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### BOOK CHAPTER

**Original citation:** Wood, Heather (2010) *Applied analytic work in forensic settings: The understanding and treatment of paedophilia*. In: *Off the couch: Contemporary psychoanalytic applications*. Taylor & Francis, London, pp. 143-159. ISBN 0415476151, 9780415476157

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Paedophilia is defined as a mental health problem by both of the major classificatory systems in use in mental health, ICD 10 (WHO, 1994) and DSM IV (American Psychiatric Association, 2000), yet psychological treatments for this disorder and theoretical models of the condition are not well-established. NHS services for such patients are patchy.

DSM IV defines paedophilia in terms of sexual fantasies or urges towards a prepubescent child or children; ICD 10 defines it as “A sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal age”. Thus the term “paedophilia” refers to an intrapsychic state, inclination, or personality configuration, which does not necessarily express itself in action or behaviour. Ostensibly there is widespread public concern about paedophilia, yet it is in fact the crime of child sexual abuse which attracts media attention, rather than this mental disorder. While those who are suffering from paedophilia are more likely to sexually abuse a child than those without paedophilic impulses, some paedophiles never act out sexually with children (Federoff et al, 2001), and some of those who sexually abuse children are not primarily paedophilic in their sexual orientation (Freund, Watson and Dickey, 1991; Seto, 2004). While there is considerable overlap between the occurrence of child sexual abuse and paedophilia, the two cannot be equated.

Why should it be that models of, and treatments for a recognised mental disorder are so poorly developed? There are likely to be a number of reasons for this, including the

heterogeneity of those afflicted and the complex and variable antecedents of this disorder. But perhaps one obstacle to the development of an understanding of paedophilia is that it is a subject which arouses such uncomfortable feelings that it is unpleasant to dwell on. Most complex subjects repay study, yet when the subject matter concerns the wilful elaboration of fantasies of the sexual abuse of children, it is tempting to turn away and think about something else.

A literature search of treatments for paedophilia reveals little beyond sex offender treatment programmes, or programmes with a cognitive-behavioural focus. "Treatment" within the criminal justice system and much of forensic mental health generally refers to programmes aimed at reducing the risk of recidivism. Offender treatment programmes focus on the modification of cognitions and behaviours which are thought to be significant precursors of offending, and this concern with behaviour and risk is an appropriate priority within the criminal justice system. However, patients seeking psychotherapy who have participated in sex offender treatment programmes complain that they know all the strategies, but they cannot trust themselves to use them; they sense that there is some unconscious process within themselves that could lead them to override well-learned cognitive and behavioural strategies. A psycho-educational model is often insufficient to reach the unconscious, irrational and deeply-ingrained factors underpinning paedophilic impulses.

The Challenge Project (Craissati, 1998) is a multi-agency programme in South East London for perpetrators of child sexual abuse who are returning to the community. The

programme is exceptionally broad and thorough, addressing cognitive distortions such as denial and minimisation, as well as victim empathy and relapse prevention, but also addressing personality factors such as fear of adult intimacy, and process factors in therapy such as transference and countertransference. However, even within such a comprehensive programme, the treatment of deviant sexual fantasies consists of attempts to help sex offenders modify or control their fantasies, and develop acceptable alternatives (Craissati, 1998 p. 68). There is no established treatment which claims to resolve or dissolve the underlying paedophilic fantasies, and which could be seen to treat or “cure” the underlying disorder.

A psychoanalytic approach is no exception to this and gains from this type of therapy are variable. The psychoanalytic treatment of paedophilia has not been subjected to stringent research evaluation, it requires long-term input from experienced clinicians, and only a subset of those with convictions or paedophilic impulses are suitable, as patient motivation is pivotal. In addition, there is no agreed psychoanalytic model of paedophilia, but only a set of working ideas that may help to understand this phenomenon. Nevertheless, when faced with a complex psychosexual phenomenon such as paedophilia, a psychoanalytic model which addresses both psychosexual development and unconscious interpersonal processes, has much to offer, not just to the patients but also to the staff working with them.

People who have committed sexual offences against children, and, by association, those with paedophilia, typically evoke reactions of incomprehension and all too often also of

condemnation and disgust, not only in the public but also in those who work with them. Working within prison or secure mental health settings with those who have sexually abused children, it is often uncomfortable to hold in mind both the “perpetrator” who has committed a sexual assault on a child (and knowledge of that person’s index offence), and the “victim” within the perpetrator, the person who themselves may have experienced a traumatic and abusive history. To recognise the often sad and traumatic history of the paedophile or the child sex offender makes him “one of us”, an unfortunate person built of the same stuff as everyone else, but for whom things have gone badly wrong in life. Splitting the perpetrator from his history, and focusing only on the crime the person has committed, may allow a less conflicted attitude to prevail where everything monstrous or bad is projected into him, potentially leading to an attitude of unbridled condemnation or disgust. Institutions may perpetuate this split, by consigning to an archive the older case notes which contain the account of personal and social history, or by appearing to marginalise the social workers who hold knowledge of the social history, so that frontline care staff on a ward may have no knowledge of the person’s background.

Panic and alarm about risks of child abuse can also pervade the process of risk assessment and can distort judgement. Where potential sexual abuse of children is involved, professionals may be understandably averse to risk, leading to very cautious decisions about risk management; however, “caution” can be the vehicle for the expression of punitive attitudes towards the paedophile, with the consequence that risk management strategies become irrationally punitive and restrictive. In other situations,

the risk of sexual abuse becomes such a preoccupation that emotional abuse, which may also be occurring, is unseen or ignored.

Acts of child sexual abuse breach a fundamental taboo, and people who have committed such acts may be seen as monstrous or evil, capable of anything. Conversely, someone who has committed a particularly serious crime but is not paedophilic may be seen to be a danger to children, as if someone who could do something so awful must inevitably also harbour fantasies of abusing a child. Psychoanalytic supervision and consultation can enhance the understanding of such processes and so lessen splitting, projections and preconceptions, thereby contributing to a more thoughtful and compassionate approach to care, and a more reasoned approach to risk assessment and management.

The Portman Clinic, part of the Tavistock and Portman NHS Foundation Trust, offers psychoanalytic assessments and group and individual treatment to people with problems of violence, criminality and compulsive sexual behaviours across a national catchment area. Paedophilia is one of the most common reasons for referral. Despite the difficulties of understanding and treating paedophilia, the clinical work undertaken at the Portman Clinic over decades has contributed to “Portman Lore” about paedophilia. This has informed published papers (see for example Glasser, 1988; Campbell, 1994; Glasser et al, 2001), teaching, supervision and consultation with staff in a range of settings. A psychoanalytic model can offer a useful framework for thinking about client/ practitioner relationships, the meaning of an index offence and the aetiology of psychopathology, whatever the overt treatment model within a service, and whether in prisons, hospitals or

the community. This chapter draws on this clinical and supervisory work. It outlines a framework for thinking about paedophilia that can support staff working in this field, helping them to make sense of behaviours and interpersonal processes that can prove challenging and disturbing.

### **A psychoanalytic model of paedophilia**

Psychoanalytic theory is not a single theory but an umbrella term for a range of theoretical perspectives and models, and theories of perversion are no exception to this. In turn, the term “paedophilia” encompasses a range of conditions; Hale (personal communication) has suggested that the term “paedosexualities” is preferable, and eliminates any suggestion that this is concerned with “love of” a child. In terms of aetiology, it is clear that there is no single pathway to paedophilia, and no specific childhood experiences which are either necessary or sufficient condition for paedophilia. Although it is not possible to provide a unified model of paedophilia, there are certain psychological features or processes which are common to many people presenting with paedophilia and some of the key elements of contemporary thinking about paedophilia at the Portman Clinic will be outlined.

### **The collapse of Oedipal structures and the generational boundary**

The person suffering from paedophilia believes, either implicitly or explicitly, that a child is an appropriate sexual partner for an adult. A psychoanalytic perspective would assume

that, for an individual to arrive at such a position, there had been a failure of the normal developmental process that would culminate in someone desiring an age-appropriate sexual partner in adulthood.

For Freud (1905), far from sexuality being acquired at puberty with the maturation of the sexual organs, sexuality, in the broadest sense, begins at birth. In his view, the child is a sensuous being, charged with an energy to seek pleasure and gratification, which is particularly sought through stimulation of the mucous membranes of the body – of the lips, the anus, and later the genitals. The child has a natural curiosity about bodies and bodily processes, and the child's focus of interest and theories about the world mature as he or she matures (see Horne, 2001). However this “infantile sexuality” is not equivalent to adult sexuality, but the precursor and prototype of it.

The recognition of gender differences heralds a crucial stage in a child's emotional development, paving the way for the development of desire for one who is different from the self. While contemporary psychoanalysts consider that early configurations of the Oedipus Complex occur within the first year of life, Freud thought that the processes which distinguish the Oedipus Complex occurred at about three to five years of age. Freud postulated that the boy<sup>1</sup>'s discovery of gender differences at this age carries the potential of being a source of pride and a blow to the boy's omnipotence. He cannot provide everything from within himself but needs to seek another who will complement him and allow him to feel whole. Freud argues that the boy then longs for an exclusive

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<sup>1</sup> The focus of this chapter will be on paedophilia and psychosexual development in males, since the prevalence of paedophilia amongst women is low and the criminal and psychological profile of female offenders seems quite distinct (see Seto (2004) and Hall and Hall (2007)) and will not be addressed here.



relationship with his mother, with whom he already has an intense, primary attachment from infancy. Under the influence of the Oedipal stage, this attachment develops into a desire to be her partner. This invites the second blow to his omnipotence: actually he is not of the same generation as his mother and she desires a partner of her own age. He is not big enough to fulfil a mature woman. The third blow to his omnipotence is that he cannot have what he wants now. He has to wait, and grow, so that he can eventually have a partner of his own. These processes are unlikely to be experienced as articulated conscious thoughts; occurring at an unconscious or preconscious level, they are unlikely to be recalled in a coherent way.

Freud suggested that these Oedipal issues need to be reworked at puberty, when there is a biologically-driven surge of libido, which pervades the adolescent's closest relationships, potentially those with the immediate family. At this stage there needs to be a restatement of the incest taboo and the generational boundary, so that these impulses are eventually directed out of the family, and in time become focused on a non-familial, age-appropriate partner or love-object. This will contribute to the development of a mature sexual identity in which the teenager begins to experience himself physically, psychologically and sexually as an adult.

The Oedipus Complex therefore establishes three crucial "facts of life" (Money-Kyrle, 1971), the fact of gender difference, the fact of generational difference, and the deferment of gratification or impulse control. It is possible to construe paedophilia as an attempt to deny these facts of life, and specifically the fact of generational difference. The

paedophile insists, in at least one part of his mind, that a child is an appropriate sexual partner for an adult.

Freud recognised that these developmental stages are never completely surpassed or totally resolved, and that we all carry within ourselves the residues of these past experiences. Within every adult there is an Oedipal child, and, at least, an unconscious memory of these conflicts and strivings. The Oedipal phase and puberty may hold a particular fascination for the paedophile because of the sexual significance of these transitions, and the fact that, for him, these transitions have not been adequately traversed. Hall and Hall (2007) report a study by Snyder (2000) of federal statistics for the US, which found a bimodal distribution for the age of the abused child, with peaks occurring at 5 and 14 years of age, which would approximately coincide with Oedipal phase and puberty. The paedophile will, almost by definition, not have established clear sexual and generational boundaries within his own mind, and this may lead to an urge to corrupt or disrupt the development of the child who is undergoing these pivotal transitions. The Oedipal and pubertal child, experiencing a surge of libido and a longing to be adult and intimate, may also be particularly vulnerable to the approaches of a predatory adult at this time.

Thus paedophilia involves a fantasy of the violation of the normal psychosexual development of the child, and moreover, this is often what the paedophile intends to accomplish. As one patient put it, paedophilia is “the abuse of the child’s normal sexuality” (Hale, personal communication). Feeling his own psychosexual development

to have been damaged or incomplete, the man with paedophilic impulses envies the normal or unsullied child, and may wish to damage or destroy the child's nascent sexuality.

What could have gone wrong for the paedophile that Oedipal structures have never been firmly established in his mind, leading to a wish to spoil or sully the psychosexual development of a child? Empirical studies consistently point to an elevated rate of sexual abuse in people who subsequently go on to be perpetrators of abuse, suggesting that many perpetrators have experienced intrusions and disruption of their own psychosexual development. With figures ranging between 28% and 93% (Hall and Hall, 2007), but converging around 35-50% compared with approximately 15% for male random controls, a history of sexual abuse appears to be significant but not a necessary precondition for becoming a perpetrator. We know that many people who have been abused do not go on to abuse others, and many people who become perpetrators have not experienced frank sexual abuse. The "cycle of abuse" is not inevitable or immutable. Clinical experience would suggest that, even where there is no frank sexual abuse, in the personal histories of paedophiles there has very often been a breaching of generational sexual boundaries, with boys exposed to parental sexual behaviour, or treated in a sexualised way by a parent or significant adult, or exposed to their father's pornography, or aware of paedophilic currents in their father's or mother's mind. The concrete nature of the experience varies, but in all cases significant adults are no longer seen to uphold sexual boundaries and the incest taboo, but are seen themselves to blur or flout generational boundaries.

A psychoanalytic model, focussing as it does on the developmental origins of adult psychopathology, therefore acknowledges the way in which the adult paedophile has themselves experienced a breaching of sexual boundaries and disruption of their sexual development. This is not to view the paedophile as only a victim of their history. The challenge is to hold in mind both the “victim” and the “perpetrator” aspects of our patients, so that one is not led to collude with the victim, nor to condemn the perpetrator or potential perpetrator, but to understand the interrelationship between these two facets of the person’s personality and history and the way in which becoming a perpetrator, in fantasy or in actuality, may be used to manage feelings evoked by previously being a victim.

### **Primitive anxieties and pre-Oedipal disturbance**

The classical, Freudian model of the Oedipus Complex continues to offer a central scaffolding in the understanding of paedophilia. However, this model has been extended and elaborated by more contemporary psychoanalytic thinking, specifically taking into account projective processes, primitive underlying anxieties, and the complex nature of the superego in perverse and offender patients.

In order to understand why one person responds to an experience of sexual abuse or the breakdown of Oedipal structures by becoming a paedophile themselves while another does not, it is necessary to look at the emotional context and earlier experience, to

understand what the person brings with them to the Oedipal stage and relationships to significant adults.

Glasser (1979) argued that a perversion represents a particular kind of psychic solution to a configuration which he called the “core complex”, which he postulated occurred first in infancy, but which represents a universal conflict, experienced by all. For Glasser, psychological separation from the first attachment figure or object, normally the mother, brings with it a dilemma: there is an urge to get back inside and fuse with the object to become one in a blissful union. However, to be fused with the object brings with it the threat of being completely taken over, losing oneself, and suffering psychic annihilation. This arouses intense hostility towards the object which is seen to be the source of threat, and anxiety that, were this hostility to be expressed, the object would be damaged, destroyed or lost. The alternative, to withdraw from the object, carries with it the threat of abandonment, isolation and depression. In Glasser’s view, the solution found by the perverse individual is to sexualise the aggression felt towards the object, so that the urge to destroy is converted in a sado-masochistic desire to hurt and make the other suffer. This allows a relationship to the other to continue so the object is not lost, and the destructiveness is “made safe” or contained by fusion with libido and subsequent expression as sado-masochism. Glasser (1988) postulates that the core complex underpins paedophilia and indeed all perversions.

A small number of empirical studies have attempted to identify variables which increase the likelihood of those who have been sexually abused going on to become perpetrators

themselves. A repeated finding of a history of neglect or loss (Canon, 2001; Glasser, 2001) concurs with clinical observations from the Portman Clinic that underpinning the perverse solution in paedophilic patients, there is often a sense of a bleak “depressive wasteland”. This is far removed from the relatively mature depression associated with the loss of a whole or ambivalently-loved object, but is rather an experience of annihilation or total emptiness, described by one patient as the “black hole at the centre of [his] universe”. Such bleak depression seems to be associated with a lack of availability or responsiveness in the maternal object, an experience that may derive from an experience of a mother with post-natal or subsequent depression, or narcissistic withdrawal and unavailability. If this has been experienced very early in life, then core complex anxieties, bringing with them the threat of loss and abandonment, will hold a particular terror, and the drive to find a solution that “preserves” a relationship to the object and offers a vehicle for the expression of rage may be particularly acute.

### **The use of sexualization as a defensive solution**

A quality which distinguishes those with perversions as opposed to other forms of pathology is the use of sexualisation as a habitual defence. Sexualisation can be thought of as a specific type of manic defence, that is, a defence which functions to protect the individual from experiencing depression or associated affects. The feelings associated with sexualisation are often of exhilaration, excitement and power, and are particularly useful when the feelings to be avoided are of depression, guilt, helplessness or inadequacy. Clinical experience would suggest that there are a range of possible

pathways which lead to sexualisation becoming a characteristic defence for a particular individual, and specifically for someone suffering from paedophilia.

It is important not to rule out constitutional differences in levels of libido or sexual drive, which may predispose a child to turn to masturbation as a source of comfort from an early age. However, clinical experience suggests that family context is also crucially important, and that the parents themselves have often used sexualisation as a characteristic defence mechanism, or as an “anti-depressant”. Perhaps the child witnessed the parents’ sexualized behaviour with each other, or one or other parent with a string of sexual partners. The mother may have had a sexualized investment in the child’s body, taking undue pleasure in his physical care or in his masculine physique. Sometimes the sexualization encountered in significant adults will have tipped over into frank sexual abuse. It is notable that Seghorn et al (1987) found sexualisation within the family to increase the likelihood of an abused child becoming a perpetrator.

It is also striking how often such patients recount a childhood experience of isolation or impoverished social relationships, either as an only child, or, for some other reason, distanced from peers and siblings. As boys they may have turned to masturbation for stimulation, comfort and an illusion of companionship, in which the penis is thought of as a friend (Hale, personal communication). Where there has been maternal deprivation the penis may come to substitute for an absent maternal breast and a focus on the genitals and sexual excitement may be used to defend against an experience of depression, humiliation and emptiness.

## **Narcissistic relating and the use of the child as a vessel for projection**

The paedophile presents a puzzle in terms of how we understand identification: on the one hand he may seem to feel himself to be a child and to be very identified with children; on the other hand, his capacity to really appreciate the psychic reality and developmental needs of a child is severely impaired. One way of understanding this is in terms of the fluidity of identifications: at one moment he feels himself to be like a child, at another moment, all vulnerability is projected into an actual child and he feels only powerful, sadistic or triumphant. It is also possible to see that relationships to children are essentially narcissistic: the child becomes a screen or vessel for the projection of the paedophile's unresolved issues about his own childhood.

Glasser (1988) describes a number of qualities that may be projected onto the child. First, he suggests, the paedophile may see in the child his own idealised child-self on whom he lavishes idealised parental love. Since Glasser's paper was published, clinicians have become more aware of the role of destructive envy in these patterns of identification. Where there is apparent idealisation of the child's purity and innocence there is often envy and a desire to spoil and attack that which is idealised.

Secondly, the child may carry projections relating to the deprived child-self (Glasser, 1988). The child is seen to be needy and vulnerable, and the paedophile imagines himself providing care and attention for which the child is hungry. Thus he may be attempting to



symbolically assuage the deprived child within himself. It is striking how often the child victims are presented as vulnerable children whose neediness “invites” attention. The paedophile, who has himself not come to terms with the disappointment of his own Oedipal longings, may imagine that the child will at some level welcome his approach. Again, this comes back to a confusion of childhood sexuality and adult sexuality; children long for intimacy, contact and attention, but they rarely wish for an actual experience of sex with another person unless they have learned that this is the only way to obtain that contact and attention.

Prior to or after an act of sexual abuse, the individual may be able to recognize a conscious identification with the child, in comments that acknowledge that he knows what it is like to be a deprived child, or the child reminded him of himself at that age, for example. At the moment when physical sexual abuse occurs, it is as though a conscious identification with the child (a conscious identification which can be thought about) must be replaced by projective identification. The painful or unbearable aspects of the self are projected into the child so that the child contains all deprivation and vulnerability and the perpetrator feels himself to be, either the bounteous adult, or the powerful adult sadistically triumphing over the child. Thus at the moment of abuse, any conscious identification with the child, or capacity for empathy with the child, is eclipsed by an unconscious identification which allows projective identification to dominate the mental picture.

## **The nature of the superego in perversions and paedophilia**

Studies of normal populations suggest that it is reasonably commonplace for people to have passing sexual thoughts or fantasies about children (see Seto, 2004), with 5% of US college students admitting to masturbating to fantasies of sex with children (Briere and Runtz, 1989). However, the majority of people censure such thoughts and censure any enactment of these thoughts. What distinguishes the paedophile is either that his superego does not lead him to censure such thoughts, or that he is driven to defy any internal constraints or controls. In terms of how we understand the relationship to the superego in paedophilia, a range of configurations are encountered in clinical practice.

Where there has been a failure of the parents to maintain a safe Oedipal structure within the family, with appropriate sexual and generational boundaries, it is likely that there will be a poorly structured or weak superego. Figures in positions of authority may be assumed to be weak or ineffectual as the individual projects his own uncertainty about boundaries and rules, and crucially his uncertainty about the taboo on incest or cross-generational sexual relationships. Where there has been an active breaching of generational boundaries there may be an identification with a superego that is actively corrupt or inconsistent.

A second possibility is that there is defiance of a superego that is experienced as persecutory. Glasser (1979) argues that where core complex anxieties dominate, to fully assimilate the superego into the psyche would be experienced as risking a loss of self or

identity, as the superego would appear to take over or threaten to annihilate the self. The superego therefore remains as a separate object within the psyche, and the ego maintains independence from it by defiance and risk-taking. This model implies that the “fault line” which leads to subsequent deformity of the superego originates in very early experience and fantasy, rather than occurring through later social learning within the family.

An alternative view would be suggested by O’Shaughnessey’s (1999) notion of the abnormal superego based on a Kleinian model where the superego originates not at age four to five, but in the paranoid-schizoid position of early infancy. The superego will then be shaped by failures of contact and containment in early infancy, and acquires the qualities of a split-off “bad” object which is primitive and vengeful. This accords with the clinical impression that people who offend against children are not lacking a superego, but are acting to defy a superego experienced as crushing, persecutory and attacking. Those people who find their way to psychotherapy, and admittedly this may be a select group, are often plagued by a ferocious internal condemnation of themselves. Violent or perverse acts are often underpinned by feelings of self-loathing and disgust, which are temporarily projected onto the other during an abusive sexual act. In the course of therapy, intense feelings of shame about the self, and the person’s own, failed development may also emerge (see Campbell, 1994).

### **The structure of a treatment service**

Psychoanalysis and psychoanalytic psychotherapy focus on the internal world of the patient; the clinician strives to adopt a position of neutrality towards the various aspects of the patient's psyche, and as such, normally avoids "taking sides", endorsing one course of action or another. The patient is largely left to make their own decisions about how to act, and sometimes, to make their own mistakes. When working with patients who characteristically resort to action as a means of managing feelings or thoughts which they are unable to bear, and where these actions may risk considerable harm to the individual or an other, the therapist cannot be neutral to the actions of the patient. A major concern in providing forensic psychotherapy is how to set up structures around the therapy that take appropriate account of risk and a responsible approach to the prevention of harm and the protection of vulnerable others, while not undermining the therapist's focus on the patient's internal world. Sometimes threats of action which evoke anxiety in others are a means of communicating the person's anxiety about himself and mobilising help; at other times such threats may provide the patient with a perverse excitement, and may serve as a distraction from internal suffering or the impoverishment of his internal world. Thus to contain and work effectively with such patients requires an approach which takes account both of the risk of harm, and of the psychological function of raising alarm.

With patients suffering from paedophilia, it is essential to have service structures in place that can be mobilised if there is a threat of enactment or the risk of harm to a child. It is not in the interests of the patient or the child to allow such a situation to progress until a child is abused. We are all aware of the potential harm to the child: what is frequently forgotten is the consequences for the paedophile if he harms a child. As well as the risks

of arrest and imprisonment, there are considerable intrapsychic costs such as the guilt and shame consequent upon such an act.

All patients offered treatment at the Portman Clinic will have a therapist and a case manager, where the case manager is often the original assessor. Depending on the history and perceived degree of risk, during the course of treatment the patient may derive additional support from mental health or forensic services in his locality, a probation officer, or Multi Agency Public Protection Arrangements. As far as possible the case manager will manage liaison with external agencies, leaving the therapist free to maintain a role uncontaminated by intrusions from the service network. If there is awareness of increasing risk that cannot be reliably contained within the therapeutic relationship, the patient may meet with the case manager to address risk issues more explicitly; if this occurs the patient potentially can have an experience of two clinicians, symbolically a “parental couple”, able to think together about his care within the Clinic.

Treatment offered at the Portman Clinic is normally long-term. In their review of literature on paedophilia, Hall and Hall (2007) note both the frequency of onset in adolescence, and the enduring nature of this problem, with those who offend against children disproportionately represented amongst older sex offenders. By the time people with these problems reach therapy they may have been struggling with paedophilic impulses for decades. Many have profound difficulties with intimacy and have found safety and pleasure in the paedophilic solution, which they are reluctant to relinquish; they may struggle to tolerate a therapeutic relationship. In these circumstances it is

important to be realistic about the length of treatment required and to think in terms of years rather than weeks or months.

Group treatment is often seen to be the treatment of choice for people suffering from paedophilia, many of whom are profoundly isolated by virtue of their difficulties in social relating and the stigma of their condition. The challenge offered by other members within a group can be very constructive, and, if core complex anxieties are acute, individual therapy may be regarded as unbearably claustrophobic, leading to a preference for group treatment. The experience of the Clinic is that in therapy groups with a mix of presenting problems and pathologies, those who have sexually abused children are often scapegoated and their difficulties about inclusion may be perpetuated. Those with convictions for the sexual abuse of children are normally treated in a separate group, with a small number being offered individual treatment. Groups meet weekly with a single therapist.

### **Key features of a psychoanalytic approach to therapy**

There is no standard formula for psychoanalytic treatment as the course of therapy will be unique to each patient, reflecting their particular concerns and, to some extent, the orientation and emphasis of the clinician. Nevertheless it is possible to identify some general themes in the psychoanalytic treatment of paedophilia.

A psychoanalytic approach will pay particular attention to the detail of the enacted or fantasised behaviour, believing that the exact form of such acts is not arbitrary, but will be an expression of highly-charged anxieties, conflicts and object relationships within the patient. The specific behaviour which is desired or enacted is suffused with meaning, if this can be unravelled and understood. Freud described how the symptoms of a neurotic patient can represent a confluence of a number of different conflicts or unresolved issues within the psyche, each of which lends shape to the final form of the symptom; as such, symptoms are “overdetermined” (Freud and Breuer, 1895). In the same way, in forensic psychotherapy the form and nature of the index offence or desired act will have been determined and shaped by the patient’s history, object relations, and unconscious fantasy. Where the individual is unable to talk about a severely traumatic personal history, the index offence may be the best available guide to understanding the patient’s early experience. The challenge for the therapist will be to allow the description of such acts or fantasies in therapy, without adopting a stance that may be experienced by the patient as voyeuristic or intrusive, or as colluding with perverse excitement. Constant attention will be given to the transference and countertransference as such material is explored.

Psychoanalytic models of perversion (see Glover, 1933; Glasser, 1979; Stoller, 1975) place considerable emphasis on the fusion of libidinal and aggressive currents in perversion, and the sexualisation of aggression. In the work of the Portman Clinic, severe aggression and sadism are not usually seen as primary, but as a reaction to profound anxieties about intimacy (e.g. core complex anxieties), or engendered by deprivation, frustration or humiliation. Patients are often at their most aggressive or hostile when they

feel that they are fighting for psychological survival (see Glasser's (1998) notion of self-preservative violence), when they are desperately trying to avoid experiencing guilt, or when hostility seems the only way to control or hold onto an object who represents a considerable threat.

Patients presenting with paedophilia, like many others, often come to therapy quite unaware of the degree of sadism or hatred encapsulated in their behaviour. Part of the work of therapy will be to recognise this when it occurs, and to understand the function of the aggression or sadism.

All perversions are characterised by the use of sexualisation as a defence. Often in the course of a session it is possible to observe the moment at which a patient, suddenly unable to tolerate whatever they are experiencing, will take off into sexualised talk about their fantasies or behaviours. It is often difficult to distinguish between a sexualised display, used defensively, and a more revealing disclosure of sensitive or painful thoughts, revealed in the service of therapeutic work. Sometimes elements of the interaction with the patient will have both qualities, or a truthful disclosure may evoke anxiety in the patient, and then be "hijacked" by something more perverse in him, so that any vulnerability which he has revealed is obscured, and the disclosure is treated as though it were only exhibitionistic, sadistic or masochistic. The therapist's countertransference is the best guide to the nature of the contact in any particular moment. By repeatedly taking up with the patient these moments of flight into sexualised



thoughts and the nature of the experiences from which the patient is fleeing, the frequency and intensity of the use of sexualisation may diminish.

A sexually abusive act, either in fantasy or reality, can also be seen as a way in which the perpetrator temporarily rids himself of intolerable feelings and projects them into another. The more he is able to bear the damage, pain or shame he feels within himself, the less it may be necessary to project this into a vulnerable child.

As with any “acting out disorders”, the person is seen as resorting to action when he is unable to contain thoughts, feelings or psychological conflicts. Levinson and Fonagy (2004) have highlighted the link between a failure of mentalization and recourse to violence in a prison population, and a psychoanalytic model would also see action as a way of discharging or managing feelings which cannot be borne and thought about. A feature of therapy would be for the patient to be able to reflect on the thoughts or feelings which precede impulsive or harmful action. It is assumed that these feelings are excluded from consciousness because they cannot be tolerated, so it may only be through tools that access the unconscious – through free association or interpretation of the transference in the context of a therapeutic relationship – that they can be brought into awareness and thought about.

The therapist working with perverse and paedophilic patients will be required to manage projections in the transference relating to the superego. Therapists typically experience being seen alternately as weak and collusive, punitive and judgemental, or despising and

disgusted by the patient. Through projective identification the therapist will not only be the object of such projections but will be drawn in to experiencing and, at times, enacting these qualities. The subject of child abuse is one that evokes intense emotions, and therapists are not exempt from these pressures. The therapist will attempt to distinguish his or her own reactions from the intense feelings of self-disgust, self-loathing and shame which the patient with paedophilia frequently brings to the therapeutic relationship, which constantly invade and shape the therapeutic interaction and impact on the therapist's countertransference.

For the therapist, maintaining a clear moral compass and a position of therapeutic neutrality, so that he or she can understand the internal pressures to which the patient is subject from a harsh or abnormal superego, is a considerable challenge. With time the patient can be helped to see the function of deceptive, harmful or corrupt behaviours, and the price which he pays internally for such acts. For some patients who have undisclosed offences this may entail working with them to a point where they chose to report an offence they have previously committed.

Implicit in a psychoanalytic approach is an assumption that the pursuit of a child as a sexual partner, either in the mind or in reality, represents a flight from the difficulties of forging and sustaining an intimate relationship with another adult. The therapeutic relationship potentially represents a means to obtain help, but for the patient it confronts them with a version of the situation which they most dread, and is often experienced as a minefield. In order to contain the patient's anxieties so that they can bear to remain in

treatment, it is necessary to be constantly vigilant to the manifestations of anxiety and defensiveness in the transference, and to take these up, as appropriate, with the patient, as well as allowing space for the patient to explore his anxieties and to develop trust in the therapist. Working with patients with perversions one repeatedly finds that apparent progress is followed by retreat, either in the nature of the contact, or in missed sessions or increased acting out. As these defensive retreats are addressed they will hopefully lessen.

In terms of the aims and outcomes of treatment, do patients ever relinquish a paedophilic orientation? For those described by Glasser (1988) as “invariant paedophiles”, it is unlikely that this current within the psyche will ever dissolve completely. However, of the twenty patients treated in a slow-open group at the Portman Clinic over a period of 10 years, only one re-offended during that time (Hale, personal communication), and this person only offended after dropping out the group. Many found less harmful ways of managing their impulses and themselves. Some found greater harmony and ease within themselves. All of them, by virtue of participation in the group, gained self-understanding and a reduction in isolation. How these outcomes compare with the outcomes achieved by a comprehensive treatment package such as that offered by the Challenge Project (Craissati, 1998) is a subject for research. Clinical experience suggests the need for a range of different treatment options and one type of treatment may follow another; some people may gain most when they are able to progress from a structured CBT programme, to long-term analytic treatment.

There are limitations to the applicability of a psychoanalytic approach. There are people with paedophilia who deny the suffering that their condition or behaviour causes to themselves or others, and these people are unlikely to benefit from psychoanalytic treatment at that point in time. Where prevention of recidivism is a priority, treatment programmes focussing on behaviour management may be the most appropriate first step. But for those people who seek therapeutic change, the psychoanalytic perspective is distinguished by a determination to engage with the disturbed and disturbing internal world of the person suffering from paedophilia, and to understand the unconscious and affective roots of adult sexual fantasies and enactment. For the many people whose lives are profoundly impaired by this serious mental health disorder, there is an urgent need for improved understanding of this condition and for the further development and dissemination of psychological therapy.

### **Acknowledgements**

I am very grateful to Rob Hale for generously sharing his experience and thoughts about working with people with paedophilia and for discussion of this paper. While I take responsibility for the views expressed here, these ideas have been shaped by extensive discussions within the Portman Clinic involving all clinicians; I am particularly indebted to Rob Hale, Sira Dermen and Don Campbell.

American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders*, 4<sup>th</sup> edition, text revision (DSM IV – TR). Washington DC: American Psychiatric Association

Briere, J. and Runtz, M. (1989) University males' sexual interest in children: predicting potential indices of "pedophilia" in a non-forensic sample. *Child Abuse and Neglect*, 13, 65-75

Campbell, D. (1994) Breaching the shame shield: thoughts on the assessment of adolescent sexual abusers. *Journal of Child Psychotherapy*, 20 (3), 309-326

Cannon, M (2001) The perils of prediction. Invited commentary on: Cycles of child sexual abuse. *British Journal of Psychiatry*, 179, 495-497

Craissati, J (1998) *Child sexual abusers. A community treatment approach*. Hove, E. Sussex: Psychology Press

Federoff, J.P., Smolewska, K., Selhi, Z., Ng, E. and Bradford, J.M. (2001) Victimless pedophiles. Poster presented at the Annual Meeting of the International Academy of Sex research, Montreal, Quebec. Cited in Seto (2004)

Freud, S. (1905) Three essays on the theory of sexuality. In J. Strachey (ed.), *The Standard Edition of the works of Sigmund Freud, VII*. London: Hogarth

Freud, S. and Breuer, J. (1895) Studies on Hysteria. *Standard Edition*, Vol 20, London: Hogarth Press.

Freund, K., Watson, R. and Dickey, R. (1991) Sex offences against female children perpetrated by men who are not paedophiles. *Journal of Sex Research*, 28, 409-423

Glasser, M (1979) Some aspects of the role of aggression in the perversions. In I. Rosen (Ed) *Sexual Deviation* (2<sup>nd</sup> edition). Oxford: OUP

Glasser. M (1988) Psychodynamic aspects of paedophilia. *Psychoanalytic Psychotherapy*, 3 (2), 121-135

Glasser, M. (1998) On violence: A preliminary communication. *International Journal of Psychoanalysis*, 79, 887-902

Glasser, M. Kolvin, I., Campbell, D., Glasser, A., Leitch, I. and Ferrley, S. (2001) Cycles of child sexual abuse: links between being a victim and becoming a perpetrator. *British Journal of Psychiatry*, 179, 482-494

Glover, E. (1933) The relation of perversion-formation to the development of reality sense. *International Journal of Psycho-Analysis*, 14 (4)

Hall, R.C.W. and Hall, R.C. (2007) A profile of pedophilia: definition, characteristics of offenders, treatment outcomes and forensic issues. *Mayo Clinic Proceedings*, April 2007, 82 (4), 457-471. ProQuest Medical Library [www.mayoclinicproceedings.com](http://www.mayoclinicproceedings.com)

Horne, A. (2001) Of bodies and babies: sexuality and sexual theories in childhood and adolescence. In C. Harding (Ed) *Sexuality. Psychoanalytic Perspectives*. Hove: Brunner-Routledge

Levinson, A. and Fonagy, P. (2004) Offending and attachment: the relationship between interpersonal awareness and offending in a prison population with psychiatric disorder. *Canadian Journal of Psychoanalysis*, 12 (2), 225-251

Money-Kyrle, R. (1971) The aim of psychoanalysis. In D.Meltzer and E.O'Shughnessey (Eds) *The Collected Papers of Roger Money-Kyrle*. Perthshire: Clunie Press.

O'Shaughnessey, E. (1999) Relating to the superego. *International Journal of Psychoanalysis*, 80, 861-870

Seghorn, T., Prentky, R. and Boucher, R.J. (1987) Childhood sexual abuse in the lives of sexually aggressive offenders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 26, 262-267

Seto, M.C. (2004) Paedophilia and sexual offences against children. *Annual Review of Sex Research*, 15, 321-361, ProQuest Medical Library.

Snyder, H.N. (2000) Sexual assault of young children as reported to law enforcement; victim, incident and offender characteristics. Washington DC: US Department of Justice, Bureau of Justice Statistics, 2000. Publication NCJ 182990

Stoller, R.J. (1975) *Perversion: the erotic form of hatred*. London: Quartet

World Health Organisation (1994) *International Classification of Diseases*, (10<sup>th</sup> revision). Geneva: World Health Organisation



