PEDOPHILIA: AN UPDATE ON THEORY AND PRACTICE

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The number of sexual attacks on children is staggering, yet is is extremely difficult to understand what effective treatments are available for the pedophile by reviewing the literature. Therefore, the authors present an update of the changing conceptualizations regarding the offenders and their victims. An overview of the currently used modalities to treat the pedophile is presented with emphasis on the promising cognitive-behavioral approach. A brief description of this approach is given with two case illustrations.

Pedophilia is an extremely important contemporary topic which is unfortunately replete with misconceptions. Almost everything about the topic of pedophilia—theory and practice—is fraught with controversy and uncertainty. Even the term pedophilia is a misnomer. A translation of the word from the Greek means "love of the child," which is in marked contrast to the usual behavior of the aggressive child molester towards his victims. The study of pedophilia, therefore, requires continual evaluation of new data and its integration into more effective treatment approaches. This paper will attempt to update theoretical and treatment approaches and present the case for a cognitive-behavioral approach as the core treatment modality.

A recurring question is to what extent is the sexual abuse of children more common today than in the past. Testimony, such as that given by Senator Paula Hawkins (R.-Fla.), and reported in the New York Times April 27, 1984, suggests that child sexual abuse has always existed but in the past has been ignored, disbelieved, or underreported by society. She disclosed that she had been sexually abused by a 60-year-old neighbor when she was five, but the judge believed she was lying.

Our society's reluctance to deal with this sensitive topic is to some degree exemplified in the neuropsychiatric field. An early example of this fact is that Breuer,

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Freud's early collaborator, retreated from psychology when the significance of childhood sexual trauma in the lives of his patients became apparent to him. This sensitivity about childhood sexual attacks may also partially explain the notoriety given former psychoanalyst Jeffrey Masson's recently published book *The Assault on Truth: Freud's Suppression of the Seduction Theory*.[1] In his controversial book, Masson accuses Freud of denying the truth of sexual assaults on children and substituting the role of patients' fantasies in the development of mental illness, not through scientific reasoning but out of personal weakness. In an earlier publication, Peters[2] had contended that the combination of cultural and personal factors influenced most psychiatrists, including Freud himself, to attribute reports of childhood sexual attacks to Oedipal fantasies. "This position relieved the guilt of adults."

EPIDEMIOLOGIC DIFFERENCES

Despite this increased awareness, the incidence of child sexual abuse can only be roughly estimated as it remains underreported and poorly documented.

The following are some of the factors in underreporting: (1) Children frequently do not report the sexual experience because of fear, shame, guilt, and loyalty to the offender; (2) Family members are reluctant to report the incident out of concern for further victimization of the child in the legal process; (3) Since many of the perpetrators are related or known to the family, there is a tendency not to report the matter; (4) Additionally, those cases of child sexual abuse which are seen as nonviolent in nature are probably less likely to be reported than incidents of physical abuse and neglect of children.

Despite the legal mandate to report suspected child abuse, doctors, and other professionals frequently fail to report. James *et al.*,[3] comment that the results of their random sampling of physicians in Washington State indicates that even in the cases of severe sexual trauma to the child, physicians are not sufficiently reporting these cases as mandated by law. They found that the most common types of child sexual abuse encountered by these physicians was incest by the natural father or stepfather with a daughter. There were two main reasons for this lack of physician reporting: (1) belief that the reporting would be harmful to the family, and (2) dissatisfaction with the manner in which state agencies handle such cases. Brant and Tisza,[4] working at the Children's Hospital Medical Center in Boston, found in a one-year retrospective study of the emergency room log that out of 56,000 emergency room visits, 52 cases of possible sexual abuse were located. Only five cases had been reported to the child abuse team in the hospital. In at least 25% of the cases, the professional staff had not considered the diagnosis of sexual abuse. They conclude that hospital personnel must be sensitized to this issue and alerted to the signs and symptomatology of these cases in order to make the appropriate diagnosis. Henderson,[5] in reviewing the epidemiological data relating to incest, concludes that sampling procedures account for the seemingly higher rate among the socioeconomically disadvantaged population. This group is the one most likely to be brought to the attention of the Child Protective Agencies and the Courts.

A 1981 study of sexual deviates by Abel *et al.*,[6] highlights the usual gross underreporting by offenders of the number of their victims. However, when these of-

fenders were guaranteed confidentiality, the mean number of victims per offender was the following: heterosexual incest—2.1; heterosexual rape—5.8; homosexual pedophilia—30.6; and heterosexual pedophilia—62.4.

A major reason for poor documentation of child abuse is the way in which data are processed by the criminal justice system. The Specific Arrest Offense Crime Analysis Unit of the New York City Police Department, for example, gives the age ranges of the offenders who account for the total of 591 sex-related arrests in 1983 in Bronx County. There is no similar breakdown of age patterns of the victims. This makes it difficult to retrieve accurate information about the incidence of pedophilia. Interestingly, in Bronx County in the years 1981, 1982, and 1983, there were only two arrests per year for incest. In a more comprehensive survey, Amir[7] estimated that only between ten percent and forty percent of rapes are ever reported. It appears that child sexual assault is even less frequently reported.

Compounding the imprecision of the data is the fact that in well over 90 percent of criminal cases, offenders plead guilty to a lesser offense (plea bargain) and are ultimately convicted of a lesser charge. Again, once incarcerated, the ages of the offenders are recorded but not the ages of their victims.

Despite the above limitations, the following estimates seemingly provide the most updated epidemiologic information. A careful study of the police records in Minneapolis made by Jaffe *et al.*,[8] in 1970 revealed that sexual crimes against children constituted one-third of a total of 291 reported sex crimes in that city. Rape, sodomy, and sexual intercourse total 11% of the reports. The mean age of the child victim was 10.7 years. Rape victimization involving girls less than 13 years of age has been estimated by Wells[9] to be in the range of 58% of a total of 2,000 British rape victims. Writing on pedophilia in 1965, Glueck[10] estimated that one-half to two-thirds of all adolescent girls are sexually abused before reaching adulthood. Woodling and Kossoris[11] estimated that one-quarter of all adolescent girls are sexually misused before reaching adulthood and that less than 50% of these crimes are ever reported to either a physician or law enforcement agency. In a five-year study of sexual crimes against children in Brooklyn, DeFrancis[12] found that the molestation rate was 149.2 per 100,000 children. Surveys of predominently white, middle-class populations have shown that approximately 10% of the women polled report having had a childhood sexual experience with an older male relative.[13,14] Woodbury and Schwartz[15] in 1971 estimated that ten percent of all Americans have been involved in incestuous experiences.

VICTIM TRAUMATIZATION

Although not fully documented in the literature, there appears to be little doubt that sexual attacks against children cause devastating and long-lasting effects. Earlier writers tended to minimize the traumatic effects of children having sexual relations with adults.[16,17,18,19] In 1937, Bender and Blau[16] studied sixteen successive pre-adolescent admissions to the Children's Ward of Bellevue Psychiatric Hospital in New York City following sexual activities with adults. The children were seen as charming and lacking guilt, fear, or anxiety regarding the sexual experiences. In 1952, Bender and Gruget[17] published a follow-up report on these sixteen

children. They concluded that the sexual activity did not necessarily predict maladaptive adjustments in adult life. Revitch and Weiss[18] wrote in 1962 that the majority of pedophiles are harmless and the victims are aggressive and seductive children. Amir,[20] in 1972, describing the role of the victim in sex offenses, concluded: "Studies and surveys found that contrary to popular belief the child or adolescent victims often showed complicity, if not active participation, in the criminal sexual situation. In many cases, the victim subtly encouraged her own victimization because of neurosis or acting out."

The above viewpoint is in sharp contrast to the currently prevailing one that strongly condemns the offender as being the aggressor by virtue of his superior role in the relationship. He is in a position of authority to either overtly or subtly coerce the child into submitting to sexual acts. In fact, he takes advantage of the innocence of the child who may have a need for affection or a natural curiosity for most things, including perhaps exploration of bodily parts. The sex offender exploits the child to satisfy his own perverse sexual cravings. He frequently rationalizes this activity and cognitively distorts its meaning. These cognitive distortions and the larger issue of the child's inability to give informed consent to having sex with an adult have been thoroughly explored in the recent literature by Abel *et al.*[21] These authors stress that the child is unable to give informed consent because (1) the child is unaware of what he or she is giving consent to; (2) the child is not aware of accepted societal standards; (3) the child is unaware of the consequences of his or her decision; and (4) the child is in an unequal power status with adults. Therefore, the pedophile has been recently labelled a type of sexual aggressor.[22,23]

Contrary to the opinions put forth by early investigators there is increasing evidence that young victims of sexual abuse suffer severe physical and emotional damage. In a thorough study of police records, probation presentencing reports, courtroom transcripts, and medical reports, Christie, Marshall, and Lanthier[24] in 1978 reported on 150 incarcerated sex offenders. They found that 58 percent of the child molesters were violent during the commission of the crime and 42 percent of the child victims were physically injured.

Concering longlasting emotional effects resulting from childhood sexual abuse, Katan,[25] in 1973, provides a psychoanalytic evaluation of the traumatic effects of child sexual abuse. She wrote about two of her patients who typify six such cases which she had psychoanalyzed. One women in her 30's, who had been seduced by her father as a child, complained of contant agitation, anxieties, and depression. Another woman, in her 20's, sought treatment because of severe depression and an inhibiting fear of men. At the age of 3, the nursemaid's boyfriend had inserted his penis and ejaculated into her mouth. Katan wrote that all of these patients had many pathological tendencies and symptoms with a "marked tendency to repeat the traumatic incident in various ways throughout life." Katan explained the failure of some of these patients to prevent similar victimization of their own children as a form of repetition compulsion. These patients appeared to fantasize acquiring a penis and identifying with men as a means to "escape the unbelievably low self-esteem. . . . Without the penis they felt themselves to be nothing and this made vaginal gratification impossible."

Based upon his experiences at the Philadelphia General Hospital and in private practice, Peters[3] stated unequivocally that "sexual assaults in childhood

emerged as the root of psychiatric problems in adulthood." Burgess and Holmstrom[26,27] believe that children suffer the same rape trauma syndrome as adult victims; the apparent differences are only manifestations of the developmental stage of the victim. In 1984, Carmen *et al.*,[28] report that almost half of 188 male and female adult patients had histories of physical and/or sexual abuse. The male victims were more likely to have abused others. The abused female victims on the other hand, were more likely to direct their anger and aggression against themselves. This study clearly highlights the role of trauma in the lives of patients.

In 1978, McGuire and Wagner[29] report on the high rate of sexual victimization in the early lives of women seeking treatment for sexual dysfunction. Becker *et al.*,[30] evaluated 83 victims of rape and incest and found that 56 percent were having sexual dysfunctions, 71 percent of whom stated that the sexual assault precipitated the dysfunction. The most common sexual problems were fear of sex, inhibited arousal and desire dysfunction.

All of the above cited studies must surely undermine Brongersma's[31] argument that victim traumatization is an exaggerated phenomenon. That author posits in regard to victims of pedophilic acts that "traumatization is only secondary due to the reactions of upset parents and policemen."

DIAGNOSTIC CONSIDERATIONS

The evolving classification of pedophilia in the three editions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders is reflective of the way the sexual deviations have been perceived. In both DSM-I and DSM-II, pedophilia was perceived as symptomatic of severe underlying pathology. However, in DSM-III (1980), pedophilia is classfied as a subcategory under the new term of paraphiliac disorders and independent of sociopathic or personality labels.

Recent physiological studies have been able to discriminate sexual aggressives from a normal control population. According to Zuckerman,[32] the most accurate physiological measurements of sexual arousal are obtained by the use of the penile transducer. Studies by Abel *et al.*,[6] have indicated that the majority of pedophiles exhibit arousal to other paraphilias and often to appropriate sexual stimuli. Although incest offenders have been traditionally described in the literature[33,34] as a product of a dysfunctional family, they also show this generalization of arousal patterns. Consequently, we view many adult incest offenders as not being significantly different from pedophiles except that incest offenders have greater access to their victims. Therefore, the dysfunctional state in many families may be the result rather than the cause of incest behavior.

The penile transducer provides the means for a more accurate diagnosis of the individual pedophile's sexual arousal pattern. It also affords an objective means of monitoring treatment response.

AN INTEGRATED PROGRAM

The first phase in our integrated treatment program is a thorough assessment. The purpose of this assessment is to determine eligibility for treatment. Individuals who

are actively psychotic, predominantly antisocial, heavy substance abusers, and the severely mentally retarded or organic would not benefit from this treatment program. The evaluation includes a detailed psychiatric and sexual history as well as numerous psychometric tests. One reliable penile transducer is a mercury strain gauge in the form of a thin rubber ring which encircles the penis. As erection occurs, the strain gauge widens and generates a change in electrical output which can then be measured as a percentage of the patient's full erection.

Generally, treatment comprises approximately 30 group therapy sessions of between 8 to 12 patients per group, but this may vary depending upon individual treatment needs. The purpose of the treatment regimen is to reduce the rate of sexual attacks by changing the patient's deviant arousal patterns to more socially appropriate ones and concomitantly to provide him with the skills to relate better with adults. There are typically six components to the treatment: Two components—covert sensitization and masturbatory satiation—are self-control techniques designed to reduce and control deviant sexual arousal. The other treatment components include cognitive restructuring or re-examining faulty sexual attitudes, sex education, social skills training, and assertiveness training. During the course of treatment, additional penile erection measurements are taken in the laboratory to check on the patient's progress.

In addition to group therapy, and dependent upon the individual client's needs, other treatment interventions can be recommended including insight-oriented therapy, pharmacotherapy, conjoint therapy, and family therapy.

LEGAL CONCERNS

Since most of the cases concern offenders involved with the criminal justice system, legal and ethical considerations are paramount. These considerations necessitate the use of separate consent forms, detailing the risks, benefits, and procedures of both the assessment and treatment phases. The limits of confidentiality in accordance with applicable laws and regulations are carefully explained. The consent forms emphasize that participation in the program is voluntary and that the patient may choose to leave at any time. The issue of coercion is also partially addressed by stressing that he may elect an entirely different treatment program, i.e. a psychodynamic therapy. The whole program conforms to the guidelines established by the Institutional Review Board (I.R.B.) of the hospital.

CASE NO. 1

Mr. A. is a 38-year-old white male, employed as a certified public accountant in a large corporation, who was involved in incestuous relationships with his now 11 and 14-year-old natural daughters over a period of several years. His deviant behavior began when he was under considerable job-related and marital stress. It coincided with his changing jobs to a more demanding one and having persisting doubts about his performance. He had few friends and his wife did not provide emotional support. In fact, they had become increasingly emotionally distant and less sexually active with each other. Since he came from a conservative background and had a strict sense of morality, he did not consider having an extra-marital relationship. He

felt particularly fond of and close to his eldest daughter who was then 9 years old. Initially, he had her sit on his lap for long periods of time while he fondled her genital area. About two months later the sexual involvement progressed to oral-genital sex and then to penile-vaginal intercourse. He always felt guilty afterward, but managed to rationalize that whatever he did was out of love for her. Also, he falsely interpreted her lack of physical resistance to mean enjoyment of the sexual activities. At times, when overwhelmed with guilt, he promised himself he would stop, but the urge returned and invariably he continued. When this elder daughter experienced puberty, he turned to his younger daughter. The same pattern repeated itself.

About nine months ago, when the elder daughter watched a television drama on child sexual abuse, she reported the incest to her mother. When she confronted her husband, he readily admitted his guilt and she demanded that he leave the home. She then consulted a social service agency for children who contacted him and insisted that he seek treatment.

The patient was very remorseful about his admitted incest, but denied other sexual deviations including pedophilic behavior outside of the family. He also revealed that he had been sexually abused as a child by his own father. Psychiatric interviews revealed obsessive-compulsive characteristics but no significant psychopathology. Initial laboratory assessment indicated high arousal to adult consenting sex, adolescent girls and young girls. He was extremely motivated to reconcile with his family and was cooperative in all the treatment procedures. His wife and two daughters received treatment in another clinic. In his last phase of treatment the patient and his wife entered conjoint therapy in an attempt at reconciliation.

COURSE OF TREATMENT

The patient entered both group and individual therapy. Group therapy consisted of the above-outlined format. Individual therapy was deemed necessary to provide support and insight. Care was taken not to allow the patient to rationalize his behavior and transfer responsibility to either unconscious determinants beyond his control or to family members. By self-report and laboratory assessment there was a marked reduction in deviant arousal at post-10, 20, and 30 sessions (refer to graph No. 1). His non-deviant arousal remained high throughout treatment. Among the benefits of individual psychotherapy were his increased self-esteem and renewed hope to get on with life.

CASE NO. 2

Mr. B. is a 29-year-old single black male who was recently released from prison after serving five years for sexually abusing a seven-year-old female. He was on closely supervised parole with the condition that he receive treatment for his pedophilic disorder. He had never had a consensual sexual relation with an adult female and had always had difficulty making friends. He lived alone and was socially isolated. He was then employed as a construction laborer.

Mr. B's deviant sexual behavior had escalated over time. At 13 he became aware of exhibitionistic tendencies to young girls which he became increasingly unable to control. He also started masturbating to sadistic fantasies about young girls. At 16 he compulsively cruised children's playgrounds and brutally forced an eight-year-old girl to fellate him. By age 20 he had sexually assaulted at least 10 young girls before his first arrest that year for child sexual abuse. He served two years in prison. Upon release, he quickly returned to the same pattern of deviant sexual behavior and while still on parole, was again convicted of child abuse. At no time in prison did he receive treatment for his sexual deviation.

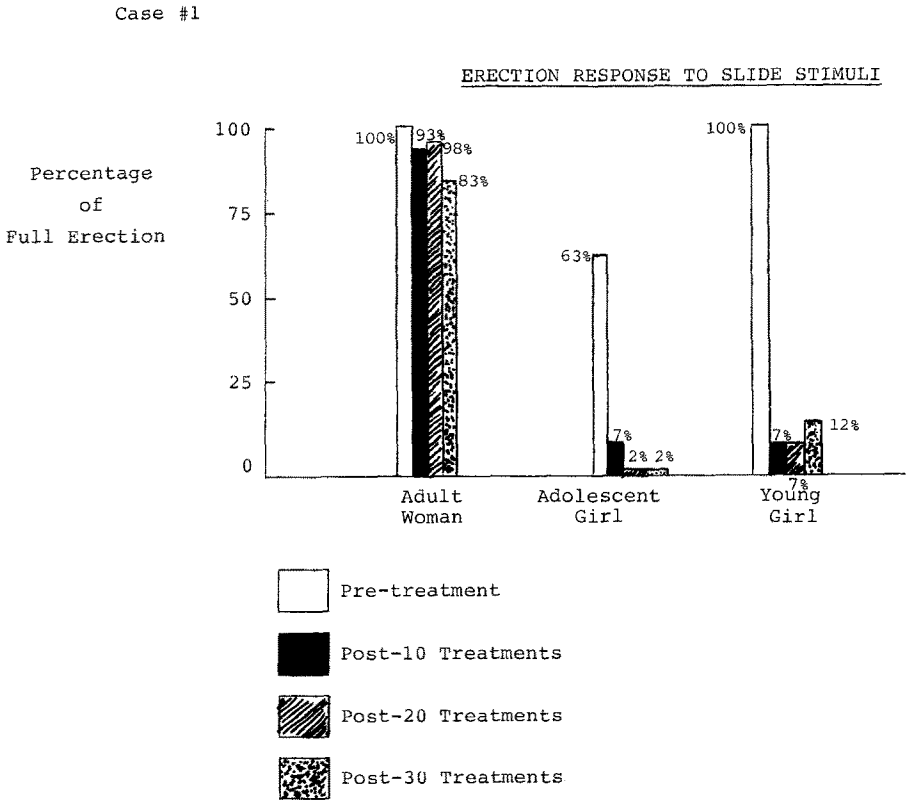
Mr. B. presented as an articulate but socially deficient man who reported continuing exhibitionistic, sadistic, and pedophilic urges. Initial laboratory results showed that his strong-

est attraction was to adolescent and young girls. He also demonstrated moderate arousal to adult heterosexual consenting sex. As a temporary means of control the major tranquilizer Mellaril was prescribed. The initial data shown on graph No. 2 were obtained while Mr. B. was on this tranquilizer.

COURSE OF TREATMENT

This patient was not as cooperative with treatment as was case No. 1. He occasionally missed group sessions with poor or no excuses. It was also difficult for him to carry out the social skills tasks. This was consistent with his personality disorder. As a result, considerable effort was expended to keep him in treatment. Extra individual sessions were required. After about 10 sessions the Mellaril medication was discontinued. Post-10 and 20 laboratory assessments indicated a gradual decrease in deviant arousal and an increase in non-deviant arousal. At post-30 he showed an increase in arousal to adult females and a significant decrease to young females. However, the patient's deviant arousal to adolescent girls remained at approximately the same level as that of post-20.

It is important to point out that both post-20 and 30 laboratory results were obtained when the patient was no longer on Mellaril medication. Despite the lack of total reduction in arousal to deviant stimuli seen in the last two laboratory studies, the patient had not recidivated and stated he felt in control of his impulses. It is probable that his initial and post-10 laboratory results might have been much higher had he not been on Mellaril. Therefore, his sub-



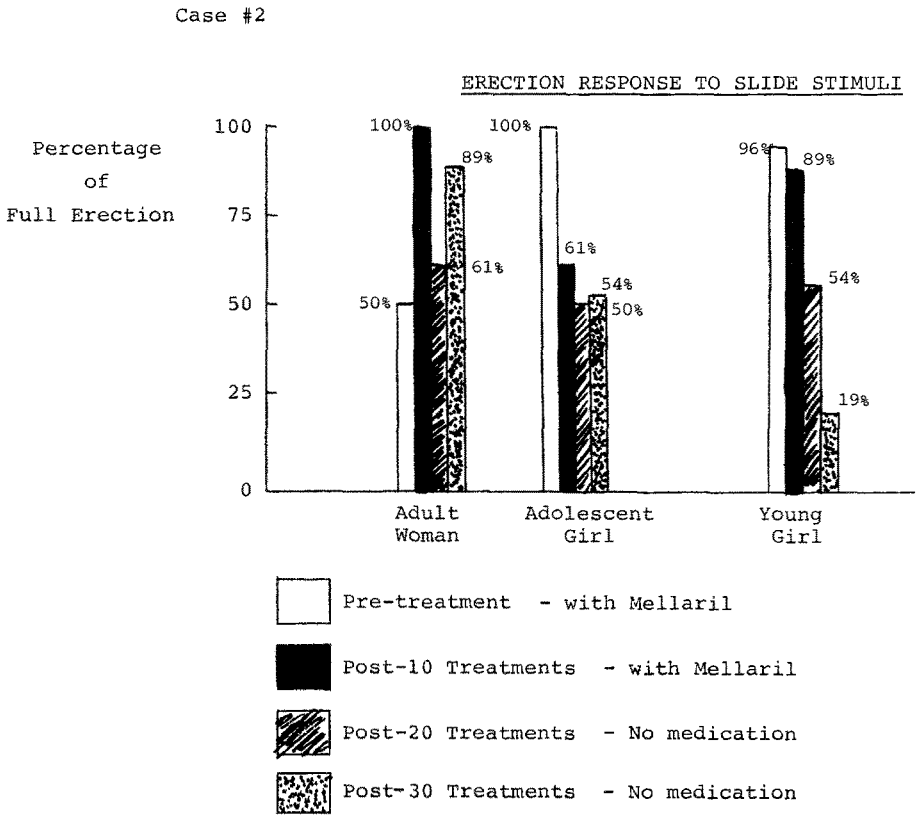
sequent studies though still high were seen as relatively reduced. Of course, this patient had to be continued in treatment.

OTHER TREATMENT MODALITIES

In addition to the cognitive-behavioral treatment, it is important to enumerate and examine some of the other treatment approaches. In 1980, Meyer,[35] wrote, "There is not one sex therapy but instead there are a variety of treatment modalities, each with its strengths and weaknesses and areas of applicability." Our position is that in the treatment of most paraphilias, the cognitive-behavioral approach with its emphasis on the reduction of deviant arousal is a necessity, though other treatment goals and modalities may be appropriate and crucial complements.

(a) Traditional psychotherapy (individual, group, and family

There is no doubt that in selected cases, individual psychotherapy can be beneficial. The final breakdown of controls resulting in the pedophilic act may be, at least in part, related to psychological distress, i.e. a job loss. This may be amenable to a dyadic psychotherapeutic relationship. Symptoms of anxiety, depression, guilt and



low self-esteem, if not already problematic may, in the ensuing arrest and disclosure stages, constitute a post-traumatic syndrome for the offender. Anxiolytic and antidepressant medications may have to be prescribed. The therapist, however, should heed McGaghy's[36] caveat that the "insights" acquired by the pedophile not be allowed to serve as justification for his perverted behavior.

Perhaps the most common form of treatment of sex offenders is group therapy. In 1958, Peters[37,38] organized an analytic group psychotherapy program for probationed sex offenders at Philadelphia General Hospital. A variety of innovations have since been introduced in group therapy such as the use of anonymous tape exchanges between incarcerated sex offenders and outside university students by Anderson[39] in Wisconsin and the Reeducation of Attitudes and Repressed Emotions (ROARE) approach by Prendergast[40] in New Jersey. Giarreto's[41] family therapy program emphasizes the importance of working with all members of the incest family. This well-known program in Santa Clara County, California, also includes self-help programs, e.g. Parents United.

(b) Phenothiazine Treatment

The use of phenothiazines (Mellaril) in the treatment of sexual deviant behavior was first reported by Bartholomew[42] in 1964. It was shown to produce secondary impotence, an obvious desirable goal for outpatient sex offenders. In a 1968 article Bartholomew[43] reported on the use of fluphenazine enanthate (Prolixin) in reducing sexual drive and performance in 17 of 26 patients with sexual deviations. The exact mechanism responsible is still unknown, but phenothiazines impact on the central nervous system and have been shown to decrease the circulating plasma testosterone level. This medication, like all forms of pharmacotherapy, has an effect only when it is used. In our own program Mellaril is sometimes prescribed. It serves as a temporary external control in high risk cases until the patient learns internal control.

(c) Androgen-depleting agents

Cyproterone acetate (CPA) and medroxyprogesterone acetate (MPA, Depo-Provera) have been used to reduce the plasma testosterone level from the normal male level (400-1000 nanogram[ng]%) to the normal female level (40-100 nanogram[ng]%). This marked decrease is correlated with a reduction in sexual drive, usually between one to three weeks after beginning treatment. Although CPA is used in Europe, it is not approved for use in the United States. MPA, a synthetic progestin which has been used for years in various female disorders, has been granted experimental usage for the treatment of paraphiliacs under FDA regulation. The drug is administered by depot-injection in dosage levels of 300-400 mg intramuscularly every 7 to 10 days. MPA decreases the production rate of testosterone by inhibiting the pituitary secretion of luteinizing hormone (LH) and by the induction of the enzyme testosterone A-ring-reductase in the liver which accelerates testosterone metabolism. MPA also is believed to inhibit follicle stimulating hormone (FSH). Some of MPA's more common side effects are drowsiness, weight gain, and increased blood pressure. Its potentially more serious side effects are

thrombophlebitis, pulmonary embolism, and exacerbation of diabetes mellitus. It has also been shown to produce breast cancer in female beagle dogs.

The major clinical research center using Depo-Provera is the Biosexual Psychohormonal Clinic at the Johns Hopkins Hospital in Baltimore, Maryland, under the current directorship of Dr. Fred S. Berlin. Interestingly, Berlin and Meinecke[44] reported in 1981 that of 20 men who participated in an early study, 3 showed recurrence of sexually deviant behavior while taking the medication. One of these was clearly related to alcohol usage. Of the 11 patients who discontinued MPA against medical advice, 10 relapsed. This represented a dropout rate in excess of 50%.

The major drawback of MPA (Depo-Provera) is that though the sexual drive is reduced, the direction of the drive is not altered. And so, after 7-10 days of discontinuation of the medication, libido, erectile and ejaculatory capacity begin to return along with the original subjective deviant drive. The deviant behavior is then likely to resume unless other therapy (e.g. covert sensitization) is provided.

(d) Castration

Aside from ethical considerations, the results of surgical castration in the treatment of sex offenders are both variable and unreliable. Heim[45] found that 8(40%) of 20 castrated men continued to have sexual intercourse 3 to 7 years after castration. Eibl[46] was able to show that 19(50%) of 38 sex offenders castrated 3 to 5 years before had full erections by penile plethysmography while viewing a sex movie. In a 1979 review of the European literature on the topic, Heim and Jursch[47] concluded that there is no scientific or ethical basis for the use of castration as a modality of treatment for the sex offender.

(e) Psychosurgery

From 1962 to 1979, 74 men and one woman who were considered sexually abnormal underwent stereotaxic hypothalmotomies in the Federal Republic of Germany. Rieber and Sigusch,[48] in reviewing the reports on these cases, concluded that because of methodological errors and inadequacies, the findings could not be used. Schmidt and Schorsch[49] similarly concluded that the neurophysiological bases for stereotaxic hypothalmotomic surgery on humans appear highly questionable and that the subsequent followup studies were based on poor methodologies.

TREATMENT OUTCOMES

In a 1978 survey of treatment programs for sex offenders, Brecker[50] pointed out how few programs there were in the country, with many of them being less than six years old. He was impressed though by the variety of innovative approaches and felt that these treatment programs opposed the traditional attitude that sex offenders were essentially untreatable. Much of this pessimism about treatment, he believed, stemmed from the popularity of the book on sex offenses, titled *Psychopathia Sexualis*, by Dr. Richard von Krafft-Ebing,[51] which was published in 1886. That book described in graphic detail heinous sexual murders and in the same style de-

picted such common sexual deviations as exhibitionism, voyeurism, etc. This pattern of grouping all types of sex offenders together revives the stereotype in the public's mind with the term "sex offender." The term "sexual psychopath," derived from Krafft-Ebing's *Psychopathia Sexualis*, is still to be found in the laws of many states. In 1977, the Group for the Advancement of Psychiatry reversed itself and recommended unequivocally that "sexual psychopath" and special sexual offender statutes be repealed. The GAP wrote: "What we reject in particular is stigmatization by way of special sex psychopath statutes with an indeterminate nature and with generalizations about treatment when the main goal is really to remove these people from society."[52]

In determining the relative efficacy of treatment programs, there are several serious problems: different patient populations, inadequate or non-existent control groups, varying criteria for improvement, and minimal follow-up data after five years. The most recent available follow-up data regarding a cognitive-behavioral program has been from the Sexual Behavior Clinic of the New York Psychiatric Institute. Specifically, 88.6 per cent at a six-month followup, and 79 per cent at a one-year followup of their research subjects who completed the entire course of treatment had not reoffended [Personal communication, Dr. Judith Becker of New York Psychiatric Institute, 1984]. It is important to point out that this followup information was obtained by both self-report and laboratory studies. As these data cover less than five years, this must necessarily be considered only a preliminary report. We also do not have as yet their published breakdown per diagnostic category. Generally we would expect that incest cases upon disclosure and then treatment would have a very low recidivism rate, whereas repeat or non-incest pedophile offenders would have a much higher one.

Our program has been in existence for approximately one year and so there has been insufficient time to report on follow-ups. Forty offenders are now actively in treatment. Their primary diagnoses are the following: female incest—10; female young pedophile—6; male young pedophile—5; female adolescent ephebophile—1; male adolescent ephebophile—5; exhibitionism—5; adult female rape—4; frottage—4. There are 36 in group therapy and 4 in individual cognitive-behavioral therapy. Each of the cases in individual treatment are for various reasons inappropriate for group intervention. One is a female sex offender, two are mentally retarded, and the fourth patient has cerebral organic deficits and experiences paranoid ideation. Eight patients were evaluated and determined inappropriate for the sex offender program. Of these eight cases, one was mentally retarded with severe personality deficiencies, a second was severely alcoholic, and a third had a schizoaffective disorder and was only marginally compensated. Four patients had a variety of personal difficulties that precluded entry into treatment. Only one patient was actively psychotic and represented the sole psychotic individual. That person's reported offense was exhibitionism.

Although it is impossible at this point to evaluate treatment outcome of our program on a statistically significant basis, it is noteworthy to observe present trends. Of the 40 patients who entered treatment, only two recidivated and were subsequently incarcerated. It should be emphasized that both of these patients were noncompliant with the treatment regimen.

Giarretto[41] reports on 600 white middleclass incest families, of which 75 per cent involved the father and daughter. These families were involved with the Child Sexual Abuse Treatment Program (CSATP) of the Juvenile Probation Department in California's Santa Clara County. He asserts that no recidivism has been reported in the six-year period of the program's existence. The children had been returned to the families within the first month. He admits that it is difficult to predict the ultimate long-term success rate of these families. It is also important to note that his data is based on selfreport alone.

The Joseph Peters Institute in Philadelphia, in a 10 year followup of group therapy with sex offender patients, found that the variable most strongly associated with subsequent arrest was the offender's prior arrest rate per year. Specifically, offenders with a low adult sex crime arrest history (0.0 to 0.3 per year) had a recidivism rate of only 7.9 percent. In contrast, those offenders with a sex crime arrest of 0.31 to 1.39 per year had a higher recidivism rate of 26.2 percent.[38]

Alcoholism should also be considered a contributory condition in predicting treatment outcome. Although alcoholism is not considered a causal factor, Rada[53] and others[54,55,56] believe that a substantial percentage of sex offenders drank just prior to the crime. On the basis of his research into the matter, Rada is impressed by the number of factors suggesting that "alcohol may be more directly causal in child molestation than in rape."[53]

CONCLUSION

It is important to point out that most sex offenders are not incarcerated. Of those estimated 11-13% of sex offenders who have been incarcerated, very few receive specific treatment for their sexual deviancy, and once released are likely to reoffend. Ideally, treatment should be continuous and take place in every phase of the criminal justice system: during the arrest, incarceration, probation, and parole stages. This would then allow the judges to make appropriate dispositional decisions with the understanding that wherever the offender will be sent he will receive adequate treatment. Rappeport[57] notes that "enforced treatment is nonetheless treatment and can, in fact, produce changes which are desirable from the standpoint of the individual and society. "On the basis of his experience with an enforced group therapy program for sex offenders in Baltimore, Maryland, he further asserts that "when close probation supervision forces patients to attend, very satisfactory results can be obtained by outpatient treatment of those with repeated offenses."

Despite all the inherent problems in the treatment of paraphiliacs, it is the authors' contention that cognitive-behavioral therapy provides an effective specific and comprehensive approach to this extremely difficult population. This treatment approach targets the specific behavior which must be immediately controlled in order to prevent further victimization. It provides the means of accurately assessing deviant arousal patterns which lead to deviant behaviors. Furthermore, it affords an objective method of monitoring treatment compliance and response.

REFERENCES

1. Masson JM: *The Assault on Truth: Freud's Suppression of the Seduction Theory.* New York, Farrar, Straus and Giroux, 1984.
2. Peters JJ: Children who are victims of sexual assault and the psychology of offenders. *A J Psychotherapy, 30*:398–421, 1976.
3. James J, Womack WM, Strauss F: Physician reporting of sexual abuse of children. *J Am Med Asoc, 240*:1145–1146, 1978.
4. Brant RST, Tisza VB: The sexually misused child. *Am J Orthopsychiatry, 47*:80–90, 1977.
5. Henderson DJ: Incest: a synthesis of data. *Canadian Psychiatric Association, 17*:299–313, 1972.
6. Abel GG, Becker JV, Murphy WE, Flanagan B: Identifying dangerous child molesters. In Stuart R(Ed.), *Violent Behavior—Social Learning Approaches to Prediction, Management and Treatment.* New York, Brunner/Mazel, 1981.
7. Amir M: *Patterns in Forcible Rape.* Chicago, University of Chicago Press, 1971.
8. Jaffe AC, Dynneson L, Bensel HWT: Sexual abuse of children: an epidemiologic study. *Am J Diseases of Children, 129*:689–692, 1975.
9. Wells NH: Sexual offenses as seen by a woman police surgeon. *British Medical Journal, 5109*:1404–1408, 1958.
10. Glueck BC: Pedophilia. In Slovenk R(Ed.), *Sexual Behavior and the Law,* Springfield, Ill., Charles C. Thomas, 1965.
11. Woodling BA, Kossoris PD: Sexual misuse: rape, molestation, and incest. *Pediatric Clinics of North America, 28* :481–499, 1981.
12. DeFrancis V: *Protecting the Child Victim of Sex Crimes Committed by Adults.* Denver, American Human Association, 1969.
13. Landis J: Experiences of 500 children with adult sexual deviation. *Psychiatric Quarterly Supplement, 30*:91–109, 1956.
14. Finkelhor D: *Sexually Victimized Children.* New York, Free Press, 1979.
15. Woodbury J, Scwartz E: *The Silent Sin.* New York, New American Library, 1971.
16. Bender L, Blau A: The reaction of children to sexual relations with adults. *Am J Orthopsychiatry, 7*:500–518, 1937.
17. Bender L, Gruget FAE: A followup report on children who had atypical sexual experiences. *Am J Orthopsychiatry, 22*:825–837, 1952.
18. Revitch E, Weiss RG: The pedophiliac offender. *Dis Nervous System, 23*:73–78, 1962.
19. Yorukoglu A, Kemph JP: Children not severely damaged by incest with a parent. *J Am Acad Child Psychiatry,* 111–124, 1966.
20. Amir M: The role of the victim in sex offenses. In Resnik HLP, Wolfgang ME (Eds.), *Sexual Behaviors: Social, Clinical and Legal Aspects.* Boston, Little Brown and Company, 1972.
21. Abel GG, Becker JV, Cunningham-Rathner J: Complications, consent, and cognitions in sex between children and adults. *Int J Law and Psychiatry. 7*:89–103, 1984.
22. Marshall WL, Earls CM, Segal Z, Darke J: A behavioral program for the assessment and treatment of sexual aggressors. In Craig KD, McMahon RJ(Eds.), *Advances in Clinical Behavior Therapy.* New York, Brunner/Mazel, 1983.
23. Abel, GG, Becker JV, Skinner LJ: Aggressive behavior and sex. In Meyer JK (Ed.), Symposium on Sexuality. *Psychiatric Clinics of North America, 3*:133–151, 1980.
24. Christie M, Marshall W, Lanthier R: *A Descriptive Study of Incarcerated Rapists and Pedophiles.* Report to the Solicitor General of Canada, Ottawa, 1979.
25. Katan A: Children who were raped. *The Psychoanalytic Study of the Child, 28*:208–224, 1973.
26. Burgess AW, Holmstrom LL: Rape: *Victims of Crisis.* Bowie, Maryland, Robert J. Brady Co., 1975.
27. Burgess AW, Holmstrom LL: Sexual trauma of children and adolescents: pressure, sex, and secrecy. *Nursing Clinics of North America, 10*:551–563, 1975.
28. Carmen (Hilberman) E, Rieker PP, Mills T: Victims of violence and psychiatric illness. *Am J Psychiatry, 141*:378–383, 1984.
29. McGuire L, Wagner N: Sexual dysfunction in women who were molested as children: one response pattern and suggestions for treatment. *J Sex and Marital Therapy, 4*:11–15, 1978.
30. Becker JV, Skinner LJ, Abel GG, Tracey EC: Incidence and types of sexual dysfunctions in rape and incest victims. *J Sex and Marital Therapy, 10*:185–192, 1984.
31. Brongersma E: Aggression against pedophiles. *Int J Law and Psychiatry, 7*:79–87, 1984.
32. Zuckerman M: Physiological measures of sexual arousal in the human. *Psychological Bulletin, 75*:297–329, 1971.
33. Kaufman I, Peck AL, Tagiuri CK: The family constellation and overt incestuous relations between father and daughter. *Am J Orthopsychiatry, 24*:266–279, 1954.

34. Lustig N, Dresser JW, Spellman SW, Murray TB: Incest- a family group survival pattern. *Archives of General Psychiatry, 14*:31–40, 1966.
35. Meyer JK: Foreward, In the Symposium on Sexuality. *Psychiatric Clinics of North America, 3*, 1980.
36. McGaghy CH: Child Molesters: a study of their careers as deviants. In Clenard MB, Quinney R(Eds.), *Criminal Behavior Systems: A Typology*. New York, Holt, Rinehart and Winston, 1967.
37. Peters JJ: The development of group psychotherapy programs in various settings. Proceedings of the Second Institute of the American Group Psychotherapy Association in New York City, 1958. Reported in, Resnik HLP, Peters JJ: Outpatient group therapy with convicted pedophiles. *International Journal of Group Psychotherapy, 17*:151–158, 1967.
38. Peters JJ, Roether HA: Group psychotherapy for probationed sex offenders. In Resnik HLP, Wolfgang ME(Eds.), *Sexual Behaviors—Social, Clinical, and Legal Aspects*. Boston, Little, Brown and Company, 1972.
39. Anderson RE: The exchange of tape recordings as a catalyst in group psychotherapy with sex offenders. *Int J Group Psychotherapy 19*:214–220, 1969.
40. Prendergast WE: R.O.A.R.E./Reeducation of attitudes (and) repressed emotions (unpublished paper). Reported by Brecker EM: *Treatment Programs for Sex Offenders*. National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U.S. Department of Justice, Washington D.C., pages 43–35, U.S. Government Printing Office, Stack Number 027-000-00591-8, January, 1978.
41. Giarretto H, Giarretto A, Sgroi SM: Coordinated community treatment of incest. In Burgess AW, Groth AN, Holmstrom LL, Sgroi SM(Eds.), *Sexual Assault of Children and Adolescents*. Lexington, Mass., Lexington Books, 1978.
42. Bartholomew AA: Some side-effects of Thioridazine. *Med J Australia, 1*:57, 1964.
43. Bartholomew AA: A long-acting phenothiazine as a possible agent to control deviant sexual behavior. *Am J Psychiatry, 124*:917–923, 1968.
44. Berlin FS, Meinecke CF: Treatment of sex offenders with antiandrogenic medication: conceptualization review of treatment modalities and preliminary findings. *Am J Psychiatry, 138*:601–607, 1981.
45. Heim N: Castration in treatment of sex offenders: results of a pilot study. Proceedings of the German Conference on Treatment Possibilities for Sex Offenders in Eppingen, Stuttgart in 1977. Report in, Heim N, Hursch CJ: Castration for sex offenders; treatment or punishment? A review and critique of recent European literature. *Archives of Sexual Behavior, 8*:281–304, 1979.
46. Eibl E: Treatment and after-care of 300 sex offenders, especially with regard to penile plethysmography. Reported in, Heim N, Jursch CJ: Castration for sex offenders: treatment or punishment? A review and critique of recent European literature. *Archives of Sexual Behavior, 8*:281–304, 1979.
47. Heim N, Jursch CJ: Castration for sex offenders: treatment or punishment? A review and critique of recent European literature. *Archives of Sexual Behavior, 8*:281–304, 1979.
48. Rieber I, Sigusch V: Psychosurgery on sex offenders and sexual deviants in West Germany. *Archives of Sexual Behavior, 8*:523–527, 1979.
49. Schmidt G, Schorsch E: Psychosurgery of sexually deviant patients: review and analysis of new empirical findings. *Archives of Sexual Behavior, 10*:301–323, 1979.
50. Brecker EM: *Treatment Programs for the Sex Offender*. National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U.S. Department of Justice, U.S. Government Printing Office, Stock Number 027-000-00591-8, Washington, D.C., January, 1978.
51. Kraft-Ebing R von: *Psychopathia Sexualis*. Translation from the 12th German Edition by Klaf FS. New York, Stein and Day, 1965.
52. Group for the Advancement of Psychiatry: *Psychiatry and Sex Psychopath Legislation: The 30's to the 80's*. IX, Publication No. 98, New York, 1977.
53. Rada R, Kellner R, Laws D, Winslow W: Drinking, alcoholism, and the mentally disordered sex offender. *Bull Am Acad Psychiatry Law, 6*:296–300, 1979.
54. Groth, AN: Patterns of sexual assault against children and adolescents. In Burgess AW, Groth AN, Holmstrom LL, Sgroi SM(Eds.), *Sexual Assault of Children and Adolescents*, Lexington Mass., Lexington Books, 1978.
55. Groth AN: Men Who Rape: *The Psychology of the Offender*. New York, Plenum Press, 1979.
56. Tracy F, Connelly H, Mergenbesser L, MacDonald D: Program evaluation: recidivism research involving sex offenders. In Greer JG, Stuart IR (Eds.), The Sexual Aggressor-Current Perspectives on Treatment. New York, Van Nostrand Reinhold Company, 1983.
57. Rappeport JR: Enforced treatment—is it treatment? *Bull Am Acad Psychiatry Law, 2*:148,158, 1974.