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# Are pedophiles treatable? Evidence from North American studies

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Abstract

*This paper briefly reviews the concepts of pedophilia and sexual interests and then describes evidence indicating that it is possible to effectively treat pedophiles. Evidence indicates that the sexual interests of pedophiles in children can be effectively replaced by a stronger sexual interest in adults. The studies reported in this paper also reveal that treating pedophiles, as well as other nonpedophilic child molesters, markedly reduces their propensity to abuse children.*

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Key words: pedophilia, treatment

## Introduction

Some clinicians express the belief that pedophilia is untreatable. In some forms this is intended to mean that pedophiles will not respond to treatment by reducing their propensity to molest children sexually. An alternative, somewhat more restrictive form of the belief that pedophiles are untreatable indicates that the specific sexual interest in children that these men have is unmodifiable. From this perspective the best that treatment can achieve is to have pedophiles learn to control the expression of their deviant sexual interests. In this paper I will describe evidence that contradicts these two forms of the claim that pedophiles are intractable to treatment, but first it is necessary to discuss the meaning of the term pedophile.

## Definition of pedophilia

The Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA) serves in North America, and in many other countries, to direct diagnostic practices by providing defining criteria of all disorders. The diagnosis of pedophilia in the DSM is not meant to apply to everyone who sexually molests a child. Even as early as DSM-III [1] it was pointed out that "Isolated sexual acts with children do not warrant the diagnosis of pedophilia". Up to DSM-IV [2] pedophilia was limited to those child molesters who had "recurrent intense sexual urges and sexually arousing fantasies involving sexual activity with a prepubescent child or children" DSM-III-R [3]. Most researchers have interpreted this to mean that pedophilia is limited to only those child molesters who report, or for whom assessments reveal, a persistent sexual interest (or sexual preference for) children (see Freund for a clear statement of this view [4]). The publication of DSM-IV [2, p. 528], expanded the definition to include "behaviors involving sexual activity with a prepubescent child or children".

This behavioral addition to the definition presents problems because it implies that any person who engages in sex with children is a pedophile. However, diagnosticians still maintain a distinction between child molesters who are, or who are not, pedophiles, based on whether or not they have a persistent and clear sexual attraction to children. To make this distinction the diagnostician must either conduct a test that assesses sexual interests or make an inference based on the offender's history and his presentation at interview. The latter process presents difficulties, since sexual offenders are not usually truthful repor-

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ters, and it seems guaranteed to reduce interdiagnostician reliability. Where possible clinicians have relied on the results of phallometric testing to infer sexual interests [5].

The phallometric test (also called "penile plethysmography" or "PPG") presents the client with various forms of sexual stimuli depicting acts with adults or children and may vary the depiction of consent, force, or violence. During these presentations of sexual stimuli, a device is attached to the man's penis to record erectile changes. A sexual interest or preference is evident when the client displays either greater arousal to adult sexual partners (a normative interest), or greater arousal to children (a deviant, or pedophilic, interest), or greater arousal to force, nonconsenting sex with an adult (a deviant, or rape, interest). Phallometry has limitations but it does appear to be useful in defining current sexual interests [6]. Interestingly, Kingston, Firestone, Moulden and Bradford [7] found that using either DSM criteria alone, or phallometric results alone, or a combination of the two, produced classifications of child molesters (N = 206) that were approximately equivalent although phallometry alone tended to classify somewhat more as pedophilic.

Unfortunately phallometric testing is not always available to clinicians so they often have to rely on drawing inferences from the available information. As a consequence the interdiagnostician reliability of "pedophilia" is far from satisfactory [8, 10]. This problem is made worse by the rather careless use of the label in the literature. Many authors use the term pedophile to describe all child molesters; sometimes, but not always, such authors limit the use of the term to only those child molesters who abuse other people's children. In my discussion of the issues concerning whether or not pedophiles can be treated, I will attempt to restrict my use of the term to only those child molesters who either meet current DSM criteria or who reveal deviant interests in children at phallometric asessments.

## Treatment responses of pedophiles

Actually there are no published studies that specifically compare the responses to treatment of pedophilic child molesters with the responses of nonpedophilic child molesters. Fortunately we have relevant data from our report of the long-term outcome of our community-based treatment program [11]. In the original article the reported recidivism rates were derived from both official and unofficial data sources, resulting in reoffense rates that were between 2 and 3 times greater than official information revealed. For this paper I will report only the official recidivism rates so that readers can more readily compare the data with other studies.

Among the 58 untreated offenders, 18 were diagnosed as pedophilic by a forensic psychiatrist at a court evaluation prior to their referral to our clinic or they were so diagnosed at our clinic. The overall recidivism rate for these untreated offenders was, according to the Canadian Police Information Centre's (CPIC) national records, 16.4%. Of the 18 diagnosed as pedophiles, 5 reoffended resulting in a 27.8% recidivism rate. Thus the untreated pedophiles reoffended at almost double the rate of the overall group, an observation consistent with the expectations of most clinicians. However, among the treated group the reoffense rates of the pedophilic and nonpedophilic child molesters were almost equal.

Of the 68 treated child molesters in the study, 22 were diagnosed as pedophiles which is almost the same proportion as in the untreated group. I then examined the phallometric test results of these 22 clients; 17 of them also met phallometric criteria for pedophilia (i.e., they displayed arousal to children that was greater than 80% of their arousal to adults). Thus, according to both criteria (i.e., clinician's diagnosis and phallometric sexual responses), these 17 child molesters were pedophilic.

The overall official reoffense rate for the treated group was 6.8%. However, among the 17 unequivocal pedophiles only 1 had reoffended. This rate (i.e., 5.9%) of reoffending among the pedophiles is somewhat lower than the rate for the 51 treated nonpedophiles (7.8%), and lower than the overall rate for the treated group. Had I simply relied on the psychiatrists' diagnoses the results would have been much the same; in both cases the treated "pedophiles" did at least as well as the nonpedophiles. In addition, the treated pedophiles had far lower reoffense rates (i.e., 5.9%) than did the untreated pedophiles (i.e., 27.8%). Thus, the results appear to contradict the claim that pedophiles are untreatable, despite the rather small numbers in these analyses.

## The modification of deviant sexual interests

For the claim that sexual interests (or sexual preferences) cannot be changed there is a plethora of data that contradict this view. First, however I need to discuss the meaning of the terms "sexual interest", "sexual preference" and "sexual orientation".

**Sexual orientation** usually refers to a preference for male or female adults (i.e., gender orientation) and

I will follow that practice. Attempts to change sexual orientation (which was restricted to attempts to change homosexual men into heterosexuals) all but ceased in most Western countries sometime in the 1960 and 1970s, partly because such attempts were usually unsuccessful, at least with exclusive homosexuals [12]. With changes in society's attitudes toward homosexuality, most clinicians nowadays refuse to try to modify sexual orientation. Given that treatment approaches have radically changed since the 1970s, it remains a somewhat open question as to whether or not sexual orientation is modifiable. However, whatever the answer is to this question, the fact remains that attempts to change homosexuals into heterosexuals are largely driven by prejudicial, and unfounded, attitudes about sexual orientation that have no place in clinical practice.

**Sexual preferences** describe a person's characteristic preference for particular kinds of sexual activity, or for people of a particular age, or for some specific stimuli (e.g., fetishistic stimuli). Whereas there is evidence suggesting a biological basis for sexual orientation even among homosexual males [13] there is presently no evidence pointing to an inborn sexual attraction to children [14, 15]. While there is some, but very weak, evidence of neurological impairment in a small number of child molesters, these same impairments have been found in all types of offenders [16]. Exactly why some men sexually molest children is presently not clear although we [17––19] have offered theoretical accounts of how this might happen. These theories, which are evidence-based, suggest that a sexual interest in children arises from various experiences in the childhood, adolescence, and adulthood of these men. The reader is referred to these articles for more details.

At phallometric assessments approximately 50% of identified nonfamilial child molesters display either greater sexual arousal to children than to adults, equal arousal to both, or arousal to children that is within at least 80% of the maximum response to adults. Each of these groups are thought to need treatment directed at modifying these deviant interests. However, even though those child molesters who display between 80% and 100% of arousal to children compared to their responses to adults, are considered to be deviant and in need of specialized treatment, they clearly do not have a **sexual preference** for children; rather, they can be said to display a deviant **sexual interest** in children. For convenience, in this paper I will refer to both these groups of child molesters (i.e., those with a preference for, and those with an interest in, children) as having a deviant sexual interest in children.

If we are correct in claiming that sexual interests are acquired, then quite obviously this opens the possibility that such interests can be reversed. This assumption is, in fact, the guiding notion upon which all behavioral procedures aimed at modifying sexual interests are based. Such procedures have taken many forms, far too numerous to describe here. However these procedures, even in the very earliest days of their use (see the historical reviews by Marshall&Laws [20] and Laws&Marshall [21]), have proven to be effective [22–25]. For example, my colleagues and I have reported a series of controlled single-case studies [26–31] applying behavioral procedures with 10 clearly pedophilic child molesters (as defined by both psychiatric diagnoses and phallometric assessments). Our evaluations of the behavioral treatment interventions revealed dramatic reductions in arousal to children and also the long-term elimination of deviant acts. We have recently updated the long-term evaluation of these cases by accessing the CPIC national data base. This recent update revealed that none of these 10 pedophilic child molesters have reoffended over what is now a 30-year period. It is also important to note that repeated post-treatment phallometric evaluations conducted up to 2-years after treatment, consistently revealed normal sexual interests in these 10 offenders. These findings are consistent with numerous other reports in the literature revealing both stable changes in sexual interests over extended time and a marked reduction in (and in many cases, an elimination of) reoffense rates.

Origins of pedophilic interests and their comprehensive treatment

Our view of child molesters [19, 32, 33] is that these men turn to children for sex (and for intimacy and emotional comfort) because their life history has not equipped them with the skills, attitudes, emotional regulation, and self-confidence that are necessary to meet their needs in appropriate ways with adults. For example, Howells [34] showed that child molesters felt more comfortable with children who they viewed as nonthreatening, obliging, and easy to control, whereas adults were seen by these men as threatening, demanding, and controlling. We have also reviewed evidence that reveald serious disruptions in the childhood relations between child molesters and their parents that led to reduced self-worth and poor relationship skills [35]. Given our view of child molestation, we have built a comprehensive treatment program that has evolved over the years [11, 36–38] into its present form [39]. This program addresses a wide range of issues: self-esteem, shame, coping skills, empathy, healthy sexual functioning, and relationship

and intimacy skills, as well as emotional and behavioral self-regulation. In addition, we assist these offenders in the generation of a long-term plan aimed at developing a better, more fulfilling lifestyle (see [40] for details). Of course, for the pedophilic offenders we also employ specific procedures to modify their deviant sexual interests (see [41] in press).

In order to test our view that child molesters turn to children for sex, comfort and intimacy because they do not have the capacity necessary to meet these needs with adults, I conducted a study involving carefully selected, highly deviant child molesters. If our thesis is correct, then simply providing child molesters with the capacity to relate effectively with adults (i.e., provide them with the skills, attitudes, and self-confidence) and the opportunity to put these skills into practice, should eliminate their need to turn to children. In laboratory studies of the extinction of a formerly desirable behavior, it has been shown that the process of extinction (i.e., the loss of the previously desired response) is markedly accelerated and made more stable over time, when a new and rewarding behavior replaces the old one [42]. In the present instance this means that among child molesters the provision of the skills necessary to meet sexual and intimacy needs with adults, and providing the opportunity to enact these new skills with an adult partner, should lead to the extinction of sexual interests in children and a corresponding increased sexual interest in adults.

To provide the strongest test of this idea, I [43] carefully selected child molesters who displayed greater arousal to children than to adults at phallometric assessment. Furthermore, among these men I selected only those who had numerous victims and whose offending was repeated over several years. In addition most of them had engaged in penile penetration of their victim's vagina or anus, and most had used some degree of forcefulness in their offenses. Each of them admitted to a long-term sexual interest in children which was manifest in both overt behavior and frequent masturbatory fantasies. All of them were diagnosed as pedophilic by a forensic psychiatrist and each displayed greater arousal to children at phallometric assessment. Thus, I chose only quite deviant child molesters who also clearly met criteria for pedophilia. These clients then entered our comprehensive treatment program except that I deliberately withheld any mention of deviant sexual interests and did not employ any procedures aimed at modifying such interests.

It is important to note that in the prison setting where this program was conducted, inmates have regular conjugal visits with their current established sexual partner. Some of these men, despite their clear sexual interests, had a relationship with an adult for some time prior to their conviction so these long-term partners were the ones involved in the conjugal visits. Others had formed relationships while in prison involving women with whom they had corresponded or who they had met as volunteers. Kingston et al. [7] found no differences in the likelihood of being married between pedophilic and nonpedophilic child molesters, so perhaps it is not surprising that both our groups (i.e., pedophiles and nonpedophiles) had partners with whom they could enjoy conjugal visits. These conjugal visits involve the offender and his partner residing in a private small house on the prison grounds for approximately two days. This allows them to practice all the relationship skills we are teaching them, and also permits them the privacy to have sexual relationships with their partner.

Post-treatment phallometric assessments of the pedophilic offenders in my study [43], revealed normalized sexual interests in each of the participants. Arousal to children was markedly reduced to levels far lower than arousal to adults and was, in fact, somewhat lower than the sexual responses to children shown by the majority of nonoffending males. Arousal to adults among these men had markedly increased at post-treatment to levels comparable to that shown by normal males. These results again point to the fact that deviant sexual interests are modifiable.

## Conclusions

I believe the above studies, and the extensive range of reports in the sexual offender literature, indicate that pedophiles are as responsive to psychological treatment as are nonpedophilic child molesters. Both groups show markedly lowered reoffense rates after release to the community and there appears to be no real difference in recidivism between the pedophilic and the nonpedophilic child molesters. Furthermore, the implementation of specific behavioral procedures to modify the sexual interests of pedophiles has been shown to alter their sexual interests such that these interests are normalized by treatment. Also providing pedophiles with the skills, attitudes, and self-confidence necessary to equip them to meet their sexual and intimacy needs with adults, appears to normalize their sexual interests without the need to directly target their deviant interests. Long-term recidivism studies indicate that child molesters, including pedophiles, who enter psychological treatment, have remarkably lower reoffense rates than would be

expected were they left untreated. Most importantly, there appears to be no difference in the responses of pedophilic and nonpedophilic child molesters to treatment.

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