Sheldon Travin,[1] *M.D.; Harvey Bluestone,*[1] *M.D.;*
Emily Coleman,[2] *M.A.; Ken Cullen,*[2] *B. A.; John Melella,*[3]
M.S.W.

Pedophile Types and Treatment Perspectives

REFERENCE: Travin, S., Bluestone, H., Coleman, E., Cullen, K., and Melella, J., **"Pedophile Types and Treatment Perspectives,"** *Journal of Forensic Sciences*, JFSCA, Vol. 31, No. 2, April 1986, pp. 614-620.

ABSTRACT: Pedophiles constitute a heterogeneous group of sex offenders. Direct physiological assessment of sexual arousal has significantly increased our diagnostic skill and capability of monitoring treatment response. Erectile response studies have indicated that the majority of pedophiles and incest offenders show arousal to other paraphilias and frequently to appropriate adult sexual stimuli. Many sexual offenders deny or minimize their problem during initial interviews, but when confronted with laboratory results indicating deviant sexual arousal, they often acknowledge and elaborate on the paraphilia(s). Complete data and diagnoses are crucial in integrating treatment in the cognitive-behavioral paradigm.

KEYWORDS: psychiatry, criminal sex offenses, deviant sexual behavior, paraphilia, penile transducer, penile erectile response, cognitive-behavioral treatment

Increasingly, researchers have recognized that pedophiles constitute a heterogeneous group of sex offenders. This evolving conceptualization of pedophiles derives partially from improved techniques in diagnosing offenders. As a result of these developments, new treatment approaches more accurately address the specific needs of individual patients.

In the past, the assessment of pedophilia relied heavily on self-report, supplemented by corroborating history from police records. More recently, measurement of erectile response to explicit sexual stimuli has significantly contributed to obtaining accurate diagnoses. It has been the authors' experience that when the sex offender is confronted with laboratory results indicating deviant sexual arousal, he more readily acknowledges his deviant behavior and accepts treatment. Indeed, the offenders often disclose sexual behaviors not mentioned initially. These added data are crucial in developing and implementing appropriate treatment.

These points will be illustrated later in this article by three case histories. It is important to point out that this information was obtained from the sex offenders without guaranteeing confidentiality except in accordance with the existing applicable laws and regulations.

Received for publication 18 May 1985; accepted for publication 18 June 1985.

[1]Associate director and director, respectively, Department of Psychiatry, Bronx-Lebanon Hospital Center, Bronx, NY; assistant clinical professor of psychiatry and professor of psychiatry, respectively, Albert Einstein College of Medicine, Bronx, NY.

[2]Program coordinators of the Sex Offender Program, Forensic Psychiatry Clinic, Bronx-Lebanon Hospital Center.

[3]Chief, Forensic Psychiatry Clinic, Bronx-Lebanon Hospital Center.

The Development of Pedophilia as a Diagnostic Classification

In the past, studies of pedophiles have usually emphasized the inadequate relationships of pedophiles with adult women. In 1951, Bowman wrote that a large percentage of these offenders are impotent and feel too inadequate to approach an adult woman [*1*]. Bowman also felt that "sex is only one aspect of the personality and that it cannot be completely isolated and studied apart from the rest of the personality." Revitch and Weiss [*2*] found many pedophiles to be both emotionally and physically underdeveloped. Pacht et al [*3*] believed that the majority of sex offenders had immature personalities.

Researchers have also attempted to categorize pedophiles in various ways. Cohen et al [*4*] identified three groups of pedophiles: (1) a pedophile-fixated type who has never been able to maintain mature object relationships with his peers; (2) a pedophile-regressed type who managed to have mature peer relationships, but after some confrontation concerning his sexual adequacy or threat to his masculine image began engaging in pedophilic acts; and (3) a pedophile-aggressive type who mainly selects boys for sexually sadistic acts. Groth [*5*] also described fixated and regressed pedophiles. Tasto [*6*] has separated pedophiles into three groups according to their ability to interact socially with adult women and by their sexual arousability to women and children.

Whether pedophilia is indicative of an underlying personality disorder remains under discussion. In 1968, Swanson [*7*] stressed the contributory nature of life events rather than focusing solely on a predictable personality structure. In a review article about child molestation, Quincy [*8*] stated that pedophilic behavior does not necessarily signify a persistent character trait in the offender.

The three editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* reflect the ways that sexual deviations have been conceptualized. In *DSM-I* (1952) [*9*], pedophilia was categorized as sexual deviation and placed under "sociopathic personality disturbance." In *DSM-II* (1968) [*10*], pedophilia was listed with the subgroup of sexual deviations under "personality disorders and certain other nonpsychotic mental disorders." Thus, in both *DSM-I* and *DSM-II*, pedophilia was considered a symptom of underlying personality pathology. Eventually, in *DSM-III* (1980) [*11*], pedophilia was classified as a subcategory under paraphiliac disorders and not associated with sociopathic or personality labels. *DSM-III* does mention, however, that "paraphilias may be multiple or may coexist with other mental disorders such as Schizophrenia or various Personality Disorders." Pedophilia is specifically 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."

Assessment of Pedophiles by Penile Erectile Reponses

Although *DSM-III* is a refinement in our perception of the problem over the preceding two DSMs, new research has further advanced our conceptualization of pedophila. Physiological studies are now able to make subtle differentiations empirically among pedophile types based upon their sexual arousal patterns. In an article reviewing assessment techniques, Zuckerman [*12*] concluded that the most accurate physiological measurements are obtained through the use of the penile transducer.

Studies by Abel et al [*13*] have revealed that the majority of pedophiles show arousal to other paraphilias and often to appropriate sexual stimuli. Although incest offenders are usually viewed in the literature as emerging from a dysfunctional family [*14,15*], they also show this generalization of arousal patterns. Therefore, an adult incest offender is currently not differentiated by many behaviorists from a pedophile other than by his access to the victim. Incest behavior is thus seen by many behaviorists as the cause, rather than as the result, of the dysfunctional state of the family. Marshall et al [*16*] comment that whereas rapists may have motivations other than sexual motivation, the pedophile is primarily sexually moti-

vated. Earls [*17*] points out that some sexual aggressors cannot be identified using penile erectile measurements, but he adds that pedophiles are more easily identified by this technique than any other.

Assessment of Dangerousness

Erectile responses to depictions of violence have assumed a position of prominence in the diagnostic workup of the pedophile. This has particular relevance because Christie et al [*18*] have found in their close scrutiny of police records and medical reports of child victims that, contrary to popular feeling, in more than 50% of the cases excessive physical force was used and 42% of the children were physically injured. Obviously, the prediction of dangerousness cannot be made exclusively by erectile responses, but they should suggest this possibility for the clinician. Marshall et al [*16*] emphasize that whereas erectile responses in rapists are not always pronounced when violence is portrayed, violent pedophiles do show significant arousal in the laboratory to physical aggression.

Abel et al [*13*] computed a Pedophile Aggression Index (PAI), based upon the client's erectile responses to 2-min audiotaped stimulus cues. Specifically, the PAI is the arousal to pedophilic aggressive sexual acts divided by a pedophilic mutually consenting cue. The mean PAI value for less dangerous offenders was 0.67 and the mean PAI value for sadistic child molesters was 2.16.

Similarly, Avery et al [*19*] devised a Dangerous Child Abuse Index (DCAI). They compared 16 less dangerous with 15 more dangerous child molesters by assessing their maximum erectile responses to five-minute audiotaped descriptions of five categories of sexual activities with children. Each offender's highest mean maximum response obtained with the pedophilic aggressive cues was divided by his mean maximum response obtained with the pedophilic consenting intercourse tapes. The less dangerous group generated an average DCAI score of 0.54 and the more dangerous group had an average score of 1.04.

Interview and Psychometric Assessment

Although sexual arousal patterns measured by physiological means are significant, it still constitutes only one component in the evaluation of the sexual aggressor. Earls [*17*] has pointed out the mistake of viewing sexual aggression in a unidimensional perspective. He outlines a wide range of empirical factors that are either etiological or assumed to have some relation to the crime: anger control, alcohol, perceptions of the victims' reaction, deficits in social skills, attitudes towards women, level of sexual knowledge, socio-economic status, and so forth. One way to assess these factors is through clinical interview and psychometric testing.

A standard psychiatric examination is necessary to identify individuals whose severe psychopathology eliminates them from the cognitive-behavioral therapy program for sexual deviation. For example, schizophrenics, substance abusers, and the severely mentally retarded and organically impaired would not be able to participate or benefit. In addition to the psychiatric interview, a detailed sexual history, focusing upon the development and nature of the paraphilia, is needed. The therapist should obtain such information as the onset and course of the sexually deviant behavior, victim characteristics, situational factors such as stress, drugs, and opportunity and the offender's history of child sexual abuse. At the very least, interviewing the offender who denies his problem still offers a means to assess his resistance and his level of motivation for treatment.

Several psychometric tests are employed with sex offenders. The Rathus schedule [*20*] and Adult Self-Expression Scale [*21*] evaluate the individual's assertiveness; an inability to express feelings and the resulting frustration may be related to sexual acting out. The Derogatis Sexual Functioning Inventory [*22*] provides information on a number of potentially

relevant factors, including sexual knowledge, attitudes toward sexuality, body image, sex drive, and fantasy. Careful assessment of each offender's unique cognitive distortions, which he uses to justify his deviant sexual behavior, is also crucial [*23*]. These cognitive distortions will be directly confronted in therapy. As depression often results when an offender faces his sexual problem, the Beck Depression Scale is useful in monitoring the patient's depression level. Finally, standard psychometric tests such as the Minnesota Multiphasic Personality Inventory and the Eysenck Personality Inventory are frequently administered to sexual offenders.

Confrontation of Offender with Laboratory Data

As mentioned above, the laboratory assessment of sexual arousal patterns is indispensible as a means of confrontation with sex offenders. Many offenders either flatly deny having a paraphiliac disorder or minimize the extent of the problem. If they do admit to child sexual abuse, they are usually reluctant to disclose the extent of the sexual act and will often only acknowledge an activity such as fondling. Confronting the offender with the laboratory results frequently elicits admission of sexual deviation(s) or more detailed and accurate reports on the frequency and nature of the paraphilia. Resistance is an issue in any therapy, but with sex offenders therapy is unlikely to be beneficial until the offender is willing at least to admit to sexual deviation. Laboratory assessment via the penile transducer is effective in confronting this type of resistance.

Interpreting the Laboratory Data

A careful interpretation of the laboratory data must be made before arriving at any diagnosis. It is important to point out that erection responses below 10% are generally characterized as artefact. However, it is the relative arousal to deviant stimuli versus nondeviant stimuli rather than the absolute arousal of either that is the most significant criteria in the diagnosis. For example, a male showing a 30% arousal to rape cues may well be within normal limits especially if this client has higher arousal to nondeviant cues. On the other hand, if the highest arousal is 30% to deviant cues and there is lower arousal to nondeviant cues, a sexual problem is indicated.

Case Studies

Case 1—Female Incest

Mr. A. was a 35-year-old man separated from his wife and two children after incest with the older 12-year-old daughter was reported by the victim. The Child Protective Services referred him for assessment and treatment of his sexual deviancy after he was removed from the home. Initially, he acknowledged having fondled his daughter on a few occasions, but nothing else. After the laboratory results were shown to him (Table 1), he admitted to repeated oral-genital sex with his daughter and also to having had sex with one adolescent female outside of the family.

Case 2—Female Adolescent Pedophile

Mr. B. was a 40-year-old unemployed man, separated from his wife for many years, and with a history of episodic alcohol abuse. His intellectual functioning was in the borderline range. He had been undergoing treatment for depression, and when he acknowledged having sexually abused adolescent females in the past and being still attracted to them, he was referred for assessment of his sexual problem. Initially, he denied having any other paraphi-

TABLE 1—*Erection response to slide cues for Case 1.*

Pretreatment	
Stimulus Cue	Avg % Erection
Adult female	51
Adult male	9
Adolescent female	63
Adolescent male	41
Young female	7

liac arousal or behavior. However, when confronted with the laboratory results (Table 2) he reported molesting several young females and one adolescent male.

Case 3—Female Pedophile

Mr. C. was a 40-year-old single man who was recently released from prison after serving 5 years for sexually molesting an 8-year-old girl. At the outset of the assessment procedure, he vehemently protested his innocence and flatly denied committing any offense. Confronted with his laboratory results (Table 3), he admitted that he did sexually abuse the 8-year-old girl. Subsequently, during group therapy, he admitted to further pedophilic acts.

Cognitive-Behavioral Treatment

The additional diagnoses and data obtained from the patient is meaningfully incorporated into a rational and individualized treatment approach. The cognitive-behavioral therapy paradigm consists of two major self-control techniques (covert sensitization and maturbatory satiation) and cognitive restructuring, social and assertiveness skills, and sex education. This paradigm was established at the Sexual Behavior Clinic of the New York Psychiatric Institute by Abel and Becker.

Treatment comprises approximately 30 group therapy sessions with 8 to 12 group mem-

TABLE 2—*Erection response to slide cues for Case 2.*

Pretreatment	
Stimulus Cues	Avg % Erection
Adult female	7
Adult male	0
Adolescent female	60
Adolescent male	10
Young female	57

TABLE 3—*Erection response to slide cues for Case 3.*

Pretreatment	
Stimulus Cue	Avg % Erection
Adult female	80
Adult male	12
Adolescent female	86
Adolescent male	11
Young female	53

bers having a variety of paraphiliac disorders. Covert sensitization involves pairing in the offender's mind aversive images with the deviant sexual fantasies. In masturbatory satiation, the patient masturbates to ejaculation for 10 minutes using adult mutually consenting sexual fantasies, then continues to masturbate for the next 50 minutes focusing on selected aspects of the deviant sexual fantasies, thereby satiating their erotic factor.

Since these techniques involve the patient's deviant fantasies, it is important that the patient uses fantasies that correspond to the actual deviant behaviors. Therefore, the importance of precise diagnoses is self-evident. For example, in Case 1, the fantasies surrounding oral-genital sex with Mr. A's daughter and other female adolescent pedophilic attractions must be incorporated in the hierarchy of fantasies employed in the two self-control techniques. This applies as well to Case 2 in incorporating fantasies of young females and in Case 3 in incorporating adolescent female fantasies. Covert sensitization and masturbatory satiation are the two components in the cognitive-behavioral paradigm that focus on teaching skills to control and decrease deviant sexual arousal. A basic presumption is that the existence of a sexually deviant arousal pattern is an important factor leading to the sexually deviant behavior. Periodic laboratory assessments throughout treatment and follow-up evaluations can thus offer a measure of treatment effectiveness and signal the need for further therapeutic intervention.

Conclusion

A variety of questions about the internal and external validity and the generalization of these sexual arousal responses outside the laboratory setting have also been raised by Farkas [*24*] and other [*25-28*]. Though acknowledging the problem of sexual response faking, Laws and Holmes [*29*] conclude that the use of penile erectile measurements nevertheless remains the single best index of sexual arousal. These measurements, however, should not be treated "reverently as a truly objective measure." Rosen and Kopel [*30*] stress that a clinician should utilize multiple variables for a comprehensive assessment of clinical outcome. They also state that reliance on the client's self-report exclusively during the subsequent two-year period of followup produced a succession of false outcome assessments.

We have likewise concluded that detailed sexual histories and corroborating reports are important but that penile erectile responses are the essential component of any evaluation of the pedophile. Without its use, we would only be able to diagnose and treat the problem acknowledged by the patient and miss many other diagnoses that could be crucial in an individual case. Our experience supports our contention that vital information is obtained when the offender is confronted with the laboratory results. The objective is to connect these more accurate assessments and diagnoses with rational treatment and monitoring techniques. We believe that ignoring aspects of the offender's total arousal pattern would constitute a danger to society.

References

[*1*] Bowman, K. M., "The Problems of the Sex Offender," *American Journal of Psychiatry*, Vol. 108, Oct. 1951, pp. 250-257.

[*2*] Revitch, E. and Weiss, R. G., "The Pedophiliac Offender," *Diseases of the Nervous System*, Vol. 23, No. 2, Feb. 1962, pp. 73-78.

[*3*] Pacht, A. R., Halleck, S. L., and Ehrmann, J. C., "Diagnosis and Treatment of the Sexual Offender: A Nine Year Study," *American Journal of Psychiatry*, Vol. 118, No. 7, March 1962, pp. 802-808.

[*4*] Cohen, M., Seghorn, T., and Calmas, W., "Sociometric Study of the Sex Offender," *Journal of Abnormal Psychology*, Vol. 74, No. 2, 1969, pp. 249-255.

[*5*] Groth, A. N., "Patterns of Sexual Assault Against Children and Adolescents," in *Sexual Assault of Children and Adolescents*, A. W. Burgess, A. N. Groth, L. L. Holmstrom, and S. M. Agroi, Eds., Lexington Books, Lexington, MA, 1978.

[*6*] Tasto, D. L., "Pedophilia," in *Modern Legal Medicine Psychiatry and Forensic Science*, W. J. Curran, A. L. McGarry, and C. S. Petty, Eds., F. A. Davis, Philadelphia, 1980.

[7] Swanson, D. W., "Adult Sexual Abuse of Children, The Man and Circumstances," *Diseases of the Nervous System*, Vol. 29, No. 10, Oct. 1968, pp. 677-683.
[8] Quinsey, V. L., "The Assessment and Treatment of Child Molesters: A Review," *Canadian Psychological Review*, Vol. 18, No. 3, July 1977, pp. 204-220.
[9] *Diagnostic and Statistical Manual of Mental Disorders (DSM—I)*, The American Psychiatric Association, Washington, DC, 1952.
[10] *Diagnostic and Statistical Manual of Mental Disorders (DSM-II)*, 2nd ed., The American Psychiatric Association, Washington, DC, 1968.
[11] *Diagnostic and Statistical Manual of Mental Disorders (DSM—III)*, 3rd ed., The American Psychiatric Association, Washington, DC, 1980.
[12] Zuckerman, M., "Physiological Measures of Sexual Arousal in the Human," *Psychological Bulletin*, Vol. 75, No. 5, May 1971, pp. 297-329.
[13] Abel, G. G., Becker, J. V., Murphy, W. D., and Flanagan, B., "Identifying Dangerous Child Molesters," in *Violent Behavior—Social Learning Approaches to Prediction. Management and Treatment*, R. Stuart, Ed., Brunner/Mazel, New York, 1981.
[14] Kaufman, I., Peck, A. L., and Iagiuri, C. K., "The Family Constellation and Overt Incestuous Relations between Father and Daugther," *American Journal of Orthopsychiatry*, Vol. 24, April 1954, pp. 266-279.
[15] Lustig, N., Dresser, J. W., and Spellman, T. B., "Incest—A Family Group Survival Pattern," *Archives of General Psychiatry*, Vol. 14, Jan. 1966, pp. 31-40.
[16] Marshall, W. L., Earls, C. M., Segal, Z., and Danke, J., "A Behavioral Program for the Assessment and Treatment of Sexual Aggressors," in *Advances in Clinical Behavior Therapy*, K. D. Craig and R. J. McMahon, Eds., Brunner/Mazel, New York, 1983.
[17] Earls, C. M., "Some Issues in the Assessment of Sexual Deviance," *International Journal of Law and Psychiatry*, Vol. 6, 1983, pp. 432-441.
[18] Christie, M. M., Marshall, W. L., and Lanthier, R. D., "A Descriptive Study of Incarcerated Rapists and Pedophiles," Report to the Solicitor General of Canada, Ottawa, 1979.
[19] Avery-Clark, C. A. and Laws, D. R., "Differential Erection Response Patterns of Sexual Child Abusers to Stimuli Describing Activities with Children," *Behavior Therapy*, Vol. 15, 1984, pp. 71-83.
[20] Rathus, S. A., "A 30-Item Schedule for Assessing Assertive Behavior," *Behavior Therapy*, Vol. 4, 1973, pp. 298-406.
[21] Gay, M. L., Hollandsworth, J. G., and Galassi, J. P., "An Assertiveness Inventory for Adults," *Journal of Counseling Psychology*, Vol. 22, 1975, pp. 340-344.
[22] Derogatis, L. R., "Psychological Assessment of Psychosexual Functioning," *The Psychiatric Clinics of North America*, Vol. 3, No. 1, April 1980.
[23] Abel, G. G., Becker, J. V., and Cunningham-Rathner, J., "Complications, Consent, and Cognitions in Sex Between Children and Adults," *International Journal of Law and Psychiatry*, Vol. 7, 1984, pp. 89-103.
[24] Farkas, G. M., "Comments on Levin et al. and Rosen and Kopel: Internal and External Validity Issues," *Journal of Consulting and Clinical Psychology*, Vol. 46, No. 6, 1978, pp. 1515-1516.
[25] Henson, D. E. and Rubin, H. B., "Voluntary Control of Eroticism," *Journal of Applied Behavior Analysis*, Vol. 4, No. 1, Spring 1971, pp. 37-44.
[26] Laws, D. R. and Rubin, H. B., "Instructional Control of an Autonomic Sexual Response," *Journal of Applied Behavior Analysis*, Vol. 2, 1969, pp. 93-99.
[27] Murphy, W. D., Krisak, J., Stalgaitis, S., and Anderson, K., "The Use of Penile Tumescence Measures with Incarcerated Rapists: Further Validity Issues," *Archives of Sexual Behavior*, Vol. 13, No. 6, 1984, pp. 545-554.
[28] Murphy, W. D., Haynes, M. R., Coleman, E. M., and Flanagan, B., "Sexual Responding of 'Nonrapists' to Aggressive Sexual Themes: Normative Data," *Journal of Behavioral Assessment Techniques*, in press.
[29] Laws, D. R. and Holmes, M. L., "Sexual Response Faking by Pedophiles," in *Treatment of Sexual Aggressives*, G. G. Abel, Ed., *Criminal Justice and Behavior*, Vol. 5, 1978, pp. 343-356.
[30] Rosen, R. C. and Kopel, S.A., "Role of Penile Tumescence Measurement in the Behavioral Treatment of Sexual Deviation: Issues of Validity," *Journal of Consulting and Clinical Psychology*, Vol. 46, No. 6, 1978, pp. 1519-1521.

Address requests for reprints or additional information to
Sheldon Travin, M.D.
Bronx-Lebanon Hospital Center
Forensic Psychiatry Clinic
Bronx Criminal Court Bldg.
215 E. 161st St., Rm. 333
Bronx, NY 10451