PARAPHILIC SEX OFFENDERS: A LITERATURE REVIEW AND PROPOSAL FOR PROGRAM DEVELOPMENT IN VICTORIA

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

1.0  THE NATURE OF THE PARAPHILIAS

1.1  PARAPHILIAS

1.2  PAEDOPHILIA
   1.2.1  Definitions and Diagnostic Criteria
   1.2.2  Historical and cultural prevalence
   1.2.3  Biological and legal definitions

1.3  ETIOLOGY OF PAEDOPHILIA
   1.3.1  Predisposition
   1.3.2  Psycho-physiological factors
   1.3.3  Organic impairment
   1.3.4  Endocrine differences
   1.3.5  Alcohol and drug abuse
   1.3.6  Sexual-abuse victims
   1.3.7  Psychological factors
   1.3.8  Theoretical models
   1.3.9  An integrated theoretical model
      1.3.9.1  Emotional congruence
      1.3.9.2  Sexual arousal
      1.3.9.3  Blockage
      1.3.9.4  Disinhibition

1.4  A FEMINIST PERSPECTIVE OF SEXUAL ASSAULT

1.5  ONSET OF PAEDOPHILIA

1.6  OTHER PARAPHILIAS
   1.6.1  Multiple paraphilic offending
   1.6.2  Demographic characteristics

1.7  SUMMARY

2.0  PREVALENCE AND INCIDENCE: THE EXTENT OF PAEDOPHILIC OFFENDING

2.1  INCIDENCE STUDIES
2.2 PREVALENCE STUDIES

2.3 METHODOLOGY

2.3.1 Variation due to number and nature of screen questions

2.4 SUMMARY

3.0 IMPACT OF CHILD SEXUAL ABUSE

3.1 SHORT-TERM EFFECTS

3.2 LONG-TERM EFFECTS

3.3 SUMMARY

4.0 TREATMENT INTERVENTIONS FOR THE PARAPHILIAS

4.1 PHARMACOLOGICAL
4.1.1 Clinical studies using MPA
4.1.2 Clinical studies using CPA
4.1.3 Summary

4.2 COGNITIVE BEHAVIOURAL TREATMENT PROGRAMS
4.2.1 Sexual behaviour
4.2.2 Cognitive distortions
4.2.3 Social skills
4.2.4 Program design
4.2.5 Outcome evaluations
4.2.6 Residential programs
4.2.7 Outpatient programs
4.2.8 Summary

5.0 CHILD-ABUSE PREVENTION PROGRAMS

5.1 CHILDREN

5.2 PARENTS

5.3 PROFESSIONALS

5.4 RESEARCH EVALUATION

5.5 SUMMARY

REFERENCES
This report, which reviews paraphilic (and in particular paedophiliac) sex offending, is offered as part of the background to a proposal for a Centre for Education, Research and Treatment of Sex Offenders in Victoria. A brief outline of the proposal appears at the end of the executive summary.

This report reviews the nature of paraphilia and paedophilia; and the causes, incidence, impact, prevention, treatment and treatment outcome of paedophilia.

1. **The nature of paraphilia**

Paraphilia describes the condition where there is a long-standing and resistant deviant sexual arousal pattern. The condition can include paedophilia, zoophilia, sexual sadism or masochism, exhibitionism, voyeureism, frottage and fetishism. The present report focuses on paedophilia; however, much of the information is relevant to all paraphilia.

**Paedophilia**

Paedophilia describes the condition where pre-pubescent children become the focus of adults' sexual arousal. The condition develops in adolescence.

Targets can be the same sex or the opposite sex; and can be inside the family or outside, or both.

To be diagnosed as a paedophiliac the patient must have experienced a six-month period of intense sexual urges and fantasies relating to pre-pubescent children; and must either have had sexual interaction with a child or been markedly distressed by those urges and fantasies.

The expression of paedophilia may involve using pre-pubescent children for gratification, and this may include sexual intercourse, physical force, rape, exhibitionism, voyeureism, fondling, or digital penetration.

Most paedophiliacs are men. When a woman is a perpetrator there is often a male accomplice and the woman's behaviour may be not defined as true paedophilia. Recent study, however, suggests that female paedophilia may be more common than previously thought.

Paedophilia appears over the centuries to have been part of the social fabric of most cultures, as it is today.

A distinction needs to be made between socio-legal paedophilia (usually defined as involving a victim under the age of legal consent, or a female under 16) and biological paedophilia, involving a pre-pubescent victim (usually under about 12 years). While attraction to the pre-pubescent is biologically dysfunctional and may therefore be regarded as pathological, attraction to the adolescent is not - although it is socio-legally
dysfunctional. The favoured view is that the offender may be regarded as paedophilic if victims are consistently of an age where they are without secondary sexual characteristics.

2. **Causes of paedophilia**

Researchers have investigated a number of possible predisposing factors. These have included: patterns of sexual arousal; impaired brain function; disorders of the endocrine gland; alcohol and drug use; a history of childhood sexual abuse (over 50 per cent report having been sexually abused in childhood); personality; and mal-adaptive social conditioning.

There are no neat conclusions to be drawn about the nature of paraphilia in general or paedophilia in particular. The causes are multi-faceted. Theories explored raise four relevant questions.

1. Why would a person find it gratifying to relate sexually to a child?
2. Why would a person be sexually aroused by a child?
3. Why would a person be blocked in seeking gratification from adult sources?
4. Why is a person not deterred by the established socio-legal restraints?

The feminist view of sexual assault raises important questions about the causes of sexual assault in general. This view is that sexual assault is the result of a socially accepted system that eroticises female submission to the male; feminists maintain that it is therefore an exaggeration of the current norms rather than a deviation.

Feminists believe that social change is the answer. At the same time, they support efforts to reduce existing sexual assault.

As well as addressing the immediate aspects of sexual assault, the proposed Centre in Victoria would be able, through research and education, to address the deeper issue of social attitude.

**Other paraphilias**

All paraphilic behaviour involves repeated sexual activity: with non-consenting partners; or with humans, involving real or simulated suffering or humiliation; or using a non-human object for sexual arousal.

One point of view about the diagnosis of paraphilia is that the behaviour must be *necessary* for sexual arousal; another view is that this criterion is too restrictive since many paraphiliacs concurrently carry on non-deviant sexual activity.

**Multiple paraphilic offending**

Studies indicate that many paraphiliacs practise more than one kind of deviant behaviour. For example, an individual may have male and female targets; or incestuous and non-incestuous targets; or may target children, adolescents, and adults; or may practise contact and non-contact behaviour.

The implications for treatment are that it is non-productive to treat individual paraphilias as separate and distinct disorders.

**Demographics**
Paraphiliacs, including paedophiles, come from all sections of society and represent the male population except for deviant sexual behaviour.

3. **Incidence and prevalence of paedophilia**

An inherent difficulty in studies of incidence and prevalence is that perpetrators or their victims must be willing to offer information.

North American figures from 1976 show a steep increase in incidence; this may be due to more cases coming to light. Even so, it is generally agreed that the true incidence is far greater than the figures suggest.

**Prevalence** studies seek to establish the percentage of the population that has been the victim of child sexual abuse. Victim reports are considered to be the most accurate measure. Differences in the definition of abuse and in survey methodology are thought to account for the wide variation in rates recorded. Like incidence, prevalence is thought to be grossly underestimated.

Prevalence studies are believed to provide a more accurate picture than incidence studies, but in general it can be concluded only that between 10 and 50 per cent of the female population have been victims of child sexual abuse.

4. **Impact of child sexual abuse**

Child sexual abuse is likely to result in a range of difficulties in later life, and there is a significantly higher proportion of psychopathology after ten years or more. There is a clear difference between the short-term effects (for example fear, truancy) and the long-term effects (for example depression, over-representation in female correction institutions).

It is therefore clear that paedophilia represents a significant public-health problem deserving urgent attention. It is expected that the proposed Centre would be effective in addressing the Victorian problem, and would provide a centre of strength for a much wider positive effect.

5. **Treatment interventions**

There are two main approaches to treatment - pharmacological and cognitive behavioural.

For pharmacological treatments two structurally similar drugs have been used extensively - medroxy progesterone acetate (MPA), marketed as Depo Provera and used for 20 years, and cyproterone acetate (CPA), marketed as Androcur, and used less widely in the United States and Australia. Both reduce male hormone levels and have the effect of reducing sexual drive and sexual responses to paedophilic stimuli: both offer cause for optimism in the treatment of offenders.

In relation to suitability for treatment with these two anti-androgenes, it may be important to distinguish between two categories of paedophile: those with poor impulse control, where
the child victim is a surrogate partner; and those who are compelled to approach children, and for whom impulse is less of a factor. This area needs more investigation.

Most clinical studies using the drugs tend to focus on immediate results. Most, but not all, clinicians believe that the therapeutic effects of MPA disappear within three weeks - and there are side-effects. CPA is being received with favour by clinicians and appears to have ongoing benefits after treatment stops; however, no information is available about long-term effects, or how they might affect relapse rates. The proposed Centre would have an obvious role in assessing the value of these drugs in the treatment of child sex abuse.

The aim of cognitive behavioural treatment is to change the stimulus for sexual arousal from the inappropriate to the appropriate. Three main areas are targeted: sexual behaviour (using, for example, aversion therapy); thinking patterns (using, for example, the rehearsing of more reasonable beliefs); and social skills (using behaviour models through role-playing).

Program design includes one-to-one treatment; and group therapy, which is more attractive economically and is gaining favour because of the insights of group members into the behaviour being treated.

While outpatient treatment is more economic and may be more appropriate for some offenders, community risk may preclude it and indicate that an inpatient program in a secure setting is more appropriate. Both have their place.

Duration of programs varies. There is no research indicating the most effective length. Clinicians have to make their decisions on the basis of three factors:

* effectiveness for the patient
* the number of patients requiring treatment
* economic restraints.

Evaluating outcomes of cognitive behavioural treatment is difficult because community risk precludes setting up a control group by random means; instead, results are evaluated by comparing re-offence rates of treated offenders with existing re-offence data for untreated offenders. Other limitations on evaluation include:

* methods of selection for treatment
* dropout rate
* numbers of patients evaluated
* length of follow-up period
* type of reporting.

The limitations on evaluation acknowledged, outcome figures generally indicate a significant improvement in re-offence rates and suggest that cognitive behavioural intervention is non-intrusive, relatively economical (outpatient programs particularly), and effective in reducing offending. The proposed Centre would offer extensive opportunities for this type of behavioural intervention and for its evaluation, and would help to answer the need for further research into many aspects of treatment.
6. **Prevention programs**

Sexual-abuse prevention programs target three groups: children, parents, and professionals. All the programs emphasise education and coping skills, and work on the following premises:

* a significant percentage of children suffer abuse
* a large number of victims are never identified
* with certain information victimisation can be prevented or identified at an early stage.

**Evaluation** of prevention programs suggests that for children a difficult concept is that a sexual abuser may be someone they know and love. Programs for children are effective if they take into account the difficulty children have in retaining information. No measure is yet available of the effectiveness of programs for parents and professionals, but they appear valid. In general, more evaluation is needed.

**PROPOSAL**

Centre for Education, Research and Treatment of Sex Offenders

The proposal for this centre originated on recommendations of the April 1990 Conference on Sexual Offences (sponsored by the Victorian Government).

The **rationale** is to provide education, research and treatment facilities more adequate than the present ones, in response to demand from clinicians working with sex offenders.

There are four concurrent developments. The funding for the first three has been provided by the Health Department.

* Establishing of a Chair in Forensic Psychiatry at Monash University.
* Appointment of Associate Professor in Forensic Psychiatry at Melbourne University.
* Relocation of Parliament Place Clinic to purpose-designed premises in the Treasury complex. The new location will accommodate the proposed Centre.
* Evaluation of sex-offender programs at the Parliament Place Clinic. This has highlighted the present lack of resources.

The proposed Centre will be affiliated with Melbourne University's Department of Psychiatry and headed initially by the new Associate Professor in Forensic Psychiatry, who will have responsibility for the Centre's treatment, research and education. The current statutory program will remain the responsibility of Parliament Place Clinic.

The treatment will supplement the present statutory program and consultancy with the Prison Sex Offender Program; and will provide programs for voluntary referrals, using fee-for-service where possible.

The Centre will encourage and sponsor post-graduate research in all relevant departments.

The contribution to education will serve the needs of undergraduates, postgraduates and
clinicians. There will be a small library specialising in relevant research and journals; the OOC Resource Centre will provide this service.

The resource requirements will be two full-time clinical psychologists, a full-time laboratory technician, and a half-time research officer. The required recurrent budget will be $135,000.
1.0 THE NATURE OF THE PARAPHILIAS

1.1 PARAPHILIAS

The paraphilias are described in the Diagnostic and Statistical Manual of Mental Disorders (1987) as sexual disorders `Characterised by recurrent intense sexual urges and fantasies in response to sexual objects or situations that are not part of normative arousal patterns'. In other words the paraphilias are said to describe a condition where there is a long-standing and resistant deviant sexual-arousal pattern. These can include paedophilia, exhibitionism, voyeurism, frottage and fetishism. This paper will focus on paedophilia, although much of the information presented is relevant to all paraphilias.

1.2 PAEDOPHILIA

1.2.1 Definitions and Diagnostic Criteria

Paedophilia, which translates to `love of children', describes the condition where pre-pubescent children elicit and become the focus of sexual arousal of adults. The usual diagnostic criteria require a six-month period of recurrent intense sexual urges and sexually arousing fantasies that involve sexual activity with pre-pubescent children. In addition the patient must have either acted on these urges or be markedly distressed by them. Paedophilia can be limited to same-sex or opposite-sex targets (homosexual or heterosexual); and it may involve incestuous activity, or behaviour outside the family sphere (extra-familial abuse), or both (Diagnostic and Statistical Manual 1987).

The expression of paedophilia by way of child sexual abuse can involve a number of activities, all of which are characterised by the use of a pre-pubescent child for the gratification of an adult and may be manifested in sexual intercourse, physical force, rape, exhibitionism, voyeurism, fondling, or digital penetration.

It is generally agreed that paedophilia is primarily perpetrated by men. Estimates of paedophilic sexual abuse committed by women range from approximately 5% to 20%, (Barnard, Fuller & Robbins 1988; Barnard, Fuller &
Robbins 1989; Moore 1984). An examination of these cases, however, reveals that a number of female perpetrators have male accomplices and their behaviour may not necessarily fall clearly within the definition of true paedophilia. More recent trends however, indicate that female paedophilic activity may be more common than was previously thought to be the case (French 1991).

1.2.2 Historical and cultural prevalence

The sexual use of pre-pubescent children has a long history. It is well documented (Vanggaard 1972) that the use of pre-pubescent boys was common practice in ancient Greece. Medieval canon law officially forbade marriage to girls less than 12 years old; however, it was not uncommon to find girls of 10 years old married to men three times their age (Nobile 1976). It is well documented (Goodrich 1976) that major cities in Europe are littered with children of both sexes acting as prostitutes. According to Trumback (1977) historical accounts from the eighteenth century demonstrate that adult—child sexual activity was accepted practice in Japan, China, Africa, Arabia, Turkey, Egypt and the Islamic areas of India. It would appear that these practices have by no means disappeared in modern times. A number of published ‘travel guides’ explicitly give advice as to how to engage in sexual activity with children. These include the Gentlemen’s Guide to the Pleasures of Discreet Europe (1975) and ‘Lusty Europe’ (Mankoss 1973 cited in Ames & Houston 1990). There is ample evidence to suggest that the intra-familial and extra-familial sexual use of children has a long history and spans most cultures.

1.2.3 Biological and legal definitions

During the 17th and 18th centuries the definition of childhood was biological rather than socio-legal; in effect, therefore, childhood tended to be much briefer. This was the case in pre-industrial Western society, as well as in primitive cultures. Childhood in the case of the female ended with menstruation, and in the case of the male ended when he could physically assume a man’s role (DeMause 1974). A more recent trend in Western society has been to arbitrarily define childhood with a chronological age before which we consider both males and females psychologically and morally children. A number of researchers (Ames & Houston 1990) argue that sexual exploitation of children defined in a socio-legal sense is not necessarily identical to that which involves children in the biological sense. Socio-legal paedophilia is usually defined as involving a victim under the age of legal consent, or, in the
case of females, under 16 years of age; whereas biological paedophilia is usually defined as the sexual use of pre-pubescent children, usually approximately 12 years of age and under. Accordingly, legal paedophilia may have markedly different dimensions from biological paedophilia. From a biological point of view attraction to pre-pubescent children is obviously biologically dysfunctional, whereas attraction to post-pubescent children is not, even though it is dysfunctional in a socio-legal sense in that it is both culturally disapproved and illegal. Some researchers have described the differences between these two behaviours as being akin to ‘true’ paedophilia, as opposed to rape or carnal knowledge where the victim represents a surrogate ‘partner’ not necessarily chosen for their young age. This period of physiological maturity but socio-legal immaturity presents a problem for researchers studying paedophilia in trying to set a point beyond which sexual interaction with children is pathological as opposed to purely criminal behaviour.

Ames and Houston (1990) argue that researchers should use the biological point of maturity as the line between childhood and adulthood when studying paedophilia. In doing so they argue that the practice of sexual activity with post-pubescent but legally defined children is essentially criminal in nature rather than paedophilic. In making this distinction Ames argues that researchers and clinicians should use the criterion of a secondary sex characteristics in subjects as the distinguishing factor when identifying and making a diagnosis on paedophilia. In other words, if the offender’s victims are consistently without secondary sexual characteristics the patient may be classified as paedophilic. Similarly the *Diagnostic and Statistical Manual* (1987) definition of paedophilia stipulates pre-pubescent children as the focus of sexual arousal. Unfortunately, researchers working in this area have failed to agree on an age-limit defining paedophilia, making comparisons between studies difficult.

1.3 ETIOLOGY OF PAEDOPHILIA

1.3.1 Predisposition

Predisposition for paedophilic behaviour is generally agreed to be complex, consisting of both sexual and non-sexual factors that vary widely across individuals. Groth, Hobson and Garry (1982) found little evidence that race, religion, intelligence, education, occupation or social class can differentiate the paedophile from the general population. A number of studies (Barnard et al. 1988, Barnard et al. 1989) indicate that there are a number of psychological as well as sociological factors associated with paedophilic behaviour. These
include stress, dysfunctional home situations, family violence, substance abuse and interpersonal deficits. Paedophiles tend to differ from the general population in terms of cognitive beliefs (Abel, Becker & Cunningham-Rathner 1984) which tend to rationalise adult—child sexual activity and therefore allow them to avoid the negative intra-psychic aspects of their antisocial behaviour.

1.3.2 Psycho-physiological factors
A number of studies have attempted to identify psycho-physiological factors that might distinguish paedophiles from the general population (Freund 1967, Freund & Blanchard 1989). These studies investigate sexual arousal patterns using biofeedback machinery or penile plethysmography, which measures the penile blood flow by way of circumference, or volume. They argue that the paedophile can be distinguished from the general population in terms of his physiological reaction to certain stimuli as measured by penile blood flow. This research indicates that it is possible to identify paedophiles from non-paedophiles as well as paedophilic offenders from non-paedophilic sex offenders. This research identifies differential responding patterns to different stimuli, including child subjects, adult subjects, and adult subjects in scenes depicting violent coercion. The extent to which this technology will accurately identify the paraphilic from the non-paraphilic patient is questionable, however. Considering that the individual's response is open to manipulation and that it is a well documented characteristic of the paedophile to deny his behaviour, this technology has been questioned in terms of its ability to identify a denying paedophile (Fuller 1989). A detailed analysis of this issue is beyond the scope of this paper suffice to say that the accuracy of this technology in detecting and tracking responses is very much open to debate (McConaghy 1990).

1.3.3 Organic impairment
A number of researchers (Miller, Cummings & McIntyre 1986; Lillie, Cummings & Benson 1983) have attempted to identify possible organic impairment present in the paedophilic population. Their studies identify some paedophilic behaviour associated with hypothalamic lesions, alterations in neurotransmitters, and some seizure disorders. These results, however, while indicating a loose association, by no means offer strong support for the hypothesis that paedophilic behaviour is the result of organic brain syndrome.

1.3.4 Endocrine differences
Researchers have investigated whether endocrine differences are associated with paedophilia (Berlin 1983, Schiavi, Theilgaard & Owen 1984). Since testosterone regulates male sexual arousal it was felt the abnormalities in
testosterone levels might contribute to abnormal sexual-arousal patterns. Support for this proposal is slim, however, and there is little evidence to support the hypothesis that plasma testosterone levels are consistently altered in the paedophilic population (Gaffner & Berlin 1984, Fuller 1989).

1.3.5 Alcohol and drug abuse

The extent to which alcohol and/or drug abuse is associated with paedophilic offending has been examined by numerous researchers. A study by Earls et al. 1984 (cited in Ames & Houston 1990) examined a sample of 34 incarcerated paedophiles and found that 26% had committed their crimes under the influence of drugs or alcohol. This percentage, however, is considerably less than the estimates for the general offending (incarcerated) population, which range from 60 to 80%. This suggests that alcohol and/or drug abuse is not a significant factor.

1.3.6 Sexual-abuse victims

Earls et al. 1984 (cited in Ames & Houston 1990) found that 53% of his sample (34 incarcerated paedophiles) claimed to have been victims of sexual abuse in early childhood. This lends support to the popular belief of an inter-generational effect of child sexual abuse. This phenomenon has been replicated in a number of studies. Bard et al. (1987) examined a sample of 68 paedophiles incarcerated in Massachusetts USA; 57% reported having been victims of sexual abuse in childhood. This procedure was administered to a population of 107 rapists in the same institution; it was found that 23% reported being victims of child sexual abuse. The validity of this self-report data has been questioned, however (Finkelhor 1986). At present it is not possible to confirm its accuracy.

1.3.7 Psychological factors

A number of researchers have attempted to describe the psychological functioning of paedophilic offenders. Ames et al. 1987 (cited in Ames & Houston 1990) examined a number of psychological factors and compared paedophilic and non-paedophilic sex offenders. The authors found that paedophilic offenders had a higher frequency of avoidant and dependent personalities and lower frequencies of anti social personalities than those who committed sexual offences against adult women. Wilson and Cox (1983) interviewed 77 paedophiles and found them to present as introverted, sensitive, shy, lonely and depressed — as measured by the Eysenck Personality Inventory.
Ames and Houston (1990) argue that intra-familial (incestuous) child sex abusers present with a different pathology from that of extra-familial child sex abusers. Virkkunen (1974) found that intra-familial sexual abuses frequently involve alcohol abuse. This is in contrast to Earls et al. 1984 (cited in Ames & Houston 1990), who found relatively low level of alcohol abuse. Gebhard et al. (1965) reported that incestuous fathers seldom display diagnosable mental problems. This research adds some credence to the hypothesis that the extra-familial sexual abuser may be a more compulsive offender, as opposed to the incestuous offender who is rather more `impulsive' and whose offences more frequently involve alcohol abuse. Possible differences between intra-familial and extra-familial abusers deserve further research.

1.3.8 Theoretical models

Much of the literature regarding paedophilia is essentially atheoretical (Ames & Houston 1990). This is not to say that theorists have failed to postulate models for the existence of this behaviour. Psycho-dynamic theory essentially sees attraction to pre-pubescent children as representing unresolved conflicts, arrested development, mastery of trauma through repetition and identification with the aggressor, and unresolved oedipal dynamics. (Araji & Finkelhor 1985). Sociologists, on the other hand, have tended to attribute this behaviour in part to the socialisation process: through child pornography and/or advertising; cultural tolerance; and male socialisation to dominant patriarchal norms as well as other repressive attitudes towards sexual behaviour (Finkelhor 1984). Possibly the most popular and practical theory for the existence of paedophilia is that of the behavioural scientists. These theorists essentially see appropriate sexual behaviour as the result of a learning and conditioning process, and that therefore inappropriate sexual behaviour is the result of maladaptive learning and conditioning from early childhood experience. Accordingly, behaviourists argue that it is possible to reshape and relearn appropriate sexual responding through various behavioural techniques. These techniques will be reviewed later in this paper.

1.3.9 An integrated theoretical model

According to Finkelhor (1986), the basic flaw in most theories appears to be their attempt to explain child sexual abuse, in all of its various forms, with one single theory. Whilst this goal is admirable, attempts by and large have been inadequate in explaining the full range and diversity of paedophilic behaviour. As pointed out by Finkelhor (1986), behaviour which comes under the classification of paedophilia can range from the compulsive, predatory child rapist who has a long history of stalking and assaulting his victims in a violent
manner, to vastly different cases involving a man who, after years of seemingly happy and successful heterosexual activity with his wife, approaches one of his children. Given the diversity of the behaviour in question, theorists (Finkelhor 1986) have argued for multi-factorial explanations as a more comprehensive means of explaining paedophilia. Finkelhor, in his review of the theoretical literature, identified four factors concerned with explaining child sexual abuse. According to Finkelhor most of the theoretical literature can be grouped under one or more of the following factors.

1.3.9.1 Emotional congruence
The majority of theories that fall into this category are psychoanalytic in orientation (Groth & Burgenn 1979) and have described paedophilia as representing arrested psychological development. This behaviour is explained on the basis of omnipotence and control, or as identification with the aggressor (Loss & Glansey 1983).

A number of theories point to society as a whole and the socialisation process as being primarily responsible for the existence of paedophilic behaviour. Russell (1986) points out that socialisation promotes the theme that males want sexual and emotional relationships with partners who are subservient, innocent, vulnerable and less powerful. This process he argues, contributes to the development of paedophilic behaviour.

One study (Howells 1979) offers some positive support for the hypothesis that children are sexually attractive to paedophilic offenders
because the offenders are able to dominate their victims. These theories that postulate psycho-dynamic explanations by way of mastery of trauma through repetition and identification with the aggressor, are indirectly supported by several studies. These studies report a high proportion of sexual abusers being victims of sexual abuse in childhood.

1.3.9.2 Sexual arousal
The second category of theories attempts to explain why an adult would be sexually gratified by a child. The fact that this phenomenon exists is substantiated by considerable research examining the psychophysiological responses of subjects to a range of child stimuli. These studies track paedophilic and non-paedophilic subjects' responses by way of blood flow to the penis when exposed to deviant and non-deviant stimuli, slides or videotapes. The vast majority of these studies demonstrate quite clearly that the paedophilic offender has a considerably higher level of sexual arousal as measured by penile blood flow to child subjects, as compared with non-paedophilic controls (Abel et al. 1981; Freund & Lanvegin 1976; and Freund et al. 1973). Most of the theories attempting to explain how sexual arousal to pre-pubescent children develops are behaviourally oriented (Abel & Blanchard 1974, Bandura 1973). These theories postulate that as normal sexual responding is the result of a complex pattern of behaviour learnt via childhood conditioning, likewise so is abnormal sexual responding. This theory postulates that the erotic power of pre-pubescent subjects is maintained via repeated masturbation where children are the subjects of fantasy, thereby continually pairing the subject with the positive experience of orgasm. In this way over time the subject or stimuli develops erotic connotations via a process of classical conditioning. Theories explaining how subjects begin this process are few; however, some authors have argued that childhood sexual abuse may act as a model to the victim such that after the event the victim mimics the behaviour in fantasy and over time becomes sexually attracted to children. The fact that between 50 and 60% of paedophilic offenders report being child victims themselves adds weight to this hypothesis.

Again these theories receive indirect support through numerous
studies that demonstrate, via psycho-physiological assessment, that paedophilic offenders show a heightened sexual arousal to child stimuli, compared with non-offenders. Theories that postulate a process of conditioning through early childhood have some support in the studies showing a higher frequency of child molestation having been perpetrated against the paedophilic offending population.

1.3.9.3 Blockage

The third category of theories refers to those that attempt to explain why paedophilic offenders are unable to find sexual gratification and fulfilment through adult sexual/social relationships. Theories explaining this factor tend to fall into two categories: that of a family dynamics model and that of a behavioural learning model. The behavioural learning model essentially postulates that socio-sexual behaviour is made up of a complex array of skills that are learnt during childhood, adolescence and adult life. This theory postulates that for a variety of reasons the individual has failed to learn the appropriate skills. He is therefore unable to develop gratifying social and sexual relationships in adulthood, and reverts to children where the skills requirement is less critical. Obviously this theory is inadequate in explaining the large number of paedophilic offenders (particularly incest offenders) who have been able to establish and maintain seemingly effective psycho-sexual relationships via marriage and family.

The family dynamics model essentially postulates that a breakdown in marital relationships can contribute to paedophilic offending, (DeYoung 1982). Some theorists (Weinberg 1955) argue that dysfunctional family dynamics (for example those involving repressive sexual norms) or a `closed' family system can contribute to the expression of paedophilic behaviour.

These theories receive mixed support from the research. The theories postulating a lack of social skill in perpetrators relating to adults are generally supported in the research (Hammer & Glueck 1957). Further there are some studies (although uncontrolled) that suggest that paedophilic offenders suffer from high sexual anxiety (Goldstein, Cant
Theories postulating unresolved oedipal dynamics receive only slim anecdotal evidence, indicating that family problems are evident in the background of paedophilic offenders.

1.3.9.4 Disinhibition

The fourth category of theories attempts to explain why the normal legal and social sanctions against adult—child sex fail to inhibit such activity in the paedophilic offender. The feminist theory (Rush 1980) argues that society by and large sanctions child sexual abuse through subtle messages contained in the media, etc. This has the effect of reinforcing offenders' rationalisations for acting out, thereby reducing inhibitions and the effect of social sanctions against such behaviour (Russell 1984).

A number of theorists (Hammer & Glueck 1957) have attempted to explain disinhibition in perpetrators as a symptom of psychosis, neurological impairment and/or alcoholism. Certainly numerous theorists and researchers would agree the paedophilic offender has generally poor impulse control (Groth, Hobson & Garry 1982). It has been argued that this is the result of a cognitive deficit, marked by an absence in consequential thinking. A number of theorists (Pithers 1990) have postulated cognitive models where situational stress acts to exert a disinhibiting effect where the offender is more predisposed towards acting out because it has the effect of temporarily relieving the negative effect of the stressor. McConaghy (1990) postulates a behaviour completion hypothesis as one explanation for the disinhibition of offenders. According to this model, a tight ritual or a string of connected events resulting in the offending behaviour. Once the sequence is commenced the perpetrator will experience extreme anxiety if the sequence is not completed.

These theories receive only mixed support from the research. Hammer and Glueck (1957) identify inadequate control of impulses as a significant factor in sex offenders. Other studies (Gebhard, Gagnan & Pomeroy 1965) however, found evidence of this factor in only a minority of their paedophilic sample. Those theories that postulate organic impairment or senility as the causal factor behind disinhibition receive little or no support from the research (Quinsy, Chaplan & Carragan 1979, 1980). Aarens et al. (1978) reviewed empirical studies concerning alcohol abuse and found that the incidence of abuse at the
time of offending ranged from 19% to 49%. At best it seems the role of alcohol is significant, but does not explain disinhibition in the majority of paedophilic cases.

In concluding, Finkelhor (1986) suggests that there is mixed empirical support for at least some of each of the four categories into which most child-abuse theories fall. At present, however, no one theory can be said to be backed by comprehensive empirical data. Rather, each appears to have some relevance in explaining child sexual abuse.
1.4 A FEMINIST PERSPECTIVE OF SEXUAL ASSAULT

Over the past two decades the feminist movement has been a consistent contributor to our understanding and acknowledgment of sexual assault in general, and therefore a review of this literature is appropriate. Arguably the feminist movement sensitised the community to the existence of a widespread but previously closeted problem. This lead to formal survey research that has consistently documented the high prevalence of all forms of sexual assault. This research is discussed in more detail in 2.2, ‘Prevalence Studies’. Feminist theory has not only contributed significantly to the public's acknowledgement of this large problem but also offers an analysis of the problem that is qualitatively different from the traditional psycho medical approach. In general terms feminist theory views sexual assault as intrinsic to and the result of a system/society where the male holds the majority of power and is dominant. Feminists argue that our society legitimises many forms of sexual assault through its glorification of male sexual dominance over females. Many argue that the dominant culture in our society defines sexuality in a context where male dominance and power and female submission is highly eroticised. In this context sexual assault is not seen as 'deviant' in the sociological sense but an exaggeration of the current prevailing norms, (Herman 1990). Many feminist theorists would argue that this dominance and its expression in sexual assault actually serves a political function in preserving the system of male dominance through intimidation, (Brownmiller 1975). Thus the feminist perspective of sexual assault including paedophilia challenges the conventional view that defines the behaviour as deviant and in terms of psychopathology. Rather, feminist theory sees this behaviour as an expression of prevailing social norms and political power structure.

In support of this contention feminists point to the survey research which clearly indicates that the majority of victims are female (although more recent evidence indicates that boys are a sizeable minority) and further, that the vast majority of offenders are male. Many would argue that the prevalence studies indicate that up to one-third of females have been the victim of some form of sexual assault and that therefore a corresponding proportion of males have been involved in the assaulting. Proportions of this size cannot be regarded as abhorrent and pathological but rather as part of normal behaviour. In a study by Koss, Gidycz and Wisniewski (1987) the authors found that 4.4% of their subjects (male college students aged 21) acknowledged having committed rape in a dating situation, and another 3.3% acknowledged attempted rape. This study also demonstrated a spectrum of sexual behaviour ranging from the aggressive to the unaggressive. Results found that 25.1% of subjects acknowledged using some form of coercion to achieve sexual relations with an unwilling partner. Similar results have been found in other studies.
In a study by Finkelhor and Lewis (1987, cited in Marshall & Barbaree 1990), which involved a random survey, between 4 and 17% of their male subjects acknowledged having molested a child.

Feminist theory argues that rape and child molestation, essentially being social artefacts, will be more common in those societies and cultures where male dominance is strong. Feminist theory cites the existence of cross-cultural studies (Sanday, 1981) which argue that rape is more prevalent in cultures where male figures are ‘worshipped’, where violence is glorified and where women hold little political and economic power and where child care is an inferior occupation. They argue that these conditions exist in modern Western cultures and are expressed in many ways that indicate sexual-assault-condoning attitudes. The best-known expression of this exists in pornography, which frequently eroticises non-consensual sex. The popularity of this medium offers evidence of the existence of paedophilia-supportive and rape-supportive attitudes in our society. Further, a number of surveys examining the attitudes of males offer strong evidence that rape-supportive attitudes are common in the general population. Burt (1980) surveyed high school and college students and found that a majority of subjects considered the use of force acceptable to achieve sexual relations in certain circumstances, e.g. if the woman was ‘teasing’ or getting the man ‘excited’. Further studies demonstrate that scenarios depicting sexual violence are found to be sexually arousing by a significant proportion of the male population (Malamuth & Dennerstein 1984). In this study the author examined college students and found that a majority found a scenario involving a female victim initially being subdued by her male partner and then finally succumbing, to be as sexually arousing as a consensual scenario.

Given what appears to be an acceptance amongst these populations for coercive sexual behaviour it is argued that such an environment provides a powerful indoctrination and socialising effect at a critical age in the development of sexual behaviour. Further research indicates (Abel et al. 1987) that this period, i.e. adolescence 14 to 20 years, is crucial in the development of sexually deviant behaviour.

Further evidence supporting the feminist contention that sexual abuse represents an existing social/political power imbalance comes from the research examining the psychological make-up of the sexual assaulter. In a study by Briere et al. (1984, cited in Herman 1990) the author examined differences between young males who had committed sexual assaults, and controls. While the author isolated differences in attitudes and arousal to assaultive deviant stimuli, the author found that psychological assessment could not distinguish the two groups: no significant differences between
the sexually assaultive men and the controls were found using standard psychological screening tests of pathology. In other words, while the experimental group possessed different attitudes, they were not different in terms of psycho-pathology. This position has been reinforced by a number of authors. It would appear that, by and large, sex offenders represent the normal population. The vast majority do not qualify for any psychiatric diagnosis (Abel, Rouleau & Cunningham-Rathner 1985) and certainly the majority cannot be distinguished in any demographic sense (Abel et al. 1987). As stated by Abel et al. (1984):

... these paraphiliacs are not strange people. They are people who have one slice of their behaviour that is very disruptive to them and to others; behaviour they cannot control. But the other aspects of their lives can be pretty stable. We have executives, computer operators, insurance salesmen, college students, and people in a variety of occupations in our program. They are just like everyone else, except they cannot control one aspect of their behaviour.

From this standpoint feminist theory argues that attempts to classify paraphiliac behaviour as 'sick' in terms of psycho-pathology are inaccurate and somewhat destructive as they distract us from the true cause of such behaviour, the dominant social culture. Further feminist theory has argued that such a practise of diagnosing behaviour in medical/psychiatric terms can serve to remove responsibility for such behaviour from the individual; that is it is seen to be compulsive and involuntary. According to feminist theory, sexual assault against women will continue until the society that maintains it is challenged in a fundamental way and ceases to promote social attitudes and a power structure that is supportive of male dominance and female submissiveness. While holding to this proposition that the primary solution to the problem of sex offending in the community is social change, most modern feminists are at the same time supportive of efforts aimed at reducing the offending of perpetrators that is, secondary intervention. Such interventions include consistent and appropriate penal sanctions for offenders in an effort to deter and convey a clear message to society that such behaviour is unacceptable. Further, many feminists are supportive of interventions that do not minimise responsibility for offending behaviour and have been demonstrated to be effective in reducing the risk of repeated offences (Herman 1990, Stordeur & Stille 1989) These include the behavioural and pharmacological interventions, which will be reviewed later in 4.0, 'Interventions'.

1.5 ONSET OF PAEDOPHILIA

The research concerning the pathogenesis of paedophilia is scanty (Fuller 1989). Clinical experience suggests that the most common age of onset is within adolescence as this is the time when individuals generally become sexually active and establish their sexual identities. In a study by Abel et al. (1985) subjects
including homosexual paedophiles, heterosexual paedophiles, exhibitionists and rapists were interviewed as to the age of onset of their paraphilic behaviour. In all groups, between 10 and 30% of subjects experienced onset at or before age 14, whilst between 45 and 75% of all subjects had experienced onset of paraphilic behaviour by age 19.

1.6 OTHER PARAPHILIAS

This paper has thus far concentrated on paedophilia as it is arguably the most prevalent of the paraphilias and is the most costly in terms of victim trauma/injury. However, it is also appropriate to consider the other paraphilias.

The major source of diagnostic criteria for the paraphilias comes from the *Diagnostic and Statistical Manual* (1987). Paraphilias, according to the Manual, are characterised by recurrent intense sexual urges and fantasies in response to sexual objects or situations that are not part of normative arousals patterns. For a diagnosis of paraphilia to be made the subject needs to present with fantasies or behaviour that are consistent and repetitive for a period of not less than six months. The paraphilias are further subdivided in terms of the focus of sexual fantasy and/or behaviour. The major paraphilias and their definitions are as follows.

(1) Paedophilia, described above, where pre-pubescent children elicit and become the focus and sexual arousal of adults.

(2) Fetishism, where the subject shows a consistent preference for the use of non-human objects for sexual arousal. The most common cases involve the use of underwear or other sexually related paraphernalia as the focus for sexual arousal.

(3) Exhibitionism, where the act of exposing one's genitals to another person becomes the focus for sexual arousal. This exposure can be accompanied by masturbation.

(4) Voyeurism, where the act of passively observing another or others in some form of sexually related activity becomes the focus for sexual arousal. Usual cases presented under this category involve public voyeurism, including the common 'peeping Tom' scenario.

(5) Zoophilia, involving sexual activity with animals.

(6) Sexual masochism, where pain and/or humiliation, real or simulated, is inflicted
on the patient and is the subject of sexual arousal.

(7) Sexual sadism, where the patient's focus for sexual arousal involves inflicting pain and/or humiliation on a partner or victim.

In other words, the paraphilias involve either:

- Repetitive sexual activity with non-consenting partners
- Repeated sexual activity involving the use of a non-human object for sexual arousal
- Repetitive sexual activity with humans involving real or simulated suffering or humiliation.

According to *Diagnostic and Statistical Manual* (1987), for the diagnosis of paraphilia to be made the deviant or bizarre sexual behaviour and/or fantasy must be *necessary* for sexual arousal. Numerous theorists and practitioners (Abel et al. 1987) have questioned this criteria as unnecessarily restrictive. While it is a common feature of the paraphilias that the deviant sexual arousal is persistent and distressing, it is also common that many paraphiliacs also engage in concurrent non-deviant sexual behaviour. In a study of self-reported crimes of non-incarcerated paraphiliacs (Abel et al. 1987) the authors found that approximately 50% of participants reporting paraphilic behaviour were living with a woman or had been previously married.

### 1.6.1 Multiple paraphilic offending

In Abel et al. (1987) the authors examined self-reported sex crimes of their subjects. Obviously the validity of these responses depends greatly on the ability of the researchers to offer confidentiality to their subjects. For this purpose the authors obtained a U.S. federal government exemption from the laws requiring the reporting of offences. This study reported that incestuous paedophiles repeatedly molest the same child, with a mean of 1.8 victims and an average of 45.2 individual acts of molestation in the case of female targets, and in the case of male targets an average of 1.7 victims with an average of 36.5 individual molestations per victim. This contrasts with the non-incestuous paedophile population, who were found to have a mean of 19.8 female victims with an average of 1.2 individual molestations per victim, and an average of 150.2 male victims with an average of 1.9 individual molestations per victim. It should be noted that in the case of the non-incestuous sample the median was significantly lower than the mean for the number of victims (1.3 in the case of female targets and 4.4 in the case of male targets), indicating that there were a number of subjects who had a very high number of victims; this inflated the
mean score. In this study the authors were interested in the degree to which offenders confine themselves to a distinct and separate paraphilia or, conversely, the degree to which they engage in multiple paraphilic behaviour. With respect to sex of victims Abel et al. found that 67.2% of subjects targeted females only and 11.9% males only. However, 20% of subjects engaged in paraphilic behaviour involving both males and females. With respect to age of victims the authors divided this dimension into three categories:

1. children under the age of 14
2. adolescents 14 to 17 years
3. adults (17 years plus).

Results showed that 49% of subjects targeted one age group, 31% were involved in two age groups and 11.2% were involved in all three age categories. With respect to contact (child molestation, frottage) and non-contact (voyeurism, exhibitionism) the authors found that 50% of subjects participated in contact behaviours only and 14.9% participated in non-contact behaviour only, while 26% participated in both contact and non-contact paraphilic behaviour. Perhaps the most widely held belief regarding the exclusivity of paraphilic offenders involve that of incestuous versus non-incestuous offenders. In the study carried out by Abel et al., results showed that 56.1% of subjects participated in extra-familial paraphilic behaviour only and 12% participated in intra-familial paraphilic behaviour only, while 23.3% offended against both family and non-family members irrespective of familial relationships.

Table 1 represents the percentage of cross-diagnosis by paraphilic type (Abel et al. 1987). As can be seen from Table 1 the degree of cross-diagnosis is the rule rather than the exception. For those subjects with a primary diagnosis involving the non-contact behaviour of exhibitionism. Forty-six per cent of exhibitionists in this study were or had been involved in intra-familial female paedophilia. As is shown in Table 1, the authors included not only those categories of paraphilia described in the *Diagnostic and Statistical Manual* (1987) but also those with ‘gender identity disorders and diatonic homosexuals’ (Abel et al. 1987, p. 9). In presenting this data the present author makes no assumptions as to the appropriateness of including these categories.

This study clearly contradicts the conventional literature that paraphiliacs have one specific category of deviant sexual behaviour. Contrary to this, the above data reflect quite the opposite; that is, that individuals with one paraphilia only
are uncommon, and that the majority of paraphiliacs have a multiple paraphilic interest.

### Table 1: Percentage of Cross Diagnosis by Paraphilia

<table>
<thead>
<tr>
<th>Paraphilia</th>
<th>Female Homosexual</th>
<th>Female Pedophile</th>
<th>Male Homosexual</th>
<th>Male Pedophile</th>
<th>Rare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Homosexual</td>
<td>224</td>
<td>78</td>
<td>78</td>
<td>27</td>
<td>55</td>
</tr>
<tr>
<td>Female Pedophile</td>
<td>100</td>
<td>25</td>
<td>35</td>
<td>12</td>
<td>25</td>
</tr>
<tr>
<td>Male Homosexual</td>
<td>78</td>
<td>15</td>
<td>30</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Male Pedophile</td>
<td>51</td>
<td>100</td>
<td>12</td>
<td>28</td>
<td>11</td>
</tr>
<tr>
<td>Female Incest</td>
<td>51</td>
<td>100</td>
<td>12</td>
<td>28</td>
<td>11</td>
</tr>
<tr>
<td>Female Pedophile</td>
<td>100</td>
<td>35</td>
<td>12</td>
<td>28</td>
<td>11</td>
</tr>
<tr>
<td>Male Incest</td>
<td>100</td>
<td>12</td>
<td>25</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Male Pedophile</td>
<td>78</td>
<td>15</td>
<td>30</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Rape</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Vaginism</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Obscene Mail</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transvestism</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Transsexuality</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sadoism</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Masochism</td>
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<td>0</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Homosexuality</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Obscene Phone</td>
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<td>0</td>
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<tr>
<td>Policing</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bestiality</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Utopia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caprophilia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Amoral to Odor</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Note: Differences in percentages reflect the varying diagnostic criteria and populations studied.*
1.6.2 Demographic characteristics

The above findings not only have implications for treatment interventions but also for aetiological characteristics of the various paraphilias. The results of the study carried out by Abel et al. indicate that it is non-productive to treat the individual paraphilias as separate and distinct disorders, but that paraphilia can, at least to some extent, be regarded as one disorder. As stated in 1.3.1, research examining demographic characteristics of the paedophile population have failed to show any significant association of offender groups with any particular social class, religion or ethnic group. Studies examining demographics of the greater paraphilic group come to similar conclusions. Of the 561 subjects in the study carried out by Abel et al. (1987), ages ranged from 13 to 76 years with a mean of 31.5. The majority were moderately educated with 40% having one year of college education. Subjects came from all socio-economic levels and were representative of the ethnic sub-groups of the general population. Two-thirds were working and 50% were presently living with a female companion or had been previously married. In other words, results of this study indicate that paraphiliacs, like paedophiles, are male and come from all sections of society and are representative of the general male population with the exception of aberrant and deviant sexual behaviour.

1.7 SUMMARY

What then can be said about the nature of paraphilia and in particular paedophilia? Firstly, and most importantly, on a number of characteristics there appears to be a great deal of heterogeneity across the group. Given the existing research there is little evidence that religion, intelligence, education, race, occupation or social class can differentiate the paraphiliac from the general population. Paraphiliacs as a group do not appear to differ from the general population in terms of plasma testosterone levels, nor is there significant evidence of organic brain syndrome. Whilst paraphilic offenders abuse alcohol and drugs at a higher proportion than that of the general population (particularly in the case of incest offenders), their alcohol and drug abuse is significantly less than that of the general offender (incarcerated) population. The majority of paraphiliacs will experience the onset of deviant sexual arousal in adolescence between the age of 14 and 19, and in the case of paedophilia will go on to commit large numbers of offences against large numbers of victims (non-incestuous paedohiles) or against relatively few victims (incestuous paedophiles). The paraphilic population do not appear to confine themselves to one particular paraphilia, but rather engage in a number of sexually deviant behaviours including, for
example, exhibitionism, voyeurism and rape. The single most distinguishing feature of the paedophiles is that they are male. Further approximately 50-60% report being sexually abused themselves prior to puberty. The validity of this data, however, is questionable and cannot be confirmed at present.

The bulk of the research to date has failed to elicit any clear trends as to the aetiology of the paedophiliac. It would appear that just as the development of `normal' sexual response is multi-faceted, complex, and influenced by a large number of incompletely understood factors, so is deviant sexual arousal a complex psycho-physiological experience is influenced by a large and varying number of factors not at present fully understood.
2.0 PREVALENCE AND INCIDENCE: THE EXTENT OF PAEDOPHILIC OFFENDING

Efforts to objectively establish the true extent of paedophilic offending have traditionally been fraught with a number of obstacles inherent in adult—child sexual activity. In order to quantify the extent of the problem, either perpetrators or their victims must be willing to offer such information; yet the very nature of the activity, its shame and secrecy, and the threat of criminal sanctions, will all work to discourage such open communication. As a result most cases of child sexual abuse do not come to the attention of law enforcement agencies, welfare agencies or professionals (Finkelhor & Hotaling 1983). It is conservatively estimated that approximately 1 in 60 sexual crimes actually lead to arrest (Abel et al. 1984).

2.1 INCIDENCE STUDIES

The bulk of the research investigating the extent of paedophilic behaviour in the community has come out of North America and can be divided into two basic groups. The group of studies involves estimates of incidence of child—adult sexual activity over a given period. This is expressed as the number of new cases/offences over a given period. The two major studies in this area were conducted by the American Humane Association and the National Centre on Child Abuse and Neglect (cited in Finkelhor 1986). The AHA acted as a data collection agency: most institutions working in the area of child sexual abuse summarised and pass on their statistics to the AHA. From this data the AHA extrapolated to the general population of the United States and estimated that between 1976 and 1983 the number of child sexual-abuse cases reported to agencies were: 1976, 7,559; 1977, 11,617; 1978, 12,257; 1979, 27,247; 1980, 37,366; 1981, 37,441; 1982, 56,607; 1983, 71,961. These were the estimates of the number of cases; not the number of individual children, since each case could involve several children. The National Centre on Child Abuse and Neglect surveyed not only agencies regularly dealing with child sexual abuse, but all other professionals who might come in contact with the problem. The study estimated that 44,700 children were sexually abused in the year beginning May 1, 1979; this was equivalent to an incidence rate of 0.7 per 100,000 children.

Finkelhor (1984), reflecting the large variance in the incidence studies, estimated that between 46,000 and 92,000 boys are sexually victimised each year in the United States and that the number of girls may be three times higher. Numerous other studies (including Barnard et al. 1989 and Barnard et al. 1988) have estimated that between 100,000 and 500,000 children are the victims of sexual abuse in the United
States each year.

While the above studies provide useful information about the reporting of child sexual abuse, it is generally recognised that the steep increases in the statistics are probably due to increased education and community awareness of the problem, as well as to increased attention by way of professional detecting and reporting. Nevertheless, given the generally recognised reluctance on the part of victims and their parents to report abuse, as well as the obvious logistical difficulties in collecting and collating such information, it is generally recognised that these figures grossly underestimate the true incidence of the problem.

### 2.2 PREVALENCE STUDIES

The second basic group of studies in this area involves estimates of the prevalence of paedophilic offending in the community. These studies result in an estimate of percentage of the population that has been victims of child sexual abuse. Because most incidences of child sexual abuse are never reported to authorities, the use in these surveys of victim reports is generally seen to be a more accurate measure of the extent of the problem in the community. Results from these studies, however, vary widely — in the case of female victims from figures of 6% to over 50% — and are generally seen to reflect differences in methodology as opposed to a real variation. In a study by Wyatt (1985) the author used a sample of 248 women from Los Angeles. In this study the author defined child sexual abuse as abuse occurring before the age of 18. The definition included all types of abuse, including contact and non-contact (exposing, and verbal suggestions as to sexual contact). Cases where there was an age discrepancy of 5 years between the offender and the victim or where the experience was unwanted and involved some degree of coercion, were included. This study reported a prevalence of 62% of child sexual abuse. In a study by Burnam (1985, cited in Finkelhor 1986) the author examined 1,623 female subjects (selected randomly). This study defined sexual abuse as occurring before the age of 16 and included contact abuse as well as verbal propositions, but excluded exposures. This study reported that 6% of subjects experienced child sexual abuse. Thus it would appear that the differences in operational definitions of abuse including age of victim do account for at least some of the variation in results. In a study by Russell (1983) the author used a random sample of 930 women from San Francisco. In this study Russell used two definitions of sexual abuse: first, a narrow definition that involved all types of contact abuse (both intrafamilial and extrafamilial) up to the age of 13, and completed or attempted forcible rapes between the ages of 14 and 17; and second, a broader definition that included the above as well as exposures and verbal propositions. This study reported prevalence rates of 54% with the broader
definition, and 38% according to the narrow definition.

Differences in operational definitions of sexual abuse do not, however, fully account for the wide variation in prevalence rates reported within the literature. In a study by Finkelhor (1979) the author included all types of contact and non contact abuse and reported prevalence rates of 19%, less than half that reported by Russell (1983).

In attempting to account for the wide variation reported across prevalence studies, one may be tempted to look for differences in a subject population. Studies using younger samples, (college students) do not appear to consistently result in differing prevalence rates from those with samples involving a wider range of age (community sample). In Wyatt’s (1985) study reported above, the women in the younger age group (18-16) showed a slightly lower prevalence for sexual abuse from that of the older group (27-36 years): 60% and 64% respectively. However, in a study reported in Bagley & Ramsay et al. (1985) of the Canadian national population survey, the reverse was the case, with higher rates of child sexual abuse amongst the younger group of women aged 18-20.

Differences in the education and socio-economic status of the samples used have been examined for possible contribution to the differing prevalence rates reported across studies. This speculation is based on the assumption that samples using college students may underestimate the prevalence of victims because of the samples bias to the middle class, and because psychological impairment resulting from abuse may also impair educational attainment. This is not borne out in the studies, however. Those studies using community samples (Wyatt 1985, Russell 1986, Finkelhor 1984) do not report consistently higher rates of prevalence than those studies using college student samples (Finkelhor, 1979, Fromuth 1983).

2.3 METHODOLOGY
An examination of the different methodologies used across studies does seem to provide the best indication as to reasons for the wide variation in prevalence rates. Studies examining prevalence rates of child sexual abuse can be divided according to three major means of data collections. These include telephone interviews, face-to-face interviews and self-administered questionnaires. In a review of the research, Finkelhor (1986) examined prevalence rates reported in various studies and compared their means of data collection as classified above. This review of 14 controlled studies indicated that there was a relationship between prevalence rates and the means of data collection. Of the 7 studies that used self-administered questionnaires, with one exception the studies reported prevalence rates of 22% or
less. Of those studies that used the telephone-interview technique, 2 reported relatively low prevalence rates (11% and 13%), and one reported a prevalence rate of 27%). In contrast to these studies, those studies that used face-to-face interviews appeared to produce somewhat higher prevalence rates, although this trend is not entirely clear. Of 4 studies reviewed, one produced an extremely low prevalence rate (6%), whilst the remaining three produced rates of 22%, 54% and 62% (see Table 2).

Possible explanations for this difference must be tentative, but are worth noting. It may be that child sexual abuse, with its associated shame, etc., may be under-reported when interviewees are provided an anonymous opportunity to respond to such inquiries. Of course authors examining data-collection techniques have postulated that the reverse is the case, arguing that anonymous methods of inquiry such as self-administered questionnaires lower the degree of denial and under-reporting (Bradburn 1983). Nevertheless it may be that in the present area of investigation the face-to-face interview provides an opportunity for a well-trained interviewer to develop a rapport with the interviewee and offer the opportunity for some form of ‘therapeutic’ self-disclosure. Further, as pointed out by Finkelhor (1986), a well-trained interviewer will be able to attend to a number of behavioural cues and, if the interview is conducted in a sympathetic and non-judgmental manner, convey a message of acceptability of disclosure. Future research examining prevalence rates in the community should address these questions and, in order to minimise denial and under-reporting, provide well-trained interviewers.
<table>
<thead>
<tr>
<th>Mode of Administration</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-administered questionnaire</td>
<td></td>
</tr>
<tr>
<td>Badgley (1984)</td>
<td>34</td>
</tr>
<tr>
<td>Finkelhor (1970)</td>
<td>19</td>
</tr>
<tr>
<td>Finkelhor (1984)</td>
<td>15</td>
</tr>
<tr>
<td>Fromuth (1983)</td>
<td>22</td>
</tr>
<tr>
<td>Kercher &amp; McShane (1984)</td>
<td>11</td>
</tr>
<tr>
<td>Miller (1976)</td>
<td>14</td>
</tr>
<tr>
<td>Seidner &amp; Calhoun (1984)</td>
<td>11</td>
</tr>
<tr>
<td>Face-to-face interviews</td>
<td></td>
</tr>
<tr>
<td>Bagley &amp; Ramsay (in press)</td>
<td>22</td>
</tr>
<tr>
<td>Burnam (1985)</td>
<td>6</td>
</tr>
<tr>
<td>Russell (1983)</td>
<td>54</td>
</tr>
<tr>
<td>Wyatt (1985)</td>
<td>52</td>
</tr>
<tr>
<td>Telephone interview</td>
<td></td>
</tr>
<tr>
<td>Kackley Market Research (1983)</td>
<td>11</td>
</tr>
<tr>
<td>Lewis (1985)</td>
<td>27</td>
</tr>
<tr>
<td>Murphy</td>
<td>13</td>
</tr>
</tbody>
</table>

NOTE: F(2,11 = 1.95, p = .18
2.3.1 Variation due to number and nature of screen questions

When the studies reviewed above (see Table 3) are categorised according to the number of screen questions used in their surveys, it appears that there is also a relationship between prevalence rates reported and the number of screen questions. The studies reviewed above used between one and 14 screen questions, as can be seen from this table. Of the 6 studies that used one screen question, e.g. ‘Have you ever been sexually molested as a child?’ all reported prevalence rates between 6% and 22%. The studies that used between 2 and 4 screen questions reported rates of between 11% and 34%, and those studies using more than 4 screen questions reported rates of 54% and 62%.

The type of question used in these surveys also appears to account for some of the variation in results. Studies using questions that were behaviour-specific, e.g. ‘Has anyone touched or attempted to touch your genitalia before the age of 16?’ appeared to produce higher prevalence rates than those using more general questions (Finkelhor 1986). More general questions are those that use such terms as ‘molestation’ or ‘child abuse’, e.g. ‘Have you ever been a victim of child sexual abuse?’, where the definition of child sexual abuse is open to interpretation.

If, as has been suggested above, child sexual abuse is behaviour that is prone to under-reporting by victims, it is possible that terms such as ‘child molestation’ may not match the definition of what some past victims may define or interpret as their previous child sexual encounter/abuse. Thus the more specific questions are open to less interpretation and avoidance or under-reporting. Further, a similar explanation could apply to the co-variance between the number of screen questions and prevalence rate. The more screen questions used, the more time and opportunity there is for the interviewees to match their own experiences with the questions asked.
**TABLE 3: PREVALENCE RATES FOR WOMEN BY NUMBER OF SCREEN QUESTIONS**

Prevalence Rates for Women by Number of Screen Questions
(Percentages)

<table>
<thead>
<tr>
<th>Rate</th>
<th>1 question</th>
<th>2 – 4 questions</th>
<th>More than 4 questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Miller (1976) 14</td>
<td>Lewis (1985) 27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Murphy 13</td>
<td>Seidner &amp; Calhoun (1984) 11</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: F(2,11) = 31.27, p < .0001
2.4 SUMMARY

In summary, the question of incidence and prevalence of child sexual abuse in the community is not a simple one. Certainly, commonly reported rates of one in 4 women experiencing child sexual abuse are an over-simplification of what is a complex and difficult question. It would appear that given the nature of child sexual abuse with its associated shame and its sometimes punitive intervention by government agencies, studies relying on statistics provided by child welfare agencies, etc., will grossly underestimate the incidence of this problem in our community. There are numerous studies (Russell 1983) that report substantial differences between prior sexual abuse and the proportion of subjects that have reported these events to an official agency. Further, the substantial differences between the statistics provided by the incidence studies and those of the prevalence studies suggest that the former grossly underestimates the extent of the problem. While the prevalence studies appear to provide a more accurate picture of the level of this problem by not relying on official figures, the studies are nevertheless fraught with methodological problems and at this stage prohibit definitive conclusions about the true percentage of child sexual abuse victims in our community. While there have been a number of excellent studies addressing this problem over the past decade, their results vary markedly according to sample used and means of data collection. Those studies using a wide definition of child sexual abuse, i.e. any contact or non-contact sexual advance prior to the ages of 16 or 17, understandably report higher prevalence rates, e.g. 54% (Russell 1983). Similarly, those studies using face-to-face interviews to collect data from their subjects report higher prevalence rates of between 22% and 62%, as do those studies using specific rather than general screen questions. Further, it appears that, to a degree, the more screen questions used in identifying child abuse victims, the higher the detection rate. Given the above constraints, at present one is able to conclude only that child sexual abuse, depending on its definition and how and what one asks subjects, will range from somewhere between 10% and 50% in the female population.
3.0 IMPACT OF CHILD SEXUAL ABUSE

For the past decades researchers have hotly contested the relative impact of child sexual abuse.Whilst clinicians have long observed and reported considerable short term and long term post abuse trauma in their patients, the objective research has been somewhat less clear. A number of researchers (Henderson 1983) have argued that child sexual abuse either does not produce long-standing traumatic impact, or that this impact has failed to be clearly established in the studies because of inadequate sampling techniques and other methodological problems. Nevertheless, evidence from well-controlled and well-designed studies has been accumulating over the past 10 years. These studies provide a clear indication that child sexual abuse does result in considerable psychological, social and sexual pathology in a significant proportion of victims. The main questions to be asked here are concerned with the nature and duration of child sexual abuse: what sorts of problems/pathology result from child sexual abuse, and how long do these problems/pathology last? For the purposes of this review the impact of child sexual abuse will be divided into short-term effects, defined as 2 years following abuse, and the long-term impact, defined as beyond 2 years after abuse. The reasons for this arbitrary division is simply that it is a common practice in the research (Finkelhor 1986), and secondly there appears to be quite different and distinguishable reactions in the short term as opposed to the long term.

3.1 SHORT-TERM EFFECTS

There are a number of studies that lend support to the well-known clinical observation that child sexual abuse victims suffer a range of negative emotional effects. Anderson, Back, Griffith (1986) examined 155 female adolescent assault victims, and reported psycho-social problems in 63% of their subjects. Externalised psycho-social sequelae, e.g. phobias, depression, guilt and shame were noted in 67% of the incest victims and 49% of the extra-familial abuse victims. Externalised sequelae, e.g. truancy and school problems, were noted in 66% of the intra-familial victims and 21% of the extra-familial victims. These findings are common in the literature. De Francis (1969) found that 66% of child sexual abuse victims were `emotionally disturbed'. Unfortunately the above studies failed to use controls or standardised instruments, and it is therefore difficult to interpret their findings clearly as many of their judgements may have been subjective.

In a study by Gomes-Schwartz, Horowitz & Sauzier (1985) the authors used instruments with published norms and test-validation data, enabling contrasts to be made with the general population. Subjects used in this study had all been victimised
in the six months prior to testing, and ranged from infancy to 18 years of age. The results of this study show significant differences between the subject sample and the normal population on scores of overt behaviour, somaticised reactions, internal emotional states and self-esteem. The highest incidence of pathology was found in the 7-13 age group - with 40% scoring the `seriously disturbed' range (Louisville Behaviour Check List, the Purdue Self Concepts Scale, the Gottschalk-Glesser Content Analysis Scale and the Peers-Harris Self Concept Scale). Of the 4-6 age group, 17% scored within the range of clinically significant pathology, and the adolescent group showed the least amount of psychopathology.

The most common reaction to child sexual abuse found in the empirical literature is fear. Gomes-Schwartz et al. (1985) found that 45% of their 7-13 age group sample, 36% of the 14-18 age group, and 13% of their 4-6 age group showed elevated fear reactions as measured by the Louisville Behaviour Check List. Other studies, De Francis (1969) have reported elevated fear in as much as 83% of child sexual abuse victims.

Reactions of anger and hostility are commonly reported in the clinical literature, but have also been reported in the empirical studies. Gomes-Schwartz et al. (1985) found that 13-17% of the 4-6 age group and 45-50% of the 7-13 age group showed increased levels of anger and hostility compared with population norms, as measured by the Louisville Behaviour Check List and the Gottschalk Glesser Content Analysis Scales.

Other common emotional reactions found in the research include reduced self esteem or negative self concept (De Francis 1969), and shame and guilt (Anderson 1981 cited in Finkelhor 1986).

Numerous studies have demonstrated a number of somatic complaints associated with child sexual-abuse. These include sleep disturbances and eating disorders. Peters (1986) reported that 20% of child sexual abuse victims experienced eating disorders and 31% experienced sleep disturbance. It has been noted in some studies that pregnancy can be a consequence of child sexual abuse (De Francis 1969). Further a number of researchers (Frederick 1986) have reported inappropriate sexual behaviour in adolescent victims, including excessive sexual curiosity, open masturbation and frequent exposure of genitals. Social functioning appears to be deleteriously affected in a significant proportion of child victims. This effect can include running away from home, truancy and early (adolescent) marriages.
In summary, it would appear that the research is clear in showing that child sexual abuse does indeed lead to a number of initial deleterious reactions. These include such psycho-social problems as anxiety, fear, anger and inappropriate sexual behaviour.

3.2 LONG-TERM EFFECTS
Possibly the most common reaction to child sexual abuse reported in the literature is depression in later adult life. In Sedney and Brooks (1984) adult subjects with histories of child sexual abuse have been found to have consistently greater proportions of depressive symptoms as compared to controls. In Sedney and Brooks (1984) the authors used a sample of 301 female university students and found that 65% reported experiences of depressive symptoms, compared with 43% of the control group. Further, 18% (compared with 4%) had been hospitalised for depression. In a study by Briere and Runtz (1985) the authors used the Hopkins Symptom Checklist, a standardised device that, among other things, tests for depressive symptoms. The authors reported that the abused subjects reported more depressive symptoms than the non-abused subjects in the 12 months prior to the test.

Numerous studies have observed a number of somatic disturbances in adults who were sexually abused as children. These include tension, anxiety and anxiety attacks (Sedney & Brooks 1984, Briere & Runtz 1985), and eating disorders, including anorexia and bulimia (Finkelhor 1986). Further it had been reported that sexual abuse victims experience symptoms of disassociation, or out-of-body sensations where patients feel that they are spectators to events.

It is commonly reported (DeYoung 1982, Meiselman 1978, Herman & Hirschman 1981) that victims of child sexual abuse experience difficulty in social functioning. This includes a difficulty in interpersonal skills, relating to both men and women. Further, victims of child sexual abuse often have difficulty trusting others in adult life. Briere and Runtz (1985) found that 84% of their incest subjects reported fear of men, compared with 15% of their control non-victim sample. The authors also found that victims have difficulty in close relationships. Of the abuse victims, 64% had difficulty in relating to their husband or sex partner, compared with 40% of non-victims.

It is not surprising that victims of child sexual abuse often have difficulty in parenting roles in later life. In a study by Goodwin, McCarthy and DiVasto (1981) the authors noted that 24% of mothers being treated for child abusing (not necessarily sexual) were themselves victims of child sexual abuse. This compared with 3% of a non abusive control group.
Poor self-esteem is often reported in the clinical literature as a factor associated with child sexual abuse. The empirical research strongly indicates that negative self-concept is a long-term consequence for a significant proportion of child sexual-abuse victims. In a study by Bagley and Ramsay (1985) the authors used the Cooper Smith Self Esteem Inventory to measure self-concept, and found that 19% of their victim sample scored in the ‘very poor’ category as opposed to 5% of the control group. Of the experimental group, 9% scored very good levels of self-concept compared with 20% of controls.

These figures are considerably greater in clinical samples of incest victims, which show that between 60—87% of incest victims report predominantly negative self-images.

Researchers have also examined the extent to which child sexual-abuse victims are abused in adult life. Russell (1984) reported that 38% of her female victim sample had physically violent husbands, compared with 17% of non victim controls. The author also reported that between 62% and 40% of the victim sample had been sexually assaulted by their husbands, compared with 21% of the control group. Similar figures have been reported in other studies, confirming increased incidence of domestic violence and sexual assault (Briere 1984).

Following this trend a number of researchers have produced evidence of increased general victimisation among women who were sexually abused in childhood. Russell (1986) and Fromuth (1983) found that women who were abused in childhood are more likely to be sexually abused in adulthood. The exact nature of this connection, and how child sexual abuse leads to increased victimisation in adulthood, is unclear and requires further research.

Of all the long-term consequences of child sexual abuse, disturbances in adult sexual relationships are probably the easiest to understand. A number of studies using clinical samples report consistent significant differences in the proportion of sexual difficulties experienced by victim groups as compared with non-victim control groups. Meiselman (1978) reported that 87% of the victim group experienced sexual difficulty, compared with 20% of the control group (women attending the clinic were not all victims of child sexual abuse). Similar results, although not as extreme, have been found in other studies (Briere 1984, Herman and Hirschman 1981). It would appear that sexual difficulty as a result of child sexual abuse can be expressed not only by sexual anxiety and avoidance of sexual activity, but conversely and paradoxically by extremely promiscuous behaviour. High levels of promiscuity and sexualised
behaviour have been found in victim groups by a number of researchers (Herman 1981, Meiselman 1978). Further, research has demonstrated a connection between abuse and later prostitution. Silvert and Pines (1981) reported that 60% of prostitutes interviewed reported being sexually abused by an average of 2 people prior to the age of 16, with a mean age of 10 years at first victimisation. Similar results have been reported by numerous researchers (James & Neyerdig 1977). However, one study (Fields 1981) indicates that when age, race and education are controlled for, the experimental control differences are narrowed, i.e. 45% compared with 37% for the control group.

The connection between childhood sexual abuse and later substance abuse has been well documented in the clinical and empirical research. Briere (1984) reported that 27% of abuse victims had a history of alcoholism, compared with 11% of non-victim controls, and 21% of the experimental group had a history of drug addiction, versus 2% of controls. Similarly Peters (1984, cited in Finkelhor, 1986) reported that 17% of the victim sample had signs of alcohol abuse versus 4% of the controls, and 27% abused drugs compared with 12% of the controls. Unfortunately, little comparable research has been conducted in Australia. Substance-abuse treatment agencies, however, frequently report a high proportion of child sexual-abuse victims reported in their client intakes. In particular, Odyssey House Melbourne reports that 76% of their residents claim histories of childhood sexual abuse (Lamberti, J. 1991, personal communication, April). While it is well documented that substance abuse and crime are interconnected, it is nevertheless significant that child sexual-abuse victims are over-represented in female correctional institutions. In a recent report `Women in Prison: Task Force' (Lamberti 1985) it was estimated that 80% of female prisoners had been victims of child sexual abuse.

3.3 SUMMARY

Empirical research clearly indicates that child sexual abuse is likely to result in a range of psycho-social difficulties in later life. The significance of this should not be overlooked, particularly considering that most of the research cited above reports significantly higher proportions of psycho-pathology some ten years or more following the abuse. This pathology is likely to manifest itself in anxiety, low self-esteem, depression, increased victimisation (including domestic, sexual and interpersonal difficulty), difficulty in parenting (including increased incidence of child neglect and abuse), alcoholism, and drug abuse and its associated criminality. While it is not possible to quantify the total impact of childhood sexual abuse, it is quite clear that it is a problem that imposes considerable psychological and economic costs on its victims and on the community in general. The most conservative objective research
indicates that 20% of females in our community will have experienced childhood sexual abuse (the figures are considerably higher if definitions include non contact abuse). When one considers that research clearly shows that this abuse manifests in a range of varying psycho-pathology that is detectable 10 years following abuse, it is clear that childhood sexual abuse, or paedophilia, represents a considerable public health problem deserving urgent attention.
4.1 PHARMACOLOGICAL

The use of psycho-pharmacological agents in the treatment of paraphiliacs began with Depo Provera in 1966 at John Hopkins University (Bradford & Pawlak 1987). This treatment is based on the premise that Depo Provera suppresses, or lessens the frequency of erection, ejaculation and deviant sexual arousal (Melella, Travin & Cullen 1989). Depo Provera is a long-acting injectable form of medroxyprogesterone acetate (MPA), a synthetic progesterone classified pharmacologically as an anti-androgen. Anti-androgens inhibit the release of the male-hormone androgen from the testicles. Some progestinic hormone is normally present in the male body, but at a very low level. Increasing this level allows progesterone to compete with androgen and take over. Androgen is a sexual activator, progesterone is sexually inert. Depo Provera inhibits, through its effect upon neural pathways, the releasing of luteinising hormone from pituitary gland. Luteinising hormone is the chemical messenger that stimulates the testicles to produce androgen. Hence the effect of Depo Provera is to reduce androgen levels, especially testosterone, in the bloodstream. Typically in the adult male Depo Provera can reduce plasma testosterone to that of a normal pre-pubertal boy.

Depo Provera appears to also have an effect upon the brain (Cooper 1986) in small doses as it is used in the treatment of sex offenders. This influence on the brain produces a tranquilising effect, where patients report feeling relief from the urge to act out sexually.

Physiological effects resulting from the use of this drug include decreases in penile erections and ejaculations and reduced production of sperm (Melella et al. 1989). A number of side-effects from the use of Depo Provera have been cited in the literature. Subjects usually gain weight and may develop high blood pressure. Others experience hot flushes, cold sweats, muscle weakness, nightmares and fatigue. Depo Provera can decrease the size of the testes.

Physiological changes attributed to Depo Provera appear to be reversible following cessation of treatment. Ten days to 3 weeks after cessation of treatment erectile and ejaculatory capacities return, including formerly suppressed sexual drive. Some clinicians argue, however, that this is not necessarily the case (Cooper 1986) with therapeutic effects continuing longer after cessation of treatment.
The other major psychotropic medication used in the treatment of paraphilia is cyproterone acetate (CPA), marketed as Androcur. CPA is structurally similar to MPA, and both result in the lowering of plasma testosterone. CPA suppresses the formation of testosterone at an early stage in its synthesis, and blocks central and peripheral androgen receptors. While this drug has not been as widely used in the United States and Australia as Depo Provera, it has resulted in considerable enthusiasm among clinicians working in the field and appears likely to be used more frequently in the future.

4.1.1 Clinical studies using MPA

Most of the clinical studies using MPA as a libido suppressor have been reported in the past 20 years. Unfortunately many of these studies lack the suitable controls, sufficient follow-up (Griggor 1990), and the numbers of statistical significance necessary to draw clear conclusions. Money (1972) treated 9 paraphiliacs with MPA on a weekly dosage of 300-400 milligrams administered intramuscularly. The author reported decreased frequency of erections, reductions in sexual drive and reduced orgasm rates. Money (1976) later described reduction in deviant sexual activity in 23 patients, and noted that these therapeutic effects had maintained for eight years.

In a study by Langevin et al. (1979) the authors treated 8 exhibitionists with MPA as well as with a placebo treatment phase, and compared the two conditions using plethysmographic technology, which measures penile blood flow. The authors reported no differences between the placebo and drug therapy in the effect on penile measures. In a study by Kiersch (1990) the author administered Depo Provera and a control (saline) to 8 paedophiles resident in a State public hospital. The trials were conducted over six-four week periods where each subject acted as his own control. Experimental and control differences were measured by patient self-reports and physiological data obtained via plethysmographic technology. Results from this study found that patients self-reported a reduction in deviant fantasising as well as masturbation, in both the experimental and placebo conditions. The physiological assessment likewise failed to distinguish the MPA from placebo. While these results are disappointing, the authors point out that in two of the eight subjects', testosterone levels returned to pre-treatment levels in 6-8 weeks following cessation of the treatment, with the majority requiring longer periods of return to pre-treatment testosterone levels. Thus one explanation for the lack of experimental—control differences is that the therapeutic effect of the experimental condition extends into the control condition.
In a study by Berlin et al. (1981 cited in Bradford 1990), the authors treated 20 chronic paraphilic males with MPA. Of this group, 11 discontinued the treatment contrary to medical advice (10 subsequently re-offended). Of the remaining 9, 3 re-offended whilst on treatment. This result has been interpreted optimistically: `... it is clear that MPA is an effective treatment provided patients comply with treatment' (Bradford 1990). However, given the lack of controls and small numbers, i.e. 3 patients out of 9, it would seem difficult to draw any clear conclusions from this particular study.

In a study by Gagne (1981) the author offered treatment using MPA and Milieu therapy to 48 patients over a period of 12 months. The author reported that 40 of these patients improved substantially and that this was maintained throughout the follow-up period; however, the length of this follow-up was not given. Two further studies — Cordoba and Chapel (1983) and Wincze, Bansal and Malamud (1986) — report reductions in sexual behaviour following treatment with MPA. These studies reported, however, that resulting plasma testosterone levels were a poor indicator of sexual drive as measured by patients' self-report.

4.1.2 Clinical studies using CPA

Like the clinical studies using MPA, the clinical studies of CPA treatment largely lack adequate controls and long-term follow-up of the subjects’ sexual activity and offending. Rather these studies tend to examine the immediate results of treatment as measured by plasma testosterone levels, physiological assessment by way of penile circumference, and self reported sexual activity/drive.

In a study by Bancroft et al. (1974) the authors compared the use of CPA to the use of ethinyl estradiol (EE). The authors reported that there were no significant differences between the two drugs with regard to physiological assessment by way of erectile response. When compared to baseline responses, both drugs had significantly lowered self reported sexual activity. CPA produced lowered self-rated sexual arousal during penile tumescence testing, whereas the EE did not.

In a large study (N = 547) by Laschet and Laschet (1975) the authors treated a varying group of paraphiliacs with varying dosages ranging from 50-200 mg per day to 300-600 mg as either weekly or fortnightly injections. The authors reported reductions in erections, sexual fantasies and sexual drive, which were
correlated with reduced levels of plasma testosterone. Of the 25 patients that were followed up to 5 years following treatment, none had recidivated.

In a single case study by Bradford and Pawlak (1987) the authors reported that CPA produced a significant reduction in sexual responding in a paedophilic patient. The authors reported that this particular case was somewhat difficult and had failed to respond to prior behavioural treatment. Further, the authors reported that this treatment produced a differential effect with regard to paedophilic and non-paedophilic stimuli. While the patient's responses to paedophilic stimuli were significantly reduced, responses to adult-consenting sexual stimuli were not. In another study by Bradford and Pawlak (cited in Bradford 1990) the authors used CPA in a double-blind placebo cross-over study. This sample included sexual offenders with a mean of 2.5 convictions per year prior to treatment. The authors reported that CPA significantly reduced testosterone levels, compared with placebo and baseline. CPA significantly reduced responses as measured by penile tumescence to both visual and covert sexual stimuli, compared with placebo. The authors report a significant reduction in self-reported sexual interest and activities as well as reduced sexual tension and masturbation, as compared with the saline baseline condition. As part of this study the authors classified subjects into high-testosterone group and low-testosterone group. The authors observed that CPA had a greater effect in lowering plasma testosterone levels in the high-testosterone group. Sexual-arousal responses to paedophilic stimuli were reduced in both groupings. It was concluded that CPA is effective in reducing sexual responses to paraphilic stimuli, regardless of whether testosterone levels are within the normal range or high prior to treatment.

While there have been numerous studies addressing the efficacy of CPA and MPA in the treatment of sexual deviations, the majority of these studies lack controls and follow-up. Obvious ethical considerations prohibit the random allocation of patients to a no-treatment control group for a long-term follow-up period, considering the risk this would involve to the community. Therefore a number of studies use a double-blind procedure where each subject acts as his own control. In a study by Cooper (1981) the author used such a design with nine paraphilic offenders. Each subject received five conditions consecutively: no treatment; treatment with CPA; second no treatment; Placebo; third no treatment. Each of the five phases lasted four weeks and thus the study lasted twenty weeks in total. The subjects were measured on a number of criteria during each of the treatment and non-treatment phases. These measures
were:

(1) spontaneous day-time erections
(2) spontaneous sexual outlets to orgasm—ejaculation
(3) sexual-interests score
(4) concomitant sexual arousal/pleasure during programmed masturbation.

Results of this study show a significant decline in the above measures in the treatment-with-CPA phase as compared to both the no-treatment phase and the placebo (saline-injection) phase.

This study clearly indicates that CPA is effective in reducing sexual drive/libido as measured by those indicators described above.

While studies of this kind are cause for optimism, they fall short of providing clear information about the generalisation of therapeutic effects over the long term. In order to demonstrate this, studies need to follow up their subjects for at least a number of years, recording their behaviour and re-offence rate. As stated above, randomised controls are not feasible over the long term and therefore studies usually compare their follow-up data with available statistics regarding the offence rates in comparable untreated groups. LeMaire (1956, cited in Ortmann 1980) reported re-offence data relating to 3185 Danish men convicted of sexual offences during the period 1929 to 1939. Of those convicted of one sexual offence at the commencement of study, the relapse rate was 16.8% during the ten-year period. As would be expected, when the number of convictions increases so does the percentage relapse rate. Those men convicted of five sexual offences showed a 50% relapse rate. Interestingly, the relapse rate declined beyond five convictions. These men were followed up to the period 1951-1952 by Christiansen et al. (1965 cited in Ortmann 1980). They found that for those individuals with several prior sexual-offence convictions, the relapse rate over the 22-year period was 23.5%. The total relapse rate for the group, regardless of the number of previous convictions, was 9.7%. As stated above, to what degree there data offer a valid control comparison is uncertain, and it is likely that those subjects included in the clinical studies would at least fall into the category of multiple offenders (relapse rate 23.5%) to five-time offenders (relapse rate of 50%). This data is important when interpreting the efficacy of interventions. If one takes the view that the most valid comparison would be that of the five-time
offenders, i.e. a relapse rate of 50%, the challenge of for researchers is therefore to demonstrate efficacy below this figure over the long term. Unfortunately this standard has not been applied in a number of studies. Ortmann (1980) in a review of the research examining the use of CPA, compares the relapse rate of subjects prior to treatment with the relapse rate following treatment. The calculation of relapse rate prior to treatment is not described. For a number of studies the reported relapse rate prior to treatment was 100%. Obviously these kinds of comparisons are rather dubious and ignore the criminological data which indicate that, conservatively, one in two chronic untreated sex offenders will not re-offend. There appears to be a considerable need for carefully designed research to answer a number of fundamental questions relating to the use of both MPA and CPA. These include:

- indications and contra-indications
- duration of treatment
- relapse rate after cessation of treatment.

4.1.3 Summary

While these studies offer cause for optimism the need for long-term follow-up is of critical importance. The use of anti-androgens in the treatment of paraphilia offers the potential for an effective and economical means of reducing offending. Nevertheless, questions remain as to how to most effectively use these agents, including dosage and duration of treatment. At present there appears to be considerable disagreement about the generalisation of therapeutic effect following cessation of treatment. According to Melella (1989) the physiological changes attributed to Depo Provera are reversible within 10 days after cessation of treatment, when erectile and ejaculatory capacities return, as well as formerly suppressed sexual drive. Other authors, however, have the view that the positive effects of treatment will continue following cessation. Bradford (1990) argues that generalisation may be an important difference between the use of CPA and MPA. The author argues that with CPA, following a treatment period of 6-12 months, the treatment can be gradually tapered off without a corresponding increase in paraphilic sexual drive. According to Bradford this does not seem to be the case with MPA.

Further questions remain as to selection of patients suitable for treatment with the anti-androgens. Myers (1990) distinguishes between two groups of paedophilic offenders. He describes the first as a disinhibited group: the
paedophilic behaviour represents an impulsive act where impulse control has been impaired and where the victim represents ‘a surrogate for an adult partner’. This group largely consists of heterosexual offenders. The second he describes as a group who are compelled to engage in sexual activity with children, and for whom impulse control is not as an important factor. This group, according to Myers, consists largely of the homosexual offenders. Following this distinction, Myers classifies the first group as non-paraphilic offenders and the second as paraphilic offenders. This distinction requires further investigation and may have important implications for the use of anti-androgens.

4.2 COGNITIVE BEHAVIOURAL TREATMENT PROGRAMS

The major alternative means of treating paraphilic offenders involves the use of cognitive behavioural psychotherapy. Behavioural approaches to the treatment of sex offenders commenced with the notion that the primary motivation for such behaviour was inappropriate sexual attraction. Therefore it was seen that the most effective means of treating such behaviour was to alter deviant sexual preferences (Barlow 1978). These early programs (Bond & Evans 1967) sought to reduce inappropriate sexual arousal by employing behavioural interventions, principally aversive therapy, which pairs the inappropriate sexual target (children in the case of paedophiles, the act of exposure in the case of exhibitionists) with an aversive stimulus. Over time theorists and clinicians came to the view that deviant sexual behaviour had its underpinnings in a variety of areas that required intervention, in addition to programs aimed at reshaping sexual arousal patterns. While there is considerable variety in the content of cognitive behavioural programs, there appears to be general agreement that these programs attempt to target three major areas, sexual behaviour, cognitive distortions, and social skills (Marshall & Barbaree 1990). These major areas are discussed below.

4.2.1 Sexual behaviour

As stated in 4.2, behavioural treatment of sex offending commenced with the assumption that these behaviours were based solely on deviant or inappropriate sexual attraction. Hence, therapists utilised a number of behavioural techniques (principally aversive therapy) aimed at reducing inappropriate sexual responding. Inappropriate sexual preference is usually assessed either by way of clinical interview or, more recently, by way of physiological assessment (using penile plethysmography, which measures blood flow to the penis in response to certain deviant stimuli). These
procedures are based on two assumptions: first, that such assessments can accurately assess deviant sexual interest, and, second, that deviant sexual interest as measured will necessarily lead to inappropriate, offending behaviour. More recently authors have questioned these assumptions. McConaghy (1990) argues that there is no evidence available to show that penile circumference assessment is a valid measure of an individual paedophile's or rapist's tendencies. Marshall and Barbaree (1990) have questioned the validity of the assumption that deviant sexual fantasies necessarily precede deviant sexual behaviour. As pointed out by Marshall and Barbaree, the validity of this treatment component can be adequately tested only in an experimental framework that involves comparing a comprehensive program including components aimed at reducing deviant sexual interest, with a program including no components aimed at sexual modification, but otherwise identical. To date such an evaluation has not been completed (Marshall & Barbaree 1990). Decisions as to when such intervention is justified are by no means straightforward. For example, should the therapist use techniques of this kind only when it is clear that there is deviant sexual arousal greater than that of 'normal' sexual interest, or are they justified and required even on occasions when there is highly developed non-deviant sexual interest but a low level of deviant sexual arousal? These questions have become important, particularly considering the growth in plethysmography, which gives precise measures of blood flow to the penis. In considering these questions, researchers have developed the concept of a 'paedophile index', which is expressed in a ratio of per cent of full erection to deviant stimulus divided by per cent of full erection to non-deviant stimulus (Abel et al. 1978). While detailed discussion of this area is beyond the scope of the present paper, it is nevertheless useful to note, particularly considering the classification made by some theorists (Myers 1990) distinguishing between the paraphilic and non-paraphilic offender groups (see 5.1.3).

The reduction of deviant sexual arousal is a basic aim of most comprehensive cognitive behavioural programs (see 4.2). Procedures used in this endeavour vary, but are all based on classical conditioning principles and are one of a number of aversive therapy techniques that pair the inappropriate stimulus (sex with children, or exposure) with an aversive event. The aversive stimulus employed can be mild electric shock or some form of olfactory aversion. Marshall and Barbaree (1990) use such techniques and have their patients carry smelling salts to be used whenever deviant thoughts occur. Other techniques such as masturbatory satiation (Abel et al. 1984) involve the patient
masturbating to orgasm using non-deviant fantasies following which they concentrate on a common deviant and erotic image while attempting to masturbate. This procedure is continued for up to one hour. It is based on the premise that attempting to masturbate immediately following orgasm is essentially aversive, and when paired with the deviant image will have generalising effects. Repeated use of such techniques has been shown to be effective in reducing deviant sexual arousal as measured via penile plethysmography. Repeated pairing of deviant images with physical aversive events, i.e. electric shock, has been shown to produce positive changes in the laboratory (Quinsey & Marshall 1983). Repeated use of masturbatory satiation has also been demonstrated to lead to therapeutic effects as measured in the laboratory (Abel et al. 1984).

Covert sensitisation is another commonly used technique aimed at reducing deviant sexual arousal. Typically this technique involves patients constructing a short story that involves the usual sequence of events leading to their offensive behaviour. The patient rehearses this sequence and inserts a highly aversive negative event prior to the act being committed. Repeated covert rehearsals of this sequence and its negative consequences, it is believed, helps to insert thoughts about the possible negative consequences of such behaviour into typical thinking so that when such thoughts do occur the patient is more likely to think of the negative consequences. It is thought that the technique is also useful in helping to reveal to the patient the sequence of events leading to offending, so that he can recognise the danger at an early stage.

A further technique aimed at modifying sexual responding is sexual education, which is common to cognitive behavioural programs (Abel et al. 1984). These components are based on the premise that sexual dysfunction and false and erroneous beliefs about sex are common amongst paraphilic offenders. Hence the object of sexual education is to discuss appropriate sexual behaviour and identify sexual dysfunctions (for example impotence, premature ejaculation, and erroneous beliefs regarding male—female sexuality and relationships) in an attempt to help solve these problems and improve non-deviant sexual functioning.

4.2.2 Cognitive distortions

The second major area of cognitive behavioural programs uses cognitive restructuring. These techniques are based on procedures developed by
cognitive therapists (Beck 1976). Theorists and clinicians (Abel & Rouleau 1986) have identified distorted thinking patterns as a common feature amongst paraphilic offenders. Typically these may involve beliefs that support and help rationalise offending behaviour. In the case of child molesters, common beliefs might be `sex with children is in some way beneficial to the child or educational', `that it does not cause any physical or emotional harm', `that children were sexually provocative and wanted and enjoyed sex'. In the case of exhibitionists, beliefs such as `their victims found their exposure enjoyable and titillating' are commonly reported by clinicians working in the area. Further, minimisation of harm is common amongst paraphilic offenders as well as a minimising or denial of responsibility for offences. Claims such as `I was drunk at the time', `Sex with my wife is unsatisfying', effect to reduce responsibility for offending. In cognitive restructuring the patient's views are examined and challenged by the therapist as to their validity. Over time, more reasonable beliefs are offered to the patient, who is encouraged to rehearse such statements in an attempt to change internal dialogue. It has long been recognised that such techniques cannot be effective unless the patient is motivated to change behaviour and recognises the benefit in altering belief systems and self-talk.

4.2.3 Social skills
The third major area addressed in cognitive behavioural programs involves some form of social skills enhancement. Such interventions are based on the premise that social inadequacy or incompetence is a common feature among sex offenders. This inadequacy prevents offenders redirecting their interests to more appropriate interaction, and further creates considerable stress and anxiety which in itself can contribute to the re-offending cycle. While programs may vary in their specific aims and objectives, they usually contain some element that aims at increasing hetero-social skills in an attempt to encourage appropriate social/sexual activity. More recently, programs have broadened their objectives in this area to promote more general social effectiveness, including assertive behaviour and use of leisure time (Priest, Lee & Hart 1989; Marshall & Barbaree 1984).

The usual technique employed in this area is role playing, where patients are instructed to role-play difficult social interactions with either the therapist or other members of the treatment group. In this context the therapist acting with a patient or with a co-therapist can serve to model appropriate behaviour and/or directly instruct participants in appropriate social skills. Addressing such behaviours in a group setting obviously has advantages in that other participants can also provide valuable feedback as to appropriateness of social behaviour.

4.2.4 Program design
While most cognitive behavioural programs address each of the areas outlined above, they do however vary in other significant dimensions. A number of clinicians will offer treatment programs based on the above on an individual, one-to-one basis. Over recent years, however, economic restraints have encouraged therapists to be more efficient and offer programs in a group setting. It has been argued that offering such programs in a group setting has therapeutic advantages in that group members can often act as defacto therapists and provide valuable insights into pathological thinking and behaviour that are unavailable to therapists.

Cognitive behavioural programs vary in terms of their setting. Many programs are offered on an outpatient basis where patients attend regularly but otherwise live in the community. Alternatively they are offered in an inpatient setting, usually a secure institution — a jail or a secure hospital. Advantages and disadvantages exist for both settings, and it is not possible to conclude either way as to effectiveness. Rather it appears that each has a valuable place in providing an appropriate setting for treatment. The key issue in this decision appears to be the risk to the community. High risk offenders are unlikely to be released into the community and it is therefore appropriate and opportune to offer treatment programs in a secure environment. On the other hand, if this is not necessary, outpatient treatment programs can provide a far more economic means of treatment (Abel 1990).

Duration of programs varies considerably. Priest et al. (1989) offer a program on an outpatient basis over a seven-month period. Abel et al. (1987) provides a program on an outpatient basis for a period of approximately four months. On the other hand, Freeman-Longo, 1990 personnel communication, February 1990) advocates inpatient and outpatient programs of no less than twelve months. To the author’s knowledge, there is no research indicating an optimal program length in terms of effectiveness. Further, program intensity must be taken into account when considering this factor: an outpatient program offering two hours' contact per week will vary considerably from an inpatient program where active therapy can occur on a daily basis. Obviously when considering program length clinicians must take into account economic constraints and balance the requirements of providing a thorough and effective treatment program with the equally important necessity of treating as many offenders as possible.

4.2.5 Outcome evaluations

In reviewing the research evaluating the effectiveness of cognitive behavioural programs in treating the paraphilias, one is mindful that most case studies lack valid control comparisons. In order to effectively demonstrate the relative benefit of such interventions, outcome data need to be contrasted with data
available from a control group designated via random allocation from the larger sample prior to intervention. For a number of reasons including unacceptable risk to the community, such comparisons do not exist. In the absence of this, researchers have usually compared outcome data with the literature reporting recidivism among untreated offenders. As pointed out by Marshall and Barbaree (1990) such control comparisons are inadequate as there is no assurance that the two populations are identical. It has been long recognised (Abel et al. 1987) that different offending backgrounds have markedly different re-offence rates. Exhibitionists are considered to have extremely high re-offence rates (between 40 and 70%, Cox 1980), while intra-familial (incest) offenders are generally recognised to have lower rates of re-offence (4-10% Gibbens, Soothill & Way 1978) compared with extrafamilial offenders (10-40%). Molesters of girls have a lower re-offence rate (10-29%) than molesters of boys (13-40%, Furby 1989). Nevertheless, in the absence of randomly allocated controls, data of untreated re-offence rates serves as some yardstick for comparison.
4.2.6 Residential programs

Freeman-Longo (1984) evaluated the effectiveness of the Sex Offender Unit at the Oregon State Hospital. This long term program (24 to 30 months) processed (i.e. successfully graduated) twenty patients who were subsequently released during 1979-1983. The author reported that none committed a sexual offence during this period although two were returned to prison for non-sexual related offences. In a study by Prentky and Burgess (1990) the authors examine the effectiveness of an inpatient residential program. For the purposes of evaluation they used a five-year follow-up and reported that out of a sample of 129, thirty-two were charged with a victim-involved sexual offence. This equates to a re-offence rate of 25% over this period. They compared this result with the result of Marshall and Barbaree's study (1988, cited in Prentky & Burgess 1990) study in which the authors reported re-offence rates of 53 untreated child molesters. This sample included incest-only offenders (known for their lower re-offence rates). Prentky reports that when the incest-only offenders are removed from the untreated group their re-offence rates are 40-42%. In a study by Davidson (1979, cited in Marshall & Barbaree 1990) the author reports on the re-offence rates of paraphilic offenders following a residential treatment program. According to the author the overall recidivism rate for this group was 11.5%. Following this, Davidson (1984, cited in Marshall & Barbaree 1990) provided a comparison group from data of untreated sex offenders who were incarcerated in the same institution prior to the availability of this treatment program. Their re-offence rate was almost double that of the treated group.

4.2.7 Outpatient programs

Of the outpatient programs reported in the literature, the work of Abel et al. (1987) and Abel et al. (1988), based in Atlanta, Georgia USA, is possibly the most well known and will be reviewed first. Abel and colleagues offer an outpatient treatment program with modules addressing the three major areas outlined above. What is possibly unique about this program is the strict confidentiality with which information concerning re-offending is treated by the practitioners. Patients participating in this program are told that their attendance is entirely voluntary, that they can withdraw at any time, and that information concerning their re-offending behaviour is treated with strict confidence and is used for the purposes of evaluation only. Accordingly the program outcome measurements used by Abel et al. are patients' self-reports. While one may question the accuracy of these self-reports, the work of Abel et al. (1987) concerning non-detected offending behaviour among patients
appears to indicate that it is a relatively accurate source of data, certainly producing higher levels of re-offence rate than reported statistics. Abel et al. (1988) treated ninety-eight child molesters of both boys and girls and reported a 12.2% re-offence rate at one year follow-ups. Considering the generally recognised higher rate of re-offence in untreated patients within this group, the study carried out by Abel et al. clearly demonstrates the efficiency and benefit of the program’s intervention. Of course longer follow-up would have been valuable, particularly considering the Marshall and Barbaree (1990) data showing a significant increase in re-offence rate beyond two years post-treatment.

In a study by Marshall and Barbaree (1988, cited in Marshall & Barbaree 1990) the authors assessed a total of 169 child molesters who presented at their clinic in Canada. Of this group, 126 admitted guilt and were designated as suitable for treatment. Of the group of 126 58 were unable to participate in treatment for reasons other than those related to the nature of the treatment program, e.g. they lived too far away from the clinic. This group became the control for the study. The authors, for the purposes of follow-up, used three sources of data. These included official police records, non-official police records, and self-report information. The authors reported that non-official police records produced higher rates of re-offence than official police records and were interpreted as being more accurate. The self-report information was unsatisfactory, producing the zero re-offence rates in those they were able to follow up (27), while at the same time official and unofficial police records indicated clearly that members of this group had indeed re-offended. The authors point out (Marshall & Barbaree 1990) that this does not necessarily implicate all self-report information as unreliable. They note that the Abel et al. (1987) and Abel et al. (1988) self-report information was gained under circumstances where the authors obtained a exemption from the laws of reporting criminal acts; this was likely to increase the validity of the information. Marshall & Barbaree (1988) reported a 17.9% re-offending rate among non-incestuous child (girl) molesters at 48 months’ mean follow-up; this compares favourably with 42.9% re-offending among untreated controls. Child (boy) molesters had a 13.3% re-offence rate compared with 42.9% in untreated controls. Incest offenders had a re-offence rate of 8% at 34 months’ follow-up compared with 21.7% in untreated controls; and exhibitionists had a re-offence rate of 47.8% at 57 months’ follow-up compared with 66.7% in untreated controls. This study perhaps offers the most comprehensive data concerning the effectiveness of cognitive behavioural treatment interventions. Its follow-up
periods are adequate, ranging from 34 months to 57 months; the data sources are varied, including official and non-official police records; and most importantly it provides re-offence data for a comparison group that, while not randomly allocated, are nevertheless a distinct improvement.

In a study by Wolfe (1984) the author treated two groups of child molesters — non-incestuous, girls and non-incestuous, boys — and rapists. The author used probation reports as follow-up for mean length of 13.5 months. The author reported 4.5% re-offence rate for the molesters of girls and no re-offences for the molesters of boys and for rapists. While the above results are indeed encouraging, three qualifications are needed. First the source of follow-up data (probation reports) may not be the most accurate; second numbers were not large, particularly in the groups reporting no re-offences (N=17 for the molesters of boys, N = 3 for rapists). Finally, Wolfe's selection criteria are somewhat selective. While the author excludes any patients who are psychotic or grossly inadequate, he also excludes those who are physically violent, have extensive non-sexual criminal history, counterproductive attitudes, and poor motivation levels. Given the highly selected nature of the remaining population, one would expect this group to be a relatively low-risk sub-set.

4.2.8 Summary

Before making conclusions about the effectiveness of these interventions, one note of caution should be raised concerning the high level of subject drop-out or pre-treatment exclusion. Obviously this is an important factor in evaluating the efficiency of a program and its ability to offer benefit to offenders. Abel et al. (1988) report a 35% drop-out rate, while Marshall & Barbaree (1988) reported that 43 of their initial 169 patients were unable to participate in treatment because of denial. These figures must be kept in mind, particularly considering that the resulting group is usually compared with re-offence data for untreated offenders who are not a self-selecting group. With this in mind it would nevertheless appear that cognitive behavioural procedures do offer an effective means of reducing offending behaviour. The considerable experimental/control differences, particularly in the Marshall and Barbaree (1988) study and the work of Abel et al. (1988), clearly indicate the effectiveness of these behavioural procedures, which offer a relatively economical (particularly in the case of outpatient group programs) and non-intrusive means of intervention.
5.0 CHILD-ABUSE PREVENTION PROGRAMS

Programs aimed at the prevention of sexual abuse began in the late 1970s in North America (Finkelhor 1986). The rationale for such programs was, first, that a significant percentage of all children suffer from some form of sexual abuse and, second, that while there has been an increase in the number and effectiveness of services available for victims it is apparent that a large proportion of victims are never identified. Therefore these services can at best be expected to service a minority of victims. Plainly, a broader approach was needed. Thus the logic of prevention programs rests on the assumption that with certain information victimisation can be prevented or identified at an early stage, preventing much trauma. The major difference between the prevention programs are their target audiences. The three variously targeted audiences are:

(1) children
(2) parents
(3) professionals working with children: i.e. schoolteachers, doctors.

5.1 CHILDREN

The prevention programs targeted at primary-school children usually have three basic themes, (Finkelhor 1986). First, these programs aim to educate children about what sexual abuse is and that certain behaviours are bad, and that children should be alert to people who attempt to do such things to them. Second, these programs attempt to educate children about people who might be abusers. Traditionally these kinds of messages have focussed on the stranger, and parents have been vigilant in their attempts to alert their children to `beware of strangers'. However, our current knowledge about who a potential perpetrator can be demonstrates clearly that perpetrators are often related to the victim or is a well-known friend. Third, these programs attempt to equip the young child with skills and action in the event of attempted abuse. This might be to tell someone trusted not to be ashamed, and to keep telling that person until some action is taken.

Most prevention programs now recognise that boys as well as girls are potential victims for child sexual abuse. Current statistics (Finkelhor 1986) estimate one male victim for every two to three female victims. Therefore programs aimed at educating young children are conducted in mixed settings or directed towards boys and girls independently. In addition, research has shown that victimisation can occur at a very early age; therefore prevention programs need to be directed towards young children, in third or fourth grade and need to pitch their message so that it can be understood and retained.
5.2 PARENTS
The second major target audience for prevention programs has been parents of young children. It is considered that there are advantages in such programs in that parents, as the primary educators of their children, can communicate the essential messages of child-directed programs. Additionally, parents may become more sensitised to the problem and detect it at an early stage. Further, it has been argued that such programs may have the effect of deterring potential abusers (Snowden 1986). The importance of educating parents about child sexual abuse is highlighted in a number of surveys demonstrating that parents of young children have great difficulty in recognising the realities of child sexual abuse or are ignorant of the facts. A North American study of 521 parents of children aged 6-14 (Finkelhor 1984) reported that 29% had had discussions with their children about sexual abuse. Of these discussions 53% included the possibility of abuse by an adult acquaintance; 22% by a family member; and in most cases the discussions did not take place until at or after nine years of age. There is little doubt that many parents have great difficulty in broaching this topic with their young children. Undoubtedly in some cases it evokes painful memories of sexual abuse perpetrated on these parents. In other cases parents may be fearful that such discussions with young children will evoke considerable fear and distrust of other family members. The value of well-designed programs is their ability to reduce anxieties of parents by providing them with well-scripted stories and discussions that are understandable to young children. Some authors have argued that, unlike other well-known dangers to young children, e.g. kidnapping, where parents have a well-rehearsed simple message `Beware of Strangers', in the case of child sexual abuse parents do not have a standard story or warning for their children and must improvise. If prevention programs can provide parents with effective messages or stories they may be less anxious, and much more inclined to discuss such matters with their children.

5.3 PROFESSIONALS
The third major target for prevention programs the professional working with young children. The two major groups in this category are primary-school teachers and physicians. There is little doubt that in recent years these professions have become far more sensitised to the issue of child sexual abuse. This has been reflected in the public debate regarding legislation requiring mandatory reporting of such cases by professionals. Certainly, increasing the knowledge of teachers offers an economical means of detecting abuse cases at the early stage, particularly considering teachers' regular contact with a class of young children. Therefore teachers educated in such matters would be in a position to detect unusual behaviour in their pupils, investigate,
and take appropriate action.
Physicians, while having much less regular contact with young children are in a unique position to recognise and detect abuse cases, because of the intimate nature of their contact.

5.4 RESEARCH EVALUATION
Much of the research evaluating such programs has come out of North America and has concentrated on those programs targeting children. In a study by Plummer (1984, cited in Finkelhor 1986) 69 fifth-graders were tested on their knowledge and attitudes towards sexual abuse prior to and after participating in a three-day education/prevention program. This study also included follow-up tests at three months post-program and eight months post-program. The pre-test and immediate post-test comparisons showed a significant increase in the participants' knowledge of sexual abuse. Children were aware of the distinction between sexual abuse and physical abuse and were aware that potential molesters could be well known to them.
Unfortunately this study revealed that much of these gains was lost at the eight-month post-program re-test. In particular, subjects had reverted to the pre-program notion that perpetrators were generally people unknown to them.

In a study by Rae (1986) the author examined a workbook-based sex-abuse prevention program for children in third grade. As in Plummer's 1984 study (cited in Finkelhor 1986), the children appeared to benefit from the program as measured by the immediate post-program test. However, a number of these gains were lost at a four-week follow-up, including the notion that potential molesters could be someone well known to them.

A number of similar studies (Toal 1985; Downer 1984) have evaluated prevention programs with primary-school children and demonstrated a clear benefit in terms of children's knowledge and assertive skills after completing the program.

5.5 SUMMARY
In summarising it is perhaps premature to generalise from the relatively few studies that evaluated prevention programs. Regarding those studies examining programs directed at children, it would appear that they are effective in increasing the knowledge of young children as well as their assertive skills, but that children have difficulty in retaining this information. This appears to be particularly the case for more difficult concepts, which (for example) require children to accept that a potential perpetrator could be someone they know and love. With respect to those programs directed towards parents and professional groups, it is not possible at this stage to
conclude either way as to their effectiveness. While each strategy possesses much face validity, further research is needed to evaluate their effectiveness before clear conclusions can be made.
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