THE TREATMENT OF PEDOPHILIA BY RATIONAL-EMOTIVE THERAPY: A CASE STUDY

by

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ABSTRACT

Previous research is satiated with publications on behavior therapy techniques and deprived of a methodology for answering the basic question of clinical behavior therapy: Which modification procedure should be employed with the particular problem of pedophilia and its' treatment? Recently, researchers have begun to address this question (e.g., Kjoloth, 1979; McGarry, 1984; Munjack, 1984; Sidley, 1990). This study sought to examine the utility of a specific form of cognitive-behavioral therapy, Rational-Emotive Therapy (RET) in the treatment of pedophilia. An ABA design was selected. This design utilizes a baseline for behavior (A) which allows the researcher to determine where the client is functioning currently, then applying therapy and taking another measurement of the clients behavior (B) now allows the researcher to determine the effect of therapy. Finally returning the client to his baseline behavior by withdrawing therapy and taking another measurement (A), enables the researcher to assess the effects of therapy on the pedophile. Results suggest that RET may not be an effective therapeutic strategy to adopt with this population because the therapy is so brief. Further studies should attempt to replicate the present
results and examine the utility of other specific intervention techniques with a similar population of pedophiles.
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<table>
<thead>
<tr>
<th>Chapter</th>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Background</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Purpose</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Statement of Hypotheses</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Rationale</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Significance</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Operational Definition of Terms</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Assumptions and Limitations</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Organization of the Remainder of the Study</td>
<td>14</td>
</tr>
<tr>
<td>II</td>
<td>LITERATURE REVIEW</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Psycho dynamic theories</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Cognitive-Behavioral Theories</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Biosocial Theories</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Rational-Emotive Therapy</td>
<td>29</td>
</tr>
<tr>
<td>III</td>
<td>METHOD</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Research Design</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Subject</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Measures</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Sexual Thoughts</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Abel and Becker Sexual Interest Inventory</td>
<td>37</td>
</tr>
</tbody>
</table>
CHAPTER 1
INTRODUCTION

On the surface, the significance of pedophilia and the sexual abuse of children is not so obvious. Currently, there exists an inclination to view child-adult sex as harmless and a reluctance to hold molesters responsible for their behavior. One way or another, child molesters get permission for what they do. Further still, some professionals who work in the field of incest believe that some incest may be a positive, healthy experience or at worst dull and neutral (Freeman-Longo, 1986).

Introduction

When looking at the problem of pedophilia it is a widespread belief that for the most part no real harm is being done by the pedophile, particularly if the victim happens to be a male child. Males are considered by our society to be "sexually promiscuous" anyway, so "any" involvement with sex by a male, young or old, is considered "typical" behavior for males. This is one of the reasons treatment of pedophilia is so difficult. Another reason it is difficult to treat the pedophile is because he "feels" that he is doing the child a "service," and has done nothing wrong, also because of the enormous amount of attention that is paid to the child, many times the child is reluctant to
"tell" anyone about the pedophile or to testify against him in a court of law.

Pedophilia is the sexual desire in an adult for a child (Webster's Dictionary, 1992). Pedophile feelings are defined as feelings of attraction to children. They are distinguished from what is usually called "love of children" by the fact that sexual attraction is also present. Pedophile feelings cannot be reduced to their sexual aspect alone, however. Often the pedophile shows an intense interest in what children do and think and in the ways in which they experience the world around them (Becker, et al., 1986). Pedophiles experience recurrent, intense, sexual urges and sexually arousing fantasies involving sexual activity with a prepubescent child. Pedophiles generally report an attraction to children of a particular age range, which may be as specific as within a range of only one or two years. Attraction to girls is twice as common as attraction to boys. Many pedophiles are sexually aroused by both young boys and young girls. Some pedophiles are sexually attracted only to children (exclusive type) whereas others are sometimes attracted to adults (non-exclusive type) (Abel, Becker, and Cunningham-Rathner, 1984).

Adult-child sex is an active, prevalent pastime and presents an increasing problem. Speculation as to the number of incidents varies from five to five hundred
thousand to one million per year and from five to thirty-five million persons who will experience a sexual encounter with an adult during childhood. National statistics indicate that fully 25 per cent of the female population and 9 percent of the male population, hence approximately twenty-five million women and three million men in the United States, will experience a sexual encounter with an adult in childhood (Burgess, et al. 1978). Most reported adult human sexual behavior with children and adolescents concerns sexual behavior involving adult males rather than adult females, by a ratio of 10:1 (Abel et al., 1984; Gebhard, et al., 1965). Apparently other factors are at work among women. Women have a greater amount of physical contact with others before that contact becomes recognized as "sexual." Women are expected to interact affectionately and physically with children. Also, women are less genitaly centered in their sexual behavior. All of these factors may buffer and prevent them from identifying themselves as pedophiles (Shaffer, 1964; Weisner and Gallimore, 1977).

Pedophilia has existed since earliest recorded history. The Bible and Jewish tradition both contain accounts of sex between adults and children. For example, Jewish tradition held that a female child of "three years and one day" could be betrothed by sexual intercourse with her father's
permission. Jewish tradition recommended that a daughter be given in marriage when na'rah happened (between the age of twelve and twelve and a half) but a father could marry her off well before that time. Further, intercourse with one younger was not a crime but invalid. In other words, if the prospective groom (or rapist) could penetrate the child just once more after her third birthday, he could legitimately claim her as bride. The Book of Numbers also speaks of betrothal at three years and one day (New American Bible, 1983).

Pedophilia has important medical and emotional costs. Adult sex with children presents an increasing serious health problem. Cases of rectal fissures, lesions, poor sphincter control, lacerated vaginas, foreign bodies in the anus and vagina, perforated anal and vaginal walls, death by asphyxiation, chronic choking from gonorrheal tonsillitis, are almost always related to adult sexual encounters with children (Money, 1987). In one study, of twenty cases of genital gonorrheal infection in children aged one to four, nineteen had a history of adult-child sex. A history of adult-child sex was obtained in all twenty-five cases of infected children between five and nine, and the same was true of all 116 cases of children between fourteen and fifteen. In another study, 160 of 161 cases of this illness in children resulted from sexual contacts with adults
(Finkelhor, 1986). Risk of teenage pregnancy and its concomitant complications exist as well. The death rate from complications of pregnancy, birth and delivery is sixty percent higher for women who become pregnant before they are fifteen, while the rate for fifteen to nineteen year old adolescents is 13 percent greater than for mothers in their early twenties. Mothers aged fifteen to nineteen are more likely to die from hemorrhage, miscarriage, and toxemia as well (Groth, 1979).

The cost in human suffering is enormous as well. Compared to non abused children, survivors of child abuse are at high risk to develop severe depression (Halleck, 1965), inability to function (Groth, 1979), psychosis (Finkelhor, 1979), and suicide (Finch, 1973).

Recently, cognitive methods have been applied to the clinical treatment of pedophilia (Abel, et al., 1984). Several recent reviews of cognitive approaches have been published (Dobson, 1988). Such approaches posit that patients' emotional and behavioral responses are largely contingent on how they construe their experience (Turk, Meichenbaum, & Genest, 1983). However, until recently there has been a paucity of studies examining the cognition's thought to be important in pedophilia. The present study, was designed to investigate a cognitive approach to the treatment of pedophilia.
Background

This study took place in the Southwest United States, Phoenix, Arizona. The subject was an 18 year old single white male who lived in institutional settings since the age of 12. His father is imprisoned for molesting him, and his mother was in prison for drug and income tax related offenses. The subject had an eleventh grade education and was still enrolled in high school at the time this study took place.

If we look at statistics for the United States, we find that fully 25 percent of the female population and 9 percent of the male population, approximately twenty-five million women and three million men will experience a sexual encounter with an adult in childhood (Burgess, et al., 1978).

Purpose

The purpose of this study is to determine if rational-emotive therapy will work in the treatment of pedophilia. In the recent past cognitive methods have been applied to clinical treatment of pedophilia (Abel, et al., 1984) with little or no positive results. It is felt that rational-emotive therapy will enable the therapist and the pedophile to achieve immediate and long lasting positive results in controlling the problem.
Statement of the Hypotheses

1. It is hypothesized that rational-emotive therapy will reduce the level of irrational (nonnormative) cognitions that a typical pedophile may experience.

2. It is further hypothesized that the General Severity Index (GSI) score (which is a measure of general psychological adjustment), of the SCL-90R scale would decrease following the intervention phase of this study.

Rationale

One of the reasons that RET was chosen for this study was because in part due to the theory of RET. According to RET theory, cognitive factors play an important role in human functioning and cognition, emotion, and behavior are highly interdependent and interactive processes. RET holds that the most elegant and long-lasting changes that humans can effect are ones that involve the philosophical restructuring of irrational beliefs (Dobson, 1988). This was felt to be an appropriate inference to utilize in combating the problem of pedophilia in therapy. The GSI instrument was utilized to measure adjustment level of the pedophile. This instrument was chosen because it has been found to be a sensitive indicator of several dimensions of psychopathology.

These findings may have clinical relevance. Recent research highlights the importance of idiographic analysis
in behavior therapy (Sidley, 1990). Meyer and Turkat (1979) have expressed the concern about identifying appropriate modification procedures for particular individuals with particular problems at particular points in time. This study may be considered a preliminary attempt to test one therapeutic intervention technique with Pedophilia. These findings suggest alternative strategies would benefit this population.

Although RET is clearly aimed at modifying cognitions it lies at the center of the continuum of cognitive–behavioral therapies. It may be that a cognitive–behavioral technique which focuses more on external events, behavioral change, and associationism rather than internal (cognitive/emotional) events, conceptual/epistemic change, and constructivism would be more effective than RET which was limited to having the subject recall past events and attempt to apply current day resolutions to those events that caused the subject to offend, and then attempt to deal with them in a brief way, rather than a slower, bit by bit approach. Support for this view is one area for future study.

Several limitations of this study should be mentioned. First, this study utilized self-report measures only. Second, the subject was not assessed by a behavioral clinician. In essence, the target behavior may or may not
have been pedosexual thinking. Thus, a cognitive intervention designed to alter pedosexual thinking may have failed to do some other third variable.

Additionally, rational-emotive therapy may not be as effective a treatment with pedophiles as other cognitive models. For example, self-control therapy, stress inoculation training, problem-solving therapy, self-instructional training, covert conditioning, systematic desensitization, operant conditioning, and classical conditioning are all more focused on external events, behavioral change, and associationism. RET's greater focus on internal (cognitive/emotional) events, conceptual/epistemic change, and constructivism may account for its failure in this study.

Significance

The significance of this study is two-fold. First, previous research is satiated with publications on behavior therapy techniques and deprived of a methodology for answering the basic question of clinical behavior therapy: Which modification procedure should one employ with this particular problem at this point in time? Recently, researchers have begun to address this question (e.g., Kujoth, 1979; McGarry, 1984; Munjack, 1984; Sidley, 1990). This study sought to examine the utility of a specific form of cognitive-behavioral therapy (RET) in the treatment of
pedophilia. This is an important next step in the field of behavioral therapy. Researchers have called for an examination of several cognitive-behavioral therapies and one of the natural "laboratories" within which such investigations may occur are the patients who undergo therapy (Dobson, 1988).

This study is also important because the cognitive-behavioral therapies make specific predictions about the nature of change. Precisely for that reason, investigations are necessary to try to document if the changes that actually occur over the course of therapy coincide with the theoretical predictions. This study will attempt to determine whether or not such behavioral change predictions in rational-emotive therapy apply to pedophilic cognitions and behavior.

**Operational Definition of Terms**

1. **A-B-A Design**: A type of clinical research design where by a baseline (A) is established to record a starting point, then treatment or intervention is applied (B), the results are measured and recorded, then the subjects' treatment is stopped and another baseline (A) is recorded to determine the effect of treatment.

2. **Absolutistic Cognitions**: Dogmatic, many times religious "musts," "shoulds," "have to's," and "oughts," that a person believes must be accomplished.

3. **Adjudicated adult offender**: One who is convicted by a court of law for a particular offense.

4. **Androphiloic pedophilia**: An abnormal dread of male children, usually exclusive sexual attraction of a adult child molester to female children.
5. **Awfulizing**: This occurs when an event is rated as being more than one hundred percent bad.

6. **Baseline**: A starting point. In research or therapy it is the position at which the client is currently functioning.

7. **Classical conditioning**: Conditioning in which the conditioned stimulus (a sound of a bell) is paired with and precedes the unconditioned stimulus (as the sight of food) until the conditioned stimulus alone is sufficient to elicit the response (as salivation in a dog).

8. **Climax**: The highest or most intense point usually in sexual excitement.

9. **Coprophilia**: A marked interest in excrement, the use of feces or filth for sexual excitement.

10. **Damnation**: A tendency for humans to rate themselves and others as undeserving or "rotten," and are therefore "doomed."

11. **Depression**: A psychoneurotic or psychotic disorder marked by sadness, inactivity, difficulty with thinking and concentration, a significant increase or decrease in appetite and time spent sleeping. Feelings of hopelessness and sometimes suicidal thought patterns may emerge.

12. **Endorphins**: Any group of proteins with potent analgesic properties that occur naturally in the brain.

13. **Entrainment**: To determine or modify the phase or period of.

14. **General Severity Index**: A measurement that enables the researcher to determine how severe a subject's symptoms are in relationship to a problem.

15. **Gonorrheal tonsillitis**: An inflammation of the tonsils usually caused by genital-oral contact.

16. **Hedonistic concerns**: The belief or doctrine that pleasure or happiness is the sole or chief good in life.

17. **Hooked**: Addicted or addictive in nature causing addiction.
18. **I-can't-stand-it-itis**: Believing that one cannot experience virtually any happiness at all, under any conditions or circumstances.

19. **Interactive**: Mutual or reciprocal action.

20. **Interdependent**: Mutual dependence.

21. **Intrapsychic process**: A process of thinking that is situated within the mind, a process that is non-physical or supernatural and within the mind.

22. **Manic-depressive**: A person who has a major mental disorder characterized by mania (mental and physical hyperactivity, disorganized behavior), and psychotic depression.

23. **Modeling**: Behavior that is mimicked through observation, observed learning.

24. **Na' Rah**: In Jewish tradition, a girl's age at onset of menstruation, usually 12 to 12 and a half years old.

25. **Obsessive compulsive**: A persistent disturbing preoccupation in the thinking process that causes one to act immediately without thinking.

26. **Opponent**: A process principle that at the onset is aversive and subsequently reverses and becomes addictive.

27. **Pairbonding**: An exclusive union with a single mate at any one time: a monogamous relationship.

28. **Paraphilias**: Perverted sexual behaviors.

29. **Paraphilic fugue state**: A state of mind that exists for the pedophile where the individual may have an alternative name and an alternative juvenile wardrobe, as well as a juvenile appearance, bearing, and personality.

30. **Pedophile**: A person who is sexually attracted to children.

31. **Pedosexual**: Sexually related to children.
32. **Penile Plethysmography**: The science of measuring the penis' variations in size in the amount of blood present or passing through it through the use of a computerized instrument.

33. **Phylism**: A unit or building block of human existence that belongs to human beings, as individuals, through their heritage as members of their species.

34. **Sexuoerotic**: That which is sexually erotic and sexually arousing.

35. **Sexological**: That which only makes sense or is logical as it relates to sex.

36. **Schizoid**: That which is characterized by shyness, withdrawal, inhibition of emotional expression, and apparent diminution of affect.

37. **Somatization**: A focus on the body. Many times associated with an individual who has a major interest or focus on the body, usually body complaints and ailments.

38. **Urophilia**: A marked interest in urine. The use of urine for the purpose of sexual excitement.

**Assumptions and Limitations**

RET theory stresses the role played by cognitive factors in human functioning. Cognition, emotion, and behavior are not to be viewed as separate psychological processes but rather as processes that are highly interdependent and interactive. Thus, the statement "cognition leads to emotion" tends to accentuate a false picture of psychological separatism.

In this model, A stands for activating agent (i.e., the perception of the event), B stands for the way that perceived event is evaluated (i.e., a person's beliefs), and C stands for the emotional and behavioral consequences that
stem from B. According to RET theory humans adhere to a particular set of evaluative beliefs at B, which tends to strongly influence the perceptions they make and the environments they seek out of A.

While RET holds that beliefs do affect emotion and behavior, it also stresses that it is equally true that the way one feels and act has a profound effect on our beliefs, in that one's emotional and behavioral reactions help to create environments and skew our perceptions of these environments (Turk, D.C., Meichenbaum, D., and Genest, M., 1983). This in turn has a constraining effect on our emotional and behavioral repertoires (as in the "self-fulfilling prophecy" effect). Thus, it should be underscored that RET theory sees the person as having overlapping intrapsychic processes and as being in constant interaction with his or her social and material environment (Dobson, 1988).

**Organization of the Remainder of the Study**

Chapter two discusses the organizational structure of the literature and its review for this study.

In chapter three the methodology and identification of the research utilized in this study is elaborated upon. Chapter three also contains a description of the methodology and sample population used in this study. It also discusses the instrumentation utilized and its reliability and
validity, as well as data collection and other procedures.

Chapter four contains the presentation and analysis of the data used in presenting the findings of this study. It also organizes the data, presents the manual, guidelines and any appendixes utilized in this particular study.

Chapter five is the summary, conclusions and recommendations of this study.
CHAPTER II

REVIEW OF THE LITERATURE

Several theoretical formulations have been proposed to account for pedosexual behavior. These theoretical formulations can be loosely categorized as either psycho dynamic, cognitive-behavioral, or biosocial.

**Psycho dynamic Theories**

Psycho dynamic theories suggest identification and/or mastery processes as mechanisms by which childhood and adolescent sexual behavior with adults may lead to later adult sexual involvement with children or adolescents. It is often suggested that adult androphilic pedophilia may be the long-term outcome of a previous emotionally gratifying experience of sexual contact with an adult during childhood or adolescence (Halleck, 1965). Theoretically, for the emotionally deprived and neglected male child, sexual interaction with an older male could prove comforting and enjoyable. Through the mechanism of identification with the older partner, the male child or adolescent could be predisposed to become sexually involved with other male children or adolescents when he is an adult. Such an individual when older may identify with his older partner and select and identify with young males as the recipients of his affection and can therefore easily rationalize his
behavior (Abel, et al., 1984).

This formulation is supported indirectly by certain findings. Emotional deprivation, especially involving an inadequate or absent relationship with the father, has been suggested and found to be a correlate of male child and adolescent sexual behavior with adult males (Bender, 1965; DeJong, Emmett, & Hervada, 1982a; Finkelhor, 1984; Halleck, 1965; Ingram, 1979). Also, it has been found that adult males' retrospective self-reports of sexual contact during childhood and adolescence are not uniformly negative (Finkelhor, 1979) and that some young males may contemporaneously evaluate such an interaction as positive (Bender, 1965). Furthermore, it has been clinically observed that children sometimes interpret a disrupted sexual relationship with an adult as a loss (Burgess, et al., 1978; Burgess, et al., 1984).

Finally, research has noted that androphilic pedophiles often retrospectively self-report disrupted or poor relationships with their fathers (Gebhard et al., 1965). However, despite these suggested findings, there is at present little or no direct empirical support for this psycho dynamic formulation. A second psycho dynamic formulation emphasizes both identification and mastery processes. In this formulation, "identification with the aggressor" and the conversion of
passive experience into activity done to others are the means by which sexual trauma is said to be related to "perversion" (Rosen, 1979; Stoller, 1975; Stoller, 1979; Stoller, 1985). Stoller, particularly, has articulated the process by which sexual trauma may lead to perversion. It does have to be noted that this formulation can be applied to adult sexual behavior with adolescents as well as children.

Stoller (1989), theorizes that perverse fantasies or acts represent the recapitulation of actual trauma directed at an individual's sex or gender identity. Perverse fantasies and acts are the means by which an individual symbolically attempts to gain revenge for and mastery over a childhood sexual trauma. As a result of identification with the aggressor, the individual, through such activities, is capable of temporarily turning a passively endured childhood trauma into an actively controlled adult triumph. Such activities preserve erotic gratification and a sense of potency.

Stoller's formulation is more comprehensive than are others in that he describes how additional factors mediate the effects of early sexual trauma and that this susceptibility is attributable to early life experiences in young males. Specifically, he suggests that excessive symbiosis with the mother and deficient identification with
the father can render a male child especially vulnerable to sexual trauma. He presumes this potential cause-and-effect situation to be the case because such a male child's sense of gender identity ought to be less firmly established. Additionally, such a parent/child configuration may potentiate oedipal conflicts, which in turn contribute to future difficulties in the development of adult heterosexual behavior.

Studies of male children and adolescents involved in sexual behavior with adults and clinical observations of adjudicated adult sex offenders of children provide some indirect partial support for Stoller's formulation and suggest its relevance for a hypothesized abused/abuser relationship.

Aggressive, antisocial behavior in male children and male adolescents is a common correlate of the disclosure of sexual involvement with an adult (Burgess et al., 1984; Burgess et al., 1987; Carmen, Rieker, & Mills, 1984; Finch, 1967; Friedrich & Luecke, 1988; 1984; Summit, 1983). This behavior commonly involves a sexual element (Finkelhor, 1984). Male children and adolescents who have been sexually involved with an adult tend to become involved sexually with younger children and abuse them (Burgess et al., 1984; Burgess et al., 1987; Freeman-Longo, 1986). The functions of this behavior are theorized to be the concealment of
feelings of helplessness, the mastery of anxiety, and the re-establishment of masculinity (Burgess et al., 1984; Burgess et al., 1987; Gebhard et al., 1965).

Stoller’s psycho dynamic formulation, too, is supported by the similarities between offense characteristics and retrospective self-report data in incarcerated adult sex offenders of children or adolescents. Freeman-Longo (1986) and Groth (1979) have reported that incarcerated adult sex offenders who as children or adolescents themselves were sexually involved with adults often replicate their sexual experiences with children or adolescents when they, the incarcerated offenders, are adults. The ages of the children or adolescents with whom they become involved and the types of sexual acts performed have been noted to correspond to their own previous childhood and adolescent sexual experiences with adults.

**Cognitive-Behavioral Theories**

Cognitive-Behavioral formulations involving conditioning and/or modeling processes have been proposed as the means by which childhood and adolescent sexual behavior with adults may be related to subsequent sexual behavior with children and adolescents when these former children and adolescents themselves become adults (Howells, 1981).

McGuire, Carlisle, and Young (1965) hypothesized that non normative sexual arousal may become conditioned through
masturbatory fantasies paired with orgasm. These researchers suggested that early sexual experiences, such as sexual behavior with an adult, supply the material for these masturbatory fantasies and that through classical conditioning (i.e., conditioned stimulus = fantasy, unconditioned stimulus = orgasm), the fantasy stimuli become increasingly sexually arousing. McGuire and colleagues suggested that these masturbatory fantasies might become progressively more non normative as a result of memory distortion and selection over time. They also allow that other factors, such as feelings of physical or social inadequacy, might be important determinants of a preference for non normative sexual fantasies over more conventional ones.

There are two mechanisms by which conditioning can increase the probability of an adult’s becoming sexually involved with a child or an adolescent. First, adult sexual behavior with a child or an adolescent often clinically manifests itself in the affected child or adolescent as sexual precociousness and increased sexual behavior (Alter-Reid, Gibbs, Lachenmeyer, Sigal, & Massoth, 1986; Finkelhor et al., 1986). Theoretically, a child’s or an adolescent’s increased sexual behavior with peers could directly condition sexual arousal to children and could serve as the basis for subsequent conditioning through masturbatory
fantasies: Second, through processes like memory distortion over time, the child or adolescent who had been sexually involved with an adult could develop a masturbatory fantasy that somehow results in the conditioning of sexual arousal to children (e.g., fantasizing the self in the role of the adult).

Modeling (observational learning) also has been suggested as a process by which childhood and adolescent sexual behavior with adults may be related to subsequent sexual behavior with children and adolescents (Freeman-Longo, 1986; Howells, 1981). The child or adolescent may learn through observation that adults can and do sexually interact with children, that they experience rewarding consequences as a result of such interaction, and adolescents also are misinformed by the adult involved in the abuse about the propriety of such behavior (Burgess et al., 1987).

There is plausibility to these cognitive-behavioral formulations. In support of the conditioning hypothesis are the observations that sexual responses can be classically conditioned (Dougher, et al., 1987) and that some adjudicated adult sex offenders become sexually aroused (as assessed by penile plethysmography) by descriptions of their own childhood sexual experiences with adults (Freeman-Longo, 1986). However, in two important respects, these
formulations are limited. First, at an empirical level, for obvious forensic reasons there is no systematic development of adult sexual behavior with children or adolescents. The author seems to state that there is no step by step procedures for sexual relationships between children and adults because of our societies moral attitude toward pedophilia. Second, at a theoretical level, it is obvious that neither conditioning nor modeling processes alone can be necessary and sufficient causes for sex between adults and children in our society, because these processes simply do not exist. Other variables, such as social inadequacy, appear necessary for explaining why the child or adolescent who has been sexually involved with an adult remains sexually interested in children or adolescents when this child or adolescent becomes an adult (Howells, 1981).

Consideration of other variables is especially important for the conditioning hypothesis. Many prepubescent and pubescent children experience sexual arousal and even orgasm with peers but do not later in adulthood engage in sexual behavior with children or adolescents (Howells, 1981; Burgess et al., 1978). Thus, while conditioning and modeling mechanisms may be determinants of some adult human sexual behavior with children and adolescents, by themselves they are not adequate explanations.
Biosocial Theories

Other researchers propose biosocial explanations to account for sexual behavior between adults and children and adolescents (Eibl-Eibesfeldt, 1975; Gladue, 1975; Hutchison & Hutchison, 1975; Mackey, 1975; Taub, 1975). Society in general holds the assumption that pedophilia is a voluntary orientation. According to the biosocial position, this assumption is faulty and is based on rare and sporadic cases in which there is an overlapping of pedophilia with another. The biosocial approach begins with the concepts of phylism and pairbonding.

Phylism may be defined as "a unit or building block of human existence that belongs to human beings, as individuals, through their heritage as members of their species" (Money, 1983). In the human species the phylism of pairbonding applies to the sensuous relationship of parent and child and to the sensual relationship of lovers and of breeding partners. Although the pairs of individuals differ between one kind of pairbonding and the other, these two manifestations share some features in common. In nature's design of things, the pairbonding of infancy serves a dual developmental role. As it does with other mammals, it ensures the survival of the individual, and as a precursor of later sexuerogetic pairbonding, it also ensures the survival of the species (Mackey, 1985). Both manifestations
of pairbonding are intimately related to the skin senses through the acts of holding, cuddling, hugging, rubbing, patting, rocking, and kissing. They are both related to sucking of the nipples and to the possibility of an orgastic climax (Shaffer, 1964). In addition, both manifestations of pairbonding may be intimately related to genital arousal. Despite nature's economy in the overlapping sexological aspects of pairbonding between parent and child and lover and lover, the majority of adults require no particular effort to keep the love of a child separate and different from the love of a sexual partner (Money, 1983).

For the pedophile, the phylism of the sexueroeroticism of lover/lover bonding becomes entrained with the caretaking of the phylism of parent/child bonding. Among the paraphilias, this phenomenon of entrainment is not unique; and may be found in cases of coprophilia or urophilia, (a fetish type of paraphilia in which sexueroerotic arousal and facilitation or attainment of orgasm are responsive to and dependent upon being smeared with and/or ingesting feces or urine), as well as other paraphilias (Money, 1983).

The neurobiology of the entrainment of one phylism (a unit of human behavior) to another, as in the case of pedophilia, constitutes a scientific problem still awaiting a solution. It is possible that crossover may have its origin in an apparently minor genetic defect. There are
some cases of pedophilia, as well as of the other syndromes of paraphilia, in which there is evidence of a vulnerability factor that may be related to actual brain injury, or so-called "minimal brain damage" (Lehne, 1986; Money, 1986). A vulnerability factor has been partially substantiated in cases of eidetic imagery and schizoid hallucinosis, the cyclicity of manic-depressive illness, and a vulnerability factor that is epileptiform and akin to temporal-lobe psychomotor epilepsy (Money, 1986). It is also possible that its origin is not genomic but, rather, is a product of an error in the neurochemistries responsible for the prenatal or neonatal differentiation of sexual pathways in the developing brain (Money, 1987a). Alternatively, the timing may be later in life, in which case the error would presumably be introduced into the brain during a critical period of development when the differentiation of its love map (a developmental representation, or template, in the mind and in the brain depicting the idealized lover and the idealized program of sexuoerotic activity projected in imagery or actually engaged in with the lover) is responsive to information received through the eyes, ears, and skin senses (Money, 1986).

There are some cases of pedophilia, as well as cases of many paraphilias, in which there is definite clinical evidence of an altered state of consciousness for which an
appropriate name is "paraphilic fugue state" (Money, 1986). While in this fugue state, the patient may have an alternative name and an alternative juvenile wardrobe, as well as a juvenile appearance, bearing, and personality. His or her behavior gives the impression of a juvenile social age and of a juvenile sexuoerotic age. The pedophile in this state relates to the younger partner in the manner of a child engaging in sexual rehearsal play with another child. However, the pedophile is likely to have undergone the experience of sexuoerotic pairbonding and falling in love. It is doomed to be love unrequited, for the juvenile does not fall in love but, rather, responds with parent/child pairbonding and maybe a touch of hero worship (Money, 1983).

Finally, the principle of opponent-process has been proposed to account for pedophilia (Solomon, 1980). According to the opponent-process principle, that which at the outset is aversive subsequently reverses and becomes addictive. For example, the terror that accompanies the first free-fall parachute jumps of some learners may turn into euphoria that gets the jumper "hooked" and addicted to parachuting as either a career or a sport. It is possible that the change is mediated by a brain-released flood of the body's own opiates or endorphins (Munjack, et al., 1983).

Researchers examining this hypothesis have retrieved
biographical information from pedophiles consistent with the
principle of opponent process. For example, a juvenile who
was separated from his mother by death, a grief stricken
event, and then from his father, a second grief-causing
event, and then separated from his familiar environment by
being sent overseas to be taken care of by an aunt and
uncle, yet another grief-bearing event for this young man to
endure can cause this particular individual to look for
comfort and stability. The young lad feeling that he can at
last receive comfort and stability from his aunt and uncle
soon learn that these relatives intend to place him into a
boys’ boarding school, still yet another grief-caused event
for him to endure. Grief-stricken and devoid of
attachments, he was befriended by a pedophilic teacher and
entrapped in a Catch-22 dilemma that decreed that he would
lose his only friend if he reported the relationship and
would lose his honor if he did not. Not a very comfortable
position for this young man to be in. A resolution to the
dilemma lay in a spontaneous reversal from aversion to
attraction with respect to the illicit genital activity.
The boy decided to rationalize in his mind the illicit
genital activity in order for him to "keep" his friend and
still feel he was being "true" to himself. It was the
attraction of the young man to the pedophile, because he
needed affection and warmth that became an addiction. After
the maturation of puberty, he continued to display a
sexueroetically addictive relationship with male juveniles
exclusively because this is how he had learned to receive
"love," comfort and security as a boy, thus his "role" model
(Solomon, 1980).

No one study has examined the utility of any particular
cognitive-behavioral intervention in pedophilia. This
primary purpose of the present study was to examine the
utility of a form of cognitive-behavioral therapy known as
rational-emotive therapy in the treatment of pedophilia.

Rational-Emotive Therapy

Rational-emotive therapy (RET) was founded by Albert
Ellis in 1955 and is closely identified with the tenets of
ethical humanism (Russell, 1930, 1965), particularly with
respect to the idea that humans would do better to accept
themselves and others as human and rid themselves of the
notion that superhumans and subhumans exist. Rational-
emotive therapy also owes a unique debt to the ideas of
Alfred Adler who held that a person's behavior springs from
his or her ideas.

RET theory conceives of the person as a complex, bio-
social organism with a strong tendency to establish and
pursue a wide variety of goals and purposes. RET theory
holds that while people differ enormously in what will bring
them happiness, the fact that they do construct and pursue
personally valued goals shows that they strive to bring a sense of meaning to their lives. According to RET theory the basics human goals appear to be to stay alive and to pursue happiness; humans are thus seen as hedonistic (Dobson, 1988).

The concept of rationality is central to an understanding of the rational-emotive image of the person. Here "rational" means that which aids and abets people in achieving their basic goals and purposes. Although people are motivated by hedonistic concerns, they often experience a clash between short-range and long-range goals. RET theory holds that while people would do better to satisfy some of their short-range goals, if they are to achieve their basic goals and purposes, then they should adopt a philosophy of long-range hedonism. "Irrational" then, means that which hinders or blocks people from achieving their long-range goals and purposes. It is thus apparent that rationality is not defined in any absolute sense in RET theory, since that which aids or hinders this goal achievement is defined dependent upon the individual in his or her own particular situation (Dobson, 1988).

RET theory stresses the role played by cognitive factors in human functioning. Cognition, emotion, and behavior are not to be viewed as separate psychological processes but rather as processes that are highly
interdependent and interactive. Thus, the statement "cognition leads to emotion" tends to accentuate a false picture of psychological separatism. RET puts forth an ABC model. In this model, A stands for activating agent (i.e., the perception of the event), B stands for the way that perceived event is evaluated (i.e., a person's beliefs), and C stands for the emotional and behavioral consequences that stem from B. According to RET theory humans adhere to a particular set of evaluative beliefs at B, which tends to strongly influence the perceptions they make and the environments they seek out of A. While RET holds that beliefs do affect emotion and behavior, it also stresses that it is equally true that the way one feels and act has a profound effect on our beliefs, in that one's emotional and behavioral reactions help to create environments and skew our perceptions of these environments (Turk, D.C., Meichenbaum, D., and Genest, M., 1983). This in turn has a constraining effect on our emotional and behavioral repertoires (as in the "self-fulfilling prophecy" effect). Thus, it should be underscored that RET theory sees the person as having overlapping intrapsychic processes and as being in constant interaction with his or her social and material environment (Dobson, 1988).

According to RET theory, humans have a strong tendency to think irrationally. They display a great ease in
converting their strong preferences into devout, absolutistic demands. These absolutistic evaluations of the perceived events are couched in the form of dogmatic "musts," "shoulds," "have to's," "got to's," and "oughts." Such absolutistic cognitions are at the core of a philosophy of a dogmatic religiosity that is central to human emotional and behavioral disturbance. These beliefs are deemed to be irrational in RET theory in that they usually impede and obstruct people in the pursuit of their basic goals and purposes (Dobson, 1988).

RET theory goes on to state that if humans adhere to a philosophy of "musturbation," they will strongly tend to make a number of irrational conclusions that are deemed to be derivatives of these "musts." These derivations are viewed as irrational because they too tend to sabotage a person's basic goals and purposes. The first derivative is known as awfulizing. This occurs when an event is rated as being more than one hundred percent bad, a truly exaggerated and magical conclusion that stems from the belief "This must not be as bad as it is." The second derivative is known as I-can't-stand-it-itis. This means believing that one cannot experience virtually any happiness at all, under any conditions or circumstances, if an event that must not happen actually occurs or threatens to occur. The third derivative is damnation. Damnation represents a tendency
for humans to rate themselves and other people as sub-human or undeserving if one's self or another does not do something that they "must" do. Damnation can also be applied to the world or life conditions that are rated as being "rotten" for failing to give another person what he or she must have (Dobson, 1988).

In summary, it is possible to discern the major categories of human psychological disturbance in RET theory; ego disturbance and discomfort disturbance. In ego disturbance the person damns him or herself as a result of making musturbatory demands on the self, others, and the world. In discomfort disturbance, the person again makes demands on the self, others and the world but these demands reflect the belief that comfort and comfortable life conditions exist.

RET also holds that humans have both the ability to think about their thinking and the ability to exercise their power to choose to work towards changing their irrational thinking. Thus, people are by no means powerless slaves to their tendency towards irrational thinking; they can transcend (although not fully) its effects by deciding to actively and continually work towards changing this thinking by employing cognitive, emotive, and behavioral challenging or disputational methods. In the final analysis, then, RET theory holds a positive and optimistic view of the person
RET was chosen for this study because of the role cognitive factors appear to play in pedophilia. RET should provide an opportunity to identify the irrational beliefs, label the activating experiences, discuss the consequences, and attempt to alter the belief system in pedophiles.

Specific hypothesis consistent with the objective of this study are as follows:

1. According to RET theory, cognitive factors play an important role in human functioning and cognition, emotion, and behavior are highly interdependent and interactive processes. RET holds that the most elegant and long-lasting changes that humans can effect are ones that involve the philosophical restructuring of irrational beliefs (Dobson, 1988). Thus, it was hypothesized that RET would reduce the level of irrational (non normative cognitions).

2. Also, it was hypothesized that the General Severity Index (GSI) score of the SCL-90R would decrease following the intervention phase of this study. The GSI is an instrument used to measure adjustment level. This instrument was chosen because it has been found to be a sensitive indicator of several dimensions of psycho pathology.
CHAPTER III

METHOD

Research Design

Beginning this study this researcher had a choice of using either a nomothetic or idiographic approach to the problem of pedophilia. Since this study involved the use of one individual in a case study situation I elected to use the idiographic approach. Most case studies are idiographic because they relate to individuals while nomothetic studies relate to large groups and generally tend to deal with non-specific material. While an idiographic approach deals with the individual, it would appear this type of approach would be most appropriate to use in a clinical case study. A case study is related to bringing about behavioral change with in an individual.

Many times when a researcher tries a therapeutic approach one will use an idiographic approach so that the researcher can attempt to change the person’s behavior. The strength of the case study is that the researcher can look directly at behavioral change with one individual. The topic of pedophilia lends itself to an idiographic approach because of the nature of the problem.

Subject

The subject was obtained from a population of patients
receiving care in a large southwestern outpatient psychiatric clinic. Five hundred patients were screened to take part in the study. Patients were selected if they satisfied the following criteria: voluntary status; no evidence of organic brain syndrome; diagnostic impression of pedophilia made by attending psychiatrist; response to a modified list of sexually intrusive thoughts (see Appendix B), and not currently taking medications. Patients were excluded if they were taking psychiatric medications because such medications might alter cognitions. Discriminate validity of the sexual interest checklist has been shown in that individuals with pedophilia report more of the intrusive thoughts than normal controls (Abel et al., 1984).

Patients who fulfilled these criteria were contacted and invited to participate in a study examining the utility of cognitive therapy techniques in pedophilia. After a careful review of the admission history and assessment, family and case work, psychological testing, response to treatment, and from consultations by expert clinicians one patient was selected and agreed to participate in the study. This subject was an 18-year-old Caucasian male, and the time since diagnosis was 2.3 years.

The subjects signature was obtained on a consent form, allowing this researcher permission to utilize this information, and is in the possession of the researcher (See
Appendix A).

Measures

Sexual Thoughts

Abel and Becker Sexual Interest Inventory. The Pedophile Scale of the Abel and Becker Sexual Interest Inventory (Abel et al., 1984) was used as an index of pedosexual thinking. The Pedophile sub scale is a 22-item rationally derived self-report measure of pedosexual thoughts (See Appendix B). The scale items tap automatic sexuoerotic thoughts similar to those assessed by other measures of pedosexual thinking (sample items = 'A 10 year old girl and I are lying on the couch. I'm rubbing her soft skin, all over her body. I'm feeling her breasts,' 'A 12 year old girl is sucking my cock. I'm about to come'). Subjects indicate how they feel about the statement at the present time on a rating scale ranging from: (-3) "extremely sexually repulsive," to (+3 "extremely sexually arousing." Scoring is accomplished by adding the item scores for the total sub scale. Initial psychometric analysis of the sub scale in a pedophile population revealed an acceptable alpha coefficient value of .80. The alpha coefficient reliability relates to the internal consistency of the individual items (questions) on the sub scale that apply specifically to pedophilia. Alpha coefficients range from 0.0 to 1.0. Alpha coefficients below .4 are
unacceptable because test items at this point would be too unrelated to the specific topic being measured. Alpha coefficients that range from .5 to .6 are low. Those coefficients between .6 to .7 are considered to be moderate items, and items ranging from .8 to 1.0 are high. Alpha coefficients are related to internal consistency, and internal consistency relates to the validity of the questionnaire (what is attempting to be measured is in fact being measured, Abel an Becker Questionnaire, 1984).

Because this subject scored .80 he would be considered to be with in the high acceptance range of the alpha coefficient value.

Adjustment

Symptom Checklist-90-Revised. The SCL-90R (Derogatis, 1983) is a 90-item self-report inventory designed to assess recent symptom patterns (sample items = 'nervousness or shakiness inside,' 'feeling uneasy in crowds, such as shopping or at a movie.' Each item is rated on a five-point scale of distress ranging from: (1) "not at all" to (5) "extremely"(See Appendix C). The measure provides scores on nine symptom dimensions (obsessive compulsive, depression, paranoid ideation, interpersonal sensitivity, psychoticism, anxiety, somatization, hostility, and phobic anxiety). The psychometric characteristics of this measure have been well established (Derogatis, Rickels, & Rock, 1976; Dining and
Evans, 1977). This measure was chosen as a measure of overall adjustment.

**Procedure**

A basic single-factor baseline design was selected to evaluate this study. This was the A-B-A design. The A-B-A design includes a baseline phase (A), during which the baseline is established, and a treatment or intervention phase (B), in which the effect of the treatment is observed, and a reversal phase that returns subjects to baseline conditions. This baseline reassessment allows the determination of whether the observed changes in behavior after treatment introduction were caused by the treatment. Often times, ending the experiment after the reversal phase is undesirable, and may in some cases be unethical because the "client" or "subject" may be at risk to harm a child or themselves. When this appears to be the case the design is extended to include a second reversal that would put the subject back into the treatment condition for the second time. The resulting design is called an A-B-A-B design. The A-B-A-B design provides a complete intrasubject replication of the experiment. If the behavior returns to baseline levels during the second baseline phase (reversal), and then returns to the previous treatment levels during the second intervention phase (second reversal), there is confidence that the treatment (and not some incidental time-
correlated variable) caused the observed changes.

Initially, the subject underwent a baseline phase of 3 weeks. During each week of the baseline phase the subject was given the Abel and Becker Sexual Interest Questionnaire and the SCL-90R to establish a baseline level of non normative sexual thoughts and psychological adjustment. A running plot of the subject's scores was maintained until stability was established across time, this would then be called the baseline score, or the "A" score.

The subject then participated in a 12-week cognitive-behavioral therapy program consisting primarily of Rational-emotive therapy (RET) that generally focused on disturbance-creating irrationalities and irrational behaviors (e.g., lack of self-discipline and control). The subject received one cell of therapy (three one hour sessions per week for six weeks) and then was given the questionnaire. The answers to the questionnaire would allow the researcher to determine the effect of the therapy on the pedophile, or supply the researcher with the "B" score. The subject was then returned to the baseline, or "A" score of the study, which is the non-therapy involvement phase. After the baseline again appeared to stabilize, the subject was given another cell of therapy, the results of that therapy were measured in the form of a questionnaire, as before. The answers to the questionnaire would then allow the researcher to
determine how effective the therapy had been on the subject for a second time.
CHAPTER IV

RESULTS

In this study, the baselines obtained during the baseline phases were reasonably stable. The baselines showed neither a great deal of unsystematic variation nor any apparent systematic changes with time once stable levels were reached.

The treatment results shown in Figure 1 depict the sudden effect of the program after only a few weeks of implementation. From an average Abel and Becker scale score of 29 at baseline the subject suddenly increased to a score of 45 after the sixth week of therapy. This subject's level of pedosexual thinking (non normative sexual thoughts) increased substantially. At the same time, his General Severity Index (GSI) score rose from 2.0 to 2.5 (see Figure 2). Since the GSI relates to a broad range of symptom patterns, the subject's level of adjustment decreased.
During the reversal (withdrawal of treatment) phase, the subject’s level of non-normative sexual thoughts decreased substantially (average scale score of 27). In other words, termination of the intervention resulted in a decrease in pedosexual thinking and concomitant improvement
in adjustment as measured by the General Severity Index. Once again, the subject was taken through the A-B-C steps of RET designed to modify irrational feelings and behavior by modifying irrational thinking. Therapy focused on the activating experience(s) or event(s) (i.e., something happens or is about to happen. The situation about which the individual is having some emotional feelings) (A), underlying belief systems, thoughts, or attitudes, or expectations. What he tells himself (B), and consequences, both emotional and behavioral, of beliefs about the event(s) (i.e., what happens as a result of subject’s beliefs), (C). The therapist was careful to first elicit a description of the activating experience(s) and then proceed to discuss feelings before finally addressing beliefs. It should be noted that most therapists make the mistake of "attacking" a problem in the reverse order, B-A-C. As previously stated, following the resumption of therapy, the subject displayed an increase in Abel and Becker scale scores measuring pedosexual thinking (see Figure 1) and likewise the GSI measured an overall adjustment (see Figure 2).

The effectiveness of therapy is somewhat dependent on therapist/patient variables and failure to improve may reflect weakness in the behavioral formulation, rapport, or skill of the therapist. This study utilized therapists who were somewhat unfamiliar with the therapy for pedophiles,
and as such, since the subject was unsuccessfully treated some responsibility for failure must rest upon this fact. Finally, the subject was dually-diagnosed and failure may have been the result of some of the individual's other psychological problems and their interference in treatment. Further studies should address these limitations. In addition, there is a need to replicate the present study as well as attempt other interventions with this population.

In order to clarify that the intervention was responsible for the unsuccessful result (not some incidental time-correlated variable), the design was extended to include a second reversal that would put the subject back into the treatment condition for a second time, this would allow the researcher to duplicate the study to ensure that it was the therapy that was causing the subject to actually get worse. It appears that the treatment was ineffective in that level during the second baseline phase (reversal), because the subject in fact did get worse, according to the scores on the questionnaire. The subject was then returned to the previous treatment level during the second intervention. Because the initial levels of cognitions and symptoms in both baseline phases were substantially less than those recovered in the treatment phases, and both were recovered in replication, the treatment (rational-emotive therapy) was deemed ineffective in modifying the level of
non-normative sexual cognitions or larger factors of general adjustment levels of the subject.

RET may require more time to be effective with this population. Behaviors are deeply entrenched and take considerable energy to change. The subject in this study had years of practice of thinking certain irrational thoughts. It might be likely that it will take considerable energy to change these beliefs since some of them come to the surface quickly and automatically. It may be unrealistic to expect the subject to have changed easily in that very few things of value come easily and change usually occurs slowly. In other words RET might be ineffective when used in short term therapy because of the limited time constraints.

A recommendation may be that problem solving therapy could be more effective; because problem solving revolves more around consequences. It appears that problem solving may help pedophiles learn to solve the situation and break the pattern that has been created. When using this type of therapy, it appears to be more in the direction of focusing on external events, behavioral change and association, which may be helpful to the pedophile.
CHAPTER V

DISCUSSION

At present, the clinical literature is satiated with publications on behavior therapy techniques and deprived of a methodology for answering the basic question of clinical behavior therapy: Which modification procedure should I employ with this particular problem at this point in time? Unless the clinician can answer this question, the technology of behavior therapy is relatively limited. Recently, researchers have begun to address this question (e.g., Kujoth, 1979; McGarry, 1984; Sidley, 1990). However, no study has examined the utility of any particular cognitive-behavioral intervention in pedophilia. Such an approach is necessary if cognitive-behavioral therapy is to move forward into its third generation. This study sought to examine the utility of a specific form of cognitive-behavioral therapy (RET) in the treatment of pedophilia. In this case study, a form of baseline experiment called the ABA design was selected.

Hypothesis Number 1: In achieving the study’s main aim of reducing non normative sexual cognitions in a pedophile, the intervention was clearly an ineffective one because the pedophilic thoughts increased with the onset of therapy and decreased when therapy was stopped.
Hypothesis Number 2: In attempting to achieve a decreased General Severity Index (GSI) score (which is a measure of general psychological adjustment of the SCL-90R scale), it was noted that the repeated measures of the Abel and Becker Sexual Interest Survey and the GSI both suggest an increase in maladjustment and non-normative sexual cognitions, respectively.

In order to clarify that the intervention was responsible for the unsuccessful result (not some incidental time-correlated variable), the design was extended to include a second reversal that would put the subject back into the treatment condition for a second time. It appears that the treatment was ineffective in that the level of cognitions and symptoms returned to baseline level during the second baseline phase (reversal), and then returned to the previous treatment level during the second intervention. Because the initial levels of cognitions and symptoms in both baseline phases were substantially less than those recovered in the treatment phases and both were recovered in replication, the treatment was deemed ineffective in modifying the level of non-normative sexual cognitions nor adjustment of the subject.

It appears that these findings may have clinical relevance. In recent research, it highlights the importance of idiographic analysis in behavior therapy (Sidley, 1990).
Meyer and Turkat (1979) have expressed the concern about identifying appropriate modification procedures for particular individuals with particular problems at particular points in time. This study may be considered a preliminary attempt to test one therapeutic intervention technique with Pedophilia. These findings suggest alternative strategies would benefit this population.

Although RET is clearly aimed at modifying cognitions it lies at the center of the continuum of cognitive-behavioral therapies. It may be that a cognitive-behavioral technique which focuses more on external events, behavioral change, and associationism rather than internal (cognitive/emotional) events, conceptual/epistemic change, and constructivism would be more effective than RET which was limited to having the subject recall past events and attempt to apply current day resolutions to those events that caused the subject to offend, and then attempt to deal with them in a brief way, rather than a slower, bit by bit approach. Support for this view is one area for future study.

Several limitations of this study should be mentioned. First, this study utilized self-report measures only. Second, the subject was not assessed by a behavioral clinician. In essence, the target behavior may or may not have been pedosexual thinking. Thus, a cognitive
intervention designed to alter pedosexual thinking may have failed to do some other third variable. The effectiveness of therapy is somewhat dependent on therapist/patient variables and failure to improve may reflect weakness in the behavioral formulation, rapport, or skill of the therapist. This study utilized novice therapists, and as such, since the subject was unsuccessfully treated some responsibility for failure must rest upon this fact. Finally, the subject was dually-diagnosed and failure may have been the result of some of the individual's other psychological problems and their interference in treatment. Further studies should address these limitations. In addition, there is a need to replicate the present study as well as attempt other interventions with this population.

RET may require more time to be effective with this population. Behaviors are deeply entrenched and take considerable energy to change. The subject in this study had years of practice of thinking certain irrational thoughts. It might be likely that it will take considerable energy to change these beliefs since some of them come to the surface quickly and automatically. It may be unrealistic to expect the subject to have changed easily in that very few things of value come easily and change usually occurs slowly. In other words RET might be ineffective when used in short term therapy because of the limited time
Additionally, rational-emotive therapy may not be as effective a treatment with pedophiles as other cognitive models. For example, self-control therapy, stress inoculation training, problem-solving therapy, self-instructional training, covert conditioning, systematic desensitization, operant conditioning, and classical conditioning are all more focused on external events, behavioral change, and associationism. RET's greater focus on internal (cognitive/emotional) events, conceptual/epistemic change, and constructivism may account for its failure in this study.

A final recommendation may be that problem solving therapy may be more effective; because problem solving revolves more around consequences. Problem solving may help clients learn to solve the situation and break the pattern that has been created. Problem solving appears to be more in the direction in focusing on external events, behavioral change and association.
REFERENCES


APPENDIX A

Informed Consent
Appendix A

INFORMED CONSENT
(Please Return)

I have been informed that the purpose of this research is to examine the utility of one form of cognitive-behavioral therapy (Rational-emotive therapy) in the treatment of pedophilia. My participation will involve filling out questionnaires and undergoing therapy sessions. Though there are no risks, I understand that my participation in this research will help to determine the effectiveness of this particular form of therapy.

I understand that this research is a Master's thesis conducted by Rodney C. Kirkham under the auspices of Ronald Frost, Ph.D. I understand that participation is voluntary and that I may withdraw at any time. I understand that if I have any questions, I can call Rodney Kirkham or William Clark, M.D., ComCare, (602) 981-7735.

I understand that I may also direct questions regarding research and the rights of subjects to:

The Department of Psychology, Counseling Division
Ottawa University
(602) 371-1188

**************************

I am fully aware of the nature and extent of my participation in this research project as stated above and the possible risks arising from it. I hereby agree to participate in this project. I acknowledge that I have received a copy of this consent statement.

(Signature of subject or responsible agent)  Date

(Printed name of subject)  Date

(Signature of investigator)  Date
APPENDIX B

Abel-Becker Questionnaire
Appendix B

Abel-Becker Questionnaire

Instructions: Please circle the number beside each statement which best describes how you feel about the statement at the present time.

-3 = extremely sexually repulsive
-2 = moderately sexually repulsive
-1 = slightly sexually repulsive
0 = neutral (neither sexually arousing nor sexually repulsive)
+1 = slightly sexually arousing
+2 = moderately sexually arousing
+3 = extremely sexually arousing

1. A 25 year old man and I are lying side by side naked touching each other all over.
   -3  -2  -1  0  +1  +2  +3

2. I'm peering through a girl's window. She's an attractive brunette with a great figure; she's taking a shower.
   -3  -2  -1  0  +1  +2  +3

3. I have an erection. My penis is between an 8 year old girl's legs.
   -3  -2  -1  0  +1  +2  +3

4. I'm looking through the partially drawn window shades. I'm watching a woman sleeping. The covers have fallen off her nude body.
   -3  -2  -1  0  +1  +2  +3

5. A beautiful woman is stroking my dick and balls as she lays beside me. We are both getting excited.
   -3  -2  -1  0  +1  +2  +3

6. I'm standing over a woman I've just beaten up. She's bruised and bleeding. She can't move any more.
   -3  -2  -1  0  +1  +2  +3

7. I'm laying on top of my son. I feel his hot body beneath mine as I kiss his back and feel his skin.
   -3  -2  -1  0  +1  +2  +3
-3 = extremely sexually repulsive  
-2 = moderately sexually repulsive  
-1 = slightly sexually repulsive  
0 = neutral (neither sexually arousing nor sexually repulsive)  
+1 = slightly sexually arousing  
+2 = moderately sexually arousing  
+3 = extremely sexually arousing

8. A 10 year old girl and I are lying on the couch. I’m rubbing her soft skin, all over her body. I’m feeling her breasts.

   -3  -2  -1  0  +1  +2  +3

9. The subway train is extremely packed. I’ve really got a stiff hard-on. I’m face to face with a young woman, pushing my dick right against her. She’s trying to move away but she can’t.

   -3  -2  -1  0  +1  +2  +3

10. I’m pleading with a tall woman to stop hitting me with her belt. The pain is tremendous.

    -3  -2  -1  0  +1  +2  +3

11. I’m lying back naked on the bed with my daughter sitting on top of me. I’m stroking her naked body with my hands and pushing my fingers into her cunt.

    -3  -2  -1  0  +1  +2  +3

12. I’m pinching a 25 year old woman’s breasts with pliers. She’s beginning to bleed. She’s crying.

    -3  -2  -1  0  +1  +2  +3

13. I see two good looking 22 year old girls walking down the street. I drive slowly by with no clothes on, rubbing my penis. I get excited as they look at me with disbelief.

    -3  -2  -1  0  +1  +2  +3

14. I follow a 20 year old blonde girl into the parking lot at the public library. I take my dick out and begin to beat it as she looks at me and looks tense.

    -3  -2  -1  0  +1  +2  +3

15. I’m holding a burning cigarette butt against the big tits of a 30 year old brunette. She’s screaming for me to stop.

    -3  -2  -1  0  +1  +2  +3
-3 = extremely sexually repulsive
-2 = moderately sexually repulsive
-1 = slightly sexually repulsive
0 = neutral (neither sexually arousing nor sexually repulsive)
+1 = slightly sexually arousing
+2 = moderately sexually arousing
+3 = extremely sexually arousing

16. It's packed in the train and I've pinned a woman up against the people in front of her. I'm rubbing her ass with my hands. She tells me to stop. She can't get away from me. I just keep rubbing her.

-3 -2 -1 0 +1 +2 +3

17. It's very crowded in the subway train. I'm facing a beautiful girl. I'm rubbing her tits and her crotch. She has a blank expression on her face.

-3 -2 -1 0 +1 +2 +3

18. I'm unbuttoning my daughter's blouse. I'm feeling her small tits. She likes it.

-3 -2 -1 0 +1 +2 +3

19. I've pulled an attractive woman to the ground. I've pulled her panties off. I'm forcing my penis in her. She is screaming.

-3 -2 -1 0 +1 +2 +3

20. I'm kneeling beside my son, holding him close to me. I'm kissing his forehead and getting an erection

-3 -2 -1 0 +1 +2 +3

21. I'm pulling down my little daughter's shorts and underwear. I'm going to fingerfuck her.

-3 -2 -1 0 +1 +2 +3

22. I've forced my way into an apartment. I've forced a brunette to take off her clothes. I'm raping her.

-3 -2 -1 0 +1 +2 +3

23. I'm lying on a deserted beach with a real handsome guy. He has wrapped his arms and legs around me. He really enjoys making love with me.

-3 -2 -1 0 +1 +2 +3

24. I have a hard on. My dick is between the legs of a young boy.

-3 -2 -1 0 +1 +2 +3
-3 = extremely sexually repulsive
-2 = moderately sexually repulsive
-1 = slightly sexually repulsive
0 = neutral (neither sexually arousing nor sexually repulsive)
+1 = slightly sexually arousing
+2 = moderately sexually aroused
+3 = extremely sexually arousing

25. I would like to be a wife.
   -3   -2   -1   0   +1   +2   +3

26. We’re in the 69 position with me on top. I’m sucking a young guy’s dick as he sucks mine. I’m starting to come.
   -3   -2   -1   0   +1   +2   +3

27. A 12 year old girl is sucking my cock. I’m about to come.
   -3   -2   -1   0   +1   +2   +3

28. I’m thinking about putting on some sheer nylon tights with no crotch. I’m feeling them in my hands.
   -3   -2   -1   0   +1   +2   +3

29. I would like to have a good physique.
   -3   -2   -1   0   +1   +2   +3

30. I have a woman spread eagle on the floor. I’m torturing her, burning her fingertips.
   -3   -2   -1   0   +1   +2   +3

31. An attractive woman looks surprised as I tell her I’m going to rape her. I make her undress and put my dick between her legs as I hold her down.
   -3   -2   -1   0   +1   +2   +3

32. I would like to be a mother.
   -3   -2   -1   0   +1   +2   +3

33. I can feel myself getting turned on as my daughter hugs me. I want to screw her.
   -3   -2   -1   0   +1   +2   +3

34. I would like to be a husband.
   -3   -2   -1   0   +1   +2   +3
-3 = extremely sexually repulsive  
-2 = moderately sexually repulsive  
-1 = slightly sexually repulsive  
0 = neutral (neither sexually arousing nor sexually repulsive)  
+1 = slightly sexually arousing  
+2 = moderately sexually arousing  
+3 = extremely sexually arousing

35. I've broken into a house. No one is home. I've found some woman's underclothes and I'm pulling on some cotton panties.  
   -3  -2  -1  0  +1  +2  +3

36. I would like to wear beautiful, feminine clothes.  
   -3  -2  -1  0  +1  +2  +3

37. I go by the girl's gym at college and look through then dressing room window. I can see several girl's there, all partly undressed.  
   -3  -2  -1  0  +1  +2  +3

38. I have a hard on. My dick is between my daughter's legs as I'm ejaculating.  
   -3  -2  -1  0  +1  +2  +3

39. I feel my partner on top of me, with her knees holding my hips. She is moving up and down on my dick.  
   -3  -2  -1  0  +1  +2  +3

40. My son is curled up beside me in bed. I'm gently rubbing his small penis; he is getting an erection.  
   -3  -2  -1  0  +1  +2  +3

41. I've fucked a 25 year old woman. She has come again and again. She is thinking I am really great in bed.  
   -3  -2  -1  0  +1  +2  +3

42. I've gotten my son to rub my cock. I'm getting hard.  
   -3  -2  -1  0  +1  +2  +3

43. A beautiful woman is pinching my skin with pliers. I'm afraid she is going to pinch my balls with it too.  
   -3  -2  -1  0  +1  +2  +3

44. I'm in my sister's bedroom alone. I'm pulling on a pair of beige nylon panties.  
   -3  -2  -1  0  +1  +2  +3
-3 = extremely sexually repulsive
-2 = moderately sexually repulsive
-1 = slightly sexually repulsive
0 = neutral (neither sexually arousing nor sexually repulsive)
+1 = slightly sexually arousing
+2 = moderately sexually arousing
+3 = extremely sexually arousing

45. I'm forcing a well-stacked girl to hold still as I push my dick into her. She cries out as I rape her.

-3 -2 -1 0 +1 +2 +3

46. My hands and legs are tied up. The ropes are biting into my skin. A woman in high heeled black boots is coming towards me, snapping a whip in her hand.

-3 -2 -1 0 +1 +2 +3

47. I would like to be a woman.

-3 -2 -1 0 +1 +2 +3

48. I would like to have female genitals.

-3 -2 -1 0 +1 +2 +3

49. A 12 year old boy is sucking my cock. I am about to come.

-3 -2 -1 0 +1 +2 +3

50. A 20 year old young man is fondling my and licking my ear lobes. He has his hands in my pants, rubbing my swollen cock. We are about to have sex.

-3 -2 -1 0 +1 +2 +3

51. I'm following a woman off the subway train. I move in right behind her as she waits for the next train. The crowd moves forward onto the next train. I start to rub her ass from behind.

-3 -2 -1 0 +1 +2 +3

52. I'm lying face down on the ground. An attractive woman is sitting on my ass, slashing my back with a razor blade. I'm pleading with her to stop. The blood is gushing out.

-3 -2 -1 0 +1 +2 +3

53. A good looking man is pressing against me as we kiss very tenderly. We hold each other close.

-3 -2 -1 0 +1 +2 +3
-3 = extremely sexually repulsive
-2 = moderately sexually repulsive
-1 = slightly sexually repulsive
0 = neutral (neither sexually arousing nor sexually repulsive)
+1 = slightly sexually arousing
+2 = moderately sexually arousing
+3 = extremely sexually arousing

54. I am following a nicely built blonde, 18 year old girl down the stairs at school. I take my dick out, holding my books in front of it and begin to beat it. As I follow her, I feel it get hard.

-3 -2 -1 0 +1 +2 +3

55. I'm chained to a wall. A woman in tall, black boots is holding a burning cigarette butt close to my nipples. She smiles as she brings the cigarette closer.

-3 -2 -1 0 +1 +2 +3

56. I'm wearing a matching bra, panties and slip, all lacy. I'm touching and feeling the underclothes against my body.

-3 -2 -1 0 +1 +2 +3

57. I'm standing naked beside the car. A 20 year old girl in a bikini is coming from the swimming pool. I feel my hard penis in my hand as she sees me and looks shocked.

-3 -2 -1 0 +1 +2 +3

58. A handsome man is lying on top of me in bed. He has his tongue in my ear and his hand on my dick. I'm really excited.

-3 -2 -1 0 +1 +2 +3

59. I've gotten a young boy to rub my cock. I feel it getting hard.

-3 -2 -1 0 +1 +2 +3

60. I'm sucking my son's small dick. He seems to like it.

-3 -2 -1 0 +1 +2 +3

61. A lovely little boy is curled up beside me in bed. I'm gently rubbing his small penis.

-3 -2 -1 0 +1 +2 +3
-3 = extremely sexually repulsive
-2 = moderately sexually repulsive
-1 = slightly sexually repulsive
0 = neutral (neither sexually arousing nor sexually repulsive)
+1 = slightly sexually arousing
+2 = moderately sexually arousing
+3 = extremely sexually arousing

62. I've lured a 9 year old girl into my house. She's really good looking. I'm pulling down her shorts and underwear.
   -3  -2  -1  0  +1  +2  +3

63. I'm lying on top of my partner. She is digging her hands into my back, lifting her ass up. She is really excited.
   -3  -2  -1  0  +1  +2  +3

64. A 10 year old girl with long blonde hair is holding my dick. She seems to be fascinated by it.
   -3  -2  -1  0  +1  +2  +3

65. I have got a young woman tied down in the woods. I'm sticking needles into her vagina. She is screaming with terror.
   -3  -2  -1  0  +1  +2  +3

66. A girl in the women's bathroom has taken her clothes off. I've pinned her down. I'm starting to rape her.
   -3  -2  -1  0  +1  +2  +3

67. I'm lying on a couch, wearing only my feminine underclothes, bright red panties, large cupped-bra, sheer hose, and a see-through slip.
   -3  -2  -1  0  +1  +2  +3

68. At an apartment complex a 25 year old girl is just dressed in her panties. I'm looking at her through the window.
   -3  -2  -1  0  +1  +2  +3

69. I'm looking from my upstairs window down into the apartment across the way. I can see a woman with big tits reading with a see-through negligee on.
   -3  -2  -1  0  +1  +2  +3
-3 = extremely sexually repulsive
-2 = moderately sexually repulsive
-1 = slightly sexually repulsive
0 = neutral (neither sexually arousing nor sexually repulsive)
+1 = slightly sexually arousing
+2 = moderately sexually arousing
+3 = extremely sexually arousing

70. I've walked out of the field house shower so a young girl can see me. The 13 year old girl is surprised as she looks at my penis.

-3  -2  -1  0  +1  +2  +3

71. My partner and I are in the bath tub. She is sitting between my legs, leaning back against me. I'm playing with her tits.

-3  -2  -1  0  +1  +2  +3

72. I would like to be a man.

-3  -2  -1  0  +1  +2  +3

73. There are very few people on the suburban train. I sit down next to an attractive woman and let my hand fall down into her crotch. I start to rub her.

-3  -2  -1  0  +1  +2  +3

75. A 10 year old boy with soft dark hair is holding my dick. He seems to be fascinated by it.

-3  -2  -1  0  +1  +2  +3

APPENDIX C

SCL-90R Testing Instrument
Appendix C

SCL-90R
Below is a list of problems and complaints that people sometimes have. Read each one carefully, and select one of the numbered descriptors that best describes HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU DURING THE PAST 4 WEEKS INCLUDING TODAY. Place a number by each item as follows:

0 = Not At All
1 = A Little Bit
2 = Moderately
3 = Extremely

1. Headaches
2. Nervousness or shakiness inside
3. Repeated unpleasant thoughts that won’t leave your mind
4. Faintness or dizziness
5. Loss of sexual interest or pleasure
6. Feeling critical of others
7. The idea that someone else can control your thoughts
8. Feeling others are to blame for most of your troubles
9. Trouble remembering things
10. Worried about sloppiness or carelessness
11. Feeling easily annoyed or irritated
12. Pains in heart or chest
13. Feeling afraid in open spaces or on the streets
14. Feeling low in energy or slowed down
15. Thoughts of ending your life
16. Hearing voices that other people cannot be trusted
17. Trembling
18. Feeling that most people cannot be trusted
19. Poor appetite
20. Crying easily
21. Feeling shy or uneasy with the opposite sex
22. Feelings of being trapped or caught
23. Suddenly scared for no reason
24. Temper outbursts that you could not control
25. Feeling afraid to go out of your house alone
0  =  Not At All  
1  =  A Little Bit  
2  =  Moderately  
3  =  Extremely  

26. Blaming yourself for things  
27. Pains in lower back  
28. Feeling blocked in getting things done  
29. Feeling lonely  
30. Feeling blue  
31. Worrying too much about things  
32. Feeling no interest in things  
33. Feeling fearful  
34. Your feelings being easily hurt  
35. Other people being aware of your private thoughts  
36. Feeling others do not understand you or are unsympathetic  
37. Feeling that people are unfriendly or dislike you  
38. Having to do things very slowly to insure correctness  
39. Heart pounding or racing  
40. Nausea or upset stomach  
41. Feeling inferior to others  
42. Soreness of your muscles  
43. Feeling that you are watched or talked about by others  
44. Trouble falling asleep  
45. Having to check and double-check what you do  
46. Difficulty making decisions  
47. Feeling afraid to travel on buses, subways, or trains  
48. Trouble getting your breath  
49. Hot or cold spells  
50. Having to avoid certain things, places, or activities because they frighten you  
51. Your mind going blank  
52. Numbness or tingling in parts of your body  
53. A lump in your throat  
54. Feeling hopeless about the future  
55. Trouble concentrating  
56. Feeling weak in parts of your body  
57. Feeling tense or keyed up  
58. Heavy feelings in your arms or legs  
59. Thoughts of death or dying  
60. Overeating  
61. Feeling uneasy when people are watching or talking about you  
62. Having thoughts that are not your own
0 = Not At All
1 = A Little Bit
2 = Moderately
3 = Extremely

63. Having urges to beat, injure, or harm someone
64. Awakening in the early morning
65. Having to repeat the same actions such as touching, counting, washing
66. Sleep that is restless or disturbed
67. Having urges to break or smash things
68. Having ideas or beliefs that others do not share
69. Feeling very self-conscious with others
70. Feeling uneasy in crowds, such as shopping or at a movie
71. Feeling everything is an effort
72. Spells of terror or panic
73. Feeling uncomfortable about eating or drinking in public
74. Getting into frequent arguments
75. Feeling nervous when you are left alone
76. Others not giving you proper credit for your achievements
77. Feeling lonely even when you are with people
78. Feeling so restless you couldn’t sit still
79. Feelings of worthlessness
80. The feeling that something bad is going to happen to you
81. Shouting or throwing things
82. Feeling afraid you will faint in public
83. Feeling that people will take advantage of you if you let them
84. Having thoughts about sex that bothers you a lot
85. The idea that you should be punished for your sins
86. Thought and images of a frightening nature
87. The idea that something serious is wrong with your body
88. Never feeling close to another person
89. Feelings of guilt
90. The idea that something is wrong with your mind

SCL-90R administration scoring and procedures manual (2nd ed.). Towson, MD: Clinical Psychometric Research.