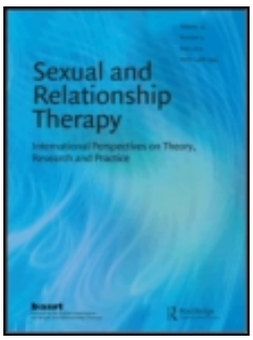

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Current developments in psychotherapy for child molesters

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ABSTRACT *This article reviews current methods and recent developments in psychotherapy for treating child molesters. Topics covered include enhancing motivation, moderating deviant sexual arousal, increasing empathy, enhancing capacity for intimacy, modifying cognitive distortions, preventing relapse and patient–treatment matching.*

Introduction

Child sexual abuse is of intense social concern, and for good reason. Recent surveys indicate that child sexual abuse is far more frequent than previously believed. For instance, surveys in the USA indicate that, conservatively, 210 000 new cases of child or adolescent sexual abuse occur annually (Finklehor, 1984) and that 15% of all girls and 7% of all boys have been sexually molested by age 18 years (Peters, Wyatt, & Finklehor, 1986). Other reviews have suggested even higher prevalence rates for child sexual abuse (see, for example, studies reviewed in Haugaard & Reppucci, 1988).

The emotional consequences of such abuse can be long-lasting. Feelings of betrayal and powerlessness are common initial responses of children, and sexually abused children commonly show precocious sexual behaviour as children (Gomes-Schwartz, Horowitz & Cardarelli, 1990), although studies with well controlled comparison groups of children are rare. Long-term emotional consequences for child sexual abuse victims are now well documented in the literature. General emotional distress, low self-esteem, depression, post-traumatic stress disorder, sexual difficulties and substance abuse have all been found in greater frequency among child sexual abuse victims than among non-victims (Prentky, 1995).

The costs of such offences incurred by society are high. Such costs include obvious direct costs, e.g. the cost of legal prosecution and incarceration of the offenders and the cost of treatment of the victims. However, indirect costs also mount, including lower productivity of victims as a result of emotional impairment

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secondary to the child sexual abuse (Prentky, 1995). Consequently, if it can be established that treating child molesters reduces recidivism, then such treatment would be justified on monetary as well as humanitarian grounds. Fortunately, evidence now exists that treating child molesters can reduce recidivism. One meta-analysis of treatment outcome studies, for instance, found that treatment reduced recidivism from 27% to 19% on average (Hall, 1995), a small but significant result, whereas other reviews have cited larger effects (Abel *et al.*, 1992; Marshall *et al.*, 1991).

Over the past 15 to 20 years, sex offender treatment programmes, have gradually converged on a common cognitive–behavioural approach. A recent survey of North American treatment programmes, for example, indicates that 88% of the adult sex offender treatment programmes surveyed characterized themselves as cognitive–behavioural, relapse prevention, or psycho-socio-educational (Freeman-Longo *et al.*, 1994). In this article, we review some of the more prevalent treatment methods used with child molesters, one major subgroup of this population.

Enhancing motivation

Treatment of sex offenders is similar to that of other individuals who have appetitive/addictive/compulsive behaviour problems, in that the first order of business is enhancing motivation. An unmotivated patient is unlikely to cooperate with the rigorous treatment protocol required. In the early stages of treatment, motivational interviewing procedures (Miller & Rollnick, 1991) can be useful. In a motivational interviewing approach, the therapist attempts to elicit from the sex offender statements that indicate an awareness of the negative consequences to himself, his loved ones and the victims. The therapist then uses the information elicited to engage the patient in treatment.

Sex offender treatment is challenging for patients. Patients must be committed to discussing behaviours and fantasies about which they are ashamed. Patients must acknowledge that they have harmed others as a result of urges and motives that are despised by the community. Perhaps most of all, patients who have extremely deviant sexual arousal patterns must give up a deep source of excitement and enjoyment. All of these factors require constant therapeutic attention to enhancing and maintaining the patient's motivation.

This initial treatment stage of enhancing motivation is critical. Many of the following treatment methods are structured and require out-of-session work, such as making audiotapes. Such action-oriented procedures would be inappropriate until a child molester patient is sufficiently committed to the treatment process so that compliance is likely. Many sex offender treatment specialists are adopting variants of the stage model of readiness for personal change (Prochaska & DiClemente, 1982). Prochaska & DiClemente propose that patients (and others) progress through identifiable stages in making personal life changes. These stages are precontemplation (no awareness of a need to change), contemplation (ambivalence regarding change), determination (making a commitment to change), action (taking

concrete steps to change) and maintenance (managing risk factors as they occur). By accurately assessing which stage the patient is in, the therapist can avoid fruitless hours struggling to get a non-compliant patient to cooperate.

Moderating deviant sexual arousal

Sexual reconditioning exercises designed to moderate deviant sexual arousal have become a mainstay of sex offender treatment during the past 20 years. Originally, behaviour therapists working with sex offenders believed that reducing deviant sexual arousal was all that was required in treating a sex offender. Later, therapists began to focus on enhancing consenting adult oriented sexual arousal as well. However, most treatment today still focuses on reducing strongly deviant sexual arousal, when present; increasing consenting adult oriented sexual arousal is less commonly the focus of treatment and less frequently discussed in the literature (cf., Quinsey & Earls, 1990, p. 286).

Many forms of reducing deviant sexual arousal involve aversive conditioning techniques. One commonly used form is covert sensitization (Cautela, 1967; Maletzky, 1991; Witt & Sager, 1988), in which the deviant sexual stimulus is paired with aversive imagery. Briefly, one common variant of covert sensitization involves having the offender make audiotapes on which he alternates between reciting the illegal sexual script (in graphic detail) and reciting aversive imagery. Such aversive imagery can range from the natural consequences of such illegal acts to other aversive stimuli, e.g. objects or events the patient finds repugnant or frightening (spiders, vomit). Some patients find an exaggeration of the consequences of being caught useful, for example, imagining the father of a victim catching the offender molesting his child and beating or dismembering the offender. Most authorities recommend enlisting the offender in selecting what imagery would be most aversive. After a few pairings of the deviant sexual script and the aversive imagery, the patient recites an escape fantasy of consenting adult sexual activity, ideally including elements of caring and emotional intimacy. Although in the past, arbitrary aversive imagery (e.g. spiders, vomit) was commonly used, currently the natural aversive consequences of the illegal sexual behaviour are by far the most frequently used aversive stimuli (Witt & Sager, 1988).

A variant that some consider more effective is assisted covert sensitization (Maletzky, 1991). In this procedure the covert aversive imagery is 'assisted' by an overt aversive stimulus. The most common stimulus is an unpleasant odour, such as ammonia. When beginning to imagine the unpleasant stimulus, the offender smells ammonia, thus reinforcing the unpleasant image with a noxious smell.

A relatively new aversive procedure is minimal arousal conditioning (Gray, 1995; Jensen, 1995). In this procedure the patient recites the deviant fantasy only until the point of beginning to experience minimal sexual arousal. He immediately presents himself with an aversive stimulus. Most commonly, again, an overt stimulus such as ammonia is used, although there is no reason a covert imagery aversive stimulus cannot be used. Minimal arousal conditioning can be useful in reducing sexual arousal in highly compulsive offenders, whose sexual arousal may not

decrease if the aversive stimulus is presented when the sexual arousal is intense. By presenting the aversive stimulus early in the fantasy/urge chain, the chain can be disrupted.

A final aversive procedure is satiation (Marshall, 1979), a procedure with a number of variants. However, the basic procedure involves the patient masturbating to orgasm to consenting adult fantasies as many times as necessary to become fully refractory. Then, during this refractory period, the patient recites deviant sexual fantasies into a tape recorder *ad nauseam*. Although original methods called for deviant recitations of at least one hour, recent work indicates that as little as 20 minutes may be sufficient to associate boredom with the previously arousing deviant sexual fantasies (Laws, 1995).

At times, patients will refuse to comply with homework assignments that require them to masturbate. Adolescents may deny any masturbation, and adults may profess religious conversions subsequent to arrest that prohibit masturbation. In such cases, the therapist can use verbal satiation. In this procedure (Laws, 1995), the patient continually recites the deviant sexual script into a tape recorder for at least 20 minutes, the assumption being that repetition will induce boredom.

With most aversive conditioning procedures—satiation aside—the therapist teaches the patient to use the procedure to control future deviant urges. No reconditioning result lasts forever. Consequently, when the patient experiences a deviant urge in the future, he must immediately present himself with an aversive stimulus. Many therapists require their offender patients to carry ammonia capsules to use when experiencing a deviant urge. Hence, therapists teach sex offender patients to use aversive conditioning as a coping skill.

Increasing empathy

Sex offender treatment specialists view victim empathy training as a core sex offender treatment component, used by 93% of programmes treating adult male offenders (Freeman-Longo *et al.*, 1994). There is a disagreement about how to define empathy, whether sex offenders possess a specific or generalized deficit, if empathy can be taught, and what may be the most effective interventions to enhance emotional awareness of victim impact issues with different types of sex offenders; nonetheless sex offender treatment specialists believe that increasing an offender's emotional recognition of victims' trauma will inhibit future offending (Hildebran & Pithers, 1989). In fact, in all areas of coercion and violence, lack of empathy can act as a strong disinhibitor (Prentky, 1995).

Enhancing victim empathy with sex offenders requires more than an intellectual understanding of the effects of sexual abuse on victims. Currently, empathy is most often defined as having both cognitive and emotional components, and most importantly, being reflected in behaviour towards others (Patterson, Worley & Murphy, 1992; Pithers, 1994). The combination of a caring relationship, accurate perspective taking, and the ability to cope with perceived distress tends to result in sympathetic and compassionate emotional responses (Hanson, in press). Empathy deficits may be present in one or all of these areas, may be general or specific, and

may be stable or situational, i.e. only present when intoxicated or when experiencing intense emotions, including sexual arousal (Hanson & Scott, 1995). A recent study of perspective taking, an individual's ability to adopt another person's perspective in a situation (Hanson & Scott, 1995), found that incest offenders' perspective-taking deficits tended to be highly specific to situations similar to their own offending. These results suggest that working on perspective-taking deficits and assisting sex offenders to recognize the suffering they have caused their victims, may be most effective with those child molesters who care about their victims, as is the case with many incest offenders. On the other hand, treatment interventions designed to increase perspective taking by focusing on victims' suffering would be contraindicated for child molesters who used overt force and are indifferent to or aroused by their victims' distress and pain.

General issues to be aware of in a victim empathy treatment component include: (a) sensitizing without desensitizing the offenders to victim trauma; (b) acknowledging personal victimization issues of the offenders without implying a causal relationship; (c) supporting the belief that all sexual assaults can be damaging; and (d) discriminating between true empathy and superficial signs of empathy (Patterson, Worley & Murphy, 1992). Environmental influences, including the effect of prison life (for incarcerated child molesters) and television talk shows, can be desensitizing factors. Video tapes about sexual abuse, role plays and bibliotherapy can be effective means to help sensitize offenders to victim impact issues (e.g. Freeman-Longo *et al.*, 1996), but there is danger in their overuse, which could result in desensitization. Childhood sexual abuse, physical abuse, neglect, and more general personal victimization issues are important treatment issues that need to be addressed without encouraging offenders to shift responsibility for their behaviour and blame others. Helping offenders to see their victims, and all other victims, as individual persons can assist in conveying the belief that all sexual assaults can be damaging, instead of some acts being worse than others. Sex offenders often learn what the therapist expects of them and what others want to see and hear, and then can readily produce tears, statements of remorse, or insight, all of which are not necessarily true signs of empathy. Patterson *et al.* (1992) recommend a flexible discussion, rather than a rigid focus on specific signs and techniques of empathy. Genuine empathy will be evident in everyday interactions outside the group setting as well as within the group; consequently, ratings and feedback from the child molester's significant others regarding empathic behaviour can be useful in assessing the effectiveness of the interventions.

Enhancing capacity for intimacy

Despite the cognitive–behavioural tone to much of the treatment literature concerning child molesters, there has been a resurgent interest in broad interpersonal issues, particularly in child molesters' ability to establish and maintain intimate adult relationships. Work in the area relies on an integration of attachment, intimacy and sex offending theories (Marshall, 1989).

Recent studies of intimacy, fear of intimacy and feelings of loneliness among sex offenders (Seidman *et al.*, 1994; Ward *et al.*, 1995a) has shown that sex offenders have significantly greater intimacy deficits than non-sex offending criminals and than a control group; extrafamilial child molesters typically score highest on fear of intimacy (Seidman *et al.*, 1994). A related study of adult attachment styles among sex offenders (Bumby & Marshall, 1995) found that over 52% of child molesters could be classified as having a fearful–avoidant attachment style. This style is characterized by a strong desire for intimacy and social contact, together with distrust and fear of rejection, resulting in emotionally distant, superficial relationships (Ward *et al.*, 1995a). These men may seek intimacy through sexual encounters with children, whom they perceive as less rejecting and less interpersonally threatening than adults.

Treatment of intimacy and bonding deficits, and the resulting loneliness, is a critical focus in current psychotherapy of child molesters. Enhancement of relationship skills through assertiveness training, social skills training and conflict resolution training have been core components of child molester therapy for many years (Abel *et al.*, 1992; Marshall, 1989; McFall, 1990). Increasing empathy, not solely for victims, is crucial, given the importance of empathy in intimate relationships (Marshall, 1989). Presently, there exist organized programmes for integrating the above areas together in a manner that decreases loneliness (Rook, 1984). Fortunately, the literature regarding treatment procedures for interpersonal skills deficits is reasonably well developed.

Modifying cognitive distortions

Cognitive distortions, self-statements that allow sex offenders to deny, minimize and justify their sex offending behaviour, are a common focus of sex offender treatment. Sex-role stereotyping, adversarial sexual beliefs and rape-myth acceptance (e.g. 'women say no, but they really mean yes') (Burt, 1980) frequently need to be addressed. The most prevalent form of cognitive distortions deal with offences themselves. Offenders tend to justify and minimize their sexually offensive behaviour. This minimization is to be expected and can be viewed simply as an attempt to reduce the cognitive dissonance that results from knowing that one has just performed a socially reprehensible action.

A variety of methods indirectly reduce such minimizations. For instance, victim empathy exercises raise the child molester's awareness of the negative consequence of his actions to his victims, thereby creating a cognitive set inconsistent with minimizing. Anger management, although on the surface unrelated to cognitive distortions, is helpful if anger, resentment, and blame of others are part of the child molester's justification scheme. Moreover, any treatment approach that enhances the child molester's self-esteem is useful, in that individuals whose self-esteem is high would be expected to feel less need to justify their actions and more able to tolerate personal failings.

Direct methods to reduce justifications involve having the child molester adopt an objective, external perspective regarding his justifications. Such procedures might

involve having the child molester with his justifications on one side of a sheet of paper and writing realistic counter-thoughts on the other side. A commonly used procedure involves role reversal role play exercises in which the child molester adopts, for example, the role of a therapist, while another individual in the therapy group adopts the role of the rationalizing, justifying child molester (Abel *et al.*, 1992).

Ward *et al.*, (1995b) have suggested an interesting explanation for sex offenders' cognitive distortions. During stressful situations and when confronted by painful circumstances, a sex offender's ability to consider his behaviour from wider perspectives is limited by a process Ward *et al.* label cognitive deconstruction. This deconstruction creates a narrowing of focus that hides from awareness such abstract notions as concern of others' welfare, the potential of criminal consequences, and even how committing the offence will change the offenders's self-opinion. While in the deconstructed state, the offender thinks at the simplest, most concrete level, only enough to meet the immediate goal of committing the sexual offence. Such limited awareness precludes wider concerns for the welfare of others, or even the long-term consequences to oneself.

This deconstruction process suggests that offenders require treatment to increase awareness of the triggers for this deconstructed state. Stress inoculation procedures in which the offender rehearses coping with the anticipated stressful situation can assist the offender in preparing to manage difficult situations and maintain wider awareness of the implications of his behaviour.

Relapse prevention

Relapse prevention refers to a group of treatment strategies designed to maintain abstinence from unwanted behaviour. Relapse prevention use behavioural skills training and cognitive interventions to enhance the child molester's ability to manage his behaviour effectively (Abel *et al.*, 1992). Originally designed to assist individuals with substance abuse problems (Marlatt & Gordon, 1980), relapse prevention has also been found to be effective with individuals who commit sexual offences (Abel *et al.*, 1992; Marshall *et al.*, 1991). This system of behavioural maintenance is designed for, and requires a level of commitment to, abstinence from the target behaviour, in this case molesting children.

The assumption of relapse prevention is that relapse is the end of point of an identifiable sequence of events. That sequence is:

(a) Abstinence: the child molester at some point is abstinent from the target behaviour. Such abstinence enhances feelings of self-efficacy and confidence. Unfortunately, these positive feelings may lead to a false sense of security.
(b) Seemingly unimportant decisions: these decisions, called variously apparently irrelevant decisions (Pithers, Marques, Gibat & Marlatt, 1983) or seemingly inimportant decisions (Steen, 1993), hidden in complex, often superficially logical rationalizations, obscure the fact that the decisions will place the child molester in high risk situations.

(c) High risk situations: these situations can consist of either some significant stressor—such as negative emotions or interpersonal conflict (Abel *et al.*, 1992)—or circumstances that provide access to potential victims and opportunity to offend.
(d) Adaptive coping response: at this point, the child molester can either recognize the nature of the risk and remove himself from the situation or fail to do so, leading him closer to relapse.
(e) Lapse: a lapse can involve either a fantasy or urge to molest children or planning the means to do so.
(f) Abstinence violation effect: when some offenders who experience a period of time without troubling deviant urges then experience those urges or recognize that they are planning an offence, they incorrectly assume that the therapy was not successful. This leaves the offender despondent and feeling hopeless about ever controlling child molesting behaviour. This has been labelled the abstinence violation effect (AVE) (Marlatt & Gordon 1980) and can be damaging to the patient's self-esteem and feelings of self-efficacy.
(g) Adaptive coping response: at this point, the child molester can, again, recognize the precarious nature of the situation and take appropriate steps—such as leaving the high risk situation or calling someone in his support system—or fail to do so and relapse, molesting a child.

Often child molesters will adamantly deny any preplanning or intent to sexually victimize. They will find themselves in high risk situations with little awareness of how they got themselves in those situations. An important part of relapse prevention is to make these offenders aware of the above identifiable chain of events that lead from abstinence to relapse. Additionally, some therapists assist the patient to cultivate a support network of friends, co-workers, relatives and therapy group members upon whom the patient can rely if under a stress or at risk.

Child molesters (and some therapists) are under the misconception that treatment for sexual offenders is only effective if the client is free from any future urges to engage in deviant behaviour. It is more realistic to assume that an individual with a habit problem might experience future urges to commit the problem behaviour. Offenders who have been given realistic expectations about the goals of treatment learn that even though troubling urges might return, that offender does not have to act on them. Through relapse prevention, child molesters learn alternative coping behaviours, reacting to the deviant urges with behaviour that demonstrates self-awareness and self-control.

Many sex offender treatment providers notice the similarity between these conceptualizations and the notion of the sexual assault cycle (Lane, 1991) used commonly by adolescent sexual offender treatment providers. Both of these frameworks have been found clinically useful. The ultimate test of effectiveness is whether the client can learn more about his or her own behaviour and develop a better sense of self-control over the deviant aspects of that behaviour.

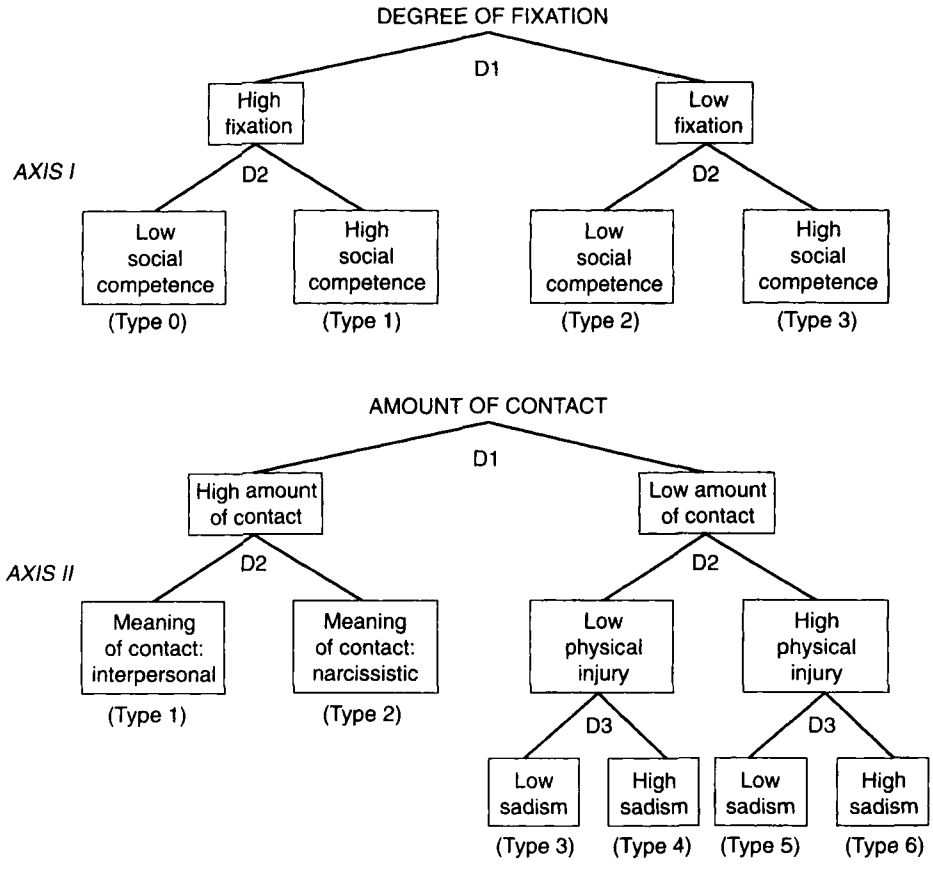

FIG. 1. Child molester classification system.
Source: Knight *et al.*, 1989; Prentky & Knight, 1990. Reprinted with permission.

Patient–treatment matching

Child molesters are a heterogeneous population. Not every child molester will require the same treatment protocol. One offender may require more rigorous sexual reconditioning exercises to reduce highly deviant arousal. Another child molester may have weaker deviant arousal, but require more assistance to increase his ability to form secure emotional attachments with other adults.

A few taxonomic systems are available that can guide the intervention process. The most empirically based system classification system (Knight, Carter & Prentky, 1989; Prentky & Knight, 1990) has two axes (see Fig. 1): Axis I (degree of fixation, or extent of sexual preoccupation with children) and Axis II (amount of contact with children).

Within the fixation axis, decisions as to whether the child molester possesses low or high social competence, based on gross measures such as ability to hold a job or maintain a long-term adult relationship, lead to the terminal leaves of this axis (Type I-0, I-1, I-2 and I-3). Within the amount of contact axis, decisions based upon the purpose of the social contact with children (interpersonally gratifying vs

narcissistically gratifying), lead to terminal leaves in the high contact branch (Type II-1 and II-2), whereas first a decision as to the level of physical injury of the victim (low vs high) and then a decision as to the quality of the child molester's sexual fantasies (sadistic vs non-sadistic) lead to the terminal leaves of this axis (Type II-3, II-4, II-5 and II-6). This clear, logical, empirically validated taxonomy can be used to guide treatment interventions.

Dealing first with fixation, highly fixated offenders will have more need for procedures that lower deviant sexual arousal. Such offenders benefit from methods that assist them in learning to disrupt deviant sexual fantasies when they occur, typically by envisioning negative consequences or sometimes by practicing olfactory aversion, i.e. smelling an ammonia capsule if experiencing a deviant fantasy. Child molesters who experience less sexual fixation on children have less need for such procedures.

Within each level of fixation, the classification tree also considers whether the child molester has low or high social competence (see Fig. 1). Here, the level of social competence would predicate the extent to which procedures are used to increase social skills, assertive skills, and the ability to establish and maintain healthy adult relationships. Moreover, if gross social competency deficits exist in the offender—including the inability to get or keep a job or to live independently, for instance—treatment would necessarily include procedures to enhance daily living skills.

Concerning extent of social contact with children, Axis II, child molesters who have extensive social contact with children are divided by the Prentky & Knight system into two groups: those whose extensive social contact is interpersonally motivated (by misdirected needs for emotional nurturance, affection or intimacy) and those whose contact is narcissistically motivated (by the desire to have ready access to children to exploit sexually). The treatment of those child molesters who are interpersonally motivated would include elements as noted above to enhance social competence and the ability to relate intimately with adults, the more appropriate source of satisfaction of such affectional needs. The treatment of those child molesters who are narcissistically motivated would include extensive victim empathy work as well as emphasis on values clarification, psychoeducation concerning others' rights (similar to feminist-oriented educational programmes, with male batterers, such as that of Pence & Paymar, 1993), and discussion of self-justifying 'thinking-errors' (Yochelson & Samenow, 1976, 1977) common among exploitive individuals.

Within the low social contact branch of the Axis II, the child molesters are divided into low and high physical injury, and within each of these branches they are divided into non-sadistic and sadistic, depending on the nature of their sexual fantasies regarding children. Interventions for the physical injury branches of the tree would be predicated upon the nature of the child molester's fantasy life. That is, a child molester with sadistic fantasies would necessarily have a heavy emphasis on treatment that reduces the strength of these aggressive sexual fantasies. He would be instructed in methods of disrupting these fantasies when they are still weak, using methods such as minimal arousal conditioning and covert sensitization. Child

molesters with a strong non-sadistic paedophilic fantasies would also have a heavy emphasis on procedures to reduce deviant arousal.

Conclusion

The treatment of child molesters has gone through a number of stages during the past 20 years. Perhaps the first stage was psychodynamic treatment, in vogue 20 to 30 years ago, the assumption being that resolution of underlying historically based, dynamic conflicts would result in age-appropriate, consensual sexual interests emerging in child molesters. The lack of empirical support for a psychodynamic approach to the problem and the frequent lack of any psychological disorder in child molesters other than a paraphilia (Abel *et al.*, 1992) led to a second stage in which behavioural practitioners went to the other extreme, believing that heavy use of aversive techniques to reduce deviant sexual arousal was all that was necessary (Quinsey & Marshall, 1983). Currently, the methods best supported empirically and in most common use are indeed cognitive–behavioural; however, there has been an integration over the years of broader intra- and interpersonal issues into the treatment. Although sexual reconditioning procedures are still commonly used, most child molester treatment specialists have a focus on intimacy, empathy and healthy social relationships, albeit using primarily structured, cognitive–behavioural methods. Further, work on relapse prevention has also focused on increasing the child molester's ability to cope with negative affect and to live a satisfying, productive life, the assumption being that such lifestyle interventions will make deviant, impulsive behaviours less likely.

Patient–treatment matching is a relatively new area. Although intuitive and plausible, as yet little empirical evidence has been collected in this area. We anticipate that, over the next 10 years, this area will be fruitful, with researchers refining which treatment methods work best with which offenders. Although recent reviews indicate a reasonable level of effectiveness for the above treatment methods (Abel *et al.*, 1992; Marshall *et al.*, 1991; Hall, 1995), systematically tailoring treatment to match the patient's specific needs and deficits is likely to enhance treatment protocol adherence and effectiveness.

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