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Brief Reports

Paedophilia: A Cognitive/Behavioural Treatment Approach in a Single Case

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Our confidence in being able to offer successful treatment of paedophilia remains low. A multifaceted cognitive/behavioural treatment approach is described in the hitherto successful treatment of a man with a 13-year history of sexually interfering with young children of both sexes.

Adams (1980) has noted that the treatment of paedophilia is often difficult. Apart from the strong emotional reactions engendered, many paedophiles see their activities as harmless, and enter treatment at the behest of legal services or to avoid imprisonment.

Despite these facts, a number of papers testify to treatment successes. The technique of covert sensitisation, described in detail later, has been used successfully by Barlow *et al* (1969) to treat paedophilia. Maletzky (1973) demonstrated that the effectiveness of this technique may be enhanced using valeric acid, a non-corrosive foul-smelling substance.

However, the treatment of paedophilia is best seen not only as a reduction of deviant sexual arousal, but also as focused more broadly on other components of deviant social and sexual functioning for the long-term maintenance of treatment effects (Barlow, 1974; Rosen & Rehm, 1977). Examples of such approaches include that of Miller & Haney (1976), who successfully combined aversion conditioning, aversion relief, social and sexual skills training, and supportive psychotherapy. Josiassen *et al* (1980) used multistage aversion and graded social skills training. The treatment programme presented incorporates a number of the behavioural methods of previous studies, but adds an important cognitive dimension to the treatment of paedophilia.

Case report

A 40-year-old man was re-referred to psychiatric services in 1985. Since 1973 he had intermittently been sexually interfering with young children. He had been convicted on two occasions for this.

The client was the youngest and only male of three siblings. He spent much of his first three years in hospital with a blood disorder. He achieved late developmental milestones and was still incontinent at the age of eight. As a child he was physically small, and was bullied throughout school. At the age of seven he was sexually assaulted by a man while in a cinema. Aged 13 he was sexually assaulted by a group of his peers at school.

The client's father was a long-distance lorry driver, absent from the family home for much of the client's youth. He described his mother as very cold and strict.

At 17 the client left home and joined the army. Aged 20, while in Germany, he had his first sexual experience, with a prostitute whom he visited infrequently until his marriage three years later, in 1968. The couple have two boys, born in 1969 and 1972.

In 1973, while posted away from the family, the client first approached a young boy. Following a second approach, to a young girl, he referred himself to an army psychiatrist. The client refused an offer of medication and quickly defaulted from the regular psychotherapy sessions offered him. He continued to interfere with children, including his own, intermittently over the next four years.

In 1977 he first began to approach older children, aged up to about eight years, and had for the first time attempted intromission with a child, who reported him. He was court-martialled in Germany and imprisoned for one year, serving sentence in England. Following his release it was recommended that he seek psychiatric help. He was initially prescribed benperidol, which he was unable to tolerate, and then cyproterone acetate. He found that this had little impact on his behaviour, and he continued to take it while reoffending.

In July 1978, the client was reconvicted. No recommendations were made to the court. The client received a two-year sentence suspended for two years. Over the next seven years the client claims to have been completely free from offence.

In 1982, having previously worked as a storeman, he gained a job as a lorry driver. This work gave him greater autonomy and gradually led him to organising his working day around being present for the schools opening and closing times. Eventually the client reoffended in early 1985 and immediately sought psychiatric help, fearing further imprisonment.

Assessment, treatment and outcome

On initial presentation the client described being eager for a treatment which would eradicate totally any sexual desire towards children. Specifically, he queried the possibility for hypnosis or psychosurgery. Following detailed assessment, four general areas requiring therapeutic intervention were identified.

(a) Extinction of the deviant fantasies and the development of heterosexual fantasy acceptable to the client.
(b) Sex education and therapy.
(c) Cognitive reappraisal: helping the client to examine and rationalise a number of his confused ideas relating to (i) the child offering consent, (ii) the client's notion of guilt, responsibility, and morality, (iii) the implications of his behaviour for himself, his family, and for the children assaulted by him.
(d) Behavioural/environmental control, including increasing the client's confidence and assertiveness with adults, helping him to find alternative employment, offering greater structure and reduced temptation, and helping him to organise spare time to reduce encounters with children during the early stages of therapy.

The client was seen weekly for the first six months of treatment. His motivation for, and compliance with, treatment remained high throughout. Initially, the first two areas described comprised the focus of treatment. The techniques of assisted covert sensitisation and orgasmic reconditioning proved very effective in helping the client to rely less on deviant fantasy to stimulate sexual arousal.

Assisted covert sensitisation requires the client to be guided through the details of his specific fantasies, imagining these scenes as depicted by the therapist. This version imagines the fantasy with the client gradually becoming more and more nauseated to the point of continuous and uncontrollable vomiting within the image. This nausea immediately ceases upon the imagined withdrawal of the deviant arousal stimulus. The foul smell of the valeric acid assists the client's imagination. High expectations are set up for the client feeling nauseous: the client's lap is covered in newspaper and a bucket is placed beside him for his convenience. This procedure was repeated several times at each session for the first four months of treatment and gradually reduced over a further three months.

Orgasmic reconditioning requires the client to masturbate, initially using deviant fantasy, but replacing that fantasy with heterosexual fantasy just before ejaculation. Gradually, the latter fantasy is introduced earlier, until such point as the client can maintain erection and achieve orgasm to the heterosexual fantasy alone. This technique was used similarly before and during intercourse, over a four-month period.

The process of sex education and therapy was conducted jointly with the client's wife. She believed that the client was seeking help for his loss of libido and was unaware of the re-emergence of her husband's real problems. Gradually the couple, both of whom were lacking in basic physiological and behavioural knowledge about sex, were able to increase the frequency of sexual intercourse from once monthly to three times weekly. Standard Masters and Johnson techniques were also used.

The cognitive processes leading to attitude change ranged broadly from the examination and discussion of issues of morality to legal definitions of guilt. The client gradually began to think more rationally, beyond his own experience of having been sexually abused, about the consequences of abuse for the child.

Additionally, helping the client to relive his prison sentence, discussion of the possible abuse of offenders by other inmates, and the effects of reconviction upon his family, all gradually brought home to him the reality of the consequences of reoffence. These attitude changes have remained consistent throughout follow-up meetings.

Finally, behavioural/environmental control involved mixed-group assertiveness training and behavioural target-setting exercises aimed at building confidence. Assertiveness questionnaires (Gambril-Richey, 1975; Rathus, 1973) provided evidence of improvement, as did the client's self-reported confidence in dealing with the public in his new employment as a shop assistant. Free time was spent initially following strict behavioural targets, many of which involved home-based DIY projects. As therapy continued, leisure activities outside the home were encouraged.

After six months, weekly appointments became bi-weekly, then monthly, and currently appointments are six-monthly. In the last four years the client reports no reoccurrence of offences against children and only rarely experiences fleeting deviant fantasy, which he is able to dismiss without difficulty. He and his wife continue to enjoy sex regularly, and he has recently been promoted in his work. Although he continues to feel mildly uncomfortable in the presence of children, these feelings are gradually diminishing.

Discussion

Bradford & Pawlak (1987) highlight a weakness in the present study in their caveat that clients' self-reports in this area are unreliable. However, in routine clinical practice measurements of penile tumescence to deviant stimuli are usually impractical, and questionnaire data offer the same potential for distortion as self-report data. In defence of the specific case presented, there was documented evidence from police and psychiatrists that on direct questioning, and without duress, the client always admitted to a reoffence.

The success of any case of this sort is undoubtedly a function of client motivation. However, the client spontaneously reported that his motivation was born largely out of his being convinced of the logic of the treatment package derived from the assessment. Having re-examined each of the different aspects of treatment at a recent follow-up meeting, the client was asked to rank order the helpfulness of each of the treatment procedures described. He placed covert sensitisation and orgasmic reconditioning equal first. All other procedures he placed equal third. He believed that the first two offered him the initial hope and then the means of altering his paedophilic fantasies, and thus the motivation to comply with and benefit from the other aspects of treatment. He emphasised however that he firmly believed that each of the components of treatment were important at different stages in the therapy.

These findings offer support for the logic of broad-based treatment procedures, and suggest that a cognitive dimension may be used to complement traditional behavioural methods in the management of paedophilia.

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Musical Hallucinations in a Deaf Elderly Woman

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Musical hallucinations had caused an 86-year-old deaf woman to become anxious and depressed. She was admitted, and tranquillising and hypnotic drugs afforded some slight improvement. The use of her hearing aid to increase ambient noise levels reduced the intensity of the hallucinations, and the patient improved.

References have rarely been made in the English scientific literature to formed auditory hallucinations related to acquired peripheral deafness (Colman, 1894; Rhein, 1913; Rozanski & Rosen, 1952). Ross *et al* (1975) presented two further cases, both with musical hallucinations, and commented that all the described cases conformed to an almost stereotyped pattern. We report a further case.

Case report

An 86-year-old married woman was admitted to our unit with a two-month history of increasing anxiety, agitation, and restlessness, and constant depression with loss of interest, insomnia, poor appetite, and early morning wakening. She complained bitterly that she had been hearing music for the previous nine months. Its onset had been sudden, and she thought that it had first occurred after underoing audiometry and wax aspiration at an ENT outpatient clinic.

The hallucinations consisted of an unaccompanied and unknown male baritone voice singing melodies either to 'la la' or to the words of traditional Scottish folk-songs. She heard them with her left ear only, describing the sounds as being located at times within her ear, and at times outwith her body. They were annoyingly repetitive: lines or verses repeated over and over again, the songs occasionally being sung *in toto*. They were fairly constantly heard, with infrequent short pauses, could not be stopped or altered by the patient, and were more intense at night and at other quiet times. They decreased in intensity with her (left) hearing aid *in situ* and switched on.

The patient was fully aware of the hallucinatory nature of her experiences. She was only marginally temporarily disorientated, with a moderately poor short-term memory, an inability to perform complex arithmetical subtractions, and a poor knowledge of current affairs. There was no previous psychiatric history or relevant family history.