Edward L. Rowan,[1] *M.D.*

Predicting the Effectiveness of Treatment for Pedophilia

REFERENCE: Rowan, E. L., **"Predicting the Effectiveness of Treatment for Pedophilia,"** *Journal of Forensic Sciences*, JFSCA, Vol. 33, No. 1, Jan. 1988, pp. 204-209.

ABSTRACT: Assessment of progress in a treatment program for pedophiles and the prediction of risk of future offenses are based upon change along four parameters: decreased objective sexual arousal to child stimuli based on negative conditioning and penile tumescence monitoring, decreased emotional congruence with children, improvement in meaningful adult relationships, and effective therapy for disinhibiting factors. The latter three are measured by rating scales completed by both patients and staff. Although statistical analysis of recidivism is in progress, it may not reflect the true frequency of reoffenses. The ability to predict successful treatment is still limited to theoretical and subjective indices.

KEYWORDS: psychiatry, pedophilia, criminal sex offenses

> Upon acceptance of a plea of guilty to the charge of aggravated felonious sexual assault, this Court imposes a sentence of 7½ to 15 years at the New Hampshire State Prison. Five years of the minimum is suspended upon successful completion of the Sex Offender Program and certification by the staff that he is no longer dangerous to children.

Such an order imposes a great deal of responsibility on the clinician who believes that his treatment program is appropriate and effective but must now assess the validity of that belief. Unfortunately, there are no clear guidelines for that assessment. This paper reviews the theoretical basis for treatment, describes the program, and suggests ways to predict success or failure. Case examples illustrate this progression.

Theoretical Basis

Pedophilia is narrowly defined by the Diagnostic and Statistical Manual of the American Psychiatric Association [*1*] as one of the paraphilias, or "the act or fantasy of engaging in sexual activity with prepubertal children as the preferred or exclusive method of achieving sexual excitement." Such a group of offenders comprises only a small part of the universe of child molesters. Another paraphilic offender, the ephibophile, is exclusively aroused by pubescent children; however, even considered together, offenders with such insistently and involuntarily repetitive imagery or acts necessary for sexual excitement are a relatively small group.

Using "pedophilia" in a broader sense, Groth [*2*] differentiated fixated from regressed pedophiles. The fixated individual is developmentally arrested so that children remain his

Received for publication 19 Feb. 1987; revised manuscript received 20 April 1987; accepted for publication 21 April 1987.

[1]Psychiatrist, Concord, NH.

Copyright © 1988 by ASTM International

primary sexual objects and he fails to develop a sexual interest in adults. The regressed individual has had adult sexual relationships but reverts to an interest in children when frustrated in adult interactions. This theory does not address the concept of the paraphilic offender per se.

Considering "pedophilia" in its broadest and most general sense as encompassing all sexual activity with or molestation of children, Finklehor et al. [3] reviewed the literature and attempted to summarize all the theoretical formulations within a four-factor model: sexual arousal, emotional congruence, blockage, and disinhibition.

Sexual Arousal—For an adult to be "turned on" by a child, there has to have been cultural or familial conditioning to sexual activity with children, victimization as a child, or early fantasy reinforced by masturbation.

Emotional Congruence—For emotional congruence, there is a level of comfort and satisfaction in relating to a child and a fit of emotional need. Frequently this is due to arrested development either through retardation, immaturity, or low self-esteem.

Blockage—Adult sexual opportunities may be blocked by traumatic experience with adult sexuality, sexual dysfunction, inadequate social skills, or marital disturbance.

Disinhibition—The pedophile may be disinhibited or lose control characterologically via impulse disorder, chronically via organicity or psychosis, acutely via alcohol, drugs, or situational stress, or culturofamilially via nonexistent family rules.

This broad definition of pedophilia would include the paraphilic, fixated, and regressed pedophiles and reflects the population seen in the criminal justice system.

As Finklehor summarized the literature about etiology, Kilmann et al. [4] summarized the literature about the treatment of pedophiles. There was no consistent approach and no theoretical basis for the treatment modalities which were utilized. Subsequently, Abel et al. [5] outlined a multifactorial treatment approach which includes five treatment strategies: correcting cognitive distortions, providing sex education, promoting social skills, decreasing deviant arousal, and increasing nondeviant arousal.

Correcting Cognitive Distortion—Cognitive distortions arise out of inappropriate attitudes and perceptions of sex roles and sex objects and must be addressed through education and insight oriented therapy.

Providing Sex Education—Sex education may be necessary for those individuals who avoid or lack adult relationships because of fear or inadequate knowledge about sexuality or both.

Promoting Social Skills—Training in social skills is also essential if the pedophile is expected to establish and maintain an adult relationship.

Decreasing Deviant Arousal—After first monitoring the arousal pattern [6], one may then try to extinguish it using aversive techniques or antiandrogenic medication [7].

Increasing Nondeviant Arousal—The most common technique for increasing appropriate arousal is that practiced during normal adolescence, masturbation to appropriate fantasy.

Treatment Program

Approximately 80 men have participated in New Hampshire's Sex Offender Treatment Program since its inception in 1983 [8]. The program is housed within a 20-bed ward within the 60-bed Secure Psychiatric Unit of the Department of Corrections. Prisoner-patients convicted of felonious sexual assault on children are invited or court ordered to participate. A few men have attended in outpatient status as part of their probation; however, such referrals are no longer accepted because, in our experience, limited time involvement results in limited progress.

The Sex Offender Ward operates as a therapeutic community with consistent treatment and custody staff. There are regular meetings to discuss ward issues, and the patients move as a group to recreation, meals, and occupational therapy. In work assignments, education,

and Alcoholics Anonymous meetings, patients may interact with other Secure Psychiatric Unit residents who are not sex offenders. The formal treatment format has expanded from an intense 12-week experience with less structured continuation to an 18-month program in 3 structured 6-month phases. A rating scale (Fig. 1) monitoring program participation, cognitive development, and social skills improvement is completed by both patients and staff at the end of each phase.

Phase I

This introductory phase includes staff led groups addressing social skills, sex education, legal education, and correction of cognitive distortion. Social skills groups emphasize modeling, role playing, and performance feedback. Assertiveness training and anger management are addressed in this phase. Cognitive distortions about sex roles and sex objects are challenged by peer group discussion of these false beliefs and interaction patterns. Each patient is asked to determine how he meets each of Finklehor's criteria and to develop a group approved treatment plan. A very powerful group exercise is a confrontation by women from an Adult Survivors of Incest group. This instills some sense of victim identification and sets the stage for future work on one's own victimization. Patients also participate in a "self-help" group which they initiated. This group is modeled on Alcoholics Anonymous and uses Carnes' *Out of the Shadows* [9] (formerly titled *The Sexual Addiction*) as its basic text. Patient leaders give tests on the content and this group also considers "relapse prevention" techniques such as recognizing the "MO" (modus operandi) and then calling for help.

The group operates actively to both confront and support group members. For those patients who have difficulty in admitting responsibility to the group, the staff may go over police reports with them individually or later read them to the group if there has been no response to individual confrontation. Patients may also be confronted with the results of penile tumescence studies as entry level responses to standardized slides had been recorded.

Phase II

The intermediate phase is available to those who have demonstrated amenability to treatment by making satisfactory progress through Phase I. Therapeutic opportunities include social skills (stress management and communication skills in this phase) and individual therapy. A major focus of individual therapy is to target ways to decrease deviant sexual arousal. Each patient keeps a "fantasy diary" and is helped to develop meaningful covert sensitization responses as negative conditioners, or, if these are not successful, aversive techniques. Ammonia is the primary negative conditioner. Monitoring of penile tumescence to individual fantasy is done to measure the success of conditioned responses. DepoProvera® is available for those who are unable to control fantasy in any other way; however, this obviously interferes with the objective monitoring of arousal patterns. Increasing nondeviant arousal is encouraged through masturbation to appropriate fantasy.

Phase III

Final phase patients may lead self-help groups and continue in individual treatment programs. Conjoint therapy is available if patient and partner wish. Social skills training includes life skills practice if near release into the community; however, the vast majority of patients do not serve their minimum sentence in 18 months. Most return to the State Prison where they continue in weekly support groups made up of former program participants.

Name ______________ Please circle one number for each statement

Date ______________

Are you . . . . . ?	Strongly agree	Agree	No opinion	Disagree	Strongly disagree
Attending all treatment opportunities	5	4	3	2	1
Improving interpersonal communication skills	5	4	3	2	1
Knowing more about sexual behavior	5	4	3	2	1
Taking responsibility for your own sexual behavior	5	4	3	2	1
Not seeing yourself as a victim of circumstance	5	4	3	2	1
Identifying problems leading to arrest	5	4	3	2	1
Seeing a need for lifestyle change	5	4	3	2	1
Participating actively in therapy	5	4	3	2	1
Accepting criticism	5	4	3	2	1
Evaluating realistically your own progress	5	4	3	2	1
Appreciating needs and feelings of others	5	4	3	2	1
Being assertive in meeting your own needs	5	4	3	2	1
Disclosing secrets and problem behaviors	5	4	3	2	1
Dealing with anger and stress appropriately	5	4	3	2	1

Rater ______________

FIG. 1—*New Hampshire Sex Offender Treatment Program rating scale.*

Prediction

Self-report of progress is the most traditional but least reliable method of assessment. Prediction based on inclusion in a particular group or class is an alternative approach. Gross generalizations such as "homosexual pedophiles are more likely to reoffend than heterosexual pedophiles" and "fixated pedophiles are more likely to reoffend than regressed pedophiles" have face validity, but may not be specific enough for individual prediction.

More objective standards may be based on the theoretical model with improvement demonstrated on each of Finklehor's four parameters. For an individual patient, this may be that he is less sexually aroused by child stimuli based on penile tumescence monitoring or that he has agreed to continue DepoProvera with monitoring of testosterone levels. Blockage to meaningful adult relationships has been addressed through social skills training or therapy; the specific disinhibition has been addressed appropriately with approaches such as alcohol counseling, antipsychotic medication, or stress reduction; emotional congruence with children has been overcome with education and therapy.

The patient's assessment of his own progress (or lack thereof) using our Likert rating scale is compared with the pooled assessment of the staff on that same scale with regard to that progress. The greater the congruence among the patient rating, staff rating, and other objective evidence of improvement, then the greater the confidence we have in our predictions.

Two brief cases illustrate these predictive indices. Both men completed the program before our acquisition of tumescence monitoring capability.

Subject A is a 42-year-old man who reported that his alcoholic father had abused his sister but not him. As an adult, Subject A was also an alcoholic and never married. Twice, when intoxicated, he made sexual contact with his niece. In treatment he was an active participant in ward government and therapy groups and Alcoholics Anonymous including the Twelve Step Program. Victim identification exercises led to great remorse and he reestablished contact with his sister, the victim's mother, to begin family reconciliation. Subject A rated his progress as high, and the staff agreed because of his openness, insight, increased self-esteem, and sincere effort to control his alcoholism. He returned to prison with a recommendation for parole.

Subject B is a 52-year-old man who grew up in a very religious household and served many years as a priest. He married a woman of similar background but was impotent with her. The couple operated a day-care center where Subject B made sexual contact with his charges to "comfort them." In treatment he was active in groups but identified more with staff than patients and always insisted that his behavior had simply been "naive." In marital sessions his wife was always supportive and never confrontive. Subject B rated his progress as high, but the staff did not agree because of his continual denial of his own sexuality, failure to understand his behavior, and lack of confrontation by his wife. He chose not to take Phase III but to return to prison to complete his short sentence in minimum custody.

The ultimate predictor might be the recidivism rate; however, given Abel's data that a very small percentage of sexual assaults are reported, then rearrest would not be a reliable indicator of reoffense. We do monitor State Police arrest records and probation reports, however. Studies of the prediction of dangerousness and outcome of psychotherapy suggest that individual therapists feel quite confident in their personal predictions about their own patients; however, the overall predictions are no better than chance. There is no ethical way to monitor free individuals in the community. We may be discouraged by our lack of objective evidence, and our theoretical and subjective estimate of our effectiveness may be the best measure we have. We must continue to treat this challenging population if we are ever to stop the victim-becomes-perpetrator-who-creates-further-victims cycle of child molestation.

References

[1] *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed., American Psychiatric Association, Washington, DC, 1980, pp. 266-275.

[2] Groth, A. N., "Treatment of the Sexual Offender in a Correctional Institution" in *The Sexual Aggressor*, J. Greer and I. Stuart, Eds., Van Nostrand Reinhold, New York, 1983, pp. 160-176.
[3] Araji, S. and Finklehor, D., "Explanations of Pedophilia: Review of Empirical Research," *Bulletin of the American Academy of Psychiatry and the Law*, Vol. 13, No. 1, Jan. 1985, pp. 17-37.
[4] Kilmann, P., Sabalis, R., Gearing, M., Bukstel, L., and Scovern, A., "The Treatment of Sexual Paraphilias: A Review of Outcome Research," *The Journal of Sex Research*, Vol. 18, No. 3, Aug. 1982, pp. 193-252.
[5] Abel, G., Becker, J., and Skinner, L., "Behavioral Approaches to Treatment of the Violent Sex Offender" in *Clinical Treatment of the Violent Person*, L. Roth, Ed., National Institute of Mental Health, Rockville, MD, 1985, pp. 100-123.
[6] Bradford, J. M. W., "The Psychiatric Evaluation of the Sexual Offender," *Newsletter of the American Academy of Psychiatry and the Law*, Vol. 10, No. 1, April 1985, pp. 18-19.
[7] Berlin, F. and Meinecke, C., "Treatment of Sex Offenders with Antiandrogenic Medication," *American Journal of Psychiatry*, Vol. 138, No. 5, May 1981, pp. 601-607.
[8] Rowan, E. and Rowan, J., "Developing a Treatment Program for Pedophiles," *Corrective and Social Psychiatry*, Vol. 31, No. 2, April 1985, pp. 62-64.
[9] Carnes, P., *Out of the Shadows*, CompCare, Minneapolis, MN, 1983.

Address requests for reprints or additional information to
Edward L. Rowan, M.D.
6-D Hills Ave.
Concord, NH 03301