

Psychological Treatment of Pedophiles

Ron Langevin, Ph.D.
Reuben A. Lang, Ph.D.

The main treatment problem of pedophilia is motivating the offender to change. Reasons for the perpetrator's resistance to therapy and strategies for motivating them to change are discussed. Current assumptions about the etiology of this sexual anomaly are examined. Results from a databank of sex offenders are reviewed to show that it is uncommon for pedophiles to be victims of sexual abuse, including incest, and few need pornography as stimulants. Therapeutic difficulties include the egocentric, egosyntonic, and erotically gratifying nature of pedophilia to the perpetrator, his unwillingness to give up his behavior, his tendency to rationalize his acts, and to see the child as consenting. Group therapy and a variety of clinical imagery procedures with case examples are discussed as ways of overcoming the poor motivational state of pedophiles for treatment.

INTRODUCTION

The treatment literature on pedophilia is sparse and dominated, it seems, largely by behavioral therapies. In fact, 78% of the reported studies most often have used aversive conditioning in one form or another (Kelly, 1982). This procedure has been the treatment of choice for modifying sexually anomalous behavior, in general, over the past 25 years. Recent reviews of the literature have been provided by Quinsey (1984) and Langevin (1983) indicating the multiplicity of problems to be faced before an effective method is available. As an alternative to aversive techniques (e.g., chemical, olfactory or electrical), less painful and physically discomforting therapeutic procedures have also been used to achieve comparable

Ron Langevin, Ph.D., is Senior Research Psychologist, Clarke Institute of Psychiatry, and Associate Professor of Psychiatry at the University of Toronto. Reuben A. Lang, Ph.D., is a Consultant Psychologist, Sex Offender Program, Alberta Hospital Edmonton. Correspondence and reprint requests should be addressed to: Dr. Ron Langevin, Clarke Institute of Psychiatry, 250 College Street, Toronto, Ontario, Canada, M5T 1R8.

Behavioral Sciences & the Law, Vol. 3, No. 4, pp. 403-419 (1985)

© 1985 John Wiley & Sons, Inc.

CCC 0735-3936/85/040403-17\$04.00

behavioral changes. Obviously a thorough review of older procedures is not possible here; instead general problems will be discussed along with new directions for treatment.

Who is Being Treated?

A major difficulty has been the definitional ambiguities surrounding pedophilia. Age-related criteria have been used with discrepancy in age between offender and victim as little as 4 years and as great as 10 years. In some instances sexual acting out with a victim up to 18 years of age has been included because it legally defined a minor. According to the diagnostic criteria of DSM III (American Psychiatric Association, 1980), pedophilia has been defined as:

... the act or fantasy of engaging in sexual activity with prepubertal children as a repeatedly preferred or exclusive method of achieving sexual excitement. The difference in age between the adult with this disorder and the prepubertal child is arbitrarily set at ten years or more. For late adolescents with this disorder, no precise age difference is specified; and clinical judgments must be used, the sexual maturity of the child as well as the age difference being taken into account.

In the past few years, assessment of penile reactions (phallometry) has been used in some reports to define pedophilia. Unfortunately, standardized phallometric tests are almost nonexistent. The few workers employing these measures have not evaluated their test stimuli for reliability and validity. Freund et al. (1972) are an exception. Their test consists of 54 movie clips of 14-second duration depicting men and women, boys and girls, as well as nonerotic neutral materials, serving as control stimuli. Although 95% of heterosexuals vs. homosexuals who prefer mature partners (androphiles) can be correctly identified, only two-thirds of admitting pedophiles and one-third of nonadmitting pedophiles can be correctly identified (Freund, Chan, & Coulthard, 1979). It is well known that phallometry can be faked (Laws & Holmen, 1978; Freund, Chan, & Coulthard, 1979; Freund, 1981; Rosen, 1973; Rosen, Shapiro & Schwartz, 1975; Earls & Marshall, 1983) and certainly men awaiting trial or probation may try to appear conventionally heterosexual. However, Freund's test only samples reactions to body shapes and not to behavior. For example, admitting pedophiles may show a response preference for exposing which would be undetected in this procedure. It is well known that exhibitionism and pedophilia overlap, but other response tendencies have also been considered important in pedophiles; namely sadism, regressive play, humiliation, and domination. Work in progress is attempting to detect faking and to extend stimuli to cover more facets of human sexuality. Too often unvalidated materials have been used clinically and legally for a measure that has high face validity and results have not been questioned.

Ultimately one must *ask* the pedophile what he erotically prefers to do, and/or one must examine his criminal record as a starting point in diagnosis and in defining

therapy goals. A critical factor in all sexual anomalies is the reluctance of clients to admit their sexual preferences and, even in admitting them, to want to let go of urges that are so powerful and rewarding, that they are willing to risk everything including family, friends, careers, and incarceration to satisfy them.

What Are We Treating?

Given that one has a client who admits his erotic attraction to minors, what goals can be set for therapy? Historically, attempts were made to suppress sexual responses with aversive conditioning. This was recognized to be ineffective by itself and more positive methods such as anxiety relief conditioning, assertion, or social skills training, instruction in human sexuality, and the like were added to increase heterosexual responsiveness. In some studies, it was found that the positive methods alone were as effective as aversive ones (Langevin, 1983).

The theoretical assumption underlying treatment has been that pedophiles are deficient in sexual capabilities with adult females. In our own work (Langevin, Hucker et al., 1985a), we found that 66% of heterosexual pedophiles were married at some time, 91% had vaginal intercourse with an adult female and even 50% of homosexual pedophiles had done so. It seems the assumptions about the pedophiles' deficiencies have been misguided and based on heterosexualcentric theoretical conceptualizations (Langevin, 1985). Traditionally, in older writings, the pedophile has been considered shy, unassertive, and sexually ignorant. (Fisher, 1969; Fisher & Howell, 1970; Howells, 1981) Once again empirical controlled studies do not support this notion (Stermac & Quinsey, 1985; Segal & Marshall 1985; Langevin et al., 1985a & b; Lang et al., 1985; Wilson & Cox, 1983). Nor are they afraid of adult females. In a phallometric study of heterosexual pedophiles, Langevin et al. (1985a) prearoused the research subjects with pictures of children. When they reached criterion penile volume changes, one of the following types of stimuli were shown: full figure nude adult female (or her breasts or pubic area); a male-female couple in sexual intercourse; and erotically neutral material or "disgusting" pictures of skin diseases. There were positive penile volume increases to all erotic materials and little change to neutrals. Only the disgust category produced detumescence. This result and other aspects of the pedophile's history led to the conclusion that they do not have an obvious aversion to adult females.

Parent-child relations and early childhood factors are important to assess, and in many types of psychotherapies they are the focus of change in so far as the client has distorted perceptions or residual memories that continue to affect his present behavior. The one empirical study available that uses a standard instrument suggests that relationships of pedophiles to their fathers are unremarkable, but mothers were perceived as stricter and less affectionate than control subjects considered their mothers (Paitich & Langevin, 1976). Pedophiles identified less with their mothers than controls did.

EARLY SEXUAL EXPERIENCES OF PEDOPHILES

Currently, popular claims implicate early sexual abuse (Groth & Burgess, 1979; Seghorn & Boucher, 1980) and use of pornography (Rush, 1980; Malamuth & Donnerstein, 1984; Densen-Gerber, 1983) as factors in maintaining, if not in creating, sexual anomalies. Empirically controlled research does not unequivocally support these assertions. From our own databank of 429 sex offenders and 54 community controls, information was extracted to examine early sex experiences of pedophiles. Details about the groups and other results are published elsewhere (Langevin, 1983). Twenty nine heterosexual pedophiles, 22 homosexual pedophiles, 160 cases of other sexual anomalies, and 54 controls were compared. The pedophiles showed "pure" anomalies with no other unusual sexual behaviors. The 160 other sexual anomalies were selected to be nonpedophilic and to have single (vs. multiple) anomalies. This group included both heterosexual and homosexual groups that prefer physically mature partners. The community controls were screened to be noncriminal, mentally healthy, nondrug, nonalcohol abusers, and free of sexual anomalies.

Before age 12, the groups differed in terms of sexual contacts which include both consenting and nonconsenting relations (Table I). Heterosexual pedophiles had less sexual experience with boys their own age than the other three groups, but they did not differ on other experiences at that time. Fifteen percent or less of all groups had extensive sexual contacts (more than five times), but the heterosexual pedophiles had significantly more with girls 4 or 5 years older or with adult women than the other three groups. Thus one could argue, for a minority of heterosexual pedophiles (14%), that early sexual experience with an adult was important. If coercion was involved is unknown.

The homosexual pedophiles are unremarkable although there is a trend for them to have had more sexual contact (14%) with males 18 or older, but they are comparable to nonpedophilic sexually anomalous men (15%) in this respect.

At ages 13 to 15, roughly puberty, the heterosexual pedophiles do not differ from controls with the exception of having more extensive experiences (more than five times) with girls their own age. The homosexual pedophiles too have more experience with boys their own age (50%), but are not distinct from nonpedophilic sexually anomalous men. It is likely that both pedophilic groups are starting to manifest their sexual preferences for youths at this time. Nonpedophiles have similar sexual experiences but will go on to enjoy adult partners.

Incestuous experiences (Table II) are also unremarkable in general. Most items are statistically nonsignificant, and only a minority of all groups showed any such experience. Thus to claim that the sexual abuser was an abused child presents several difficulties. First, only a small fraction of this large sample present with such a history. Second, nonpedophilic sex offenders showed a similar background in most respects. Third, healthy community controls do not differ in many regards from the sexually anomalous men. If the early sexual experiences adversely affected the later-to-be sex offenders in the minority who had them, it must have

TABLE I Early Sexual Experiences of Pedophiles, Other Sexually Anomalous Men, and Community Controls

		%Het Ped (N = 29)	% Hom Ped (N = 22)	% Other (N = 160)	% Controls (N = 54)
1. Age 12 or younger had sex play with:					
	Any/ >5 Times				
A. Boys your own age	*	14	45	42	28
	NS	0	14	13	6
B. Boys 4 or 5 yrs. older	**	3	14	21	4
	NS	0	0	0	0
C. Boys 18 or older	*	0	14	15	4
	+	0	0	7	0
D. Girls your own age	NS	41	27	32	44
	NS	0	0	0	0
E. Girls 4 or 5 yrs. older or adult women	+	21	5	8	15
	***	14	0	1	2
2. Age 13 to 15 had sex play with:					
A. Boys your own age	***	14	50	53	13
	NS	0	0	1	0
B. Boys 18 or older	***	0	5	30	6
	NS	0	0	1	0
C. Girls your own age	*	55	18	31	41
	*	24	5	8	6
D. Girls 4 or 5 yrs. older or adult women	*	24	0	11	20
	**	14	0	1	6

*p < .05.

**p < .01.

***p < .001.

NS not statistically significant.

been traumatic, since most men in all groups did not have more than five sexual contacts with any age sex category in Table I. Finally, a history of childhood sexual abuse, by itself, does not explain why most children who are molested do not become abuse perpetrators in later life. Apparently, a history of victimization, if indeed a causal factor, may interact with a variety of other factors (Finkelhor, 1984).

PORNOGRAPHY USE AMONG PEDOPHILES

Currently popular claims suggest that pornography plays an important role in sex offences generally, in spite of empirical evidence to the contrary. In 1970, the U.S. Commission on Pornography and Obscenity found that sex offenders were unlikely to use pornographic materials. The Canadian Government's recent report "Sexual Offences Against Children" (Badgley Commission, 1984) also showed, more specifically, that pornographic materials related to children were few indeed.

TABLE II Incestuous Experiences of Pedophiles and Other Control Groups

		Het Ped	Hom Ped	Other	Controls
<i>Incest Experience in the Family:</i>					
	<i>Any/ >5 Times</i>				
Sex Play With:					
A. Brothers	NS	4	9	17	9
	NS	0	0	3	0
B. Sisters	*	32	9	12	23
	NS	4	0	0	2
Sexual Contact With ^{aa} :					
C. Mother	NS	0	0	0	0
	NS	0	0	0	0
D. Father	NS	0	4	0	0
	NS	0	0	0	0
E. Daughter	+	14	0	8	0
	NS	7	0	2	0
F. Son	NS	0	0	1	0
	NS	0	0	1	0
G. Had sex feelings toward:					
Sister		31	5	12	36
Brother		0	9	7	6
Mother		0	0	3	0
Father		0	0	3	0
None	+	69	86	76	58
H. Ever saw parents have sex	NS	0	0	9	11
I. Ever overheard parents have sex	+	10	0	21	13
J. Saw mother undress to waist	NS	38	27	42	56
	NS	3	0	0	0
K. Saw mother nude	+	21	18	21	37
	NS	0	0	0	0
L. Mother concerned son's genitals clean	NS	48	55	52	43
M. Father concerned son's genitals clean	NS	30	32	30	20
N. Mother washed son's genitals	NS	10	27	14	17
	NS	3	14	8	6
O. Father washed son's genitals	*	0	9	4	15
	NS	0	0	3	4
P. Mother handled son's genitals in sexual way	NS	0	0	0	2
Q. Father had sex play with son	NS	0	5	1	2

NOTE: N may vary slightly from missing data. Percents may not total 100% due to rounding error.

^{aa}Items C to F are based on a second sample of 291 cases including 14 heterosexual pedophiles, 23 homosexual pedophiles, 123 "Other" sexual anomalies, and 50 nonsex nonviolent criminals. Group selection, however, is analogous to that described in text.

TABLE III Use of Pornographic Media by Pedophiles and Nonsex Offender Controls

		% Hed Ped	% Hom Ped	% Other	% Controls
	<i>Any/ >5 Times</i>				
Have you ever seen striptease?	NS	66	50	68	76
Did you enjoy stripshow (of those who saw it?)	NS	24	0	14	28
Were you dis- gusted (of those who saw it?)	NS	65	42	57	61
Do you need pornography for sexual stimula- tion?	NS	14	23	17	13
	NS	11	18	14	4*

*This control group was comprised of nonviolent, nonsex offenders, N = 46. When sex offenders are combined there is a significant tendency for them to need pornography more often than offender controls. Fisher exact $p = 0.0481$, one-tailed test.

NS Not statistically significant.

The pedophiles and community controls from our databank, as noted earlier, were compared on two items: attendance at strip shows and use of pornography for sexual stimulation. In Table III, it appears that community controls are more likely to frequent strips shows than sex offender groups, but the differences were not statistically significant. Similarly, only a minority of all groups need pornography for sexual stimulation. Hence, it is an open question in these cases where the sexual materials stimulated the men to act out or whether they help them control urges to act out by providing some cathartic sexual release. Our findings support those of the 1970 U.S. Commission on Pornography and Obscenity and Fraser (1985) which cite the lack of definitive research linking pornography use to sexual crimes.

Simple explanations of sexual anomalies often lack controlled-research data for empirical support. As a therapist, one has to be extremely cautious about theoretical explanations of sexual preferences. Sexual preference is a powerful and persistent feature of human behavior and there is no evidence that therapy in any form can change it (Langevin 1983; 1985). Our recent work (Langevin et al. 1985a) and that of others (Berlin, 1983; Gaffney & Berlin, 1984) suggests that biological factors, especially neurological and endocrine factors, may play an important role in sexual anomalies, particularly in pedophilia. However, here too, one must be cautious because of the sparsity of studies.

TREATMENT GOALS

Given the foregoing, what are the primary goals of therapy? First, one must recognize the persistence and rewarding quality of the anomalous sexual attraction to the pedophile. We cannot change his preference for children at present. We can,

however, help him *manage* his urges. Second, one must recognize that the pedophile will be reluctant to give up his sexual behavior which he perceives as positive and rewarding, just as conventional heterosexuals perceive their sexuality. Frederic (1975) reports an intriguing finding in which 73 members of the Working Group of Pedophilia were surveyed by questionnaire: very few of them wanted to lose their pedophilia. Castelnovo-Tedesco (1984) has pointed out that most patients fear change, in part, because one must give up a valued part of oneself, regardless of its maladaptive social value. It is useful to ask therapists-in-training how they would feel surrendering their sexuality permanently and taking on perhaps unrewarding and unpleasant sexual behaviors, e.g., how would a heterosexual feel in becoming a homosexual pedophile?

A key factor in the success of any treatment with pedophiles will be motivating them to change. In a study of the effectiveness of Provera (medroxyprogesterone acetate) in reducing sex drive and managing pedophilic behavior, Hucker et al. (in preparation) found that, of 34 men considered suitable for study, only 15 (44%) were willing to take the drug and of these 4 (12%) prematurely dropped out even in a 15-week trial. No motivational instructions were employed in the research study. Most often treatment failures or refusal of treatment in literature reports is not considered as seriously as it should be. Admittedly, such a "chemical castrator" as Provera often suppresses all libido by lowering the circulating testosterone level in the brain, but does not (by itself) modify the offenders' erotic preference pattern for children. Provera and similar antiandrogens may be useful in the management of pedophiles and other sex offenders but a major problem remains, that of motivating them to follow a regimen of drug use (Langevin et al., 1979).

Third, the pedophile's recognition of a need for change in behavior is an important aspect of his case management. This is easier said than done. The whole defensive picture the pedophile presents in initial assessment needs to be addressed. Conspiring to enhance their defensiveness are current legal requirements and social reaction to their behavior. In Canada, the law requires a mental health professional, among others, to notify the Children's Aid Society (CAS) of any child at risk. Thus a man seeking treatment for his pedophilia may encounter the "double agent" (Greenland, 1971) who serves as helper-therapist and informer for the law. The law at present does not encourage therapeutic relationships but then, that was not its intended purpose. Forewarning all potential clients of your responsibilities or accepting only clients known to the CAS may help to circumvent the problem to some degree. However, the social climate is punitive rather than rehabilitative at present and obtaining a client's confidence is difficult.

Fourth, we should not delude ourselves or the clients that we can actually change erotic preferences, but only stress our willingness to help him manage his urges. Too often extravagant claims have been made without empirical foundation. We have reduced our credibility and left clients wanting and angry.

In order to help the pedophile *want* to change his behavior, initial therapeutic encounters may focus on three goals:

1. Moving the offender to admit to this sexual preferences and to the actual extent of his sexual involvement with children.
2. To help him see the child as a victim rather than as a consenting partner.
3. Overcoming rationalizations about his own motives for sexual involvement with children.

Some of these goals overlap with Groth's (1983) treatment strategies for rapists and sexual aggressors, but ours are more limited in scope and make more limited theoretical assumptions.

Admitting Sexual Preferences

It is well known that sex offenders are notoriously difficult to treat. As such, they are hard-pressed to admit the full extent or frequency of occurrence of their sexually anomalous behavior. Distrust and secretiveness pervade their orientation toward significant others or outsiders; most are manipulative and exploitative.

Presenting behaviors range from denial (e.g., "I didn't do it; it's a case of mistaken identity", or "The child is lying") to pseudoadmitting (e.g., "It just happened once. I was drunk. I'm not interested in kids.") and manipulative use of religion (e.g., "I sinned but I have found God. I'm now a member of Church X. I don't need therapy now, I've been saved.") through an acceptance of pedophilia but resistance to doing anything about it (e.g., "Yes I fantasize about sex with kids. I admit it but why change? That's the way I am.") or defiant admission (e.g., "So what if I'm facing charges? I like diddling kids and you guys (therapists) know beans all about changing it anyway"). Some are genuinely concerned and wish to change, even without criminal charges coercing them into therapy.

Pedophiles are also highly resistant to any treatment process because their behaviors with children fulfill sexual needs. Much of their sexual behavior is ego-syntonic, so pedophiles experience less guilt or awareness of the emotional impact of their intrusive sexuality on children.

Seeing the Child as Victim

From a clinical perspective, acts such as sexually assaulting or sexually engaging prepubertal children are basically impersonal, narcissistic, and egocentric. By and large, erotic gratification is their primary goal. Pedophiles, especially in the current social climate, display a tendency to minimize acting out with children in their sexual history, partly to avoid the prospect of a conviction or longer prison sentence and partly to avoid social ostracism or realistic self-appraisal.

For various reasons, as noted by Sgroi (1984): "the sexual relationship with a child feels safer, less threatening, less demanding, and less problematic than a relationship with an adult" (p. 27). Perpetrators' needs for power, control, and dominance, often implicit rather than directly expressed, are gratifying and self-

serving. Sometimes physical force and verbal or implied threats are used to establish the perpetrator's authority over a resistant victim. Some sexually aggressive men engage in gratuitous violence on their victims (Marshall & Christie, 1981); they presumably enjoy the process of forcibly overpowering a child, frightening him or her, and inflicting pain. Some pedophiles, who are only able to receive primarily sexual satisfaction from children, become obsessed with their natural advantages over children.

The offenders often fail to appreciate that the child does not understand the eroticized self-generated fantasies pedophiles have of them. Cognitive distortions (Abel, Becker, & Cunningham-Rathner, 1984) such as, "She (the child) seduced me" or "She enjoyed it" or "It (the sexual act) only happened once," typify the denial used by many offenders. Abel et al. (1984) noted that one issue common to the cognitive distortions of pedophiles is that the perpetrators never attempt to validate their beliefs with other adults. When in treatment, offenders often portray their sexual activity with children as an impromptu act. Careful inquiry often reveals the opposite. Intensive interpersonal therapy, sometimes confrontative, allows individuals to gradually confide how they, in fact, preplanned the seductive act and, more importantly, to acknowledge the narcissistic pleasure they derived from sexually engaging the child while, at the same time, ignoring the child's confusion, naivety, or abreaction (Lang, 1985)

Overcoming Rationalizations

Self-report measures, often due to expectancy or social desirability factors, are frequently distorted upon initial assessment (Quinsey & Marshall, 1983; Langevin, 1983; Laws, 1984). In therapy, too, even after sentencing, many pedophiles exhibit less self-disclosure than do many other criminal offenders. This pattern of dissimulation, in our clinical experience, persists for awhile, often several months or longer. The narcissistic or self-indulgent sex offender often rationalizes the problematic behavior as being "just the way I am", and is likely to resist change, since the deviant behavior is deeply ingrained. When patients' behaviors are *ego-alien*, they appear to have a better prognosis than when behaviors are *ego-syntonic*. In the former, sexual and aggressive desires co-occur along with strong feelings of guilt and shame. In the latter, the pedophilic offender is largely free of conflict and fear. Private and public self-awareness is usually low and little empathy for the victim(s) is displayed.

Some investigators have noted the high reported incidence of pedophilia in adults who themselves were molested as children (Groth & Burgess, 1979; Seghorn & Boucher, 1980). Our own data do not support this finding. Nevertheless, at the beginning of treatment, some offenders may rationalize such traumatic occurrences to excuse their own intrusive sexuality but, later on in treatment, confess that their real motives were more hedonistic, sometimes involving force and dominance over children, despite the emotional trauma they themselves suffered when

sexually assaulted. "If you hated it (the molestation) so much, why abuse other children?" offenders are asked. This incongruity between offender as victim and perpetrator is pointed out to dispel rationalizations.

USING GROUP THERAPY

Given their manipulateness, the initial phase of treatment assists the perpetrator to recognize and define what behaviors he needs to change. In group therapy, peer pressure can be brought to bear on the unmotivated offender to induce some internal anxiety, guilt, or concern for the victims' rights. Children, being more naive, trusting, affectionate, and compliant, cannot offer their "true" consent to sexual activities normally reserved for adults, despite contrary claims (Sandfort, 1984).

Group therapy permits offenders to reexamine their hidden motives, including the factors that enhance or reduce erotic gratification. Children, offenders are told, do not question the adult's sense of inadequacy, need to control others, level of social competence, sexual performance (e.g., premature ejaculation), or low frustration tolerance. Emotional intimacy is evidently not the goal of pedophiles since children are not initially aware that the perpetrator seeks primarily sexual gratification. Though treatment is a difficult and time-consuming procedure, offenders gradually begin to disclose more of their manipulateness. Expressions of hostility, blaming others, and evasion are to be expected during all phases of treatment as offenders seek to defend their fragile ego identity.

In this respect, role-playing strategies may be especially useful. One tactic, that of reenacting the offense by other group members, while the perpetrator observes, has promising merits. This, in many cases, has a consciousness-raising effect, so that the perpetrator now sees his sexual behavior as emotionally dishonest. Group members readily point out the self-evident disparities (e.g., that of age, level of understanding, lack of a sharing relationship, deemphasis on open communication, or reciprocal feelings). Blaming the victim is another ploy. Perpetrators may, for example, allege, "The child was seductive, was curious about sex, or did not resist my advances." However, sexually opportunistic men have little compunction about abusing their authority or exchanging affection and attention for sexual activities. Several pedophiles in treatment confided they would put children into uncompromising situations, so that the child felt indebted to them (e.g., "You owe me one.")

As treatment proceeds, the level of self-disclosure increases. Trust and reciprocal respect between therapist and patient evolve. To illustrate, one heterosexual pedophile began with "She seduced me but I didn't penetrate her" to "I hardly ever penetrated her" after several months to "I ejaculated every time after full penetration" (and enjoyed it) by the fourth month of inpatient therapy. Such cases are not atypical.

CLINICAL USES OF IMAGERY

Clinical imagery techniques have proven useful in the modification of affective, cognitive and behavioral processes (Singer & Pope, 1978; Tower & Singer, 1981; Shorr, 1978; 1983). A basic assumption underlying the use of imagery techniques in altering deviant sexual arousal patterns is that the patterns of sexual responses to be imagined (*in vivo*) and real stimuli (extralaboratory sexual contact with children) are isomorphic.

According to Shorr (1983) and Singer and Pope (1978) imagery may serve as a *motivator* of changes. Coping strategies in behavior modification all rely to some extent on the person's capacity to generate some form of inner visual imagery (Singer, 1978). Needless to say, the pedophile's erotic fantasy is a mental representation that varies in its range, evocation, and erotic valence. Once created and indulged in, some fantasies maintain their erotic potency and become exceedingly difficult to extinguish. To many pedophiles, the erotic fantasy, sometimes involving elements of force and dominance, forms an integral part of the sexual interaction scenario, accompanied by orgasmic gratification.

For some sexual perpetrators, daytime or masturbatory fantasies often spill over into overt behaviors. Children are thus placed at-risk for victimization because individuals feel compelled to seek and create increasingly provocative *in vivo* tryouts of their fantasies, adding to the perpetrator's erotic excitement. Even when convicted, however, many pedophiles disavow any such erotic desires. In our experience, assisting pedophiles to externalize such fantasies with a strong erotic valence has important implications for the attainment of therapeutic goals. One case study, that by Levin et al. (1977) noted that guided imagery, which focuses on the client's ability to feel shame or guilt, may assist pedophiles who are somewhat more treatment-resistant or less guilt prone when apprehended. Maladaptive beliefs, attitudes, underlying desires, psychoaffective needs, assumptions, frustrations, and emotions can be highlighted, discussed, and better controlled. A combination of therapeutic techniques borrowed from gestalt therapy and psychodrama (Schramski & Harvey, 1983), and guided or task imagery (Leuner, 1969; Shorr, 1978, 1983) are particularly helpful.

In explaining task imagery, Shorr (1975) states that:

The important ingredient following the initial flow of imagery is to re-experience or re-do the imagery in a manner that leads to a possible healthy conflict resolution (p. 208).

Pedophilic sexual fantasies vary with feelings about sexuality, perceived opportunities for sexual encounters with children, and the mental and emotional well-being of the person. Fantasies and their behavioral concomitants change as we change. Highly therapeutic results can be achieved when a pedophile is asked to face, in some externally depicted form, the full consequences of his sexually anomalous behavior. In this respect, a wide variety of confrontation imagery may be used. In being confronted with viewing one's behavior from many different per-

spectives, reflection occurs which presumably allows one to rethink, rework, and reorganize one's lifestyle, thus providing an opportunity to rehearse new behaviors and social skills with age-appropriate partners. The following short case histories demonstrate the therapeutic usefulness of imagery.

Client A, a 42-year-old mentally borderline, divorced man, was convicted of sexual assault on a female minor. While babysitting, he was accused of enticing an 11-year old girl into a bedroom where he removed her underwear and exposed his penis. The subject performed cunnilingus on the child, then attempted to penetrate her vaginally—but failed.

Graphic portrayals of child-adult sexual activities using a large blackboard have proven beneficial in such circumstances. In one such scenario, a stick figure of the perpetrator with (exaggerated) elongated penis was drawn on the right side, the 11-year-old victim on the far left side, both offender and victim about 3 inches high. Given this image to view, the perpetrator was asked, "Does he really care for her? . . . Do they have a close relationship? . . . Does he love his penis more than her?" Thought-provoking discussion ensued. At one point, the perpetrator exclaimed, "I could not control myself." (cognitive distortion). When then asked, "Well, what if you had to pay the victim several hundred dollars if you became sexually aroused or, conversely, she had to pay you the same amount if you controlled your arousal?" The offender quickly recanted, "Then I would not become aroused." Once the offender admits he had control, then he becomes responsible and accountable for his actions. A simulated-role play with the offender introducing himself with a mock (but erect) penis, thus revealing his real motives, also had a dramatic impact on reversing the perpetrator's coercive sexuality.

Client B, a 38-year-old of average intelligence, married, father of one, prone to sodomize male children, was sentence to 1 year for the indecent assault of a 4-year-old male child. He acknowledged placing his mouth and hands on the child's "private parts" under the ploy of playing a game. He also rubbed his penis against the boy's buttocks and anal region. He is suspected of having sexually engaged at least ten other children and was himself victimized as a child.

This pedophile drew a full size self-portrait on the blackboard, then filled in the body cavity with yellow chalk to reflect his inordinate self-love. The group members asked, "Now, what love do you have left for your wife and child? . . . What room is there for them in your life?" This provoked much discussion on the offender's 'divided commitment', that is, his pedophilic interests vs. his role as father and husband. In another brief role play, the offender wore a sign saying, NO ONE KNOWS THE REAL ME, while other patients portrayed family mem-

bers, sometimes stating, "We love you." Such mini psychodramas have a powerful impact on treatment-resistant pedophiles. In this way, sexually (thematic) laden content can be expressed pictorially and, once externally depicted (or concretized), can serve as the focus of intensive discussion to dispel the offenders' cognitive distortions and to control self-generated fantasies of child-adult sexual interactions, especially the false notion of informed consent.

Client C, a 38-year-old single male of average intelligence, with an extensive history of voyeurism, indecent exposure, and serial offenses against female children, dating back to 1963, was serving a 10-month-sentence for sexual assault on a 5-year-old girl. He fondled the child's vagina while masturbating and, on one occasion, attempted digital penetration causing some minor bruises and internal bleeding to the child. He admitted to fantasizing that the child was an adult and confided, during treatment, that he had no empathy for the victim. He also confessed to molesting several young children in the park directly across from the police station.

During therapy, the offender was asked to role play how he stalked children, seduced them into sex play and, at times, talked in "little boy," the way children do in the "show-and-tell" stage of psychosexual development. This embarrassed him greatly in front of his peers. In a later session, he drew an enlarged vagina on the blackboard and discussed his excessive preoccupation with this part of female anatomy. Over time, this helped neutralize his obsessive sexual interest in children. Another useful strategy is to ask the offender to imagine himself taking a picture of the victim, naked. Then (in imagery) the genital portion only is cut out of the photo and 100 such photos are pasted in a family album. The perpetrator is then asked to introduce the child, ("This is my friend, son or daughter") while showing his friends the pictures in the album. Another variation of this theme is to have the victim (portrayed by another offender) describe what the perpetrator did in school to his or her classmates, the teacher, or principal. Then, the next day, you (the offender) appear in front of the class to explain your affection (obviously not true) for children. Such task imagery exercises, combined with role play and psychodramatic reenactments of their crimes, assists pedophiles to better control their erotic attraction to children.

These techniques are augmented by bibliotherapy, written exercises, and selected films of victims of child sexual abuse, highlighting the negative consequences that premature sexual activities may have on the naive child.

CONCLUSION

Pedophilia has been known to clinicians a long time and yet this sexual anomaly remains confusing and misunderstood. True of sexual behavior, in general, pedophilia has not been examined as extensively in empirically controlled research as one may expect, given the social concern for the child victims of pedophilic acts. Many therapies have been tried but no effective method of treatment has yet

evolved. Socially or politically motivated suppositions about pedophilia are currently popular, in spite of evidence to the contrary. Pornography, for example, does not appear to be important in establishing or in maintaining sexually anomalous behavior. Nor does sexual contact for the perpetrator as a child appear frequently enough to be a major variable in the etiology of pedophilia. In fact, the current trend to see the pedophile as sexually abused himself as a child, may serve as a rationalization in some cases to excuse their acts and to avoid change.

The goals of therapy proposed here are modest and need to be fully tested in controlled research. Nevertheless, these goals deal with a major problem in the management of sex offenders: motivating them to want to control their sexually anomalous behavior. Established techniques have been used: group therapy and clinical imagery methods, borrowed from a variety of schools. The goals of using these procedures have been limited to having the offender admit to his problem, seeing the child as victim, and overcoming rationalizations and/or denial about his own behavior. Once these goals have been met, a variety of therapy methods may be tried on a now-willing client. Spontaneous attempts at controlling sexual urges may occur. Sex drive reducing drugs (antiandrogens) may be helpful or other therapeutic goals may be attempted (e.g., examination of parent-child relations). Even so, one must continue to monitor sexual urges and coping strategies of the pedophile. We cannot, at present, change his pedophilic preference but we certainly can help him control his sexual behavior.

REFERENCES

- Abel, G. G., Becker, J. V., & Cunningham-Rathner, J. (1984). Complications, consent, and cognitions in sex between children and adults. *International Journal of Law and Psychiatry*, 7, 89-103.
- American Psychiatric Association (1980). *Diagnostic and Statistical Mental Disorders* (3rd ed.). Washington, DC.
- Badgely, R. F. (Ed) (1984). *Sexual Offenses Against Children: Report of the Committee on Sexual Offenses Against Children and Youths* (Vol. 1&2). Ottawa, Canada: Ministry of Supply & Services Canada.
- Berlin, F. S. (1983). Sex offenders: A biomedical perspective and a status report on biomedical treatment. In J. G. Greer, & I. R. Stuart (Eds), *The Sexual Aggressor: Current Perspectives and Treatment* (pp. 83-123). New York: Van Nostrand Reinhold Company.
- Castelnuovo-Tedesco, P. (1984). Psychotherapy and the fear of change. *Psychiatric Journal of the University of Ottawa*, 9, 67-70.
- Densen-Gerber, J. (1983). Why is there so much hard-core pornography nowadays? Is it a threat to society or just a nuisance. *Medical Aspects of Human Sexuality*. New York: Hospital Publications.
- Earls, C. M., & Marshall, W. L. (1983). The current state of technology in the laboratory assessment of sexual arousal patterns. In J. G. Yreer, & I. R. Stuart (Eds.), *The Sexual Aggressor: Current Perspectives and Treatment*. (pp. 336-362). New York: Van Nostrand Reinhold Co.
- Finkelhor, D. (1984). *Child Sexual Abuse*. London: The Free Press.
- Fisher, G. (1969). Psychological needs of heterosexual pedophiliacs. *Diseases of the Nervous System*, 30, 419-421.
- Fisher, G., & Howell, M. (1970). Psychological needs of homosexual pedophiles. *Diseases of the Nervous System*, 31, 623-625.
- Fraser, P. (Ed.) (1985). *Pornography and Prostitution in Canada: Report of the Special Committee Pornography & Prostitution. Vol. 1 & 2*. Ottawa, Canada: Ministry of Supply & Services.
- Frederic, B. (1975). An enquiry among a group of pedophiles. *The Journal of Sex Research*, 11, 242-255.

- Freund, K. (1981). Assessment of pedophilia. In M. Cook & K. Howells (Eds.), *Adult Sexual Interest in Children* (pp. 139-179). London: Academic Press.
- Freund, K., Chan, S., & Coulthard, R. (1979). Phallometric diagnosis with 'nonadmitters'. *Behavior Research and Therapy*, 17, 451-457.
- Freund, K., McKnight, C. K., Langevin, R., & Cibiri, S. (1972). The female child as a surrogate object. *Archives of Sexual Behavior*, 2, 119-133.
- Gaffney, G. R., & Berlin, F. S. (1984). Is there hypothalamic-pituitary-gonadal dysfunction in paedophilia? A pilot study. *British Journal of Psychiatry*, 145, 657-660.
- Greenland, C. (1971). Evaluation of violence and dangerous behavior associated with mental illness. *Seminars in Psychiatry*, 3, 345-356.
- Groth, A. N. (1983). Treatment of the sexual offender in a correctional institution. In J. G. Greer, & I. R. Stuart (Eds.), *The Sexual Aggressor: Current Perspective on Treatment*. New York: Van Nostrand Reinhold Company.
- Groth, A. N., & Burgess, A. W. (1979). Sexual trauma in the life histories of rapists and child molesters. *Victimology*, 4, 10-16.
- Howells, K. (1981). Adult sexual interest in children: Consideration relevant to theories of aetiology. In M. Cook, & K. Howells (Eds.), *Adult Sexual Interest in Children*. New York: Academic Press.
- Hucker, S. J., Langevin, R., Bain, J., & Handy, L. (in preparation). A double-blind study of provera used on pedophiles.
- Kelly, R. J. (1982). Behavioral reorientation of pedophiles: Can it be done? *Clinical Psychology Review*, 2, 387-408.
- Lang, R. A. (1985, June). *Aggression and erotic attraction in heterosexual child molesters*. A paper presented at the annual meeting of the Canadian Psychological Association, Halifax, Nova Scotia.
- Lang, R. A., Fiqia, N. A., & Plutchik, R. (1985) Personality, aggression and sexual fantasy patterns of hospitalized sex and violent offenders. *Personality & Individual Differences* (submitted for publication).
- Langevin, R. (1983). *Sexual Strands: Understanding and Treating Sexual Anomalies in Men*. Hillsdale, New Jersey: Lawrence Erlbaum Associates.
- Langevin, R., (1985). The Paraphilias. In M. H. Ben-Aron, S. J. Hucker, & C. D. Webster (Eds.), *Clinical Criminology: The Assessment and Treatment of Criminal Behavior*. Toronto: Clarke Institute of Psychiatry.
- Langevin, R., Handy, L., Russon, A. E., & Day, D. (1985b). Are incestuous fathers pedophilic, aggressive, and alcoholic? In R. Langevin (Eds.), *Erotic Preference, Gender Identity, and Aggression in Men: New Research Studies*, (pp. 161-179). Hillsdale, New Jersey: Lawrence Erlbaum Associates.
- Langevin, R., Hucker, S. J., Ben-Aron, M. H., Purms, J. E., & Hook, H. (1985a). Why are pedophiles attracted to children? In R. Langevin (Ed.), *Erotic Preference, Gender Identity, and Aggression in Men: New Research Studies*, (pp. 181-210) Hillsdale, N.J.: Lawrence Erlbaum Associates.
- Langevin, R., Paitich, D., Hucker, S. J., Newman, S., Ramsay, G., Pope, S., Geller, G., & Anderson, C. (1979). The effects of assertiveness training, provera and sex of therapist in the treatment of genital exhibitionists. *Journal of Behavior Therapy & Experimental Psychiatry* 10, 275-282.
- Laws, D. R. (1984). The assessment of dangerous sexual behavior in males. *Medicine and Law*, 3, 127-140.
- Laws, D. R., & Holmen, M. L. (1978). Sexual response faking by pedophiles. *Criminal Justice and Behavior*, 5, 343-356.
- Leuner, H. (1969). Guided affective imagery (GAI): A method of intensive psychotherapy. *American Journal of Psychotherapy*, 23, 4-22.
- Levin, S. M., Barry, S. M., Gambaro, S., Wolfensohn, L., & Smith, A. (1977). Variations of covert sensitization in the treatment of pedophilic behavior: A case study. *Journal of Consulting and Clinical Psychology*, 45, 896-907.
- Malamuth, N., & Donnerstein, E. (Eds.). (1984). *Pornography and Sexual Aggression*. New York: Academic Press.
- Marshall, W. L., & Christie, M. M. (1981). Pedophilia and aggression. *Criminal Justice and Behavior*, 8, 145-158.
- Paitrich, D. & Langevin, R. (1976). The Clarke parent-child relations questionnaire: A clinically useful test for adults. *Journal of Consulting and Clinical Psychology*, 44, 428-436.
- Quinsey, V. L. (1984). Sexual Aggression: Studies of offenders against women. In D. Weisstub (Ed.), *Law and Mental Health: International Perspectives*, 1, 84-121. New York: Pergamon Press.

- Quinsey, V. L., & Marshall, W. L. (1983). Procedures for reducing inappropriate sexual arousal: An evaluation review. In J. G. Greer, & I. R. Stuart (Eds.), *The Sexual Aggressor: Current perspectives and treatment* (pp. 267-289). New York: Van Nostrand Reinhold Company.
- Rosen, R. C. (1973). Suppression of penile tumescence by instrumental conditioning. *Psychosomatic Medicine*, 35, 509-514.
- Rosen, R. C., Shapiro, D., & Schwartz, G. (1975). Voluntary control of penile tumescence. *Psychosomatic Medicine*, 37, 479-483.
- Rush, F. (1980). *The Best Kept Secret*. New York: Prentice Hall.
- Sandfort, T. G. M. (1984). Sex in pedophilic relationships: An empirical investigation among a non-representative group for boys. *The Journal of Sex Research*, 20, 123-142.
- Schramski, T. G., & Harvey, D. R. (1983). The impact of psychodrama and role playing in the correctional environment. *International Journal of Offender Therapy and Comparative Criminology*, 27, 243-254.
- Segal, Z. V., & Marshall, W. L. (1985). Heterosocial Social Skills in a population of rapists and child molesters. *Journal of Consulting and Clinical Psychology*, 53, 55-63.
- Seghorn, T., & Boucher, R. (1980). Sexual abuse in childhood as a factor in adult sexually dangerous criminal offenses. In J. M. Samson (Ed.), *Childhood and Sexuality*. Montreal: Editions Vivantes.
- Sgroi, S. M. (Ed.) (1984). *Handbook of Clinical Intervention in Child Sexual Abuse*. Lexington, MA: Lexington Books.
- Shorr, J. E. (1975). The use of task imagery as therapy. *Psychotherapy, Theory, Research and Practice*, 12, 207-210.
- Shorr, J. E. (1978). *Go See the Movie in Your Head*. New York: Popular Library.
- Shorr, J. E. (1983). *Psychotherapy Through Imagery*. New York: Thieme-Stratton Inc.
- Singer, J. L. (1978). Experimental studies of daydreaming and the stream of thought. In K. Pope, & J. L. Singer (Eds.), *The Stream of Consciousness*. New York: Plenum.
- Singer, J. L., & Pope, K. S. (Eds.) (1978). *The Power of Human Imagination*. New York: Plenum.
- Stermac, L., & Quinsey, V. L. The social competence of incarcerated sexual assaulters. *Behavioral Assessment* (In press).
- Tower, R. B., & Singer, J. L. (1981). The management of imagery: How can it be clinically useful? In R. Plutchik, & H. Kellerman (Eds.), *Emotion: Theory, Research, and Experience: Theories of Emotion, Vol. 1* (pp. 119-159). New York: Academic Press.
- Tower, R. B., & Singer, J. L. (1981). The management of imagery: How can it be clinically useful? In R. Plutchik, & H. Kellerman (Eds.), *Emotion: Theory, Research, and Experience: Theories of Emotion, Vol. 1*, (pp. 119-159). New York: Academic Press.
- Wilson, G. D., & Cox, D. N. (1983). Personality of paedophile club members. *Personality and Individual Differences*, 4, 323-329.

Copyright of Behavioral Sciences & the Law is the property of John Wiley & Sons Inc. and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.