consequences; some experience numerous and seriously damaging sequelae, others experience some but not such severe consequences, and some victims appear to suffer few, if any, deleterious effects. In considering the evidence reviewed here, it is well to keep in mind that the nature of the sexual assault (e.g., the degree of force used, the intrusiveness of the sexual acts, the humiliating features of the abuse) and the prior or expected relationship of trust between the offender and victim are likely to be factors that modulate the victim's response. In terms of immediate outcomes, Finkelhor (1988) proposed four elements that he believed accounted for the magnitude of effects on child victims of sexual abuse. Traumatic sexualization results, so Finkelhor suggested, from premature and inaccurate learning about sex that took place during the abuse. Betrayal is greatest when the offender is someone the child previously trusted. Stigmatization follows from the child's fear of being blamed. Finally, powerlessness results from the offender's use of force and threats.

Burgess and Holstrom (1974) identified what they called the "rape trauma syndrome," which has features similar to post-traumatic stress disorder. They describe fear as the primary immediate post-assault response, which in some cases develops into full-blown phobias, panic disorders, or generalized anxiety. Flashbacks occur as do obsessional ruminations about the abuse. Various other signs of elevated emotional responding may also be evident, such as mood swings, irritability, loss of appetite, and sleep disturbances. Disturbances in sexual functioning, reduced feelings of attractiveness, withdrawal, deteriorating work

or school performance, substance use problems, and rejection of prior friends can also result from being sexually victimized (West, 1991). In particular, Burgess and Holstrom (1979) note that fewer than 40% of rape victims had sufficiently recovered within several months of the attack. Conte and Schuerman (1987) examined the responses of 369 children who had been sexually abused. They found that 27% displayed immediate consequences involving at least four problematic symptoms. Among the total group, the unfortunate immediate sequelae included loss of self-worth, emotional distress, nightmares or other sleep disturbances, aggression, and problems concentrating. These observations match other reports (Browne & Finkelhor, 1986). Longer-term effects that have been reported for child sexual abuse include eating disorders (Root & Fallon, 1988), loss of sexual responsiveness (Lindberg & Distad, 1985), problematic sexual behaviors (MacVicar, 1979; McMullen, 1987; Silbert & Pines, 1991), personality disorders (Herman & van der Kolk, 1987), and problems in emotional development (Gomes-Schwartz, Horowitz, & Sauzier, 1985).

The evidence, then, indicates that sexual offenses are likely to produce negative consequences for the victims, which in many cases will be severe and long lasting. When we combine these negative effects with the evident high occurrence of sexual offending and the countless victims involved, we can confidently declare that this is a serious social problem that requires our urgent and devoted attention. Although sexual offending has emerged from its former cloak of secrecy and denial, we still have a long way to go before we give it the attention it deserves. In our view, it is difficult to avoid the conclusion that were the victims of sexual abuse characteristically from among the privileged males of our societies, our governments would have vigorously addressed this problem long ago. Perhaps as women's voices become more powerful, and as children's rights become fully addressed, more systematic and effective processes for dealing with this blot on our societies will be established. There are many things that need to be done. Assisting, supporting, and comforting complainants through the investigation and prosecution of alleged offenses would help victims come forward, as would providing free physical and psychological support and counseling to the victims. These would seem necessary but are all too often not available.

Devoting substantially more research money to the topic, both for the victim and offender sides of the issue, is also vital if further progress is to be made. In a particularly revealing report, Goode (1994) gave details of funding provided by the U.S. National Institute of Mental Health for various problem areas. The funding sources for studies of depression in 1993 amounted to $125.3 million, while for sexual offending only $1.2 million was made available. Certainly depression causes considerable

damage to many people but so does sexual offending. A particularly ironic aspect of this imbalance in funding is that depression and various other Axis 1 and Axis 2 disorders have, as part of their etiology, the experience of being sexually victimized (Firestone & Marshall, 2003). Finally, funding treatment programs for offenders in prisons or in community programs could help reduce the incidence of future assaults by identified sexual offenders. No doubt treatment programs need to be improved but even at this time there is, as we will see, evidence that treatment of sexual offenders can have the effect of reducing the future victimization of innocent people. Such reductions in reoffense rates not only reduce harm, but they also save a considerable amount of taxpayers' dollars (Prentky & Burgess, 1990).

THE CLINICAL PICTURE

There have been essentially two ways in which sexual offenders and their problems have been described: by applying diagnoses or by simply describing the problematic features associated with the offenders. We will consider the merits of both approaches, although the present chapter will deal only with paraphilic diagnoses. Additional, or comorbid, diagnoses among sexual offenders will be discussed in chapter 5, while the problematic features of these offenders will be outlined in chapter 3.

Diagnoses

The Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association (APA) in its various incarnations has described a category of the sexual disorders called paraphilias that include some disorders relevant to sexual offending: pedophilia, sexual sadism, exhibitionism, frotteurism, voyeurism, and a catchall category labeled "paraphilias not otherwise specified [NOS]." In the latter category there is mention of some sexual crimes such as telephone scatalogia, necrophilia, and zoophilia, but no guidance is given about the criteria necessary to apply these diagnoses. Unfortunately, the DSM has not served the sexual offender field at all well and has excluded many offenders (e.g., rapists and many child molesters) who have clear problems in need of treatment. Indeed, there is no evidence available indicating that those sexual offenders who meet diagnostic criteria for a paraphilia have any more problems than those who do meet such criteria, nor does there appear to be different etiological pathways between those who do or do not have a paraphilia. Most importantly, there is no evidence of a differential

treatment response between those sexual offenders who do or do not fit into the DSM diagnostic categories. Finally, Wilson, Abracen, Picheca et al. (2003) report that a DSM-IV (APA, 1994) diagnosis of pedophilia is unrelated to subsequent recidivism.

Detailed criticisms of the relevant DSM categories of paraphilia have pointed to many problems (Marshall, 1997a, 1999, 2005a; O'Donohue, Regev, & Hagstrom, 2000), not the least of which concerns the failure of the DSM authors to demonstrate satisfactory cross-diagnostician reliability for any of the paraphilias. In fact, studies of the reliability of all DSM diagnoses have been limited, and several authors have complained about this unacceptable state of affairs (Kirk & Kutchins, 1994; Meyer, 2002; Reid, Wise, & Sutton, 1992). The only field trials of the reliability of the paraphilias conducted under the auspices of the DSM committee appeared in reference to DSM-III (APA, 1980) criteria (O'Donohue et al., 2000). Despite the fact that the criteria have changed in important ways over the subsequent revisions of the DSM, the authors of the latest versions claimed there was no need to repeat field trials because the DSM-III studies had shown the paraphilias to be reliable (see APA, 1996). This claim does not match what the early trials showed. As O'Donohue et al. (2000) note, all sexual disorders (paraphilias and dysfunctions) were collapsed in the DSM-III field trials, and although the initial kappa coefficient (the index of reliability) was sufficiently high (kappa = 0.92), the second part of the trial generated a kappa of just 0.75. There were only seven cases in the first part of the trials and only five in the second part. For decisions having important consequences, and surely deciding that someone has pedophilia or sexual sadism has very important consequences, the acceptable kappa must be at least 0.90 (Hair, Anderson, Tatham, & Black, 1998; Murphy & Davidshofer, 1995). The DSM data on the reliability of the paraphilias are clearly not acceptable.

In a particularly telling study, Levenson (2004) evaluated the reliability of various diagnoses made by two independent experienced clinicians in the preparation of their reports to courts examining whether identified sexual offenders met criteria for sexual violent predator (SVP) status. Since these diagnoses are among the required criteria for civil commitment, the diagnostic decisions are extremely important, both for the protection of the offender and the public. The diagnosis of pedophilia did best but still failed to meet satisfactory standards (kappa = 0.65). For exhibitionism the kappa was 0.36. Paraphilia NOS, it should be noted, was used in these reports to the court to identify rapists, as is common in most SVP cases (Doren, 2002), although this was definitely not the intention of the authors of the DSM. In fact, the reliability of simply diagnosing a client with any paraphilia was, in Levenson's study, just 0.47.

In two studies of the diagnosis of sexual sadism, Marshall and his colleagues (Marshall, Kennedy, & Yates, 2002; Marshall, Kennedy, Yates, & Serran, 2002) reported unacceptable levels of reliability. In the first study (Marshall, Kennedy, & Yates, 2002), they found that forensic psychiatrists in their daily practice applied the diagnosis to sexual offenders who, in fact, did not have the features specified in DSM for sexual sadists. These same psychiatrists failed to apply the diagnosis to sexual offenders whose offenses were characterized by torture, brutality, and seemingly humiliating acts. In the second study, Marshall, Kennedy, Yates, and Serran (2002) had 15 internationally renowned forensic psychiatrists indicate from detailed information (each offender's life history and offense history, the specific details of his worst offense, psychological and phallometric assessments, and the client's self-reported sexual interests) whether each of 12 offenders met criteria for sexual sadism. The resultant kappa was absurdly low (kappa = 0.14). It appears that the diagnosis of sexual sadism is not being (or perhaps cannot be) applied reliably.

Despite these and a host of other problems identified by O'Donohue et al. (2000) and by Marshall (1997a, 2005a, 2005b), the current edition of the DSM (DSM-IV-TR; APA, 2000) does employ criteria that provide a glimpse into the sort of problems some sexual offenders display. We will provide details of the criteria of each relevant disorder, and in chapter 3, we will provide a description of what research has revealed about these men.

All of the paraphilias are said to involve "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors" (APA, 2000, p. 566) concerning the particular focus of the client's desire. Pedophilia is said to involve sexual fantasies, urges, and behaviors involving prepubescent children. It is not made clear why those adults who engage in sex with prepubescent children are said to be pedophiles, but those who molest post-pubescent children are not to be considered pedophiles. In fact, identifying the age of an offender's victim is not always straightforward. Is it the victim's age at the onset of abuse or when it is reported? In addition, offenders may not tell the truth about the victim's age and objective information may not be available. Clinicians working with sexual offenders do not make this distinction between these two groups when deciding who does or does not need treatment, and both groups appear to have a similar range of problems. Furthermore, clinicians rarely apply the diagnosis of pedophilia to incest offenders and yet many men who molest their own children begin abusing them when the child is quite young and continue to do so over many years. This certainly appears to provide evidence of "recurrent" fantasies, urges, and behaviors involving sex with a child.

DSM-IV added "behaviors" to the previous criteria that simply listed urges and fantasies about children. These additional criteria have

not yet produced evident changes in diagnostic practices. If this addition of "behaviors" was taken seriously then almost all child molesters would meet criteria for pedophilia because they all engage in sexual behaviors with children. If that was the intention of the DSM authors, then diagnostic practices would have become more in line with treatment decisions, but they have not as yet. Given that diagnosticians still seem to feel that inferences must be made concerning enduring fantasies and urges about children in order to decide whether a child molester is a pedophile, current applications of the diagnosis can be expected to be unreliable. As we have seen, they do appear to be unreliable. If an inference is to be made about enduring sexual fantasies or urges about children, then we need information independent of the client's self-report, which we might suspect will not always be truthful. Phallometric evaluations or viewing time measures (see the section on "Sexual Interests" in chapter 3) have been relied on by some clinicians and researchers to identify persistent sexual fantasies or urges about children. Indeed, Freund and Blanchard (1989) see phallometry as the appropriate diagnostic test for pedophilia. We doubt that this is a satisfactory resolution.

Because rapists have not been identified in the main body of any edition of the DSM as belonging to any diagnostic category, most clinicians (when they are required to make a diagnosis) categorize rapists as having paraphilia NOS (Doren, 2002; Levenson, 2004). This is not a good solution because there are no criteria specified under that label that would describe rapists. In fact, the only diagnosis that might be appropriate would be "sexual sadism," but then only for those rapists who have sexual fantasies, urges, or behaviors that indicate sexual excitement elicited by physically or psychologically harming someone. Sexual sadism is, as we have seen, a particularly problematic diagnosis because it relies on the clinician's ability to infer such desires from evidence other than the offender's self-report, which is likely to be seen as untruthful unless he admits to sadistic desires.

For exhibitionists the diagnosis may be less problematic. These offenders typically expose themselves to numerous victims often over many years. In such cases inferring recurrent sexual fantasies, urges, and behaviors involving exposure seems straightforward, and most clinicians do not hesitate to apply the paraphilic diagnosis of exhibitionism to these clients. However, these inferences may not be as straightforward as they seem. In one study (Marshall, Payne, Barbaree, & Eccles, 1991), exhibitionists were asked about the content of their sexual fantasies. These questions were asked because very few of the exhibitionists in this study displayed sexual arousal to images of exposing despite having many victims. The exhibitionists rather sheepishly indicated that they were aroused

by fantasies of one or another of their victims requesting and engaging in sexual intercourse with them. Perhaps, despite what DSM has to say, exhibitionists are not characteristically aroused by exposing, which, of course, leaves open the question of their motivation to expose. Perhaps exhibitionistic behavior is, as Freund (1990) once claimed, a clumsy attempt at courting.

There are other problems associated with the diagnoses of the various paraphilias (see Marshall 1997a, 2005a; O'Donohue et al., 2000, for details). The basic problem with these diagnoses, as they apply to sexual offenders, is that a complete understanding of the problems these offenders have is not adequately described by the criteria outlined in the various editions of DSM.

In summary, DSM criteria have not been very helpful in work with sexual offenders. Apart from the unreliability of the paraphilic diagnoses, DSM diagnoses have little relevance for the etiology, assessment, treatment, or likely prognosis of sexual offenders. Not surprisingly, many researchers, theorists, clinicians, and assessors working with sexual offenders have ignored the DSM.

The broader clinical picture will be revealed in detail in chapter 3. For the present purposes it is sufficient to note that sexual offenders have a complex range of problems that are not apparent in DSM criteria. They have a range of distorted attitudes, beliefs, and perceptions, which have their basis in underlying maladaptive schemas. Sexual offenders also lack empathy; they have low self-esteem, poor coping styles and skills, emotional and behavioral regulation problems, dysfunctional attachment styles that result in low levels of intimacy and the experience of emotional loneliness; and they commonly have sexual interests that match their overt deviant behaviors. It is only this latter feature that is related to, although not directly expressed in, DSM criteria for the paraphilias. In addition, many sexual offenders have associated anger management issues and substance abuse problems.

Such a broad range of problems reveals the magnitude of the difficulties faced by clinicians who hope to provide treatment for these offenders. The development of treatment programs for sexual offenders, in conformity with the principles of good science, began with simple-minded concepts of the basis of sexual offending. As research revealed an ever-expanding list of the difficulties that led these men to commit sexual offenses, treatment programs expanded (see Laws & Marshall, 2003, and Marshall & Laws, 2003, for a history of their developments). As we will see in chapter 2, the targets of treatment are currently quite extensive and they are based on research that has revealed the full extent of the difficulties in effective prosocial functioning that these clients have.

Etiology

There is no one accepted model of the development of a disposition to sexually offend, but most researchers and clinicians agree on a general set of factors that seem to be etiologically significant. The main models cited in the literature have been outlined by Finkelhor (1984), Marshall and Barbaree (1990), Hall and Hirschman (1991), and Ward and Siegert (2002). More recently, Smallbone (in press) has offered another model that we believe has important implications for understanding sexual offenders. It is generally agreed that single-factor explanations of the etiology of sexual offending are incomplete (Marshall, 1996; Ward & Hudson, 1998) and that a more comprehensive, multifactorial model is required (Ward & Sorbello, 2003). The above models all meet this standard to a greater or lesser degree.

Finkelhor (1984) explains the proximal factors that trigger child molestation. He proposes that four preconditions must be met before an adult will attempt to have sex with a child. These four preconditions, however, can only be met if certain factors are true. First, sexual activities with a child must be experienced or anticipated by the offender as emotionally satisfying. Finkelhor refers to this as emotional congruence and in its broader sense this fits with Howells' (1979) finding that child molesters feel more comfortable with, and less threatened by, children than adults. This notion of emotional congruence is also consistent with the idea that child molesters seek emotional comfort and intimacy with children (Marshall, 1989a). Second, Finkelhor says children must elicit sexual arousal in offenders. Fortunately, not all adult males are sexually aroused by children. Research using measures of sexual arousal demonstrate that while some nonoffender males respond sexually to images of children, very few do, whereas a substantial number of child molesters do (Marshall & Fernandez, 2003). Third, Finkelhor claims that men who seek sex with children are blocked in their attempts to meet their sexual needs with adults. Evidence on the poverty of intimacy and adult attachment skills among sexual offenders offers support for this claim (Marshall, 1993). Finally, in order to offend, so Finkelhor claims, child molesters must overcome their inhibitions against committing such crimes. They may achieve this by cognitive strategies (e.g., rationalizing and justifying offending) or as a result of altered internal states (e.g., an angry state, a strong sense of entitlement, or intoxication).

These four factors are grouped by Finkelhor into the four preconditions he says must be met before molestation can occur. The first precondition requires that the offender must be motivated to offend; that is, molesting a child must be associated with sexual arousal, blockage, and emotional congruence. Second, disinhibition must occur; that is, the

offender must overcome inhibitions about offending. Third, conditions that allow the offender access to a victim must occur. For this to happen the offender must be alone with the child and the child must be vulnerable in some way; for example, the child may need affection or closeness, or in some other way be needy. Finally, the offender must, if necessary, be able to overcome any resistance by the child. He may use coercive tactics (e.g., he may bribe, coerce, threaten, or be forceful), or he must desensitize the child by grooming him/her over time.

There is evidence that these features of child molestation do occur (see Marshall, Serran, & Marshall, in press). However, theories of etiology also need to explain how it is that these proximal factors arise. Thus, an additional theory needs to identify more distal factors. In addition, Finkelhor's model has not been applied to other sexual offenders, although there seems no obvious reason to suppose that it would not be capable of accommodating the necessary adjustments to do so.

Hall and Hirschman's (1991) account is meant to include all sexual offenders. They propose somewhat similar factors to Finkelhor but add more distal, or at least more enduring, personality problems. They claim that for sexual offending to occur the following conditions must be met: the offender must be sexually aroused by his target (or rather by the class of his targets, i.e., children or adult females); he must hold attitudes and beliefs as well as have distorted perceptions about his victim or his class of victim; he must experience emotional dysregulation; and he must have personality deficits. These latter deficits are said to be activated under certain conditions, which then generate each of the other three factors. This aspect of Hall and Hirschman's account has important implications. As we will see in chapter 3, there is evidence that sexual responsivity to deviant acts is likely to be greater when men are intoxicated, angry, emotionally upset, or have had problematic experiences with which they are unable to cope. However, emotional dyscontrol may just as likely trigger what Hall and Hirschman call personality deficits as the other way round. Hall and Hirschman describe the particular combination of these factors that trigger specific kinds of sexual offenses. Again, however, their model is more concerned with the factors that more immediately result in offending; they do not satisfactorily explain how the personality deficits arise or why some men with similar problems, or in similar states, do not offend.

Ward's recent theorizing has encompassed a failure to self-regulate (Ward & Hudson, 2000), an inability to achieve the goals of a good life (Ward & Marshall, 2004), and a pathways-to-offending model (Ward & Siegert, 2002; Ward & Sorbello, 2003). Self-regulation governs the way in which people order their lives so that they can successfully achieve the goals they are seeking. Much of the research in the broader psychology literature on general self-regulation points to the crucial role of control

over (i.e., regulation of) emotions (Baumeister & Vohs, 2004). Affective dysregulation leads to an inability to focus on plans and their execution. Emotional lability diverts people from focusing on the long-term effects of their behavior and produces a narrowing of attention onto immediate satisfactions. As such, emotional problems produce behaviors that are not properly aimed at (i.e., regulated toward) the achievement of personal goals. Sexual offenders, so Ward claims, manifest poor behavioral regulation in that their offending behavior is concerned only with the relatively momentary satisfaction of short-term desires and fails to produce longer-term satisfaction.

Of course, these offenders also characteristically fail to articulate a comprehensive set of goals that would lead to enhanced life satisfaction and they often seem without direction in their life. People who derive maximum satisfaction in life have reasonably well-articulated goals that cover a diverse range of issues (Deci & Ryan, 2000; Emmons, 1999; Schmuck & Sheldon, 2001). It is from these notions that Ward has derived his description of the good lives model (Ward, 2002; Ward & Marshall, 2004; Ward & Stewart, 2003a). He suggests that sexual offenders fail to achieve the goals necessary to have a satisfactorily fulfilled life and that in order to compensate for this they seek more immediate satisfactions without regard for the long-term consequences of these behaviors. Thus deficits in self-regulation are at the basis of a failure to achieve a good life, such that Ward's two models (self-regulatory failure and the good lives approach) essentially point to different aspects of the same problem.

Ward's (Ward & Siegert, 2002; Ward & Sorbello, 2003) pathways model describes the steps sexual offenders take to offend that reveal their problems in self-regulation and their lack of concern for long-term goals. He suggests that sexual offending results from the combination of four issues: intimacy deficits, distorted sexual scripts, problems in emotional regulation, and cognitive distortions. The particular interplay of these four factors in any one sexual offender leads to his adoption of one of five etiological pathways (the reader is referred to Ward & Sorbello, 2003, for details of each of these pathways).

Although Ward has not yet clearly integrated these three models (i.e., self-regulation, good lives, and pathways), it is clear that this is the direction of his thought. The real advantage of the integration of Ward's models is that it involves both distal and proximal factors and attempts to account for the diverse ways in which sexual offenders pursue and enact their abusive behaviors. The origins of behavioral dysregulation, as well as the origins of poorly articulated life goals, are said to derive from disrupted childhood experiences as well as problematic experiences in teenage and adult years, particularly with regard to relationships and sexual experiences.

Our current view of the development of sexual offending represents an integration of much of what Ward outlines into our own etiological account. We developed our theory over many years by identifying the influence of a variety of specific factors, such as problematic parent–child bonds (Marshall, Hudson, & Hodkinson, 1993; Marshall & Marshall, 2000; Starzyk & Marshall, 2003), childhood sexual abuse (Dhawan & Marshall, 1996), social and cultural influences (Marshall, 1984, 1985), the role of exposure to pornography (Marshall, 1989b), conditioned sexual interests (Barbaree & Marshall, 1991; Laws & Marshall, 1990), adult attachment style and the capacity for intimacy (Marshall, 1989a, 1993, 1998), poor coping skills (Cortoni & Marshall, 2001; Marshall, Serran, & Cortoni, 2000), mood fluctuations (Marshall, Marshall, & Moulden, 2000; Marshall, Moulden, & Marshall, 2001), sexual compulsivity (Marshall & Marshall, 2001), and the failure to achieve the general goals of a satisfying life (Ward & Marshall, 2004).

At the base of our model are the problematic childhood experiences of males who become sexual offenders. These early experiences involve poor child–parent attachments; childhood physical, sexual, and emotional abuse; neglect; inconsistent discipline; and early exposure to pornography. Some combination of these experiences leads the emerging sexual offender to acquire: a low sense of self-worth; a failure to internalize the confidence, attitudes, and skills necessary to meet his needs prosocially; and a self-interested disposition or a sense of entitlement. Finally, these developmental experiences and their associated problems prompt the developing sexual offender to seek comfort in immediate rewards (e.g., sex as manifest in early and frequent masturbatory practices), rather than work toward goals that have delayed rewards. Unable to effectively consolidate relationships with peers during adolescence, which is a time when sexual interests are rapidly and fully awakened and when the shift from parental bonds to peer bonds occurs, the teenaged offender-to-be turns to the avid pursuit of self-interested goals and immediately secured satisfactions. Because sex is immediately and powerfully rewarding, such a young male is likely to seek sex with whomever and by whatever means are available. Because coerced sex (either with an adult, a peer, or a younger child) requires none of the skills the young male has failed to acquire, it represents an easy route to self-satisfaction and to the comfort of rewards that he is not able to obtain otherwise.

As he moves into adulthood bereft of the range of skills, confidence, and attitudes needed to achieve well-rounded satisfaction from his life, the young man emerging from the above background will be relatively unable to cope with life's problems. He will also be likely, by dint of his inadequacies, to create problems for himself, and he will not have the skills necessary to deal with these difficulties. He will likely respond

to these problems by either giving up efforts to cope and submitting to the consequences of this (i.e., being miserable or angry) or by avoiding the issues (e.g., using intoxicants to avoid thinking about his problems). Finally, when either placed in a situation where access to victims is readily available (e.g., as a parent, or in his job or leisure activities) or by actively seeking out a victim, he may commit a sexual offense and begin a process of becoming a chronic offender.

One apparent deficit in our model concerns the fact that some seemingly well-flunctioning individuals (e.g., professionals, academics) commit sexual offenses. However, apparent high functioning in some areas is not always matched by effectiveness in other areas, and, in any case, no theory can be expected to allow for all instances of any specific behavior. Indeed the apparent success of Freud's psychoanalytic theory to explain all behavior was seen as a clear flaw to its true explanatory power (Popper, 1963).

Smallbone (2005) has recently proposed a model that suggests it is the interaction (or mutual facilitation) of three basic systems that are evolutionarily entrenched: the caregiving (or nurturing) system, the attachment (or bonding) system, and the sexual system. Smallbone's model is particularly helpful in describing the immediate factors that produce sexual behaviors between an adult and a child when they are in close proximity over time (e.g., incest, or the offenses of a teacher, priest, or scout leader). Smallbone points to the physical proximity of the neurobiological mechanisms that underpin these three systems and suggests that the activation of one may facilitate the activation of the other two. For example, a father whose wife is intimately and sexually remote, may, by devoting his nurturing efforts to his child, come to develop such a strong bond with the child that he/she becomes his main source of satisfying his attachment needs. The activation of his attachment system in conjunction with the simultaneous activation of the nurturing system may over time produce a relationship with the child where the adult begins to treat the child as if he/she were an adult intimate partner. This state of affairs is likely (along with the facilitation provided by the ongoing activation of the nurturing and attachment systems) to lead to the activation of the sexual system, particularly as the physical comforting aspects of the behaviors become more pronounced. Like Ward's model, and ours, Smallbone's theory sees the origin of the failure to properly distinguish these three systems as lying in the childhood, teenage, and adult experiences of sexual offenders.

Smallbone's model is readily incorporated into ours, and chapter 3 provides evidence on the features of sexual offenders that emerge from their problematic childhood, youth, and adult experiences. The various references cited above that outline each of the factors in our overall