A DESCRIPTIVE STUDY OF
A PROSECUTED GROUP OF CHILD MOLESTERS

David Mace Greenberg, M.B.Ch.B.(U.C.T.) F.F.Psych.(S.A.)

Dissertation submitted in partial fulfilment of the
requirements for the degree of Master of Medicine
in Psychiatry

University of Cape Town 1990

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

University of Cape Town

For my wife
Sharon Rabinowitz Greenberg
with love and gratitude

TABLE OF CONTENTS

Page

Acknowledgements vi

CHAPTER ONE: INTRODUCTION: A SELECTIVE REVIEW OF THE MAJOR ISSUES PERTINENT TO THE DESCRIPTION, CLASSIFICATION AND ASSESSMENT OF THE CHILD MOLESTER.

1.1 Brief Historical Overview of Child Sexual Abuse 1

1.2 The Prevalence of Child Sexual Abuse 3

1.3 Problems in the literature 5

1.4 Assessment Instruments 7

1.4.1 Psychiatric history and examination 7

1.4.2 Psychological tests and rating scales 9

1.4.3 Penile plethysmograph 11

1.5 Aims 11

1.5.1 Development of the instrument 12

1.5.2 Description of two groups of child molesters 13

1.6 Terminology used in the literature 14

1.6.1 Categories of child molestors 15

1.6.2 Sub-categories of child molesters 19

CHAPTER TWO: METHOD

2.1 Identification of subjects 24

2.2 Sample 24

2.3 Demographic data 26

2.4 The Instrument :
Child Molester Questionnaire (CMQ) 27

CHAPTER THREE: RESULTS

3.1 Group A : A group of male exclusive homosexual paedophiles (not limited to incest) 29

3.2 Group B : A group of male exclusive homosexual paederasts (not limited to incest) 42

CHAPTER FOUR: DISCUSSION. TYPES OF CHILD MOLESTERS AND THE CHARACTERISTICS OF SPECIFIC SUBCATEGORIES OF CHILD MOLESTERS.

4.1 The Child Molester Questionnaire 53

4.2 Characteristics of a group of male exclusive homosexual paedophiles (not limited to incest) 58

4.3 Characteristics of a group of male exclusive homosexual paederasts (not limited to incest) 72

4.4 Recommendations 77

References 81

Appendix

A : DSM-III-R extracts on - paedophilia
- parapilias 87

B : Maudsley-type psychiatric history and examination 92

C : Child Molester Questionnaire (CMQ) 95

LIST OF FIGURES

		Page
1.	Demographic data of the male exclusive homosexual paedophile sample (Group A).	26
2.	Demographic data of the male exclusive homosexual paederast sample (Group B).	26
3.	Public response to paedophilic activities (Group A)	38
4.	Public response to paederasts activities (Group B)	50

ACKNOWLEDGEMENTS

I wish to thank my anonymous research subjects who freely gave of themselves and disclosed the inimate details of their lives, with no expectation of reward.

The Medical Research Council and University of Cape Town whose financial assistance made this project possible.

Prof. Tuviah Zabow and Prof. Eleanor Nash who made useful comments on several sections in this draft.

A special thanks to Tracey Miller for her constructive criticism and painstaking proof-reading.

Finally, my warm thanks and admiration to my wife, Sharon, who for the past two years has patiently encouraged, advised and supported me throughout.

CHAPTER I

INTRODUCTION: A SELECTIVE REVIEW OF THE MAJOR ISSUES IN THE DESCRIPTION, CLASSIFICATION AND ASSESSMENT OF THE CHILD MOLESTER

1.1 Brief Historical Overview of Child Sexual Abuse

Child sexual abuse has prevailed for centuries. In ancient Greece and Rome, sexual use of children was an accepted practice [Brown, 1985]. The concept of deviance in sexual behaviour is a judgement that is coloured by our contemporary value systems [Barnard et al., 1989]. Historically Judeo-Christian tradition has influenced our sexual attitudes. The laws which have gradually emerged prohibit the sexual use of children and have identified sex offenders as a particular group from which the community needs to be protected.

Krafft-Ebing, who published his textbook on psychosexual disorders in 1886 [Hartwitch, 1959], and Freud [1905], are major contributors to our understanding of child sex abusers. The basic premise of the psychoanalytic influence is "that all sexually deviant behaviours are theoretically and aetiologically similar, and that they represent a single type of psychopathology" [Lanyon,1986]. Attempts were made to delineate a single theory of sexual psychopathology, based on difficulties in psychosexual

development. Deviant sexual behaviour was considered a form of character disorder which is resistant to change and for which treatment is lengthy, as it is based on restructuring of the character [Lanyon 1986].

A second major view is a behavioural-cognitive approach to human disorders in which no assumptions are made about the aetiology of sexual behaviour. Treatment involves procedures for bringing about symptomatic changes in maladaptive sexual functioning and deviant urges, thoughts and feelings [Abel, Blanchard & Becker, 1978]. Examples of such procedures are reviewed by Grossman [1985], and Quinsey & Marshall [1983]. They include aversive techniques; covert sensitization; masturbatory satiation technique; orgasmic reconditioning and social skills retraining.

The American Psychiatric Association (APA) initially classified sexual deviations as character (personality) disorders in their official Manual of Mental Disorders [APA, 1968]. This reflected the attitude then prevalent that the Sexual Disorders were associated with the Personality Disorders. More recently the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) [APA, 1987] has separated the sexual deviations (paraphilias) from the Personality Disorders and placed them along with the Psychosexual Disorders. The Paraphilias are now listed on Axis 1 of the APA diagnostic classification. The relationship between the Personality Disorders, in particular the Antisocial type, and the Paraphilias, remains an area of controversy among experts working in this field and is one of the issues of importance to this study (section 4.2).

In South Africa it is illegal, in terms of section 14 of the Sexual Offences Act, No.23 of 1957, to engage in any form of sexual activity with girls or boys under the age of 16 and 19 respectively. However, prior to 1988, relatively few child molesters were prosecuted in South Africa and these were usually on an ad hoc basis. The situation changed in 1987/1988, when the South African Police established special 'Child Protection Units' (CPU) to investigate these offences. Decentralized units were established in eight different regions in the country.

The first case, which was prosecuted by the CPU's Western Cape Branch [State vs D], was heard in June 1988. This case was taken on appeal in February 1989, and set a legal precedent in sentencing trends in this country. The media subsequently fueled "hysteria amongst the community" by highlighting "the crime wave" of child molestation [Riddle, 1989]. During the period January to December 1988, 755 cases of child abuse were documented by the CPU's Western Cape Branch. Of these, 106 were listed as "rape", 217 as "indecent assault", 78 as "sodomy", 41 as "incest", 151 as "indecent acts", and 74 as contraventions of "the Child Care Act" [Robertson, 1989]. Only a relatively small percentage have since been brought to trial.

1.2 The Prevalence of Child Sexual Abuse

Child molestation occurs with alarming frequency despite strong social sanctions. Such behaviour is believed to constitute a serious risk for children's well-being and further development - psychological, moral, and/or physical [Lanyon, 1986; Erickson

1988]. The emotional impact of child sexual abuse on the victim has been recognized as a powerful social issue [Finkelhor, 1987]. Reliable statistics are unavailable because of the difficulties in detecting and confirming these offences, the respondents' conscious and unconscious defences, and the differing epidemiological standards utilized in the studies. Storr [1964] reports that the majority of paedophiles never attempt to satisfy their urges, except in fantasy. Finkel [1987] reports that the problem is underreported and the number of acts of child molestation is steadily rising.

Various studies report that between 10-60% of persons have experienced some form of sexual abuse in their childhood [Barnard et al., 1989]. For example, Landis [1956] found that 30% of male and 35% of female college students reported being molested as children and Mrazek [1984] reported that 10% to 15% of children and adolescents suffer at least one incident of sexual victimization by an adult.

In South Africa, the only prevalence study is that of Levett [1988] who reported that of 94 female university students, 44% reported sexual abuse before the age of 18 years. Of this group 48% of the abused was of a physical nature, and the remaining 52% was non-contact sexual abuse. The broad definition of sexual abuse used in this study, showed that of the 44%, 36% were kissed, touched, stroked in a sexual way; 20% were "hassled" with sexual comments (street remarks) and "noises by men"; and 16% were exposed to exhibitionism. This study is reported to reflect similar results to those in North America.

1.3 Problems in the literature

Investigators despair over their inability to describe the "typical child molester" [Grubin, 1989; Barnard et al., 1989]. Attempts to delineate a profile of the typical child molester are highly variable, frequently misleading and as a rule ambiguous. The author hypothesizes that this problem is based on a fundamental error of confusing behaviour with diagnosis: for example, child molestation is a behaviour which is performed by people with different diagnoses, such as paedophilia, mental retardation or antisocial personality disorder. In addition, terms are used vaguely and imprecisely: for example, incest is used by some authors to describe incest with paedophilia, incest with rape, or incest alone. The result of this oversight is the attribution of characteristics pertaining to the behaviour of a heterogeneous group of child molesters to specific diagnostic categories.

One consequence of this confusion is overgeneralization. For example, while the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders [APA, 1987] has improved the diagnostic criteria for the "paedophilia disorder", in that the clinician must specify: 1) the sex of the child, 2) exclusivity of the paedophilic attraction, and 3) whether this behaviour is limited to incest or not, it has failed to likewise specify which of the characteristic signs and symptoms are relevant to the various subtypes of paedophiles. The resultant descriptive characteristics arising from studies performed to validate their diagnostic criteria only further increase this confusion. The APA Task Force has attempted to circumnavigate this issue by using vague terms, such as, "usually", "some...,

others...", "may", or "can be" in their description of the characteristics of people with a paedophilia disorder (see appendix A).

Different types of people molest children for different reasons. For example, a male paedophile may molest only children as his preferred method of achieving sexual gratification; another may molest his own child because of lack of an adult sexual partner due to chronic marital conflict and alcohol abuse. A single collective description of all the subcategories, as in the DSM-III-R, does little to further our understanding of the characteristics of different subgroups. Research based on this overgeneralization is equally unlikely to be helpful. This problem is not confined to the DSM-III-R; virtually all the literature in this area fails to distinguish between the behaviour of child molestation and the different groups of people who perform this behaviour. It is therefore not surprising that there is an abundance of confounding terminology, classifications and subcategories relating to the various sexual offences against children, and that consequently, comparisons between studies are contradictory and difficult if not impossible [Freund, Heasman & Roper, 1982].

However, the majority of child molesters, both fixated and regressed offenders, appear to be highly specific with regard to the type of sex act committed [Groth & Birnbaum, 1978]. It is therefore important to distinguish subgroups in order for the clinician to become aware of the parameters of the child molesters' sexual activities, and to improve the precision, distinctiveness and reliability of their diagnoses. This, in turn, will assist in accurate decision making and the development and imple-

mentation of short, intermediate and long term management plans for this diagnostic group. In the absence of well defined groups, predictions regarding prognosis cannot be made with any rigour. We need to know what we are dealing with before we can treat it. Groth [1979] writes,

> "It is important to separate fact from fiction with regard to the sexual molestation of children and to dispel the stereotypes and myths pertaining to the offender that have developed in the absence of systematic enquiry. An accurate understanding of the characteristics of such assailants will improve the ability to work with both offenders and victims in whatever capacity, legal, medical, or the like. Myths and misconceptions can serve only to alarm us out of proportion and obstruct dealing with this issue in a rational, thoughtful, and effective manner".

Researchers have attempted to clarify this issue, but have been hampered by the inadequacy of the assessment instruments that are available. Ways of assessing and monitoring sexually deviant behaviour can be divided into three major categories. These will be outlined in the following section:

1.4 Assessment Instruments

1.4.1 Psychiatric history and examination

Traditionally, clinicians have utilized a comprehensive Maudsley type of psychiatric evaluation to assess sex offenders and sexual deviance (see appendix B). Numerous problems have been encountered with such evaluations. Firstly, specific questions which

have been shown to be significant in the study of child molestation are not routinely part of such an evaluation. For example, questions about sexually arousing urges directed towards children or a history of sexual abuse in the molester's own childhood are not routinely inquired about with this evaluation method. Thus the assessment is too broad and nonspecific for pretrial forensic evaluation for the courts or in the planning of treatment programmes. Secondly, this type of evaluation does not elicit the nature, form, extent, degree, magnitude, and frequency of such behaviour. Thirdly, this method does not differentiate between the different types and subtypes of sex offenders and sexual deviance. Fourthly, professional workers are usually accustomed to seeing the victims of such abuse and rarely encounter the perpetrators. Thus, they tend to adopt a laissez-faire approach to the interview which may lead to missing vital data [Barnard et al.,1989]. Finally, subjects tend to be sensitive about their activities and frequently deny, minimize and rationalize their behaviour. The child molester expects disapproval and rejection from the psychiatrist, psychologist, social worker and the community in general and also fears prosecution. Self-report data gathered by this method is likely to be unreliable [Grubin, 1989].

Existing instruments, for example the Derogatis Sexual Functioning Inventory, Thorne's Sex Inventory, Freund's Sexual Deviation Examination Scheme elicit general sexual histories [Paitich et al., 1977]. One of the most comprehensive instruments is the Clarke Sex History Questionnaire for Males which was designed for the assessment of a wide range of general sexual behaviours over a lengthy period of time [Paitich et al., 1977]. All these ques-

tionnaires suffer from inadequacies. They lack the required details about the characteristics of the perpetrators of child sexual offences and of the victims: for example information about the age and sex of the children targeted for abuse may help the clinician distinguish between the various types and subtypes of child molesters encountered. These instruments assess general sexual functioning and sexual deviance, and are not suitable in the assessment of specific areas, such as child molestation. Other instruments enquire about specific aspects of sexual behaviour, but fail to elicit other vital data to substantiate categories or diagnoses for example, Wilson's Sexual Fantasy Questionnaire (Wilson, 1978).

1.4.2 Psychological objective and projective tests and rating scales

Psychological instruments have also been used to assist the clinician in assessing the sexual functioning, preferences, and personality characteristics of this broad group. Examples of traditional psychological tests are the Minnesota Multiphasic Personality Inventory (MMPI), Weschsler Adult Intelligence Scale-Revised (WAIS-R), and more recently the Million Clinical Multiaxial Inventory (MCMI). Projective psychological tests such as the Rorschach Test, Thematic Apperception Test, and Draw-A-Person Test have been utilized. Behaviourally oriented laboratories have recently developed a variety of instruments to measure sexual attitudes, beliefs, orientation and experiences, for example Abel's Paedophilic Cognition Scale, Abel and Becker's Sexual Interest Cardort, the Burt Scales, and the Multiphasic Sex

Inventory [Barnard et al., 1989].

Different psychological instruments measure different aspects of the child molester's personality and his level of functioning in daily living. They fail to distinguish the child molesters from other groups with psychopathology [Barnard et al., 1989]. For example, the MMPI has proved to have poor validity in differentiating male paedophiles and rapists from men who have committed nonsexual crimes [Quinsey, Arnold & Pruesse, 1980]. They also fail to distinguish between the various types of child molesters. Therefore the validity of the test is limited to the specific aspect for which the test was designed. These tests are not diagnostic tools and therefore results obtained cannot be used to make generalizations.

More recently Sex Offender Programmes have been using batteries of psychological tests in addition to the traditional assessment methods in an attempt to overcome this problem. Sex offender treatment centers, for example the North Florida Evaluation and Treatment Center, are now utilizing a computer-assisted psychosocial testing (CAPSA) as well as the traditional batteries of psychological and behavioural tests, and a psychophysiological method to evaluate child molesters [Barnard et al.,1989]. In this particular Center the offender is assessed over an eight week period by a multidisciplinary team of professionals before he is selected for their treatment programme. These assessments are invariably expensive and require considerable time from numerous, highly-skilled personnel.

1.4.3. Penile plethysmograph

Over the past 20 years it has become increasingly popular to assess male sexual arousal using procedures which directly monitor penile tumescence. One such instrument is the penile plethysmograph. Researchers claim that by using this instrument, they are able to discriminate between the various types of child molesters and other people with paraphilia disorders [Earls and Marshal, 1983]. Some researchers are of the opinion that a "response erection" is the most reliable index of early stages of sexual arousal [Barlow, 1977]; while others question the validity of the plethysmograph because subjects are able to fake sexual responses [Hall, 1988]. However, the crucial issue is not the individual's sexual arousal, deviant or otherwise that matters, but whether that arousal ultimately crystallizes into behaviour [Grubin, 1989].

1.5 Aims

With the formation of the Child Protection Units and the escalation of publicity surrounding this subject, the author was approached by colleagues working with abused children or child molesters, to devise an assessment instrument for use by psychiatrists, psychologists, child care workers, social workers and other mental health professionals. These professionals often lacked: (1) specialized expertise in the subject of child molestation, (2) sophisticated and expensive physiological measuring equipment, (3) access to complex batteries of psychological tests and (4) expensive computer-assisted psychological testing. It is against the background of these requests and the aforementioned

discussion of both the highly variable descriptions of child molesters and the lack of a suitable instrument for their assessment that the current investigation evolved. This study has two main aims:

1.5.1 Development of the instrument

Firstly it aims to devise an better clinical assessment instrument for evaluation of child molesters. The instrument will be suitable for pretrial evaluation of sex offenders and possibly for making recommendations to the courts about sentencing. The 'Child Molester Questionnaire' (CMQ), a clinical semi-structured questionnaire will elicit comprehensive data about the form, duration, magnitude, and frequency of the child molester's sexual activity with children. A semi-structured format will be chosen to provide versatility and flexibility in order to accommodate the individuality of the subjects. It should also identify the relevant antecedents and consequences of this behaviour, and the context in which it occurs.

This study does not aim to explain how and why child molestation exists. Aetiology of child molestation behaviour is "a complex and variable interplay of biological mechanisms, psychodynamic influences, conditioning and social factors" [Barnard et al., 1989]. It is beyond the scope of this study to present all the aetiological theories for the different types and subdivisions of child molester. Aetiological explanations of paedophilia are reviewed by Finkelhor and Araji [1986]. Because this description is atheoretical with regard to aetiology, the characteristics,

for example parental relationships, will be treated by the author as associated factors rather than as of aetiological significance. The justification for this atheoretical approach is that the inclusion of aetiological theories could be an obstacle in the use of these characteristics by clinicians of varying theoretical orientations. Grubin [1989] writes, "the future lies in avoiding systems that concentrate on the interpretation of behaviour; instead, typologies based on demographic, family and behavioural characteristics which are more reliably determined should prove to be of more clinical value". The objective of the questionnaire will be to detect, elicit and describe the characteristics of people with this behaviour in order to arrive at a diagnosis. The main advantage of such a questionnaire would be to provide a relatively objective standard of comparison for both clinical and research purposes.

This questionnaire is not intended to replace the traditional clinical interview, which provides the background against which the presenting problem manifests; but rather to assist as an adjunct instrument to highlight specific data. The traditional clinical interview remains the principal diagnostic tool in the assessment of child molesters. It assists in eliciting other non-sexual conditions for the purpose of differential diagnosis of child sexual abuse, for example psychotic or mentally retarded child molesters.

1.5.2 Description of two groups of child molesters

Secondly, this study aims to describe the characteristics of two

clinically distinct subgroups of prosecuted child molesters, namely the male exclusive homosexual paedophile and the male exclusive (preference) homosexual paederast with the use of the CMQ assessment instrument; thus illustrating its utility. This second aim is the first step in redressing the error of overgeneralization and the confusion of behavioural characteristics with diagnostic categories. While the former is a subcategory of the DSM-III-R's paedophilia disorder, the latter is excluded from the APA's Manual of mental disorders despite the fact that the male paederast (see section 1.6.4 for definition) is an important group of child molesters that most closely resembles the often distorted image the public has of the "typical child molester". These two subgroups of child molesters were also selected because by definition they are almost identical except for the variable of age of the children preferred. The characteristics of these two groups could then be compared in order to possibly ascertain whether distinguishing features exist or whether the APA [1987] is justified in arbitrarily setting the "prepubescent" age limit of the children as a major criterion of the "paedophilia disorder" (p.285). Female child sex offenders were excluded from this study because of a lack of subjects.

1.6 Terminology

In this section the full spectrum of terminology used in the literature relating to child sexual abusers will be discussed in order to clarify and formulate the definitions that will be used in this dissertation.

1.6.1 Categories used in the literature

1] Child molester: Groth,Hobson,& Gary [1982] define this as "an older person whose conscious sexual desires and responses are directed, at least in part, toward dependent, developmentally immature children and adolescents who do not fully comprehend these actions and are unable to give informed consent. They also suggest that the term child molester should only be used when the pressures are psychological ones and the harm done to the child is psychological rather than physical. Langevin et al. [1985] feels that the term is too pejorative and emotional to be used in scientific investigation. He uses it to indicate all sexual acts or sexual offences against children, without implying that the offender has an erotic preference for children.

2] Child rapist: Groth [1979] notes that rape is a legal concept which is defined as any form of forcible sexual assault where the defining element is lack of consent. Consent is precluded in encounters between an adult and child because the latter has not yet developed sufficient knowledge or wisdom to be able to negotiate such an encounter on an equal basis with an adult (p.3). These acts are often associated with people with Antisocial Personality Disorder as the main diagnosis on Axis 2 of the APA classification [Greenberg, 1990].

3] Paederast: Rossman [1979] uses the term for "an adult who engages in and/or likes sexual activities with pubertal or early postpubertal adolescents between the ages of 12 and 16" (p.216). Barnard et al. [1989] writes that paedastry is the act of anal intercourse between men and boys. A similar term used for a

paederast is an ephibophile [Rowan, 1988].

4] Paedophilia: The APA [1987] has stated in the DSM-III-R that the criteria for people with a paedophilia disorder is the occurrence of "recurrent, intense, sexual urges and sexually arousing fantasies, over a period of at least six months duration, involving sexual activity with a <u>prepubescent</u> child." The person has acted on such urges,or is markedly distressed by them. The person is at least 16 years old and at least 5 years older than the child. Researchers report that paedophiles constitute a heterogeneous group of sex offenders [Travin et al, 1986] and consequently the DSM-III-R now requires the clinician to specify three further subcategories to qualify the diagnosis, viz. sex of the children, whether limited to incest or not, and whether exclusive or nonexclusive (see appendix A). This study's sample (Group A) is just one of the subgroups of paedophiles.

5] Incest: a descriptive term to define sexual relations between persons related by blood, where such relations are prohibited by law (Stedman's Medical Dictionary). Barnard et al.[1989] notes that more recently sexual contact between children and their stepfathers or adoptive parents have been included in many definitions of incest. There are numerous aetiological factors which may contribute to this behaviour for example, paedophilia, organic personality disorder or alcohol intoxication. Incest and paedophilia are not synonymous, although they may overlap for example, paedophiles engaging in incest. One of the major differences is that in paedophiles we are primarily dealing with the pathology of the individual, whereas in every case of incest, there is some form of family dysfunction [Groth, 1978].

6] Child sexual abuser: a lay term taken to mean sexual abuse in all its forms which are perpetrated against a wide spectrum of children of various ages.

7] Child sex offender: a legal term in which sexual offences prohibited by law are perpetrated against children. In South Africa the legal age at which a person may engage in sexual activity, is 16 years for a female and 19 years for a male. Most of the research relevant to the forensic psychiatrist involves sexual offenders rather than people with sexual deviance [Grubin, 1989]. 'Sexual deviance' is a clinical term describing paraphilic behaviour. Rapists, for example, are sex offenders, but not necessarily sexually deviant. Legal definitions of sexual acts forbidden by law change with changing social norms. Furthermore, the legal charge often does not reflect the circumstances of the alleged crime against the child for example, a conviction of indecent exposure may have resulted when a child rapist exposed himself with the intention of raping a child. Due to lack of evidence the charge was subsequently changed to secure a conviction. Sex offences are also frequently under-reported, undetected, unprosecuted and even more rarely result in imprisonment [Gibbons, Soothill & Way, 1981; Glaser, 1988]. There is no doubt that prosecuted child molesters represent the more severe end of the spectrum. It is therefore important for researchers to distinguish between legal and psychiatric terminology.

8] Exhibitionism: where the person exposes his genitals to an unsuspecting stranger (child) for purposes of sexual excitement with no attempt for further sexual activity with the stranger [APA, 1987].

9] Sexual sadism: where the person inflicts physical or psychological suffering on another person (child) in order to achieve sexual excitement. Sexual sadism disorder may also be associated with antisocial personality disorder. Fewer than 10% of all rapists have sexual sadism [APA, 1987].

10] Isolated sexual acts with children: The APA Manual [1987] includes this group in the differential diagnosis of paedophilia where "these acts do not necessarily warrant the diagnosis of paedophilia" (p.285). They claim that in such instances the desire for sex with a child may be understood as a substitute for a preferred but unavailable adult and that such acts may be precipitated by marital discord, recent loss, or intense loneliness. In view of the difficulties in assessing child molesters and in particular paedophiles, there is a danger of misdiagnosis. Child molestation must always be assessed on a longitudinal life pattern.

Persons with impaired judgement, social skills or impulse control: eg. mental retardation, organic personality syndrome, alcoholic intoxication and psychosis (eg.schizophrenia), may also molest children. The DSM-III-R reports that these cases should be considered as primarily mentally ill with secondary deviant sexual behaviour. "In such cases sexual acts with children are generally not the consistently preferred method for achieving sexual satisfaction" [APA, 1987].

1.6.2 Sub-categories of child molesters in the literature

1] Male versus female:

Child molestation is thought to be primarily perpetrated by males [Finkelhor & Russell, 1984], although some researchers argue that the number of female child molesters is grossly underestimated [Groth, 1978]. This is partly due to socio-cultural perspectives which view the female child molester's offences as less serious and less psychologically damaging than that of their male counterparts [Barnard et al.,1989]. Finkelhor [1984] reported that sexual abuse by women occurs in roughly 20% of the cases with male, and in 5% of the cases with female children. In Minnesota, a state known for its vigorous prosecution of child sexual abuse, convictions of women account for about 1.5% of child sexual abuse cases [Erickson, Walbek & Seely, 1988]. The DSM-III-R reports that, with the exception of Sexual Masochism, the male-female ratio for all the paraphilias, is estimated to be 20:1.

2] Homosexual versus heterosexual:

Krafft-Ebing distinguished between heterosexual, homosexual, and bisexual paedophiles [Hartwitch, 1959].Other authors also reported differences between these groups for example, homosexual molesters are more likely to recidivate and are more likely to be classified as sociopathic [Finch, 1962], less likely to be married [Mohr, Turner & Jerry, 1964], and less likely to be drinking at the time of the offence [Rada, 1976], than their heterosexual counterparts.

3] Exclusive (fixated/ preference) versus nonexclusive (regressed/ situational)

These terms are used synonymously in the literature. Groth, Hobson & Gary [1982] used the term fixated to refer to "a person who has, from adolescence, been sexually attracted primarily or exclusively to significantly younger people, and this attraction has persisted throughout his life, regardless of what sexual experiences he had" (p.6). They theorize that these molesters have an arrested psychosexual development, whereas the term regressed refers to psychopathological regressive behaviour under stress after more-or-less normal psychosexual development. Karpman [1954] distinguished "preference" child molesters who have a stable erotic preference from those who utilize children as surrogates for adult sexual partners. Howells [1981] defined preference child molesters as having a primary sexual orientation to children and as being relatively disinterested in adult partners for fulfillment of their sexual and emotional needs.

The situational (regressed) offender molests children episodically or in isolated acts. In such cases the victim acts as a surrogate for a preferred , but unavailable adult. The behaviour usually begins in adulthood, occurring after the sexual abuser has established primary sexual attraction towards an adult [Barnard et al., 1989]. Precipitating factors such as marital and family stressors, alcohol, substance abuse are often present in commission of such acts. Conte [1985] claims that these are clinical distinctions, which have no predictive value with regard to prognosis.

4] Aggressive/ violent versus nonaggressive/ nonviolent:

Some authors distinguish the violent child rapist from nonviolent child molesters [Henn, Herjanic & Vanderpearl, 1976]; however in making this distinction they do not report the amount of injury involved in the violent cases [Panton, 1978; Groth, Hobson & Gary, 1982; Abel, Becker, Murphy, and Flanagan, 1981]. Groth [1979] regards child rape as an act of aggression rather than a sexual encounter. Lanyon [1986] reports that some 10-15% of all sex offences against children are violent in nature.

5] Incestuous versus non-incestuous:

Phelan [1986] reported differences between biological fathers and stepfathers; the former tend to abuse multiple daughters, whereas the latter group usually abuse a single child. Biological fathers are more likely to engage in full intercourse (with penetration) and also tend to abuse an older aged pubertal or postpubertal child than stepfathers. Russell's [1983] study of a nonclinical population found that the incidence of intrafamilial sexual abuse was 16% and that stepfathers were seven times more likely to abuse daughters than biological fathers. Some authors suggest that this distinction is important because incest offenders respond better to treatment than sex offenders who molest children outside the family [Grubin, 1989].

6] Role of physiological sexual arousal:

Some authors claim physiological measures of sexual arousal, using a penile plethysmograph, can discriminate less from more

dangerous offenders [Avery-Clark and Laws, 1984]. Earls and Marshall [1986] reported that there are important differences between paedophiles and other paraphiliacs in their stimuli for sexual arousal and erectile responses. However controlled laboratory measurements are not always reliable indicators of complex human behaviour, which in the natural setting is influenced by a host of other variables. This laboratory investigation is presently unavailable in the Cape Peninsular district.

In this study the following definitions will be used:

1) Paedophile: "Recurrent, intense, sexual urges and sexually arousing fantasies, of at least six months' duration, involving sexual activity with a prepubescent child" [APA, 1987], with the exclusion of child rapists, i.e. persons who perform forcible sexual assaults on children.

2) Paederast: "Recurrent, intense, sexual urges and sexually arousing fantasies, of at least 6 months duration, involving sexual activity" [APA, 1987], with pubescent[1] and early postpubescent adolescents.

----

1. Marshall and Tanner [1969; 1970] give the following puberty standards for the stages of pubertal events in girls and boys. With British children: the mean age of onset of breast development begins at age 11,2 years, pubic hair at the age of 11,7, and menarche at 13,5 years. The mean age of onset of testicular enlargement is at the age of 11,6 years and pubic hair at 13,4 years. Near complete adult breast development and menarche is at age 15,3 years, but no definite age limits are possible since this development persists indefinitely. The average boy only attains full adult pubic hair at age 15,2 years. There is a standard deviation for each event of approximately one year. Tanner [1978] reports that American children begin puberty 2-6 months earlier than their British male peers, and 6-12 months earlier than their British female peers (p.197-201).

For purposes of this article, the upper age limit for pubescent development for both sexes has been arbitrarily set at the age of 16 years (inclusive), by which time most (50th centile) children have completed their pubescent phase of development.

3) Child molester: an older person who by means of persuasion or physical coercion engages in inappropriate sexual contact or sexual activity in all its forms with either a child or adolescent. This broad definition is intended to include all forms of sexual activity (aggressive and nonaggressive) with children of all ages.

4) Incest refers to all sexual activity between children and their nuclear family members, near relatives, adoptive and step-parents provided that this activity does not extend 'extra-familially' or involve an underlying erotic preference for children.

The term 'child' will be used for all persons aged 16 or younger.

CHAPTER II : METHOD

2.1 Identification of subjects

Thirty-four male child molesters were evaluated by the author using the traditional Maudsley-type psychiatric history and examination (see appendix B) in conjunction with available collateral over the period June 1988 to February 1990. Twenty-six of these subjects were referred to the Forensic Unit, Valkenberg Hospital, Cape Town by the Judiciary, the Department of Health and Welfare probationary officers or Defence Counsel acting for respondents who were unable to afford private professional evaluation. In these cases expert testimony was presented by the author to the Courts. Both pretrial and sentencing evaluations were completed on most of these cases. Eight sentenced subjects were also examined at the Maximum Security Forensic Section, Weskoppies Hospital, Pretoria. Of the 34 subjects only those who fulfilled the study's criteria constituted the final sample.

2.2 Sample

The sample consists of two distinct groups. Criteria for Group A was based on the DSM-III-R criteria for (male) paedophilia [same sex, exclusive type] (see appendix A). Exclusion criteria were

subjects whose activities were "limited to incest"; persons with a history of child rape associated with Antisocial Personality Disorder; and disorders of impaired judgement, social skills and impulse control, for example mental retardation, organic personality syndrome and psychosis. This study's sample group of male exclusive homosexual paedophiles will henceforth called Group A paedophiles.

Group B consisted of subjects involved in sexual activity exclusively with same sex children who had entered the pubertal and early post-pubertal stage of development. They fulfilled all the DSM-III-R criteria for paedophilia except in their choice of age of their victim. They repeatedly preferred (same sex) children rather than adults for achieving sexual gratification. The same exclusion criteria listed above in group A, applied to group B. This study's sample group of male exclusive homosexual paederasts will be henceforth called Group B paederasts.

Only seven subjects interviewed fulfilled the study's criteria. Four and three subjects were assigned to group A and B respectively. All seven subjects agreed to participate in the study. Informed consent was obtained to use the data for research purposes. Confidentiality was assured except in accordance with the existing laws and regulations.

2.3 Demographic data

Fig.1: Demographic data of the male exclusive homosexual paedophile sample, (Group A).

Subject	1	2	3	4
Age	44	42	24	43
Marital status	divorced	single	single	single
Children	one	-	-	-
Race	White	White	'Coloured'	White
Education	matric drama diploma	matric university uncompleted	std. 8	matric teaching diploma
Occupation	Children's theater producer	Ex-teacher self employ-ed	Church youth worker	Teacher

Fig.2: Demographic data of the male exclusive homosexual paederast sample, (Group B).

Subject	5	6	7
Age	42	48	29
Marital status	single	single	divorced
Children	-	-	-
Race	White	White	White
Education	std. 9	matric	matric
Occupation	clerk	insurance underwriter	ex-policeman supermarket manager

2.4 Instrument

A questionnaire was compiled after reviewing the literature on child molesters and the existing assessment instruments. In the process of assessing the 34 child molesters, the author found that by using sexual preference ratios, it was possible to assess the degree of exclusivity of child molestation. Sexual preference ratios are formulated by asking the subject to rate, in thought or fantasy his preference between two sexually erotic stimuli for example, an adult woman and a female child. Each pair is scored by the subject out of a total of 100 points and these two figures are then documented as a ratio. Likewise, by exploring sexual thoughts, fantasies and sexual activity, the clinician ensured assessment of the degree of severity. By exploring the sexual fantasies and thoughts, rather than the actual acts (sex offences), the author found that he was able to minimize the subjective and apparent disapproval, rejection and prosecution fears experienced by these patients.

In an attempt to assess the degree of the strength of the child molesters' sexually arousing fantasies and sexual urges emphasis was placed on the exploration of the sexual fantasies and thoughts as well as sexually arousing acts to ascertain the type, form, degree, frequency, and duration of contact with sexually arousing stimuli. Additional information was elicited, including the use of pornography; precipitating factors associated with sexual activity; restrictions imposed on sexuality; sexual relationships with peers and adults; substitutes for sexual gratification; sexual dysfunction and difficulty; conflict with society including attempts to control sexually arousing fantasies and

sexual urges; and remorse for such behaviour, to provide valuable support for the final analysis and (type and subdivision) diagnosis of these patients. A comprehensive picture of their sexual behaviour and associated features was formulated and these findings were incorporated into the 'Child Molester Questionnaire' (CMQ). The final CMQ consists of 84 semi-structured items (see appendix C).

Each of the seven subjects was then reinterviewed with the CMQ. Subjects were interviewed individually by the author in a private office. Evaluations were of 50 minutes duration and were performed over several weeks with each subject. Most subjects were seen on two occasions; a few were seen on three occasions. The CMQ was administered twice to all the subjects. Discrepancies evident in their personal accounts and/or in collateral information were clarified during the course of the evaluations. Interviews were documented by hand during the course of the evaluation. Collateral sources included police records where available, information supplied by the Court or the Welfare Department and reports of previous psychiatric and psychological evaluations. As far as possible the respondents' words are quoted directly in the results. However, where interpretations were made by the author, for example with regard to parental relationships, these are reported briefly.

CHAPTER III: RESULTS

3.1 GROUP A: A group of male exclusive homosexual paedophiles

I. EARLY HISTORY

Description of Father:

Subject: 1: Passive, distant

2: Removed, distant

3: Passive, softly spoken

4: Passive, but physically and verbally aggressive when intoxicated

Description of Mother:

Subject: 1: Domineering, overpowering, interfering, critical, strict disciplinarian

2: Domineering, capable person, emotionally distant, favourite child

3: Domineering, moody, high achieving career woman

4: Domineering, very close relationship

Family structure:

All subjects described family structures with unavailable fathers and domineering mothers. All subjects described either overt or covert conflict between parents.

Family violence:

Only subject 4 described physical abuse by father.

Parents' attitudes to sex:

All subjects reported that the subject was taboo.

Family history of sexual perversion:

None described by any of the subjects in this group.

Incest:

None was described by the subjects.

Sexual abuse as a child:

Only subject 4 reported that he was once molested on a train by a ticket inspector when he was aged 7.

Relationship with peers

All subjects reported having had few friends and superficial relationships. None reported having had meaningful relationships. All described having been teased by their peers.

Sex education

All subjects described negligible sexual education gleaned from peers and books.

II. ONSET AND COURSE DURING ADOLESCENCE AND ADULTHOOD

1) Onset

Subjects	1	2	3	4
Age of onset of paedophilic fantasy (years):	20	12	11	12
Age of onset of paedophilic contact(years):	26	20	23	26
Adolescent experimentation with same aged peers:	+	+	+	+
Adolescent experimentation with children 5 years younger:	-	-	-	-
Adolescent incest with same age family members:	-	-	+	-
Adolescent incest with family members 5 years younger:	-	-	+	-

+ = positive answer
- = negative answer

Sexual thoughts or fantasies:

Subject 1 described sexual fantasies of "a love relationship" with a child. The fantasy involved a sex act of mutual masturbation and oral sex. The fantasies were of male children only. He stated: "I was scared of girls as I might be charged with rape. As I had less and less success with (courting) girls during my late adolescence, these fantasies increased".

Subject 2 claimed he had never been attracted to females of any age group. "I was conscious of wanting to be with boys since adolescence. The reason behind this need was a yearning for sexual contact". He also described recurrent arousing sexual fantasies of "a circumcised boy being circumcised".

Subject 3 had sexual fantasies of "being married to children of either sex". There would be fantasies of mutual masturbation and oral sexual acts.

Subject 4 described fantasies of "feeling loved and comforted" by young boys. They would engage in sex acts where they would masturbate him.

2) Sexual Targets

Age of child that is most attractive

Subjects		1	2	3	4
Specific age of child	:	13	10-13	10-12	10
Range - youngest age	:	8	3	5	8
- oldest age	:	16	14	12	12

Attributes of attraction
Physical:

Subject 1 : Smell of boys hair

Subject 2 : Body shape - lean

Hair - blonde (some of the victims had black hair)

Subject 3 : Body shape - lean

Facial - handsome

Hair - "I do not like pubic hair"

Subject 4 : Body shape - muscular, slim

Mannerisms - masculine, "not effeminate"

Penis - prepubertal genital organs

Personality:

Subject 1 : Quiet sensitive children who "loved me". "Children who sought love in me and had fallen in love with me".

Subject 2 : Outgoing, sporty, physically active children. "Those who could express their pleasure in my company and relate it to me. There were no secrets between us. They would never be scared to talk about anything to me."

Subject 3 : The innocence of the child.

Subject 4 : Active and sporty."They had the same interests (music and woodwork) as me".

Sexual preference:

Ratios of their sexual preference for children

Ratio male:female

Subject 1: 90:10 in fantasy; in practice 100:0. "I feared pregnancy and rape charges".

Subject 2: 100:0 "I was never interested in girls"

Subject 3: 60:40 in fantasy, but in practice 100:0

Subject 4: 80:20 in fantasy; in practice 100:0. "I have never had any encouragement from girls. Girls expect sympathy the whole time. I detest domineering girls. I like to be the boss".

3) Course of Molestation

Pattern of relationships:

Subject	1	2	3	4
Duration of paedophilic activity (years):	15	22	2	17
Maximum number victims per year:	12	6	7	5
Maximum sexual contacts with a child:	60	240	5	300
Total number of children abused:	78	58	7	41
Length of longest relationship (years):	2.5	6	0.25	4
Frequency of contacts per week:	2	2	2	2

All three subjects reported having had several simultaneous sexual relationships during periods of sexual activity. Only subject 2 reported occasional sexual contact with 'street children' who prostituted themselves. They were paid between 50 cents and R2,00. All four subjects reported 'one-night-stand'-type of sexual contact, but due to the child's reaction or lack of opportunity, all further sexual contact ceased.

Type of relationship with children:

All subjects reported that they had performed "favours" for the children.

Subject 1 reported that 90 percent of the boys had "thrown themselves" at him and that they had "shared mutual pleasure". He would give them "special" acting roles in his productions. Occasionally he bought them presents and gave the boys lifts to their homes. If he was rejected, it was reported (but denied by the subject), that he would give them a lesser role in his theatrical production. He explained their "relationship grew out of the child's clinging". "They were in love with me. I would love them back and run my fingers over their bodies. I knew by the way they responded that they wanted it (sex)".

Subject 2 described how he picked the boys up after school or visited them at their homes while their parents were at work. He also reported that the victims would on occasion phone him to go on 'outings'. He reported that he arranged camping or fishing trips for children over weekends. He described how bodily contact would gradually increase: "I knew at what stage I could proceed and I went for this goal. Their arousal and climax would arouse me". During these contacts photographs were taken of their naked bodies. The subject reported that some of the children were "in love" with him.

Subject 3 reported that he took the boys on outings for example, the beach or mountain-hiking. Occasionally he would visit them at their homes while their parents were at work, to "help the boys with their homework". He would then initiate a game, during which he would tickle them. Gradually he would then steer this game towards sexual contact and claimed "they laughed and seemed to enjoy it".

Subject 4 claimed that he developed friendships with boys at the hostel where he was the master. He stated: "they would have the same interests and look for me after school in the hostel or classroom. He reported that he would never "buy love" for example, raise school marks or buy gifts. He did acknowledge that those children who were interested in his school subjects got extra tuition and birthday gifts for example, a music stand. He stated: "while talking to them continuously, I would put my hand on their knees and then gradually on their genitals. I want to be loved and accepted. Girls have always rejected me and I find it easier to be accepted by children. They encourage friendships and are always grateful".

Coercion

All subjects reported that there had been no physical coercion, threat of force or violence with any of their sexual offences.

Nature of contact

All subjects reported fondling, genital masturbation and mutual oral-genital sex. Subject 4 reported being sodomized by a fourteen year old boy with whom he had a four year relationship. He claimed that on this lone occasion he had "wanted to please" the child. All of the subjects denied having performed sodomy on any of the boys.

Relationship with the parents of the children

Subject 1 knew most of the parents of the boys he had molested. In conversation he encouraged and praised the child's progress with his drama classes. Parents maintained contact and he boasted that he would even receive Christmas cards.

Subject 2 stated that he became a "close" friend of the parents in question. Often he did "favours" for the parents for example, assisted with transport or finances. He stated that he "wanted to protect them from bad elements in the neighbourhood".

Subject 3 claimed that when he helped the children with their homework, he waited for the parents to return from work. He won the parents' approval as a 'protector' of the childs' interests. "They were good friends and Christians".

Subject 4 claimed he became acquainted with the parents of the children. He visited them at home and offered to help with household chores for example, cooking or house repairs.

Pornography

Subjects 1 and 2 admitted to previous possession of pornographic photographs of children. Subject 2 admitted taking photographs of children.

Situational factors associated with the offences

i) Stress, drugs and /or alcohol

These were not evident in any of the histories.

ii) Opportunity

This factor was created by all the subjects in this group.

Subject 1 - Children's drama and theater

Subject 2 - Teacher

- Boys Scouts
- Met children in public areas for example, the beach
- Child prostitutes ('street children')

Subject 3 - Christian youth movement

Subject 4 - Teacher

- Church youth club

All subjects denied any contact with any other paedophiles or 'sex rings'.

4) Other Aspects of Sexuality

Adult heterosexuality

Subject:	1	2	3	4
Ratio of sexual preference -				
Male child:female adult	90:10	100:0	80:20	90:10

(By definition this group of paedophiles has a preference/exclusivity for same sex children - see criteria)

Feelings about sexual activity with women

Subject 1 reported that he was scared of sex with women as "it could lead to babies" or interfere with his career. He had never found women sexually satisfying.

Subject 2 reported that he had never found adults of either sex sexually attractive. He stated that "it was like masturbating with an inanimate object".

Subject 3 reported that the thought was "detestable".

Subject 4 reported he felt it was too "foreign and awkward" to consider. An adult relationship would "revolt" him. He further volunteered the information that he feared a resultant pregnancy from such contact.

Relationships with women

All subjects claimed to have had non-sexual friendships with women. Only subject 2 had a casual sexual relationship with a woman. All the subjects denied long-term relationships with women. Subject 1 claimed that after a brief courtship he had married "to extinguish" his uncontrolled paraphilia. Despite their asexual relationship with his wife to be, he married her at aged 35. They had an unfulfilled sexual relationship where he felt that he was unable to satisfy her sexually.

Relationships with men

None of the subjects had meaningful non-sexual friendships. Only subject 1 described a single casual adult homosexual contact, in which he felt sexually unfulfilled.

Other paraphilia

All subjects persistently denied sexual deviations both in fantasy and sexually arousing urges which manifested in activity.

Sexual deformity or difficulty

None reported by the subjects of this group.

5) Conflict with Society

Antisocial behaviour

There was no antisocial behaviour in Subjects 1, 2, and 4. Subject 3 had one charge of "tampering with a public telephone" during his adolescence.

Fig.3: Public response to paedophilic activities.

Subject No.		1	2	3	4
Warnings	By parents	1979 X2 1984 X1	-	-	1975 X1
	By work colleagues	yes	-	-	yes
Action	By parents	blackmailed	-	-	assaulted
	By work	dismissed	-	-	dismissed X 2
	By police & courts	-	1987 fine & suspended sentence	-	-

Attempts to control paraphilia

i) Self control

Subject 1 claimed that he placed the sister of a sexually attractive boy into one of his plays and gave them both a 'lift' home in order to avoid being alone with him.

Subject 2 claimed that he tried to control his urges by immersing himself in his work.

Subject 3 claimed that he "blocked" thoughts out of his head and try to avoid contact with children.

Subject 4 claimed that he made regular new year resolutions to control his molestation activities.

ii) Control by other means:

Subject 1 : Prayed, but never confided in his Minister.

Subject 2 : Nil.

Subject 3 : By prayer and church attendance.

Subject 4 : Rededication of himself to the Church.

ii) Professional assistance:

Subject 1 reported that after his sexual activities were exposed he consulted a clinical psychologist for 6 months at the insist-

ence of his work colleagues. Therapy seemed to consist of weekly/fortnightly 'supportive' sessions.

Subject 2 stated that after being dismissed from his teaching post in 1976, he saw a psychiatrist for three sessions. He claimed that the doctor merely prescribed a course of antidepressant drugs. A pretrial psychiatric evaluation was completed in 1987, but no therapy was recommended.

Subject 3 never sought professional assistance.

Subject 4 stated that at the insistence of his teaching department, he consulted a Clinical Psychologist for a period of four months. Therapy was essentially supportive in nature and he was seen at approximately three weekly intervals.

III. MENTAL STATUS

Insight

Subject 1 felt that these acts were wrong in the 'eyes of God'. He steadfastly maintained that these were "acts of mutual love and affection" and that he had never forced himself on a child. "There was never a case where the child did not want it (sex) from me". If a child objected he withdrew his affection from the him. Although he had read in the newspapers that these acts may deviate these children into child molesters themselves, he rationalized that these were mutual loving relationships. He stated that he was "better than sadistic types" who physically harmed the child. He claimed that what affected these children was the parents' initial reactions and later explanations to the children. They filled them with guilt feelings, whereas he maintained that these relationships were beneficial to children.

Subject 2 reported that his sexual fantasies and sexually arousing urges were completely "natural" to him. He reported that if one had to line up a group of sexually attractive people of all ages and of both genders, he would always choose the male child. He stated that he enjoyed their "spirit of freedom". "They are like little wild animals who are unconstrained by adult morals of having to do the right thing". He reported that the sexual relationship did not affect them, and it all depended on the manner in which adults dealt with this matter. "A child agrees to the act and unlike rape, it is not a shock to them". He expressed concern about the conduct of the police. He claimed that children were being taken out of school and interrogated without their parents' presence or consent.

Subject 3 reported that he felt his activities were wrong in 'God's eyes' and in retrospect he had felt extremely guilty. He had read in the press that some of the children had subsequently had nightmares and feelings of guilt.

Subject 4 reported that the children had been experimenting with their sexuality. Most of them were unaffected by these activities. He reported that they matured developmentally, they "worked it out of their system" and he gradually withdrew his "love" from them. On the other hand, he claimed that these activities with boys who had homosexual tendencies were further strengthened by these relationships. He stated that he was "created to love children" and therefore it was natural for him to derive sexual satisfaction from them.

Judgement - if all legal restrictions were removed, what then?

Subject 1 wanted a "loving relationship" with a boy aged 10 to 13. He described an ideal relationship as one with a boy "compan-

ion, partner, and lover".

Subject 2 would continue these acts. He would approach the parents for permission and if they refused, he would look elsewhere as "there are plenty of fish in the sea". He refused to consent to hormonal therapy as this would destroy his sexual feelings and leave him like "a cabbage without life".

Subject 3 would choose to continue his activities with children.

Subject 4 would seek a permanent relationship with a "special" prepubescent boy and not "play the field". When the child entered the postpubertal period, he would seek a younger partner.

Remorse

Only subject 3 expressed feelings of guilt and shame regarding his activities. All subjects expressed a dissatisfaction with their impending criminal charges and the possibility of imprisonment. In the author's opinion, none of the subjects showed real concern about the children's well-being or their future psychosexual development.

3.2 GROUP B: A group of male exclusive homosexual paederasts

I. EARLY HISTORY

Description of Father

Subject: 5: Distant, alcoholic

6: Died when subject was 6 months old

7: Distant, cruel, strict disciplinarian

Description of Mother

Subject: 5: Domineering, enmeshed

6: Protective, over-indulgent, encouraged feminine interests

7: Domineering, protective, indulgent

Family structure:

All subjects described family structures with removed or absent fathers and closely bonded relationships with their mothers. Subject 5 described a stormy marital relationship, while subject 6 claimed that he was the spoilt laatlammetjie[1] of the family. Subject 7 reported that his father was always away on the farm-land and his parents seemed to live separate lives.

Family violence:

Subjects 5 and 6 described violence within the home; the former subject claimed that his father was violent when intoxicated, while the latter claimed that his step-sister and her husband frequently physically assaulted each other during the period that they lived on the farm.

----

1. An Afrikaans word meaning child born a long time after the other sibs [Kritzinger, Schoonees & Cronje, 1972].

Parents' attitudes to sex:

All three subjects reported that the subject of sex was taboo in their parents' home.

Family history of sexual perversion:

None described by any of the subjects.

Incest

All three subjects reported incest. Subjects 5 and 6 reported incestuous relationships during adolescence with same age relatives. Subject 6 and 7 reported incest with adolescent relatives during their adult years.

Sexual abuse as a child:

All three subjects reported that they had been molested as children. Subject 5 reported that he was molested by his School Principal at the age of 12. Subject 6 reported that he was molested aged 13 by a man in his mid-thirties while he was "window shopping". He further claimed that it was a pleasurable experience and that he had later returned to the pick-up-point. Subject 7 reported that his school teacher had molested him at the age of 16 years.

Relationship with peers

Subjects 5 and 6 reported that they were teased at school. They had few friends, mainly homosexual males. Subject 7 grew-up on an isolated farm and reported that he had a few meaningful friendships amongst his peer group.

Sex education

All three subjects described negligible sex education gleaned from books, peers and their sexual experiences with adults.

II. ONSET AND COURSE DURING ADOLESCENCE AND ADULTHOOD

1) Onset

Subject	5	6	7
Age of onset of paederast fantasy (years):	13	13	12
Age of onset of paederast contact (years):	16	22	22
Adolescent experimentation with same aged peers:	+	+	-
Adolescent experimentation with children 5 or more years younger:	+	-	-
Adolescent incest with same age family members:	+	+	-
Adolescent incest with family members 5 or more years younger:	-	-	-

+ = positive answer
- = negative answer

Sexual thoughts or fantasies

Subject 5 fantasized about acts involving mutual masturbation with boys whom he had previously molested. He also fantasized about "picking up" boys in public toilets. The size of their penis and buttocks would arouse him sexually. Another particular fantasy were orgies with boys.

Subject 6 claimed to be aroused by sexual fantasies of previous sexual acts where the boys responded to his advances. He claimed that their "noises" were particularly arousing to him. He fantasized about sex in public toilets and motor-cars where he was liked "by as many boys as possible".

Subject 7 described sexual fantasies of mutual masturbation with boys in his bedroom.

2) Sexual Targets

Age of child that is most attractive

Subject		5	6	7
Specific age of child -		16	16	15
Range -	youngest age:	13	13	12
-	oldest age:	24	24	25

Attributes of attraction
Physical

Subject 5 : Body shape - masculine, slim legs, broad shoulders, narrow buttocks
Facial - handsome
Penis - large size, "bulge in his pants"

Subject 6 : Body shape - slim, short, stocky, shape of buttocks
Facial - handsome appearance
Penis - large size

Subject 7 : Body shape - slim, muscular
Hair - blonde
Penis - large size

Personality

Subject 5 : Physically active, extrovert, honest, open and sincere children

Subject 6 : Bossy, aggressive boys who were not yet involved with girls

Subject 7 : Well-behaved, mature boys

Sexual preference

Ratio of sexual preference for adolescents:

All three subjects claimed a ratio of 100:0 [ratio male : female] in both fantasy and in practice.

3) Course of Molestation

Pattern of relationships

Subject	5	6	7
Duration of paederast activity (years):	21	22	8
Maximum number of victims per year:	10	350	3
Maximum number of sexual contacts with a child:	100	500	450
Total number of children abused:	112	3500	10
Length of longest relationship (years):	2	9	3
Frequency of contacts per week:	1	3-4	3-4

Type of relationship with children

All three subjects described a "father-like" relationship with the boys. All three subjects reported they that they had rewarded children financially. All subjects reported they bought the boys gifts, entertained them with videos and food, and provided them with transport.

Subject 5 reported that the boys came from deprived homes and were all involved in drug and alcohol experimentation. He claimed that he gave them shelter and encouraged them to attend school or to seek employment.

Subject 6 claimed that the boys visited and phoned him. Some of the boys lived with him for short periods. He reported that he often "cared" for them by tutoring them on "morals and responsible sexuality". He had been confident that they would never report the sexual contact as he "always had their co-operation".

Subject 7 reported that he met boys in video game shops.

Coercion

All three subjects reported that there was no physical coercion, threat of force or violence with any of their sexual contacts.

Nature of contact

All three subjects reported fondling, oral-genital sex, and mutual masturbation. Subjects 5 and 6 reported anal penetration of the boys, while subject 7 admitted only to fantasy of anal sex.

Relationship with the parents of the children

Subject 5 claimed that he had no contact with the parents.

Subject 6 claimed that he fetched the boys from their homes to spend weekends at his apartment. He thus briefly met some 30% of the parents.

Subject 7 visited the boys at their homes, hoping that the parents would be away so that he could engage in sexual activity. In one case he had met the grandmother who was the boy's sole guardian. He visited the home, bought gifts and seemed to play a paternal role. He later moved into the home as a boarder where he continued his sexual activities.

Pornography

All subjects possessed or had access to commercial pornography of adult heterosexual partners. Only subject 6 admitted to photographing adolescent boys.

Situational factors

i) Stress, alcohol and/or drugs

These were not evident in any of the subjects.

ii) Opportunity

Subject 5 - Public swimming baths, transport amenities, ice-skating-rink and cinemas. Children were all from deprived family backgrounds. Often they were experimentally involved in drugs and alcohol. He reported that most of the boys had previously been sexually

active and many were prostitutes.

Subject 6 - Public places including railway stations, cinemas and game shops. He estimated that 20% of the boys were paid male prostitutes. He paid them between 50 cents and R1.00 to spend a weekend in his apartment.

Subject 7 - Public places

iii) Contact with other molesters or 'sex rings'

Subjects 5 and 6 had contact with 'sex rings'. These rings consisted of adult male homosexual paederasts.

4) Other Aspects of Sexuality

Adult heterosexuality

Subject	5	6	7
Ratio of sexual preference -			
Ratio child (male):adult (female) attraction	100:0	100:0	80:20

(By definition this group of male paederasts had a sexual preference/exclusivity for children - see criteria for Group B).

Sexual feelings toward adult women

Subject 5 claimed that he felt no sexual attraction to adult women. He stated that he felt "uncomfortable in their company".

Subject 6 stated that he had no physical attraction towards women. Their sexual organs were "vile" and he reported that he had always felt "turned off sexually by women".

Subject 7 stated that he had occasionally experienced some sexual arousal by women, but this was very mild in comparison with his attraction to boys.

Sexual relationships with women

Subject 5 and 6 had no relationships with adult women. Subject 7 was married for 5 months. The noted reason for marital breakdown

was his failure to sexually satisfy his wife, who eventually had several extramarital relationships and later married his best friend. He subsequently had several sexually unfulfilling contacts with women, but claimed that they had always lacked personal sexual satisfaction.

Sexual relationships with men

All of the subjects described sexual attraction to men under the age of 25. Subject 5 claimed that after 30 years of age, men's "bodies deteriorate". Subject 6 felt ego-syntonic about his sexual preference and rationalized that "90% of homosexual men are attracted to adolescent boys". Subject 7 claimed that he was not aroused by men sexually, although he earlier admitted that he was attracted to "boys" up to the age of 25. He was ego-dystonic about his attraction to males and expressed feelings of guilt and shame.

Other paraphilias

All subjects in this group denied both sexual deviations in their fantasies and sexually arousing urges which manifested in behaviour.

Sexual deformity or difficulty

None of the subjects described sexual difficulties. Subject 5 claimed that he felt that he had a small penis, although it was within normal limits.

5) Conflict with Society

Other antisocial behaviour

No other antisocial behaviour was reported by the subjects.

Fig.4: Public response to paederast activity

Subject No.		5	6	7
Warnings	By parents/ guardian	1986 X1	-	1987 X1
	By work colleagues	-	-	-
Action	By parents	-	-	-
	By work	-	-	-
	By police & courts	1974 6 months suspended sentence for 3 years	1971 fine & 2 years suspended for 3 years	1989 fine or 18 months suspended for 5 years & conditions

Attempts to control paraphilia

i) Self control

All three subjects reported that they had "tried to avoid boys sexually" under the legal age of 19.

ii) Control by other means

None was reported by members of this group.

iii) Professional assistance

Subject 5 reported that following his arrest on similar charges in 1974, he saw a psychiatrist for one-hour individual sessions on a monthly basis for 9 months. He claimed that during therapy he was able to control his sexual urges and on discontinuation he soon relapsed.

III. MENTAL STATUS

Insight

Subject 5 claimed that "it did more good than harm", as he stopped the children from turning to crime, drugs and alcohol. He stated: "it's ludicrous that a boy of 17 years can die for his country, vote at 18, but only go to bed until 19". He was adamant that these activities had no harmful effects on children.

Subject 6 stated that he felt that he helped the boys more than their parents, as they confided in him and he was thus able to build up good trusting friendships. He felt that these activities were advantageous as he had provided the boys with the guidance they lacked in the form of caring and concerned "lectures". He claimed that these activities had no ill-effects, except in a small percentage of ego-dystonic homosexual boys who felt guilty and shameful of their enjoyment in these activities.

Subject 7 reported that he felt it was wrong because it was against God's laws. In spite of this, he stated that "it always seemed to just happen". He rationalized this by stating that he never forced the boys into sexual activities.

Judgement - if all legal restrictions were removed, what then?

Subject 5 claimed that if the law was changed so that it was legal to engage in sexual acts with boys, he would want to meet the boys "before they developed criminal tendencies" in order to develop long and meaningful relationships.

Subject 6 stated that he would get greedy if the laws were changed and would choose boys of 15-17 years. "It's an obsession that I must have new boys all the time". He reported that he had social standing with his homosexual friends, because he was

always surrounded by boys.

Subject 7 stated that he would continue with the boys, as there would be "nothing to worry about" if they changed the law.

Remorse

In the author's opinion none of the subjects expressed concern for the children and were motivated to seek treatment because of impending criminal charges with possible incarceration. Only subject 7 expressed feelings of guilt and shame because of his religious conflict.

CHAPTER IV

DISCUSSION

This chapter will discuss some of the aspects of the descriptive characteristics of the different types and subdivisions of child molesters that have emerged through both the review of the available literature and the study of the 34 cases undertaken by the author. The following aspects will be discussed (1) The Child Molester Questionnaire. (2) A description of the characteristics of a group of male paedophiles [exclusive, same sex, not limited to incest]. (3) A comparative description of the characteristics of a group of male paederasts and male paedophiles [exclusive, same sex, not limited to incest]. (4) Recommendations for future research and mental health needs in South Africa will be made on the basis of issues clarified in the literature survey and of suggestions arising from the study.

4.1 The Child Molester Questionnaire

A literature review revealed the deficits of the existing instruments used in the assessment of child molesters. The first major objective of this study was to devise a semi-structured questionnaire capable of eliciting the relevant characteristics of child molesters and their paraphilic behaviour. Preliminary results

indicate that the CMQ used in conjunction with the traditional clinical interview and collateral information, can provide a comprehensive assessment of this group of patients.

The first step in the assessment process is to identify the type of child molester. The present author has identified six main types of child sexual abusers [Greenberg, 1990]:

1) Mentally ill child molester
2) Paedophile
3) Paederast
4) Incestuous person (limited to the 'family')
5) Antisocial Personality Disordered person with associated child rape or sexual sadism.
6) Voyeurs and exhibitionists.

With voyeurs and exhibitionists there is usually no physical sexual contact with children. At the time of writing this dissertation the Child Protection Unit were investigating reports of child sexual abuse by satanical cults in the Cape Town area ["Devil cult", 1990]. Very little is presently known in South Africa about child sexual abuse involving these beliefs. With additional information this may constitute a further group. Although child molesters are a heterogeneous group of patients and thus often have dual diagnoses [Travin et al., 1986], this relatively simple classification gives the clinician and mental health worker a standard by which to determine suitable treatment and management plans, as well as to predict the possible potential risk of recidivism.

The CMQ enabled the author to delineate various subdivisions of child molesters with regard to the degree, frequency and exclu-

sivity of their sexual interest; their gender preference; and the form, duration, and magnitude of their sexual activity. It became apparent in this study that although sexual preference is fairly constant after puberty, actual sexual activity is dependent on numerous internal factors and external constraints. It is not sexual arousal that is of prime importance, but rather whether this arousal crystallizes into behaviour. The use of a method of exploration of sexual fantasies and ratios of sexual preference appeared to be effective in making this difficult differentiation. Self report is open to minimization and conscious denial. However, by reinterviewing the patient with serial administrations of the CMQ, the accuracy of the data elicited by this tool was further enhanced and thereby assisted the author in presentation of expert testimony to the court.

Although self-report has been criticised by some as unreliable [Grubin, 1989], it remains the mainstay of the assessment process. By dissecting out the pieces of the puzzle and constructing the full picture using this method, a relatively reliable result was obtained. This was put to the test by the author in the courts and found to favourably compare with the evidence presented. The author gave expert testimony in fourteen of these cases and on no occasion did the prosecution have additional evidence not elicited with the assistance of the CMQ. On the contrary, the CMQ elicited valuable additional data unknown to the prosecution or defence counsel which was vital to the expert testimony and final decision making regarding sentencing.

With the use of the CMQ in combination with the traditional interview and collateral, the problems encountered in the use of

the traditional interview and collateral alone (section 1.4.1), were markedly diminished in that a comprehensive evaluation was achieved from which it was then possible to comment on the exclusivity and degree of the sexual preference. By exploring the sexual fantasies rather than the actual acts, the author was able to allay some of the subjects' anxiety about expected rejection and disapproval from members of society. Questions concerning insight and judgement of their child molestation activities focussed attention on the cognitive distortions evident in these patients. The questionnaire was found to be superior to the general sexual history of the traditional interview as it highlighted specific phenomena which are not routinely included in the histories of such patients.

An opinion about potential recidivism and risks to the community is often requested by authorities. This issue has important implications for penal policy and sentencing and is one of the more difficult tasks for the clinician. A potential forensic psychiatric use of the CMQ instrument is the evaluation of both sexual deviance and sexual offences. Groth [1979] reports that there is a high risk of recidivism with child sex offenders as they do not spontaneously abandon their sexual involvements with children. In terms of predicting recidivism, taxonomies of paedophiles that have been most successful have been based on the preferred gender of the victim and the relation of the victim to the offender [Grubin, 1989]. The male paedophile and paederast [same sex, not limited to incest] are thus of particular importance to the judiciary, social and health authorities. From the descriptions in this study it is apparent that the behaviour of these two groups under study is highly repetitive, often to a

point of compulsion, rather than being the result of a temporary lapse of judgement while in a state of intoxication.

Essential descriptive data elicited with the CMQ instrument could also be of value in the development of behavioural treatment programmes with the improved understanding of the patients' sexual behaviour.

The limitations of the CMQ are its untested reliability and validity. Furthermore this instrument has only been tested by the current author on prosecuted child molesters who undoubtedly fall at the more severe end of the spectrum. Professionals who may in the future use the CMQ need to be cautious when confronting the patient about discrepancies evident in their responses to serial interviews or with collateral for it may destroy all rapport. Clinical acumen and judgement are needed to elicit and determine the relevance, reliability, and validity of such data. The importance of collateral in arriving at a definitive diagnosis still remains the most valuable investigation for the clinician and must form an integral part of the assessment.

4.2 Descriptive characteristics of a group of male exclusive, homosexual paedophiles [not limited to incest] : (Group A paedophiles)

The second objective of this study, namely to describe the characteristics of a distinct subgroup of child molesters, is the first step in redressing the error of overgeneralization resulting from previous researchers' use of ambiguous non-operational diagnostic labels. The most recent American Psychiatric Association's criteria for paedophilia [APA, 1987] requires further that the clinician specify: 1) sex of children involved, 2) exclusivity of the disorder, 3) and whether this activity is limited to incest (see Appendix A). Thus the APA acknowledges that this disorder is heterogeneous in nature. However, in their general descriptive characteristics of paedophiles, they fail to clarify whether these features are found in all the specified subgroups (see appendix A). Thus the relevance of these characteristics is questioned by the author. In discussing the characteristics of a group of male exclusive homosexual paedophiles, the author's findings will be compared with the DSM-III-R's general characteristics of paedophiles so as to highlight the importance of defining the distinct subgroupings in the paedophilic disorder when reporting signs and symptoms.

Certain cautions are necessary in interpreting these findings. Since this sample represents the severe end of the spectrum of paedophiles, relative to APA standards, it tends to manifest the "full-blown" symptomatology of the paedophile. Secondly the sample is very small; however this limitation is partly mitigated by the purity of the sample. It is not possible to give the

incidence of this subdivision of paedophilia; however percentages of convictions for sexual acts against children, seem to indicate that they are a relatively small group [Glasser, 1990]. This may account for why so little research has been done with this high-profile subdivision. Support for this view may be found in epidemiological studies of 'normal' populations where there have been reports of sexual abuse in childhood, in which relatively few cases fit the description of this subdivision [Levett, 1988]. Finally, this study's use of nonblind assessments makes interpretation of the data open to a certain amount of bias. As far as possible, however, the respondents' exact replies were quoted in the results.

Onset of the disorder: In group A paedophiles paedophilic contact usually began in their early twenties (mean age 23.75 years). However this was preceded by paedophilic fantasy which manifested during puberty (mean age 13.75 years). During adolescence they engaged in sexual experimentation with same age peers of both sexes; only a few engaged in incest or paedophilic activity with younger children. No distinction between the onset of fantasy and that of activity is made by the A.P.A. which reports that for a general population of paedophiles "this disorder usually begins at adolescence although some people with paedophilia, report that they do not become aroused by children until middle age". This finding illustrates the importance of exploring sexual fantasies. Thus if a male exclusive homosexual claimed an onset of paedophilic fantasies during adulthood, one should suspect dishonesty. Furthermore, some paedophiles who are only apprehended in their forties may deny previous activity. By eliciting awareness of paedophilic thoughts or fantasies since puberty it would

greatly assist the clinician in making a definitive diagnosis.

Course: The course of this group's sexual activity is chronic, a finding which supports the DSM-III-R characteristics "especially in those exclusively attracted to boys". An arbitrary period of over six months is defined by the DSM-III-R as one of the diagnostic criteria of this pattern of behaviour. Difficulty lies in identification of the male exclusive homosexual paedophile during his adolescence years. Only one subject reported adolescent sexual activity. This was however of an ephemeral pattern and did not extend over six months. Grubin [1989] reports that adolescent sex offenders differ from adult sex offenders, although 50% of all adult sex offenders begin in adolescence. Mohr and his associates [Mohr, Turner & Jerry, 1964] also identified an adolescent group of child molesters, which were distinguishable from molesters who present at a later age. The author hypothesizes that the majority of paedophilic acts during adolescence are more or less incidental occurrences unlike the typical chronic sustained course found in their adulthood. This fluctuation in course highlights the importance in assessing these patients on a longitudinal axis in order to arrive at a definitive diagnosis.

Group A paedophiles reported chronic persistent sexual fantasies of being "in love" or "being married" to children. They often conducted several relationships simultaneously, although they preferred intimate, enduring partners rather than child prostitutes or irregular sexual contacts. Boys were sometimes molested on average once or twice a week. Relationships of up to 6 years (average 3,1). were described by the subjects. The need for a relationship is not reported in the DSM-III-R. A common deduction

in the literature (including the DSM-III-R) regarding this need for an ongoing relationship is that it merely provides the paedophile with a regular source for expression of his sexual urges. A more probable explanation is that this intense need of love for a child highlights the exclusivity of the sexual preference and may be a characteristic of this specific subdivision.

Family background: This study indicates that the father is usually experienced as distant or removed from the nuclear family structure. In contrast the mother is usually more dominant in her family role. These characteristics are not reported in the DSM-III-R. The Portman Clinic study [Glasser, 1990] and Wilson and Cox [1983] concur that a group of heterogeneous paedophiles report their fathers as emotionally distant while their mothers are portrayed as "over-present, possessive, smothering, intrusive and domineering".

A significant difference between this specific group and the A.P.A. findings was that of the occurrence of sexual abuse in the childhood of paedophiles. This study found that a past history of sexual abuse (including incest) in the childhood of group A paedophiles was rare, unlike heterogeneous paedophiles.

No other members of group A paedophiles' families were reported to have had a paraphilic disorder. This finding contrasts with that of a single study by Gaffney, Lurie & Berlin [1984] who found paedophilic behaviour in 15% of the male relatives of a heterogeneous group of male paedophiles; however this study has not been replicated.

Age of victim: Group A paedophiles reported an attraction to children of a specific age range. The APA Manual specifies that the child is "prepubescent" and "generally 13 years or younger". "Those attracted to girls usually prefer eight-to-ten-year-olds, whereas those attracted to boys usually prefer slightly older boys". Group A paedophiles reported a minimum age limit of 6 years (mean value). The author hypothesizes that other psychopathology is usually evident in those patients who abuse children 5 years or younger. Glasser [1990] reports that as a generalization the younger the victim the more disturbed and dangerous the offender. The importance of such a finding lies in the fact that if the male homosexual paedophile is attracted to children outside the specified range listed above, the clinician should suspect other psychopathology, for example forceful sexual assault (legal rape) or sexual activity of a more polymorphous and varied nature. Furthermore, without specifying the type and subdivisions of child molesters, there is seldom agreement in the findings of studies concerning the ages of the children who are sexually abused.

Attributes of attraction: Group A paedophiles reported that there were no consistent preferred physical characteristics; of more attraction to them was that the child was emotionally needy. Further evidence for this finding of neediness on the part of the child was found in the content of their sexual fantasies. This is a particularly significant addition to the subject, since the APA only mentions that "the stimulus may be highly specific" in paraphilias generally, but does not specify what stimuli are relevant in paedophilia. This study found that this specific subdivision usually have sexual fantasies which are consistent

with their activities (which by definition are exclusive and same sex), however they may also have weak 'opposite sex' sexual fantasies. This raises questions as to whether these subjects were a true representation of this subdivision, or whether this subdivision in fact has a small percentage of sexual fantasies of female children. Support for the latter is found in their activity (over a total period of 56 years between the four subjects) which is consistently directed to male children despite the ample opportunity for sexual activity with girls during these periods.

Relationships with children: The subjects saw the child as the active partner, and themselves as the passive in a mutually rewarding sexual relationship. They steer areas of mutual interest towards their goal of sexual activity with the child. This is premeditated in that they gain the confidence of the child by developing areas of mutual enjoyment and reinforcing this with rewards. They believe that the child is "in love" with them. Persuasion, by increasing attention, acceptance, and recognition of the child, is supplemented with rewards and material gain. Group A paedophiles differs from the general DSM-III-R's description of paedophiles, who do not stress the use of persuasion in the relationship. Groth [1979] in his study of a group of fixated male paedophiles (which excluded child rapists, but included heterosexual paedophiles), similarly describes the manner by which the male exclusive homosexual paedophile establishes a relationship:

> The offender initially establishes a non-sexual relationship with the child in which the child comes to trust and to feel comfortable with the offender. Then

the offender influences the child to engage in sexual activities through the offer of some type of reward, such as candy or money; or by misrepresenting moral standards, such as telling the child that "all boys and girls do this - it's fun"; or through trickery and deception, for example, "this is going to be a game, and we're going to wrestle". The most commonly used technique of luring the child is by capitalizing on the child's need for attention, approval, and human contact. In such situations, the offender spends considerable time with the child, gives the child a lot of attention, and makes the child out to be special or a favorite.

Coercion: In the APA's description of paedophiles' relationships with children they report that "some people with this disorder threaten the child to prevent disclosure" [DSM-III-R]. However the Manual does not specify whether the "threat" is of a physical or emotional nature. An important finding of this study group A paedophiles was that no threat of physical coercion was elicited in the histories. The author's view is that the use of forceful sexual assault (child rape) is usually associated with Antisocial Personality Disorder or with Sexual Sadism [Greenberg, 1990]. This study highlights the insidious unforceful and nonviolent nature of the male exclusive homosexual paedophile's activities. This was further supported by the finding that no other antisocial behaviour was found in this group; in fact all subjects appeared to be law abiding citizens except for their covert sexual activity. In contrast, people with Antisocial or Borderline Personality Disorders often indulge in more promiscuous <u>polymorphous and varied</u> sexual behaviour with child molestation forming only one aspect of their sexual activities. This highlights the importance of differentiating Axis 1 and Axis 2 pathology, and of multiple diagnoses on the DSM-III-R multiaxial

system. Initially the DSM-II had the paraphilias grouped with the character (personality) disorders, however the DSM-III has now placed this group of disorders along with the sexual dysfunctions in a separate section called "the sexual disorders" on Axis 1. The author notes that although one can never fully separate these two axes; with regard to forceful sexual assault the APA have not gone far enough in making this differentiation. Previous history of crime is a useful indicator of subsequent criminality [Soothill & Gibbons, 1978; Christiansen et al., 1965], and therefore if elicited in the CMQ, the clinician should actively look for evidence of coercion when assessing paedophiles. Groth [1979] writes:

> ...the offense is characterized by a lack of physical force in the commission of the offense, and, in fact, the offender generally behaves in counteraggressive ways. Such offenders typically describe their victims in positive terms, such as innocent, clean, loving, open, warm, affectionate, attractive, and undemanding. They entice the child into the sexual encounter and are usually dissuaded if the child actively refuses or resists. They do not resort to force but instead seek out another, more cooperative or accommodating victim. He seeks to control the child more than to injure him/her and most of the time poses a psychological rather than a physical risk to the victim.

He concludes that child rapists are believed to be aetiologically and motivationally more similar to rapists; unlike the exclusive group A paedophiles where the pressures are psychological and the harm done to the child is psychological rather than physical. This distinction is of paramount importance in determining the appropriate disposition and treatment.

Nature of the sexual act: This study found that group A paedo-

philes are not attracted to homosexual men, and do not regard themselves as homosexual. Only one subject engaged in a casual adult homosexual act, but found this sexually ungratifying. Subjects reported that anal penetration could be "painful and messy" for the child and therefore refrained from such activity. They further denied being aroused by anal sex and this was consistent in their content of fantasies. Storr (1964) concurs with this finding. This contrasts with the general characteristics listed for paedophiles by the APA Manual, who report that some "penetrate the child's mouth or anus with their fingers, foreign objects, or penis, using varying degrees of force to achieve these ends". Because the type of sex act in people with fixated paedophilia appears to be highly specific [Groth & Birnbaum, 1978], the author is of the opinion that this may be a fairly specific characteristic of this particular group. It again highlights the importance in differentiating the Axis 2 character pathology, where people with Antisocial Personality Disorders are often "physically cruel" to their victims [DSM-III-R, p.343].

Techniques for obtaining children: This study of a group of male exclusive homosexual paedophiles supports the author's hypothesis that antisocial or assaultive behaviour are not specific characteristics of this (Axis 1) diagnosis. Unlike people with the diagnosis of Antisocial Personality Disorder, group A paedophiles take great care to win the confidence of the parents and form trusted relationships in which they play the role of mentor and protector of the child's interests. This finding clearly distinguishes this exclusive group from the heterogeneous group of paedophiles, who the DSM-III-R notes as obtaining children in various ways, for example abducting children from strangers or

bringing foster children from nonindustrialized countries. It has been documented that child molesters, in general, are not strangers but known to their victims, and are often related to the victim [Conte & Berliner, 1981; Finkelhor, 1980; Russell, 1983]. This contrasts with the Kinsey study [1953], which reported that 70% of the men offenders were strangers. Differences in the literature highlight the importance of defining the study sample with operational definitions and diagnoses.

Pornography: This study found that group A paedophiles may selectively view, read, purchase, collect photographs, films, and textual depictions focusing on his paedophilic type of stimulus. South Africa, in comparison with most first world countries, has strict censorship laws which make the collection of such pornography difficult and uncommon. One subject took his own photographs, while another purchased them from overseas. Tyler [1982] reports that paedophiles often possess a large collection of photographic records of children, which they are reluctant to destroy even when arrest is imminent. Contrary to Ennew's [1986] finding that paedophiles frequently use this material to persuade children to perform sexual acts, male homosexual paedophiles in this study only used such material when masturbating alone.

Associated situational factors: Unlike the DSM-III-R's association of paedophilic behaviour with stress, this study found that these acts are not associated with or precipitated by stress. Howells [1981] concurs with this finding and suggests that they have a compulsive quality about them. This finding has important forensic implications and therefore must be considered when giving expert testimony about the potential recidivism of this

specific group of paedophiles exclusively attracted to male children.

Sex Rings: Group A homosexual paedophiles did not coordinate their activities with other paedophiles in 'sex rings' contrary to DSM-III-R reports that paedophiles trade children. They acted alone and tended to be secretive in their activities; never confiding in friends, colleagues or religious leaders. Similar findings were reported by Groth [1979] with a group of fixated child molesters (which excluded child rapists). This finding seems to make more sense when one considers that their victims are usually fairly dependent prepubescent children and usually in close proximity to their parents or guardians. The children are usually only separated from their parents or guardians when they are placed into centres of safety, for example schools or extra-mural activities. Therefore there is little opportunity to trade children with other paedophiles. The author noted as a general rule of thumb that the older the child molested, the more likelihood that the perpetrator has contact with other people with a similar paedophilic disorder. (This hypothesis will be illustrated in section 4.3 with regard to group B paederasts who sexually molest pubertal and older children.)

Associated paraphilias: This study specifically explored sexual fantasies, thoughts and acts. Group A paedophiles reported no other paraphilias in contrast to the DSM-III-R, which has reported the findings of several researchers who claim that paedophiles suffer from other paraphilias [Abel et al., 1981]. Bancroft [1989] uses the term "polymorphous perverse" to describe this phenomenon (p.341). There may be several reasons for these

differences. Firstly, subjects may be denying these symptoms consciously. Bancroft [1989] reported that exposure to novel kinds of sexual stimulation may eventually result in experimentation. This may have some bearing on the South African context where there is a paucity of exposure to various kinds of pornography and therefore this group of subjects may rather be denying conscious awareness of dormant paraphilias. Secondly, these findings were elicited by self-report ratios of sexual preferences in fantasy and acts in contrast to behavioural assessments using penile phallometry accompanied by novel visual and auditory paraphilic material to elicit responses. However sexual arousal does not always crystallize into behaviour. Evidence for this hypothesis is supported by Schmidt's [1975] study which reports sexual arousal in both men and women by films of rape. The men were sexually aroused by the rape, although this was incompatible with their conscious ideals of sexuality. Finally, this specific subdivision may have the similar characteristic as adult homosexual men, who have a specificity in their sexual stimuli and do not have the polymorphous perversity that is reported with people who have other paraphilias.

Adult relationships: Group A paedophiles were by definition exclusively attracted to boys and this study highlighted their rejection of age-appropriate sexual partners. As reported earlier in this discussion, all subjects reported that they had never been attracted to homosexual men, and do not regard themselves as homosexual. This study found that one subject engaged in casual adult homosexual acts, but found this sexually ungratifying. This finding concurs with Groth's [1979] study. Similarly with a group of adult homosexual men, Groth & Birnbaum [1987] found

that none reported attraction to prepubescent children. Therefore adult homosexuality and homosexual paedophilia do not seem to be synonymous. With regard to adult heterosexual relationships group A paedophiles similarly reported feelings in terms such as "detestable, foreign, revolting and unattractive".

Control of paedophilia: Prior to 1988, few child molesters were prosecuted in the courts; they were usually given fines with a suspended sentence at the first known offence. Although group A paedophiles were warned by parents or dismissed by their employers (who usually took no further legal action), the subjects tended not to voluntarily seek professional help. These findings concur with those in the APA Manual. This study showed that the subjects usually used religious bodies or doctrine to convince members of the community of their sincerity in changing their pattern of behaviour. Without interventions and restrictions, they were unable to voluntarily control their sexual behaviour. These findings have important bearings on expert testimony about potential recidivism given by the forensic psychiatrist to the courts.

Insight: Group A paedophiles displayed impaired insight and did not regard themselves as being mentally or psychologically ill. They see their sexual activities as consenting acts which are beneficial to the development of the child. Instead, they viewed the parents' and society's reaction to the molestation as detrimental to the mental health of the child. Some reported that they were not distressed by their own behaviour, rather by the reaction of society; others report extreme guilt, shame and depression. Paedophilic activities are "commonly explained with

excuses or rationalizations that they have educational value for the child, that the child derives sexual pleasure from them, or that the child was sexually provocative..." [DSM-III-R]. The subjects in this study all reported that the child was "in love" with them, thus highlighting the apparent cognitive distortion that is found in this particular group of peadophiles. Finally, all subjects in this study reported that barring legal restraints they would continue with these activities.

In summary, this study highlights the importance of distinguishing the types and subtypes of child sex abusers. Characteristics described in this section of the study are assumed to be prototypic of male exclusive homosexual paedophiles [not limited to incest], and some of these are either not listed in or are contradictory to the APA Manual and the literature. In addition the description of a group of male exclusive homosexual paedophiles illustrates the utility of the CMQ. The fact that many of the findings elicited by the CMQ concur with those of Groth [1979] who looked at a similar group of male exclusive paedophiles is suggestive of the validity of this instrument.

The above description of a male exclusive homosexual paedophile is of further importance because this particular group has a recidivism rate of roughly twice that of those who prefer the opposite sex [DSM-III-R]. In addition, Abel et al. [1987] found that male child molesters who target boys outside the home had a surprisingly high number of victims compared to other remaining subdivisions. Therefore documenting their paedophilic profile will enable clinicians and the authorities to identify and understand this important group of paedophiles better.

4.3 A comparative description of the characteristics of a group of male exclusive homosexual paederasts [not limited to incest] (Group B paederasts) and Group A paedophiles

In this section first the differences and then the similarities between a specified group of male paederasts and the male paedophiles will be highlighted. There is a paucity of psychiatric and psychological information on the paederast. The APA have excluded this diagnostic group from the DSM-III-R's classification by limiting the age of the child to the prepubescent period of development. The exclusion from the official APA Manual may partly be due to the emergence of powerful lobbyist groups advocating homosexual emancipation by accepting paedophilia into the gay movement [Sandfort, 1987]. Secondly, there has been a growing trend towards calling for the sexual rights of children [Constantine, 1979]. Thirdly, adolescents are more likely to voluntarily participate in sexual relationships (which may or may not generate guilt) and thus they are less likely to report the offence, making the statistical documentation of these offences difficult. The fact that adolescents may be sexually active does not justify their sexual exploitation by adults. The paederast group therefore warrants further scientific study and inclusion into the field of child molestation.

According to this investigation, mothers of male paederasts tended to be more protective and indulgent of these subjects as children than those of homosexual exclusive paedophiles. Group B paederasts unlike Group A paedophiles had been victims of incest during their own adolescent years. Similarly, childhood experience of sexual abuse is more common in this group of paederasts

than in paedophiles. Like group A paedophiles, group B paederasts tended to have few friends, but these were usually homosexual males, unlike the former group who had superficial relationships with females.

The age of initial paraphilic contact tends to be earlier in the paederast (mean age 20 years) than group A paedophiles (mean age 23,75). Sexual fantasies in paederasts tendede to be limited exclusively to boys and may consist of sexual activity with several boys. The sight of the penis was of special significance in their sexual arousal. The paedophile on the other hand may have weak sexual fantasies about girls, although the bulk of his sexual fantasies is about boys.

Sexual targets of the paederast are usually in their pubertal period of development (mean 16 years) with a range extending from puberty to early adulthood (mean range 13-24 years). The paedophile is specifically attracted to pre-pubertal children (mean age 11) with a mean age range from 6-13.5 years. Group B paederasts seems to be more sexually aroused by the physical attributes of the adolescent, whereas the paedophile by the personality. The latter tends to seek emotionally needy children.

In the author's experience the paedophile tends to give a more reliable history of the pattern of child molestation than the paederast in spite of the fact that he acts more secretively and alone in the community. The paederast tends to have more casual relationships with children than the paedophile who prefers more intimate , long-term relationships. The paederast tends to play a concerned father-like role where material rewards are more

likely to be offered. The paedophile on the other hand offers more emotional rewards including attention, recognition and acceptance. He tends to be more deceptive and premeditative in his activities as the child is sexually naive and immature. He later stimulates the child's sexual organs to positively reinforce the sex act. Cognitively he misperceives the child as the active partner. The paederast is more likely to engage in anal sexual contact. While the paedophile takes great care to win the confidence and trust of the parent, thereby placing the child in an emotionally ambivalent predicament, the paederast does not usually make significant contact with the parents.

Although both groups may tend to collect pornography, the paederast usually uses this to sexually arouse the boys, whereas the paedophile tends to utilize this for his own personal arousal. The paederast obtains access to boys in public meeting places such as gay bars, clubs, cinemas, game centres, whereas the paedophile chooses private community areas of trust, such as schools and social or religious clubs. This reflects the lessening dependency of the adolescent on his parents or guardians. The paederast is more likely to be involved in sex-rings, whereas the paedophile tends to acts alone.

The paederast regards himself as homosexual in his sexual orientation, whereas the paedophile reports being unattracted to adult homosexuals and therefore does not identify with adult male homosexuals. In South Africa with the establishment of the Child Protection Unit in 1988, the paederast was more likely to have been identified and prosecuted. Paedophiles are more likely to use religious doctrine to deceive the public and thus regain

access to positions of trust in selected private community areas where they have access to children. With regard to insight, the paedophile tends to highlight the relationship in terms such as "in love" and "being married" to the children whereas the paederast tends to highlight the benefits of his paternal care.

Having noted the differences between these two groups A and B, similarities will be highlighted. Generally, male exclusive homosexual paedophiles and paederasts share similar parental relationships. They both have onset of specific sexually arousing fantasies during early pubertal development. Both are attracted to age-specific children and have a chronic recurrent course of sexual activity. No history of forceful physical assault, stress, alcohol or drugs is apparent in either category. They both are exclusive in their activity and have no heterosexual arousal to female adult nor female children. They are sexually aroused by specific stimuli with no reported other paraphilia, sexual dysfunction or sexual deformity. No other antisocial behaviour besides their sexual offences is apparent. Both groups lack insight into the psychological consequences of their sexual acts on the children and have impaired judgemental capacity with regard to their paraphilic behaviour.

This study found that a group of male exclusive homosexual paederasts could be distinguished from a similar group of paedophiles. Although they have a strong preference for adolescents, they also report sexual attraction to young adults to a far lesser extent. If allowed opportunity they will invariably choose adolescent children and are unlikely to engage in sexual activity with young adults. A study of adult male homosexuals by Groth &

Birnbaum [1987] found that they are unlikely to regress into sexual activity with pubertal children. Male exclusive homosexual paederasts are thus distinguishable from adult male homosexuals. The author is of the opinion that by the APA arbitrarily setting a limit of prepubertal children, an important group of child molesters is being excluded from study and possible detection by mental health workers.

4.4 Recommendations and suggestions for future health needs in South Africa

Emerging from this study of child molesters, it became apparent to the author that the existing Health Services are insufficient for the assessment, treatment and management of child molestation. Professionals who infrequently assess child molesters are usually inadequately trained to deal with such patients and often fail to appreciate the potential risks for the community. Expert testimony is being given by ill-qualified mental health professionals to ill informed judiciary with capricious results in the sentencing of offenders. For example, an experienced psychologist in private practice recently gave expert testimony to the court that a male homosexual paedophile working as a school headmaster had committed these acts "in isolation" and "none of the children was psychologically harmed". He recommended that the offender receive "short-term psychotherapy" [Bavuma, 1990]. There is a need for education about the perpetrators of child sexual molestation for professionals, judiciary, prison services and the police. Although much has been done to create awareness of the victims of child sex abuse, little attention has been given to the perpetrators of these offences. Some researchers are now calling for Forensic Sexology (the sexology of paraphiacs and all sexual offences, for example rapists which includes the assessment, management and treatment) to be recognised as a speciality in its own right [Money, 1990]

Imprisonment alone is insufficient to remedy the underlying causes of this problem [Groth, 1979]. There is presently no psychiatric facility available where people convicted of a sexual

assault could be sent for diagnostic assessment. If such a facility were created, treatment for suitable candidates could then be included as part of their sentence. Sex offenders who are likely to repeat a sexual offence and are assessed as poor candidates for treatment could be committed (indefinitely in severe cases) to a fixed prison sentence. However there should be no special grounds for distinguishing child molesters as a unique class of legal offender. The need for treatment can only be determined on clinical grounds. The type of offending behaviour is not directly related to the need for treatment and cannot be used as a basis for a specialised type of sentencing. If therapy becomes a sentence in itself, then criminal law is in danger of becoming arbitrary and capricious, and psychiatry becomes a weapon in the control of social deviance. Psychiatry will not solve the problem of crime and is, at best, only part of the answer for child molestation (Glaser, 1988). Goals or expectations of therapy should not be for a complete cure. Rather more limited goals should be defined that will enable the molester to control his deviant impulses. Parole could be considered following a good response to therapeutic interventions. Concern for the safety and welfare of children, the interests of society, and fairness towards the child molester must all be included in these decisions.

A major problem encountered with treatment of child molesters is how to measure the effects of the programme. In a review of recidivism, Furby, Weinrott & Blackshaw [1989] report that few of the statutory treatment programmes in the USA resulted in lower recidivism rates than those of untreated child molesters. They note the problems in defining the term 'recidivism': does it

refer to repeating the behaviour, rearrest, or reconviction? They report that out of six studies, five appeared to show that treatment actually worsened the recidivism rate. In contrast Barnard et al. [1989] reports that a high percentage of child molesters who remain in therapy show considerable change during the treatment process. An important finding by Furby and his colleagues [1989] was that parole supervision after treatment appeared to improve the recidivism substantially, compared with treatment without supervision.

Society, and in particular clinicians, are beginning to accept more fully their responsibilities with respect to child sexual abuse and are recognising child molestation as a crucial and worthy field of study. Research is needed in the quest for reliable and valid assessment instruments for child molesters. The CMQ's exploration of sexual fantasies and ratios of sexual preference by self-report proved to be of significant value in these assessments but is limited by its reliance on the truthfulness of the alleged offender and thus requires further investigation. Classification systems that concentrate on the interpretation of behaviour should be avoided. Instead, future studies of specific types and subdivisions of child molesters based on demographic, family and behavioural characteristics which are more reliably determined, should prove to be of more clinical value. The DSM-III-R needs further revision to include the paederast and to clarify which characteristics are specific to which subtypes of paedophilia. These empirical developments described and discussed in this dissertation can be viewed as indicating "the coming-of-age of deviant sexuality as a scientifically reputable topic that is potentially capable of being mapped, understood,

and approached with viable treatment modalities" [Lanyon 1986, p.177].

REFERENCES

Abel,G.G., Blanchard,E.B., & Becker,J.V. (1978). An integrated treatment program for rapists. In R.T.Rada (Ed.). Clinical Aspects of the Rapist. New York: Grune & Straton, p.161-214.

Abel,G.G., Becker,J.V., Murphy,W.D., & Flanagan,B. (1981). Identifying dangerious child molesters. In R.B.Stuart (Ed.), Violent behavior: Social learning approaches to prediction, management and treatment. New York: Brunner\Mazels, p.161-137.

Abel,G.G., Becker,J.V., Mittleman,M., Cunningham-Rathner,J., Rouleau,J.L. & Murphy,W.D. (1987). Self report ed sex crimes of nonincarcerated pharaphiliacs. Journal of Interpersonal Violence, 2:3.

American Psychiatry Association (1968). Diagnostic and Statistical Manual of Mental Disorders, Second Edition (DSM-II). Wshington,D.C.: American Psychiatric Association.

American Psychiatric Association (1987). Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R). Washington,D.C.: American Psychiatric Association.

Avery-Clark,C.A., & Laws,D.R. (1984). Differential erection response patterns of sexual child abusers to stimuli describing activities with children. Behavior Therapy, 15:71-83.

Bancroft,J. (1989). Human sexuality and its problems. Edinburgh: Churchill Livingstone.

Barlow,D.H. (1977). Assessment of sexual behaviour. In A.R.Ciminero, K.S.Calhoun and H.E.Adams (Eds.),Handbook of behaviour assessments, New York: Wiley.

Barnard,G.W., Fuller,A.K., Robbins,L. & Shaw,T. (1989). The Child Molester: An Integrated Approach to Evaluation and Treatment. New York: Brunner/Mazel.

Bavuma,V. (1990, May 30). Retired head guilty of indecent acts with pupils. The Argus, p.5.

Brown,N. (1985). Historical perspectives on child abuse. In A.Downer (Ed.), Prevention of Child Sexual Abuse: A Trainer's Manual. Seattle, WA: Seatle Institute for Child Advocacy Committee for Children.

Christiansen,K.O., Elers-Nielson,M., le Maire,L. and Sturup,G.K. (1965). Recidivism among sexual offenders. In K.O.Christiansen (Ed.), Scandinavian Studies in Criminology, Vol.1, London:Tavistock, p.55-85.

Constatine,L. (1979). The sexual rights of children: implications of a radical perspective. In M.Cook & G.Wilson (Eds.), Love and attraction. Oxford: Pergamon.

Conte,J.R. (1985). Clinical dimensions of adult sexual abuse of children. Behavioral Science & Law, 3:341.

Conte,J.R., & Berliner,L. (1981). Sexual abuse of children: implications for practice. Social Casework, 62:601-606.

Devil cult. (1990, May 19). Cape Times, p. 1.

Earls,C.M., and Marshall,W.L. (1983). The current state of technology in the laboratory assessment of sexual arousal patterns. In J.G.Greer and I.R.Stuart (Eds.), The sexual aggressor: current perspectives on treatment. New York: Van Nostrand.

Ennew,J. (1986). The sexual exploitation of children. London: Polity Press.

Erickson,E.H. (1963). Childhood and society, (2nd. ed.). New York: Norton.

Erickson,J.D., Walbek,N.H., and Seely,R.K. (1988). Behavior patterns of child molesters. Archives of Sexual Behavior, 17:1:77-86.

Finkel,K.C. (1987). Sexual abuse of children: an update. Canadian Medical Association Journal, 136:245.

Finkelhor,D. (1980). Sex among siblings: a survey on prevalence, variety and effects. Archives of Sexual Behaviour, 9: 171-194.

Finkelhor,D. (1984). Child Sexual Abuse: New Theory and Research. New York: Free Press.

Finkelhor,D. (1987). The sexual abuse of children: Current research reviewed. Psychiatric Annals, 17: 233.

Finkelhor,D. and Araji, S. (1986). Explinations of paedophilia: a four factor model. Journal of Sex Research, 22:145-161.

Finkelhor,D., & Russell,D. (1984). Women as perpetrators. In D.Finkelhor, Child Sexual Abuse: New Theory and Research. New York: Free Press.

Fitch,J.H. (1962). Men convicted of sexual offences against children. British Journal of Criminology, 3: 18-37.

Freud,S. (1955). Further remarks on the neuro-psychoses of defence. In J.Strachey (Ed.), The Complete Psychological Works of Sigmund Freud, Vol. III. London: Hogarth Press, p. 162-185.

Freund,K., Heasman,G.A., and Roper, V. (1982). Results of the main studies on sexual offences against children and pubescents: A review. Canadian Journal of Criminalogy, 24:387-397.

Freund,K., & Langevin,R. (1976). Bisexuality in homosexual pedophilia. Archives of Sexual Behavior, 5: 415-423.

Furby,L. Weinrott,M.R. and Blackshaw,L. (1989). Sex offender recidivism. Psychological Bullitin, 105:3-30.

Gaffney,G.R., Lurie,S.F., and Berlin,F.S. (1984). Is there familial transmission of paedophilia? Journal of Nervous and Mental Disease, 172, 9:546-548.

Gibbons,T.C.N., Soothhill,K.L., and Way,C.K. (1981). Sex offences against young girls: a long-term record study. Psychological Medicine, 11:351-357.

Glaser, W.F. (1988). Treatment or sentence for child molesters: a comparison of Australian offenders with a general prison population. International Journal of Law and Psychiatry, 11:145-156.

Glasser,M. (1990).Paedophilia. In R.Bluglass & P.Bowden (Eds.), Principles and Practice of Forensic Psychiatry, Edinburgh: Churchill Livingstone, p. 739-748.

Greenberg,D.M. (1990). Treatment of child sex offenders. Medical Sex Journal of South Africa, 1,1:9-11.

Grossman,L.S. (1985). Research directions in the evaluation and treatment of sex offenders: An analysis. Behavioral Sciences & the Law, 3: 41.

Groth,A.N. (1978). Patterns of sexual assault against children and adolescents. In A.W.Burgess, A.N.Groth, L.L.Holmstrom, & S.M.Sgroli (Eds.), Sexual Assault of Children and Adolescents. Lexington, MA: Lexington.

Groth,A.N., & Birnbaum,H.J. (1978). Adult sexual orientation and attraction to underage persons. Archives Sexual Behavior, 7:175-181.

Groth,A.N. (1979). Men who rape: the psychology of the offender, Plenum Press, New York.

Groth,A.N., Hobson,W.F., & Gary,T.S. (1982). The Child Molester: Clinical Observations. In J.Conte & D.A.Shore (Eds.) Social work and child sexual abuse, New York: Hawthorn. p. 129-144.

Grubin,D.H., & Kennedy,H.G. (1989). Sexual Deviancy. Current Opinion in Psychiatry, 2:745-749.

Hall,G.C.N., Procter,W.C., and Nelson,G.M. (1988). Validity of physiological measures of pedophilic sexual arousal in a sexual offender population. Journal of Consulting and Clinical Psychology, 56:118-122.

Hartwich,A. (1959). Abberations of Sexual Life after the "Psychopathia Sexualis" of Dr.R.V. Krafft-Ebing (translated by A.V. Burbury), London: Staples Press.

Henn,F.A., Herjanic,M. and Vanderpearl,R.H. (1976). Forensic psychiatry: profiles of two types of sex offenders. American Journal of Psychiatry, 6: 694-696.

Howells,K. (1981). Adult sexual interest in children: considerations relevant to theories of aetiology. In M.Cook & K.Howells (Eds.), Adult sexual abuse in children, Acedemic Press, London. p.55-94.

Karpman,B. (1964). The sexual offender and his offences. New York: Julian Press.

Kinsey,A.C., Pomeroy,W.B., Martin,C.E., and Gebhard,P.H. (1953). Sexual behaviour in the human female, Philadelphia: Saunders.

Kritzinger,M.S., Schoonees,P.C. and Cronje,U.J. (Eds.). (1972). Groot woordeboek afrikaans - engels. Pretoria: J.L. van Schaik Beperk.

Landis,J.J. (1956). Experiences of 500 children with adult sexual deviation. Psychiatric Quarterly Suppliment, 30:91-109.

Langevin, R. (1983) Sexual strands. Erlbaum Assoc., Hillsdale New Jersy.

Langevin,R., Hucker,S.J., Handy,L., et.al (1985). Erotic preference and aggression in paedophilia: a comparision of heterosexual, homosexual and bisexual types. In Langevin.R.(ed.) Erotic preference, gender identity and aggression in men: new research studies. Laurence Erlbaum Assoc., New Jersy.

Lanyon,R.I. (1986). Theory and treatment in child molestations. Journal of Consulting and Clinical Psychology, 54: 176.

Levett,A. (1988). Psychological Trauma: Discourses of childhood sexual abuse. Unpublished doctural thesis, University of Cape Town, Cape Town.

Marshall,W.A. and Tanner,J.M. (1969). Variations in the pattern of pubertal changes in girls. Archives of Diseases in Child., 44:291.

Marshall,W.A. and Tanner,J.M. (1970). Variations in the pattern of pubertal changes in boys. Archives of Diseases in Child., 45;13.

Money, J. (1990). Forensic sexology: paraphilic serial rape (biastophilia) and lust murder (erotophonophilia). American Journal of Psychotherapy, 64: 26-36.

Mrazek,F.J. (1984). Sexual abuse of children. In B.Lahey & A.E.Kazdin (Eds.), Advances in child clinical psychology, Plenum Press, New York, (vol.6, p.199-215).

Mrazek, P.B., Lynch,M., & Bentovim, A. (1981). Recognition of child sexual abuse in the United Kingdom. In P.B.Mrazek & C.H.Kempe (Eds.), Sexual abused children and their families Pergamon Press, Oxford, p.35-49.

Mohr, J.W., Turner, R.W. and Jerry, M.B. (1964) Pedophilia and exibitionism. University of Toronto Press, Toronto.

Panton,J. (1978). Personality differences between rapists of children and nonviolent sexual molesters of female children. Res. Comm. Psych. Psychiat. Behaviour, 3: 385-393.

Paitich,D., Langevin,R., Freeman,R., Mann,K., and Handy, L. (1977). The Clarke SHQ: A clinical sex history questionaire for males. Archives of Sexual Behavior, 6:421-436.

Phelan,P. (1986). The process of incest: Biologic father and stepfather families. Child Abuse & Neglect, 10: 531.

Quinsey,V.L., Arnold,L.S., & Pruesse,M.G. (1980). MMPI profiles of men referred for a pretrial psychiatric assessment as function of offense type. Journal of Clinical Psychology, 36: 410.

Quinsey,V.L., & Marshall,W.L. (1983). Procedures for reducing inappropiate sexual arousal: An evaluation review. In J.G.Greer & I.R.Stuart. (Eds.). The Sexual Aggressor: Current Perspectives on Treatment. New York: Van Nostrand.

Rada,R.T. (1976). Alcoholism and the child molester. Annuals N.Y. Acad. Sci., 237: 492-496.

Riddle,C. (1989,September). "Media Crime Wave", paper presented to the Proceedings of the 3rd Biennial Conference of the South African Society for Prevention of Child Abuse and Neglect.

Robertson,B.A. (1989). Child sexual abuse. Southern African Journal of Child and Adolescent Psychiatry, 1: 32-38.

Rossman,P. (1979). Sexual experience between men and boys. London: Maurice Temple Smith Ltd.

Rowan,E.L. (1988). Predicting the effectiveness of treatment for paedophilia. Journal of Forensic Sciences, 33: 204-209.

Russell,D.E.H. (1983). The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. Child Abuse & Neglect, 7: 133-146.

Sandfort,T. (1987). Paedophilia and the gay movement. Journal of Homosexuality, 13: 89-110.

Schmidt,G. (1977). Male-female differences in sexual arousal and behaviour during and after exposure to sexually explicit stimuli. Archives of Sexual Behaviour, 4: 353-366.

Soothill,K.L., and Gibbens,T.C.N. (1978). Recidivism of sexual offenders:a re-appraisal. British Journal of Criminology, 18:267-276.

State v. D. (1989). The S.A. Law Report, C.P.D., 210.

Stedman's Medical Dictionary (1976) Williams and Wilkens, Baltimore.

Storr,A. (1964). Paedophilia: Sexual Deviation. London: Penguin, p.100-108.

Tanner, J.M.(1978). Foetus into Man: Physical Growth from Conception to Maturity. London: Open Books.

Travin,S., Bluestone,H., Coleman,E., Cullen,K., and Melella,J. (1986). Pedophile types and treatment perspectives. Journal of Forensic Sciences, 31:614-620.

Tyler T. (1982). "Child pornography: The international exploitation of children",paper presented to the 4th International Congress on Child Abuse and Neglect.

Wilson,G.D. (1980). Sexual Fantasy Questionaire. In C.S. Cosselin and G.D.Wilson. Sexual Variations: Fetishism, Sadomasochism and Transvestism. London: Faber and Faber.

Wilson,G.D., and Cox,D.N. (1983). The Child Lovers. Peter Owen, London.

Sexual Disorders

(Extracts from: American Psychiatric Association (1987). Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised.)

The Sexual Disorders are divided into two groups. The Paraphilias are characterized by arousal in response to sexual objects or situations that are not part of normative arousal-activity patterns and that in varying degrees may interfere with the capacity for reciprocal, affectionate sexual activity. The Sexual Dysfunctions are characterized by inhibitions in sexual desire or the psychophysiologic changes that characterize the sexual response cycle. Finally, there is a residual class, Other Sexual Disorders, for disorders in sexual functioning that are not classifiable in any of the specific categories.

PARAPHILIAS

The essential feature of disorders in this subclass is recurrent intense sexual urges and sexually arousing fantasies generally involving either (1) nonhuman objects, (2) the suffering or humiliation of oneself or one's partner (not merely simulated), or (3) children or other nonconsenting persons. The diagnosis is made only if the person has acted on these urges, or is markedly distressed by them. In other classifications these disorders are referred to as Sexual Deviations. The term *Paraphilia* is preferable because it correctly emphasizes that the deviation (para) lies in that to which the person is attracted (philia).

For some people with a Paraphilia, paraphilic fantasies or stimuli may always be necessary for erotic arousal and are always included in sexual activity, if not actually acted out alone or with a partner. In other cases the paraphilic preferences occur only episodically, for example, during periods of stress; at other times the person is able to function sexually without paraphilic fantasies or stimuli.

The imagery in a paraphilic fantasy is frequently the stimulus for sexual excitement in people without a Paraphilia. For example, female undergarments are sexually exciting for many men; such fantasies and urges are paraphilic only when the person acts on them or is markedly distressed by them.

The imagery in a Paraphilia, e.g., of being humiliated by one's partner, may be relatively harmless and acted out with a consenting partner. More likely it is not shared by the partner, who consequently feels erotically excluded from the sexual interaction. In more extreme form, paraphilic imagery is acted out with a nonconsenting partner, and may be injurious to the partner (as in Sexual Sadism) or to the self (as in Sexual Masochism).

The Paraphilias included here are, by and large, conditions that have been specifically identified by previous classifications. Some of them are relatively common in clinics that specialize in the treatment of Paraphilias and other sexual behavior problems (e.g., Pedophilia, Voyeurism, and Exhibitionism); others are much less commonly seen in such settings (e.g., Sexual Masochism and Sexual Sadism). Because some of these disorders are associated with nonconsenting partners, they are of legal and social significance. People with these disorders tend not to regard themselves as ill, and usually come to the attention of mental health professionals only when their behavior has brought them into conflict with sexual partners or society.

The specific Paraphilias described here are: (1) Exhibitionism, (2) Fetishism, (3) Frotteurism, (4) Pedophilia, (5) Sexual Masochism, (6) Sexual Sadism, (7) Transvestic Fetishism, and (8) Voyeurism. Finally, there is a residual category, Paraphilia Not Otherwise Specified, for noting the many other Paraphilias that are less commonly encountered, or have not been sufficiently described to date to warrant inclusion as specific categories.

People with a Paraphilia commonly suffer from several varieties: in clinical settings that specialize in the treatment of Paraphilias, people with these disorders have an average of from three to four different Paraphilias. People with Paraphilias may also have other mental disorders, such as Psychoactive Substance Use Disorders or various Personality Disorders. In such cases multiple diagnoses should be made.

Criteria for the severity of the manifestations of a specific Paraphilia are provided. These guidelines distinguish, first, people who do not act on their paraphilic urge(s) from those who do. It is recognized, however, that this distinction in some cases may be more a function of various personality traits (such as the presence or absence of antisocial personality traits), the severity of psychosocial stressors, and the presence of a Psychoactive Substance Use Disorder than of factors inherent in the Paraphilia itself. The second distinction made in these guidelines is between people who have occasionally acted on a paraphilic urge and those who repeatedly do so. Again, the factors noted above rather than ones inherent in the Paraphilia itself may be involved in this distinction.

Among other clinical considerations besides severity of the manifestations are the degree to which the person requires the paraphilic imagery or fantasy for sexual arousal, the extent to which the person has harmed others or himself or herself, the degree of subjective distress, and, finally, the social or occupational impairment that is the direct result of Paraphilia-related behavior.

Associated features. Specific paraphilic imagery is selectively focused on and sought out by people with one or more Paraphilias. The person may select an occupation or develop a hobby or volunteer work that brings him into contact with the desired stimuli (e.g., selling women's shoes or lingerie in Fetishism, working with children in Pedophilia, or driving an ambulance in Sexual Sadism). The person may selectively view, read, purchase, or collect photographs, films, and textual depictions focusing on his preferred type of paraphilic stimulus.

The preferred stimulus, even within a particular Paraphilia, may be highly specific, such as ten-year-old blond boys with a light complexion and thin habitus. People who do not have a consenting partner with whom their fantasies can be acted out may purchase the services of prostitutes or others who provide specialized Paraphilia-related services (e.g., "bondage and domination" or "cross-dressing lessons") or may act out their fantasies with unwilling victims.

Frequently people with these disorders assert that the behavior causes them no distress and that their only problem is the reaction of others to their behavior. Others

report extreme guilt, shame, and depression at having to engage in an unusual sexual activity that is socially unacceptable or that they regard as immoral. There is often impairment in the capacity for reciprocal, affectionate sexual activity, and Sexual Dysfunctions may be present. Personality disturbances, particularly emotional immaturity, are also frequent, and may be severe enough to warrant an Axis II diagnosis of a Personality Disorder.

Impairment. Social and sexual relationships may suffer if others, such as a spouse (approximately one-half of the people with Paraphilias seen clinically are married), become aware of the unusual sexual behavior. In addition, if the person engages in sexual activity with a partner who refuses to cooperate in the unusual behavior, such as fetishistic or sadistic behavior, sexual excitement may be inhibited and the relationship may suffer. In some instances the unusual behavior, e.g., exhibitionistic acts or the collection of fetishes, may become the major sexual activity in the person's life.

Complications. In Sexual Masochism, the person may suffer serious physical damage. Paraphilias involving another person, particularly Voyeurism, Exhibitionism, Frotteurism, Pedophilia, and Sexual Sadism, often lead to arrest and incarceration. Sexual offenses against children constitute a significant proportion of all reported criminal sex acts. People with Exhibitionism, Pedophilia, and Voyeurism make up the majority of apprehended sex offenders.

Predisposing factors. With the exception of Pedophilia (see p. 285) and Transvestic Fetishism (see p. 289), there is no information about predisposing factors.

Prevalence. The disorders are rarely diagnosed in general clinical facilities. However, judging from the large commercial market in paraphilic pornography and paraphernalia, the prevalence in the community is believed to be far higher than that indicated by statistics from clinical facilities. Because of the highly repetitive nature of paraphilic behavior, a large percentage of the population has been victimized by people with Paraphilias.

Sex ratio. Except for Sexual Masochism, in which the sex ratio is estimated to be 20 males for each female, the other Paraphilias are practically never diagnosed in females, but some cases have been reported.

Familial pattern. No information.

Criteria for severity of manifestations of a specific Paraphilia

Mild: The person is markedly distressed by the recurrent paraphilic urges but has never acted on them.

Moderate: The person has occasionally acted on the paraphilic urge.

Severe: The person has repeatedly acted on the paraphilic urge.

302.20 Pedophilia

The essential feature of this disorder is recurrent, intense, sexual urges and sexually arousing fantasies, of at least six months' duration, involving sexual activity with a prepubescent child. The person has acted on these urges, or is markedly distressed by them. The age of the child is generally 13 or younger. The age of the person is arbitrarily set at age 16 years or older and at least 5 years older than the child. For late adolescents with the disorder, no precise age difference is specified, and clinical judgment must be used; both the sexual maturity of the child and the age difference must be taken into account.

People with Pedophilia 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. Those attracted to girls usually prefer eight-to-ten-year-olds, whereas those attracted to boys usually prefer slightly older children. Attraction to girls is apparently twice as common as attraction to boys. Many people with Pedophilia are sexually aroused by both young boys and young girls.

Some people with Pedophilia are sexually attracted only to children (exclusive type), whereas others are sometimes attracted to adults (nonexclusive type).

People with this disorder who act on their urges with children may limit their activity to undressing the child and looking, exposing themselves, masturbating in the presence of the child, or gentle touching and fondling of the child. Others, however, perform fellatio or cunnilingus on the child or penetrate the child's vagina, mouth, or anus with their fingers, foreign objects, or penis, and use varying degrees of force to achieve these ends. These activities are commonly explained with excuses or rationalizations that they have "educational value" for the child, that the child derives "sexual pleasure" from them, or that the child was "sexually provocative"—themes that are also common in pedophilic pornography.

The person may limit his activities to his own children, stepchildren, or relatives, or may victimize children outside his family. Some people with the disorder threaten the child to prevent disclosure. Others, particularly those who frequently victimize children, develop complicated techniques for obtaining children, which may include winning the trust of a child's mother, marrying a woman with an attractive child, trading children with others with the disorder, or, in rare instances, bringing foster children from nonindustrialized countries or abducting children from strangers.

Except in cases in which the disorder is associated with Sexual Sadism, the person may be generous and very attentive to the child's needs in all respects other than the

sexual victimization in order to gain the child's affection, interest, and loyalty and to prevent the child from reporting the sexual activity.

Age at onset. The disorder usually begins in adolescence, although some people with Pedophilia report that they did not become aroused by children until middle age.

Course. The course is usually chronic, especially in those attracted to boys. The frequency of pedophilic behavior often fluctuates with psychosocial stress. The recidivism rate for people with Pedophilia involving a preference for the same sex is roughly twice that of those who prefer the opposite sex.

Predisposing factors. Many people with this disorder were themselves victims of sexual abuse in childhood.

Differential diagnosis. Isolated sexual acts with children do not necessarily warrant the diagnosis of Pedophilia. Such acts may be precipitated by marital discord, recent loss, or intense loneliness. In such instances the desire for sex with a child may be understood as a substitute for a preferred but unavailable adult. When pedophilic behavior involves a family member (incest), a diagnosis of Pedophilia should be made if the diagnostic criteria are met. In such cases there often is pedophilic behavior with children outside the family. In **Mental Retardation, Organic Personality Syndrome, Alcohol Intoxication,** or **Schizophrenia** there may be a decrease in judgment, social skills, or impulse control, particularly in the elderly, that, in rare instances, leads to isolated sexual acts with children; but in such cases sexual activity with children is generally not the consistently preferred method for achieving sexual satisfaction.

In **Exhibitionism,** exposure may be to a child, but the act is not a prelude to further sexual activity with the child. **Sexual Sadism** may, in rare instances, be associated with Pedophilia, in which case both diagnoses are warranted.

Diagnostic criteria for 302.20 Pedophilia

A. Over a period of at least six months, recurrent intense sexual urges and sexually arousing fantasies involving sexual activity with a prepubescent child or children (generally age 13 or younger).

B. The person has acted on these urges, or is markedly distressed by them.

C. The person is at least 16 years old and at least 5 years older than the child or children in A.

Note: Do not include a late adolescent involved in an ongoing sexual relationship with a 12- or 13-year-old.

Specify: same sex, opposite sex, or **same and opposite sex.**

Specify if **limited to incest.**

Specify: exclusive type (attracted only to children), or **nonexclusive type.**

APPENDIX : B

PSYCHIATRIC HISTORY AND EXAMINATION

This scheme should be followed for the sake of uniformity and accessibility, but the data may of course be collected in the most convenient way. Facts and evidence should be stated in plain language rather than technical terms, and verbatim reports of what the patient says should be included especially concerning auditory hallucinations. Also examples of abnormal speech. Subjective and objective data should not be mixed, nor should details of the history and psychiatric examination. Formulation must be recorded. If information is gathered from relatives or friends, state the informant's name, relation to the patient, intimacy and length of acquaintance, impression of reliability, etc. Do not confuse such accounts with information obtained from the patient.

METHOD AND REASON FOR REFERRAL

Include the section of the Mental Health Act under which the patient is admitted if relevant. Name and address of the referring doctor or agent.

PRESENT ILLNESS

A detailed coherent account in chronological order of the illness from the earliest time at which a change was noticed. Ask yourself the question "What has brought this patient to seek help at this time ?" Let the patient tell his or her story in his or her own way.

LIFE EVENTS List the events (with dates) which have caused significant changes, impact or disturbance (either positive or negative) in his or her life during the last few years. Indicate the degree of severity (include police or legal contact, work, health, love and marriage, financial, family etc.)

HIGHEST LEVEL OF ADAPTIVE FUNCTIONING achieved during the last year. This should be described in terms of the breadth and quality of inter-personal relationships, occupational functioning and use of leisure time. Depth of involvement is the key note of this assessment. Also assess energy and initiative - sustained or fitful, easily fatigued, decline, etc. (see Appendix 3 for categories of severity)

FAMILY HISTORY

Construct a geneogram including grandparents and close family members.

Biological parents (and adoptive parents, if any) : Health, age, or age at time of death, and cause of death. Their personalities, relationships, occupations.

Other significant family figures including grandparents, other relatives, foster parents, etc.

Siblings: Enumerate in chronological order of birth with first names, ages, marital status, occupation, health or illness, personality. Miscarriages and stillbirths to be included.

Home atmosphere and influence : Assess family functioning, relationships and values in patient's formative years. Note any source of stress, e.g. marital tension, uprooting, social class.

Familial, psychiatric and medical illnesses : Note particulars which might be needed for further enquiries, e.g. names of hospitals where relatives might have been treated.

PERSONAL HISTORY

EARLY HISTORY

Pregnancy and birth : Mother's health during pregnancy. Date of birth and place. Full term birth? Normal delivery? Breast or bottle-fed? Wanted baby or not? Illegitimate?

Early development : Health and setbacks. Milestones of development, e.g. sitting up, walking, talking, bowel control.

Neurotic symptoms in childhood : Night terrors, sleep-walking, tantrums, bed-wetting, food fads, stammering, mannerisms, fear-states, model child, etc.

Health during childhood: Infections, convulsions, operations.

EDUCATION

School : Age of beginning. School changes, standard reached and age of leaving. Evidence of adaptability, ability, backwardness or disabilities. Hobbies, sports and interests. Relationship to teachers and schoolmates. Nicknames.

Further education and training (technical, university, etc.)

PSYCHOSEXUAL MATURATION

Sexual inclinations and practices : Heterosexual experiences apart from marriage. Sexual information, how received. Masturbation - age, frequency, guilt. Sexual fantasies. Homosexuality.

Menstrual History : Age at first period. Regularity, duration and amount. How regarded. Pain, premenstrual tension or psychic changes. Climacteric symptoms. Date of last period.

Marriage : Duration of acquaintance before marriage and of engagement. Wife/husband's age, occupation, personality. Compatibility. Mode and frequency of sexual intercourse, satisfaction, impotence or frigidity. Contraceptive measures. Chronological list of children and miscarriages, giving ages, names, personality, etc.

OCCUPATION : Age of starting work. Jobs held in chronological order with wages, dates, reasons for change. Longest job held. Present economic circumstances and highest level of employment in the previous year. Ambitions. Satisfaction in work or reasons for dissatisfaction.

ACTIVITIES : Religion and religious contact, leisure activities, hobbies, sports, etc.

HABITS : Alcohol, tobacco, drugs; specify amount taken (recently and earlier). Sleeping; excretory functions; appetite; eating fads; weight loss.

PRESENT DOMESTIC CIRCUMSTANCES : Where living, with whom, income, social supports including social agencies involved.

PREVIOUS ILLNESSES

Medical - Illnesses, operations, and accidents (chronological and in detail).

Psychiatric - (detailed account). Dates, duration, symptoms, where treated and the psychiatrist concerned.

BASIC PERSONALITY

Aim at giving a flesh and blood picture of the person. The following are guidelines.

Social and interpersonal relations in respect of family, friends, groups, workmates. Leader, follower, organiser, aggressive, submissive, adjustable, etc.

Intellectual activities and interests : books, films preferred. Fantasy life, day-dreaming - frequency and content. Hobbies.

Mood : Cheerful, despondent, anxious, worrying, optimistic, pessimistic, self-deprecating, satisfied, over-confident, stable, fluctuating (with or without occasion), controlled, demonstrative, etc.

Personality Traits : Withdrawn, suspicious, cold, aloof, jealous. Resentful, unstable, aggressive, stubborn. Impulsive, egocentric, overly dramatic, exhibitionistic. Timid, self-conscious, poor self-image. Dependent, passive, unconfident. Always happy, unstable mood, emotionally over-reactive. Strict, perfectionistic, rigid. Narcissistic, envious.

Values : Moral, religious, political, etc. Attitude towards self, others, health, own body, interests, work and ambitions.

PSYCHIATRIC EXAMINATION (MENTAL STATE)

GENERAL APPEARANCE, BEHAVIOUR AND SPEECH

A description as complete, accurate and lifelike as possible of what you observe.

Appearance - grooming, neatness, mode of dress and unusual features.

Behaviour - eye contact, posture, psychomotor activity such as agitation, excitement or abnormal slowness, irreverant or embarrassing behaviour, distractability, objective evidence of hallucinations, mannerisms or stereotypies, catatonic symptoms.

Speech - this refers to utterance and may range from muteness through slowness, delayed responses and restricted quantity to rapidity and pressure of talk. Note tone of voice, clarity and speech difficulties. (Content of speech is covered under THINKING below).

AFFECT AND MOOD

Affect (the external manifestations of internal feeling judged from the patient's general demeanour, facies and expressed ideas). Note emotional responses during the interview. Also anxiety, depressive demeanour, hypomanic or histrionic, suspiciousness, perplexity. Restriction, blunting, flattening, liability or incongruity of affect.

Mood (pervasive feeling tone not related to an object) Ask "How do you feel in yourself?" "What is your mood?" "How does the future look?" Enquire for suicidal ideas.

THINKING

(the capacity to manipulate symbols in the form of words, images and ideas)

Organisation of Thought

Flow - tempo: retardation, rapidity, flight of ideas, blocking, poverty of ideation, perseveration, echolalia.
Form - abnormalities of structure such as vagueness, incoherence, condensation, loss of direction, distortions, displacement of words and ideas, lack of association of ideas, overinclusiveness, talking past the point, idiosyncratic use of words, neologisms. Give verbatim examples.

Possession of Thought

Subjective experiences which the person feels are outside his control such as withdrawal, insertion or broadcasting of thoughts, or thoughts being read or influenced by others. These are commonly delusional in nature. Obsessional thoughts (ideas that enter the mind against the person's will and cannot be resisted although they are recognised as abnormal).

Content of Thought

Delusions (false and unshakeable beliefs that can cover a wide variety of experiences including ideas, perceptions and moods). For example, a conviction of control by others, ideas of reference or influence, catastrophic delusions, etc.

Delusions may be partial if expressed with doubt or full if held with complete conviction.
Note: Check for social and cultural appropriateness.

Perception

Distortions - changes in intensity, quality or form of sights and sounds. Derealisation and depersonalisation.
Illusions - false or misinterpreted perceptions arising from an external stimulus, for example a mark on the wall looks like a snake.

Perception (continued)

Hallucinations - These may occur in any sensory modality. Ask, "I should like to ask you a routine question which we ask of everybody: do you ever seem to hear noises or voices when there is no one about and nothing to explain it?"

Auditory hallucinations may occur in the form of non-verbal sounds or mutterings, as voices speaking to the person, discussing him/her in the third person, or commenting. Rate as a true hallucination if heard through the ears or a pseudo-hallucination if heard in the head. Give verbatim examples. Visual, olfactory, haptic (touch) and somatic hallucinations should also be enquired for.

COGNITIVE FUNCTIONS

(Cognition is the process of acquiring, classifying and integrating information)

AWARENESS. Assess level of consciousness and arousal. Are attention and concentration easily aroused and held? Tests (in order of difficulty) - Serial 7's, Serial 3's, or months or weeks backwards.

ORIENTATION. Test for identity, place and time.

MEMORY. Ask the patient if his/her memory is failing. Compare his account of his life with that given by others. Test by means of the Mental State Questionnaire (page). Distinguish between different memory functions as follows :

- Immediate/short-term recall - Ask the patient to remember 5 objects in the room or a shopping list and to repeat them immediately. Check for recall after a short period.
- Intermediate term recall - Ask about events of the previous day e.g. meals.
- Long-term recall - Ask about remote or historical events in the person's past which could be expected to be known. Evidence of abnormality should be further tested by more specific tests.

SYNTHESISING FUNCTIONS

CAPACITY FOR ABSTRACT THINKING : Note the use of abstract concepts or figures of speech. Seek specifically for concrete or idiosyncratic thinking. Test with proverbs :

e.g. "People in glass houses should not throw stones"
"A rolling stone gathers no moss"
"A stitch in time saves nine"

Can the person establish relationships between objects, e.g. similarity between orange and banana, orange and ball, etc.

INTELLIGENCE

Assess by school level achieved, speed of grasp, and range and quality of knowledge. An I.Q. test may be necessary.

INSIGHT

A conscious recognition by the person of his/her state of mental functioning and behaviour. There are degrees of insight varying from a simple recognition of change or disturbance ("coarse insight"), to a more discriminating type where there is deeper understanding of causation and significance. Record what the person believes are his difficulties.

JUDGMENT

The mental act of evaluating choices within the framework of a given set of values for the purpose of electing a course of action. Judgment is said to be intact if the course of action chosen is consistent with high values. This is assessed from the person's ability to draw reasonable conclusions from information or material gathered from experience. It can be tested in terms of action to be taken in social, financial and ethical situations. Also realistic plans for the future.

FINALLY

Make a statement about the reliability and validity of the information obtained on history and examination. Motivation for treatment should be noted.

NO PSYCHIATRIC EXAMINATION IS COMPLETE WITHOUT A THOROUGH PHYSICAL EXAMINATION.

APPENDIX : C

Child Molester Questionnaire

Date of interview
1st. __________
2nd. __________
3rd. __________
4th. __________

DR.DAVID GREENBERG
FORENSIC UNIT
VALKENBERG HOSPITAL

I. PERSONAL QUESTIONS

Age
Marital Status
Children
Level of education
Occupation
Race

II. EARLY HISTORY

Parents - Father) personality and relationship
- Mother)
- Family - system structure
  - functioning
  - violence
  - attitudes to sex
  - family history of child molestation
  - incest

Sexual abuse as a child - by whom

Peers - relationships

Sexual education

III. ONSET AND COURSE DURING ADOLESCENCE AND ADULTHOOD

1) Onset

Age of onset paedophile/paederast thoughts or fantasies

Age of onset paedophile/paederast contact (including incest contact)

Masturbation - content of fantasies
- frequency

- adolescent experimentation with: same age peers
  : younger children
  : incest

Content of paedophilic/paederast thoughts or fantasies

2) <u>Sexual targets</u>

Age most attracted to - max.
- min.
- specific

Attributes of attraction - physical
- personality

Relationship between child and his parents - emotionally
- tangibly

Gender preference - ratio male:female - in thought or fantasy
- in practice

3) <u>Course of molestation</u>

Pattern of relationships : [SERIAL ATTEMPTS AT EACH INTERVIEW] [Draw a life graph and plot the following]

- duration of molestation activity
- number of victims per year
- maximum no. of contacts with a child
- total no. of children abused
- length of the relationships
- frequency of contact with the child

Type of relationship with children

Nature of contact - fondling
- oral
- genital (masturbation/penetration)
- anal

Persuasion\Coercion: emotional
: physical

Type of relationship with parents

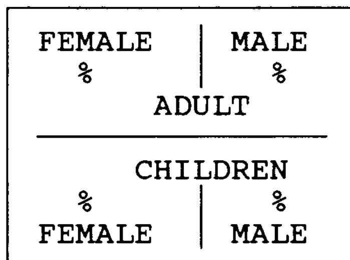
Pornography

Situational factors - stress
- alcohol / drugs
- opportunity.
- contact with other paedophiles

4) Other Aspects of Sexuality

Each of the six axes: adult male : adult female
child male : child female
adult male : child male
adult female : child female
adult female : child male
adult male : child female

are explored in terms of ratios of sexual preference with regard to both sexual thoughts, fantasies and sexual activity.



Adult heterosexuality - % attraction
- feelings towards sex with opposite sex
- relationships
- marriage

Adult homosexuality - % attraction
- feelings towards sex with homosexuals
- relationships

Other paraphilias

Sexual dysfunction/deformity

5) Conflict with Society

Previous - warnings
- court - sentence
- prison treatment
- effect of prison on paedophilia/paederast

Other anti-social behaviour

Attempts to control - i) self
- ii) outside sources:eg. religion
- iii) professional

IV. MENTAL STATUS

Personal views - (insight)
- on effects on children
- on need for treatment

If restrictions were removed, what then? -(judgement)

Assessment by the clinician of:

i) Remorse

ii) Ego defenses
- denial
- minimization
- projection
- reaction formation etc.

iii) Motivation

iv) Relationship with therapist

v) Potential for recidivism