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Misuse of Child Sexual Abuse Images: Treatment Course of a Self-identified Pedophilic Pastor

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Introduction

A pedophilic preference disorder, i.e., the existence of a sexual responsiveness to a prepubescent body age, is considered an important risk factor for recidivism in sexual offenders against children (Hanson & Morton-Bourgon, 2005). Risk-reducing approaches for the prevention of child sexual abuse therefore include persons with relevant sexual orientations who have committed child sexual abuse in the past. McGrath and colleagues, who carried out a survey on the current treatment of sexually delinquent men in the US and Canada, found that most programs work on the basis of Relapse Prevention, the Risk-Need-Responsivity (RNR) principle, the Good Lives Model (GLM) and biomedical approaches (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010). The Relapse Prevention approach focuses on teaching self-regulation skills (see Pithers, 1990; Ward, Hudson, & Keenan, 1998; Ward & Hudson, 2000). The GLM is a rehabilitation theory that conceptualizes offenses as a socially inadequate attempt to meet primary and basic human needs (e.g., relatedness, community, autonomy, etc.). Its aim is to help people lead worthy and fulfilling lives and realize their individual basic needs through socially acceptable means (see Ward & Gannon, 2006). Besides the GLM, other strength-based approaches have recently gained importance as cognitive-behavioral approaches have been criticized for their negative focus as well as for their insufficiency to improve emotional self-regulation skills or stable dysfunctional schemes (for an overview see Marshall, Marshall, Serran, & O'Brien, 2011). In this context, it has been recommended to integrate emotion-focused therapy (Greenberg, 2011) or schema therapy (Young, Klosko, & Weishaar, 2003) when treating sexual offenders against children.

Pharmacological interventions include Androgen Deprivation Therapy (ADT), Selective Serotonin Reuptake Inhibitors (SSRIs) and other drugs. Their effectiveness in reducing sexual impulses is well documented, while their evidence in terms of relapse prevention is considered controversial (for a review see Rice & Harris, 2011). Programs based on the RNR principle (Andrews & Bonta, 2006) align their treatment according to the level of intervention required (Risk), which problems need to be prioritized (Need) and how the treatment should be designed (Responsivity). The Need Principle should therefore focus on those features that are statistically associated with future delinquency, i.e., the so-called dynamic risk factors (DRF).

Currently, four dimensions of DRFs are considered to be relevant for sexual recidivism:

1. Criminological needs and automatic cognitions such as offense-supportive attitudes or emotional congruence with children,
2. Self-regulation deficits,
3. Relationship problems, and
4. Sexual problems such as deviant sexual interest or sexual preoccupation (Marshall, et al., 2011).

Two meta-analyses examining the efficacy of treatment for sexually delinquent men suggest that the risk to sexually reoffend could be significantly reduced through therapy (Hanson, et al., 2002; Lösel & Schmucker, 2005). Other authors, however, have criticized these studies for their methodological shortcomings (Dennis, et al., 2012; Rice & Harris, 2003). In their review, Dennis and colleagues (2012) conclude that effectiveness of treatment using strict methodological criteria is still lacking. They included ten studies in their review, most of which had refrained from randomized controlled trials and had not included data on recidivism, but only on dynamic risk factors that have been associated with recidivism, despite the lack of strict methodology. The authors suggest that future trials should minimize risk of bias, maximize quality of reporting and include follow-up periods of at least five years. Since the RNR model has the strongest

empirical support, it has been suggested that treatments should be based on its principles until further empirical findings are available (Hanson, Bourgon, Helmus, & Hodgson, 2009).

Current studies have dealt with the question of whether the findings on risk factors among men who have committed child sexual abuse can be transferred to users of child sexual abuse images (CSAI). A recent meta-analysis showed that users of CSAI exhibit both differences and similarities with men who have committed child sexual abuse (Babchishin, Hanson, & VanZuylen, 2015). Users of CSAI scored lower on indicators of antisociality, victim empathy, cognitive distortions, and emotional identification with children when compared with sex offenders who had offended against children and mixed offenders. They did, however, score higher on indicators of pedophilia, sexual self-regulation deficits, sexual preoccupation, and self-esteem deficits, when compared with sexual offenders against children. No differences between users of CSAI and sexual offenders against children were found when it comes to intimacy deficits, impulsivity, poor coping skills, or indicators of general mental health, such as depression or anxiety. In their therapy program for Internet offenders (i-SOTP), Middleton, Mandeville-Norden and Hayes (2009) emphasize the intimacy and emotional regulation deficits of CSAI users and recommend taking these into account in the treatment planning for these patients. Still, there is a lack of adequate, specific treatment programs for users of CSAI or knowledge on the efficacy of interventions for this target group.

Prevention Project for men feeling sexually attracted to children

The prevention project was founded to complement forensic facilities and offer confidential therapeutic support for people who feel sexually attracted to children and are afraid of committing an offense against a child or using CSAI (Beier et al., 2009). With the help of an extensive media campaign and strategic public relations, the project addresses people who are not currently under legal supervision for a sexual offense against a child or have not been legally prosecuted. An initial evaluation of the effectiveness of the therapy program shows positive therapeutic effects, especially in terms of improving risk-related deficits (Beier, et al., 2015). In 2011, a Prevention Network was established throughout Germany to define the quality standards for the diagnosis and treatment of people who feel sexually attracted to children and want to seek help. The primary goal of the treatment is to reduce the risk to sexually offend against children and/or to use CSAI by coping with problems arising from the sexual attraction to children.

Diagnostics and therapy in the prevention project

Anyone who contacts the project because of a sexual attraction to children, who is currently not under legal supervision and is interested in participating in the clinical diagnostics, is assigned a Personal Identification Number (PIN). Pedophilia was diagnosed in a multistage, multi-methodical diagnosis, starting with a semi-structured clinical interview, followed by a battery of questionnaires, computerized assessments and a final case review. According to the DSM-5 it was assessed if the person reported recurrent sexual thoughts, fantasies, or urges with prepubescent or early pubescent children over a period of at least 6 months. A history of sexual interactions with children without admission of concomitant sexual thoughts, fantasies, or urges

was not considered to be sufficient for the diagnosis. In addition to collecting information on the person's general medical history and current psychopathological status, the primary aim of this procedure is to make an in-depth diagnosis of sexual preference and an initial assessment of the risk to sexually offend against children and/or use CSAI (for an overview of the methods used, see Beier et al., 2015). Due to the lack of risk prognostic instruments in the area of non-forensic populations, the STABLE-2007 (Hanson, Harris, Scott, & Helmus, 2007) and ACUTE-2007 (Hanson et al., 2007) are used for the initial risk assessment, however, an evaluation of the suitability of these instruments for the community setting is still pending. Any participant with a pedophilic or hebephilic (other specified paraphilic disorder) disorder, who is at least 18 years old and has sufficient knowledge of the German language, is offered therapy (inclusion criteria). Individuals who are under legal supervision for child sexual abuse (criminal investigation, criminal process), are in need of treatment for an acute comorbid psychiatric disorder, suffer from organic brain impairment or who are externally motivated to contact the project (exclusion criteria), are sent to other institutions.

The therapeutic approach of the prevention project (see Institute for Sexology and Sexual Medicine: Berlin Dissexuality Therapy Program [BEDIT], 2013) is based on established methods from forensic settings and complements the Relapse Prevention approaches, the Good Lives Model, RNR principles, cognitive-behavioral approaches and pharmacological interventions with therapeutic elements of sexual medicine (emphasizing the attachment dimension of sexuality). It is founded on the assumption that the sexual preference is a relatively stable component of the individual personality. A person is not responsible for their sexual preference, but for the sexual behavior that can result from their sexual impulses. The treatment

program aims to increase perceived self-efficacy and behavioral control by helping the patient replace emotion-focused, avoiding and sexualized coping strategies with appropriate coping skills. Another goal of the program is to help strengthen the social functioning of the person and reduce offense-supportive attitudes. At the same time, it seeks to increase victim empathy for child sexual abuse and develop appropriate measures and goals for relapse prevention.

The therapy program (see BEDIT, 2013) is designed for rolling groups and consists of 12 modules (psychoeducation, acceptance and motivation, perception, emotions, sexual fantasies and behavior, empathy and perspective taking, curriculum and schemes, coping and problem solving strategies, social relations, intimacy and trust, future plans, relapse prevention). The manual, however, only provides a general orientation since both the treatment and interventions must be tailored to the specific situation and needs of each participant as well as the composition of the group. Therefore, an individual risk model is developed with each participant at the beginning of treatment in order to derive specific and approach-oriented treatment goals and simultaneously evaluate the progress. The therapists of the Prevention Network carry out the treatment according to this general guideline. The interventions, however, may vary depending on the different backgrounds of the therapists.

This case study demonstrates the course of therapy for a user of CSAI in a single setting. The present study was approved by the Institutional Review Board of the University Clinic and the patient gave written informed consent for the publication of this case study. Details irrelevant to the clinical case were altered in order to protect the client's confidentiality.

Background Information

Peter, a 47-year-old married pastor with a congenital limb defect contacted the project despite a long distance to the clinic because his pedophilia was increasingly affecting his daily routine. At times, he trawled “the Internet excessively for images of girls” in search of sexual stimulation. He reported feelings of depression and hopelessness because he was ashamed of his “addictive behavior” and the recurrent urge to search for images on the Internet. During these phases, he would withdraw, lose his enjoyment of life and have suicidal thoughts, which he had never acted on. At the initial meeting with the client, he seemed friendly but distant with limited emotional expression. He also displayed a high ability for introspection and chose his words carefully.

Peter reported growing up with an older brother in an emotionally distant family. When he was five years old, his father committed suicide. His mother subsequently underwent psychiatric treatment while he and his brother stayed with their grandmother. The relationship to his mother remains hostile to this day. Even as a little boy he felt she was ashamed of his physical handicap. He recalled many situations in which she had referred to him as “a mistake of nature,” which made Peter feel like an outsider from early on. It was not until after he graduated that he started to make music, be politically active and establish stable and close friendships that exist to this day. Yet, the sense of not belonging and feeling like a “leper” remains and is only made worse by his pedophilia. Peter remembers masturbating at the age of seven and experiencing his first ejaculation when he was 12 years old. Even then, his sexual fantasies involved significantly younger prepubescent girls (approximately 8 years of age). Today, he fantasizes exclusively about prepubertal girls and the interactions he imagines include both “tender” and violent scenes,

in which he forces them to have sex and rapes them. He finds “peeing girls” particularly arousing. The idea of a girl urinating in his face is a fundamental part of his fantasies, though he never wanted to incorporate urophilic practices into sexual interactions with women. At age 13, he had his first sexual experience with his first girlfriend (+1) before he met his current wife (-1) at the age of 16. At the beginning of the relationship, they had an intense mutual sexuality, which subsided after the birth of their daughter. Today, they have sex on a monthly basis, which is usually initiated by her. He is indeed “much more sexualized” than her, however, when they have sex he immediately “pictures girls.” This makes him feel bad because he is not fully with her. He loves his wife, likes spending time with her and enjoys when they touch each other, which for him has nothing to do with sexuality. His wife was not aware of his pedophilic or urophilic inclination and although they talked a lot with each other, incriminating topics, emotions or fears were rarely discussed.

Peter reported that he had been using the Internet “excessively” and with “very addictive potential” to search for images of girls for over a decade, especially when he had a lot of stress at work or felt unappreciated on a professional level. He would get angry and tense and feel the urge to do something good for himself, so he looked for pictures of girls urinating or sexual activities between girls and adults to masturbate to. This led to the short-term release of tension, but in the long term left him ashamed and full of self-loathing. Despite Peter’s clear condemnation of CSAI and his consequent feelings of guilt, when using these images, offense-supportive attitudes became apparent. For example, he assumed some children to gain confirmation or appreciation by having their pictures taken, minimizing the sexual assault. With respect to direct sexual contact with children, Peter credibly denied the impulse to make contact

with girls or commit a direct sexual assault. There had also never been any risky situations concerning his daughter or her girlfriends. Peter reported that his interest in girls was purely sexual and did not include a desire in a relationship with them. He preferred spending his time with adults. He reported, however, to have stopped at motorway service stations a few times trying to spot a urinating girl. He then remembered this later in the evening during masturbation.

Assessment

The existence of an exclusive pedophilic disorder sexually attracted to females according to ICD-10 (F65.4; World Health Organization [WHO], 1992) and DSM-5 (302.2; American Psychiatric Association [APA], 2013) was confirmed during the clinical interview. Peter reported sexually arousing fantasies, impulses and behavior in relation to girls that existed since his adolescence. He has had sexual contacts exclusively to adult women, in the course of which, however, he used accompanying fantasies with girls in order to maintain his sexual arousal. He felt burdened by both his fantasies as well as his use of child sexual abuse images and therefore sought therapeutic help. In addition, Peter was diagnosed with a urophilic disorder (other specified paraphilic disorder (DSM-5: 302.89; ICD-10: F65.89) and a recurrent major depressive disorder with a current moderate episode (DSM-5: 296.32; ICD-10: F33.1).

Table 1 shows the results of the psychometric tests used at the beginning of therapy. Peter showed clinically significant values for depression (ADS; Hautzinger & Bailer, 1992), general psychological distress (BSI; Franke, 2000), loneliness (UCLA-LS-R; Russel, Peplau, & Cutrona, 1980) offense-supportive attitudes (BMS; Bumby, 1996) and hypersexuality (HBI; Reid, Garos, & Carpenter, 2011). The value concerning emotional congruence with children (CIS-R; Wilson,

1999) was rather below average. In comparison to the standardization samples, the values concerning social desirability (SDS-17; Stöber, 1999) and psychopathy according to Hare (SRP-III; Paulhus et al., in press) were non-salient. The overall scores in the risk prognostic methods carried out were low to medium. The sum value determined in the ACUTE-2007 assessment was three (victim access [1], sexual preoccupation [2]), and seven in the STABLE-2007 assessment (negative emotionality [1], sexual preoccupation [2], sex as a coping mechanism [2], deviant sexual preferences [2]), which correspond to a moderate risk.

Case Conceptualization and Treatment Planning

The misuse of CSAI was conceptualized as an emotional self-regulation deficit which includes the use of poor coping strategies including sexualized coping (Cortoni & Marshall, 2001; Marshall et al., 2011). It was assumed that Peter had developed an early maladaptive scheme, which are defined as “broad pervasive themes or patterns regarding oneself and one's relationship with others, developed during childhood and early adolescence and elaborated throughout one's lifetime, that are dysfunctional to a significant degree” (Young, 1994). Peter's main scheme was labelled *inferiority scheme* and classified as defectiveness/shame, which is a feeling of being defective, bad, unwanted, inferior, or invalid in important respects (Young, et al., 2003). It was assumed that Peter had developed this stable scheme due to his frustrated basic needs for comfort and appreciation, as well as his biographically significant experience as an outsider (resulting from his mother's shame and teasing from peers because of his congenital limb defect, which was reinforced by early pedophilic fantasies). This scheme was activated in social situations (e.g., through rejection or criticism) and resulted in negative emotional states,

which Peter had never learned to deal with functionally. Instead, he used sexualized coping strategies early on to escape these aversive emotional states, which became habitual patterns over time. Based on the GLM assumption that inappropriate means are used to fulfill primary needs, it was decided that the therapy should first address Peter's frustrated needs (i.e., feelings of inadequacy and inferiority) and his sexualized coping strategies (i.e., misuse of CSAI). Following the recommendations of the Need Principle (Andrews & Bonta, 2006), the risk factors that were relevant for Peter were elaborated in an individualized risk model: criminogenic needs (offense-supportive attitudes), self-regulation deficits (emotion regulation deficits, depression, sexualized coping), relationship problems (intimacy deficits) and sexual problems (sexual preoccupation, dealing with sexual preference). There was a high risk of relapse concerning the use of CSAI. Therefore, the treatment plan involved individual therapy sessions on a weekly basis in accordance with the Risk and Responsivity Principles (Andrews & Bonta, 2006) and in order to improve self-regulation skills (Relapse Prevention).

Treatment Course

The therapy took place over a period of 23 months, in which Peter participated in a total of 55 sessions. Figure 1 illustrates the course of the therapy and the specific areas covered.

Sessions 1–5: Psychoeducation und risk model

The first five meetings focused on the use of CSAI. Psychoeducation on sexual offending behaviors, empirically supported risk factors for sexual offending, different functions of sexuality as well as the development of behavioral patterns was given in order to help the patient understand his patterns perceived as addiction. Peter reported a week of night-long “sex

sessions” over which he had little control. Based on the situations reported, the pattern taking place (frustration – feelings of inadequacy – impulse to search for pictures – sexual arousal – search for pictures – short-term relief – long-term reinforcement of shame and feelings of inadequacy) was worked out with the help of behavioral analysis. The risk factors supporting this vicious cycle were compiled in a risk model in order to make them transparent for the patient as well as to derive a therapy rationale for working on them and interrupting the usual pattern. Peter was motivated and quickly understood that the “child pornography sessions” did not “just happen,” as he had initially reported. He recognized the link between his negative mood state and lack of coping mechanisms, which resulted in the urge to use CSAI. He identified his deficits in self-regulation, noting that he had a low tolerance for negative tension and few options for changing his negative feelings besides sexual activity. In contrast to his intellectual insight, implementation of alternative behaviors proved to be difficult because of his low perceived self-efficacy with regard to his ability to influence his behavior. Therefore, after receiving appropriate training, he decided to temporarily take medication to inhibit his sexual impulses until he was confident that he could deal with the sexual urges without medication. It was anticipated that the medication would help to interrupt the previous patterns leading to the use of CSAI by reducing sexual preoccupation and hence facilitating a deeper therapeutic process.

Pharmacological intervention: Starting with session 5

After five sessions, Peter visited the in-house medical outpatient department to learn about medical treatment options. He reported that the sexual fantasies and impulses came in “waves” and particularly in stressful situations. Consequently, he felt that he needed more than just

psychotherapy to deal with the problem. The experience of having uncontrollable sexual impulses was exacerbating his feelings of inadequacy and inability to cope. He masturbated three to four times a day, however, the masturbation fantasies also stayed in his mind as he went about his everyday life.

The somatic anamnesis and examination revealed a congenital limb defect, long QT syndrome, a penicillin intolerance, and elevated blood pressure, which were treated with a sartan and a beta blocker. No other somatic illness was present. The psychiatric anamnesis confirmed a moderate depressive episode with anhedonia and insomnia as the main symptoms.

Given the cardiac condition, we refrained from treatment with selective serotonin reuptake inhibitors (SSRI). Instead, we began treatment with Naltrexone 50 mg/d. This led to an initial reduction in sexual desire, fantasies and masturbation frequency. Peter reported that he was able to gain control over his sexual impulses. The reduction was experienced as sufficient for around 14 days, after which the sexual fantasies and desire returned and stabilized at a level slightly below that prior to treatment with two to three sexual outlets through masturbations per day and around 40% of his waking time devoted to sexual fantasies. Initial adverse drug reactions included headaches, insomnia and nausea, which diminished after a few days. Persistent adverse effects included flatulence and unpleasant body odor. Since there was no further decrease in masturbation frequency or the intrusiveness of sexual fantasies and Peter started experiencing the impulse to stalk prepubertal girls that he perceived as attractive, the treatment with Naltrexone was discontinued. Instead, a temporary androgen deprivation treatment was agreed upon after giving informed consent. Treatment was initiated with 100 mg/d of oral cyproterone acetate

under cardiological supervision. After two weeks, he was given 11.25 mg of intramuscular depot triptorelin. The cyproterone acetate treatment was discontinued two weeks later. Peter reported relief due to the decrease in masturbation frequency to once a day after four weeks. Sexual fantasies involving prepubertal girls were reported to occur only sporadically. Explicit sexual images depicting prepubertal girls were no longer used. The ability to attain an erection and orgasm remained unimpaired, however, there was a decrease in ejaculation and “dry” orgasms. The triptorelin treatment resulted in blood pressure fluctuations with peak values of 180/120 (systolic/diastolic), which were resistant to medical treatment. After the second depot injection and ten months after initiating treatment, he agreed to discontinue androgen deprivation therapy with the support of further psychological treatment.

Sessions 6-20: Sexuality and dissexuality

Through the antiandrogen effect of the medication, Peter was able to stop using CSAI which was a relief to him and allowed him to deal with processing the other risk factors. It was in this context that the development and functionality of Peter’s sexuality was addressed. By working out his sexual development over the lifespan Peter recognized that he had started using masturbation as a means of escape from feelings of depreciation and being an outsider. After meeting his wife, he experienced appreciation and intimacy with her. Due to his exclusive sexual preference for girls, however, it was hard for him to integrate his sexual interests into his sexual relationship with his partner. Based on the assumption of the different functions of human sexuality (Beier & Loewit, 2011), Peter came to the conclusion that for him, the dimension of desire (arousal, orgasm) was detached from the dimension of attachment (i.e., syndyastic

dimension that is feelings of safety and acceptance, comfort, closeness). While the feeling of being loved and appreciated by his wife as well as his love towards her was contingent on the ups and downs in the relationship, the dimension of desire presented itself as biographically stable and independent from the quality of the relationship. On the one hand, desire represented a resource in Peter's life because he was able to use it to achieve positive feelings. Due to his pedophilic fantasies, however, it also reinforced his feelings of inadequacy and led to problematic behavior. The concept of dissexuality (BEDIT, 2013) was discussed in this context and his offense-supportive attitudes were questioned (e.g., "some children do like sex with adults because they feel loved this way"). The use of CSAI was therefore defined as dissexuality (socially dysfunctional sexual behavior that violates the integrity and individuality of another person¹) (see Beier, 1995) because the production of these images is based on the sexual assault of children and the continued use of these abusive images is an offense against the sexual self-determination of the children. Peter's beliefs regarding sexual contact between children and adults (e.g., some children approve of having pornographic images made of them) were discussed in a Socratic dialogue and perspective taking training was carried out using imaginary scenes (e.g., someone secretly took a picture of you while you were urinating and uploaded it on the Internet). This process helped Peter to gradually change his beliefs about CSAI. In this context, the voyeuristic observation of urinating girls was addressed and Peter could identify it as a violation of their privacy by taking their perspective.

¹ Please note that dissexuality (Beier, 1995) is not restricted to sexual offenses as defined in the criminal code, but comprises sexually deviant behaviors that violate the sexual rights of another person, e.g., stroking a child's head because it is sexually arousing, secretly removing a condom without permission, etc.

Sessions 21–32: Depression, self-devaluation, coming out to wife

The following sessions focused on Peter's self-devaluation due to his pedophilic fantasies as well as his intimacy deficits and depressive mood. Initially, elements of classic antidepressant therapy were included in some sessions (weekly journal, activity structure, relationship between behavior, cognitions, and emotions) (see Hautzinger, 2003). Yet, as Peter began to take responsibility for his use of CSAI and the resulting harm to the victims, his self-devaluation and depressive mood increased. The therapeutic attitude suggested by positive treatment approaches (for an overview see Marshall et al., 2011) was of importance in this context. Following the guiding principles suggested by Miller and Rollnick (2013), the client was accepted for exactly what he is and his absolute value was appreciated, while simultaneously taking an unequivocal stand on the abusive nature of the dissexual behavior.

One of the exercises included Peter reading his written masturbation fantasies aloud in order to help him integrate these into his self-concept (BEDIT, 2013). The idea of acceptance as the realization of reality without the need to approve of it (Linehan, 1993) was conveyed to the client. Maintaining an environment, in which the patient was listened to without judgement or condemnation was one of the most important components of the therapeutic process. This allowed him to develop the courage to come out to his wife, who still did not know about the pedophilia. Since Peter was afraid of the consequences of telling her the truth, role-playing was used to prepare him for the situation. After coming out to his wife, the couple seized the opportunity to start couples counseling.

Couples counseling (7 sessions)

Peter's wife, who was very controlled and had difficulties talking about her emotions and inner processes, was initially shocked about her husband's coming out. The first sessions focused on the relevance of the pedophilic inclination for their relationship and the consequences for their sexuality as a couple. Peter's wife felt extremely hurt by his behavior, which she found egotistical because he had put his sexual satisfaction before the well-being and safety of children and his own family. Peter was able to ask her for forgiveness and tried to explain the risk factors and activating events that had led to the use of CSAI in the past. The couple agreed to talk to each other when feelings of frustration or worthlessness arose in him that triggered negative sexual impulses. At the same time, it was made clear that it was solely Peter's responsibility not to use CSAI. Since Peter's wife witnessed his struggle and efforts, he increasingly regained her trust and was able to communicate his love for her. During the couples sessions, it was helpful to emphasize the attachment dimension of their sexuality as well as include a model of female sexual responsiveness in long-term relationships (Basson, 2000). The model states that besides spontaneous sexual impulses, the wish for emotional intimacy with the partner can lead to the desire to sexually interact with him. Over the course of the couples counseling, it was observed that the partners became closer and reported an increase in satisfying communication and sexuality. At the end of the sessions, Peter's wife reported that at first her husband's admission of a pedophilic preference appeared "like a death-sentence," but now that she recognized it as an opportunity to improve their communication and relationship.

Sessions 33–45: Treatment of schemes, emotion-focused therapy

Mere cognitive-behavioral approaches have been criticized for aggravating emotional involvement and the modification of stable dysfunctional schemes (Drake, Ward, Nathan, & Lee, 2001; Mann & Shingler, 2006). The next part of the treatment, therefore, integrated emotion-focused as well as schema therapeutic interventions in order to facilitate a durable modification of Peter's inferiority scheme. Peter was able to acknowledge that his outlasting feelings of inadequacy and inferiority and his attempts to escape these negative feelings had led to problematic behaviors. Situations, in which he felt excluded or questioned activated his inferiority scheme, which made him feel like the little boy being told he was not good enough by his mother. A schema-focused model was formulated, in which Peter's maladaptive pattern of feeling defective and inferior was depicted as an "abandoned child" and his internalized self-devaluation as a "punitive parent" (for an overview on the derivation of a schema model see Young, et al., 2003, Jacob & Arntz, 2011). Peter recognized that he had adopted his mother's devaluation and as a consequence had reacted to the frustrated needs of his inner voice telling him that he did not deserve anything better and was not loveable or good enough. Peter had tried to escape these negative feelings through masturbation, which had become habitual over the years. As soon as he felt neglected, questioned or unappreciated, he escaped through sexual fantasies. This insight allowed Peter to identify the need to establish a "healthy adult" to support the "abandoned child" against the "punitive parent." In order to encourage the client to dialogue between his aspects of self (i.e., abandoned child, punitive parent, and healthy adult), chair dialogues were used to express the different aspects (see Greenberg, 2011). In the following sessions, Peter learned the skills he needed to establish a "healthy adult." Symbols were used to

support this process (church tower, angel) and make the supporter more obvious. Peter gradually succeeded in depicting past situations according to this inner dialogue. Increasingly, he succeeded in resisting his habitual patterns and he reacted towards his first (dysfunctional) impulse and according to a functional and problem-oriented behavior. For example, he reported a situation in which a work-related decision was questioned during a meeting of the church council, which immediately activated his inferiority pattern and led to the sexual impulse to search for CSAI (at this point, Peter had discontinued the androgen deprivation therapy in order to deal with his sexual impulses on a behavioral level). He succeeded in interrupting this process by talking to his wife about the situation and his feelings of inadequacy. He was able to identify his low sense of self-efficacy and dealt with this by meeting with friends who appreciated him and understood his feelings.

Sessions 45–55: Consolidation and relapse prevention

Although Peter's perceived self-efficacy concerning his abstinence from CSAI had increased significantly, he still continued to report situations that activated past behavioral patterns, which were used during the last sessions to consolidate the progress that he had made so far. In order to further distance himself from the self-devaluation impulses, an "empty-chair dialogue" was used in order to resolve his unfinished business with his mother (Greenberg & Malcom, 2002). On a cognitive level, alternative sentences and viewpoints were collected and recorded to make a standing against the automatic cognitions (Beck, 1995). The last three sessions were used for relapse prevention (Pithers, 1990). Peter established a relapse plan of specific short-term and

long-term steps to take in the case of risk situations (e.g., talking to his wife, including friends, contacting his therapist, avoiding access to the Internet, etc.).

Evaluating Outcome and Follow-Up

In the last session, Peter confirmed that he had achieved a great deal and was proud of that. It was especially helpful to him to read his sexual fantasies aloud, deal with them and overcome his feelings of shame. He was confident that he would not resort to the use of CSAI again because he had come out to his wife, who was supportive and aware of the activating events that could lead to risk situations. As a result of his coming out, the marriage had become more intimate. There was increased communication between them and they were more sexually active. Although Peter used accompanying fantasies to reach sexual arousal and orgasm, he found the sexuality with his wife satisfying because he experienced comfort and safety with her. His wife confirmed the improvement and described the relationship to be more intimate and united and Peter to appear more satisfied overall.

On an objective level, the post-therapy scores of the questionnaires that were administered again at the end of therapy showed a significant improvement. This was reflected in the Reliable Change Indices (RCI) (see Table 1) calculated. Depressiveness, loneliness, hypersexuality and psychosocial impairment were no longer clinically significant. The sum score of the STABLE-2007 decreased marginally from seven to four, which still corresponded to a moderate risk. This can be ascribed to the unchanged coding for the sexual deviancy even though the sexual self-regulation skills had improved.

Sixteen months after the end of treatment, Peter reported that he was still doing well in a follow-up interview and that there had not been any relapses concerning the use of CSAI. He has been abstinent for three years. He reported to have improved his listening to his “inner supporter” and relying on himself in dealing with frustrating situations in order to find problem-oriented solutions. By then, it had become clear to him that Christmas is a difficult time because his frustrated needs for comfort and appreciation are stronger at this time of the year. He saw that his relapse plan worked and that he could confide in his wife and talk to her about his feelings. After the end of treatment, Peter contacted the therapy institute once to get medication (nalmefene, 18 mg) to take as needed. Nalmefene is an antagonist at the μ -opioid receptor and agonist at the κ -opioid receptor. It has recently been approved for the use as an on demand medication in alcohol dependence in Germany and has shown some effectiveness in the treatment of other behavioral disorders (see e.g. Grant, Odlaug, Potenza, Hollander, & Kim, 2010). Peter took the medication once when he felt a strong sexual urge to look for CSAI on the Internet. Ultimately, he managed not to act on these impulses and reported feeling confident about not using CSAI in the future.

Discussion

The present case study introduced Peter, a 47-year-old pastor who contacted the therapeutic institution due to his excessive use of CSAI. The course of treatment mainly dealt with the patterns that made Peter react to perceived rejection by seeking sexual arousal with CSAI. The therapy initially focused on Peter’s self-regulation deficits by pharmacologically reducing his sexual impulses in order to establish alternative coping mechanisms for dealing with his negative

mood states, rejection and self-devaluation. Biographically stable patterns were processed with the aid of schema therapeutic and emotion-focused techniques. As part of Peter's coming out to his wife, couples therapy was implemented in order to facilitate examination of the pedophilic preference and enhance communication and sexuality within the relationship. Overall, the therapy can be seen as successful since Peter has managed to desist from the use of CSAI for three years now and the depressive symptomatology, feelings of loneliness and intimacy deficits could be decreased.

The reported case of a self-identified pedophilic man seeking treatment offers some aspects that are worth being discussed for their implications regarding treatment of people at risk to sexually offend against children or to misuse child sexual abuse images. Peter's treatment course might be exemplary for the group of pedophilic men described in the review by Cantor and McPhail (2016). They review the literature concerning a group of men who seek therapeutic help in order to desist from sexual contacts with children or the use of CSAI. They summarize that these pedophilic men are less likely to view sexual activity with children as acceptable and are more able to manage their sexual impulses. Also, the authors indicate that treatment may prevent these men from pursuing sexual contact with children or use CSAI but that the understanding of how treatment helps these individuals is still lacking. They point to research to address sexual pre-occupation, hypersexuality or the management of sexual arousal. The i-SOTP, a therapy program for online offenders (Middleton et al., 2009), focuses on intervention strategies targeted especially at intimacy and emotion regulation deficits since it has been suggested that these are significantly more prominent in users of CSAI (Middleton, Elliott, Mandeville-Norden, & Beech, 2006; Laulik, Allam, & Sheridan, 2006). According to these

findings, Internet offenders tend to use sexuality as a coping mechanism to avoid negative mood states and CSAI to gain temporary relief (Morahan-Martin & Schumacher, 2000). This applies to Peter, whose risk to use CSAI was considered high due to distinct emotional self-regulation deficits and sexualized coping strategies on the background of his pedophilic preference. At the same time, his risk to directly sexually offend against children was considered rather low. Several studies have addressed the question of cross-over from the use of CSAI to direct sexual offending against children (Bourke & Hernandez, 2009; Endrass et al., 2009; Houtepen, Sijtsema, and Bogaerts, 2014; Seto & Eke, 2005). From this literature, the majority of CSAI users seems to not adopt contact sexual offense behaviors in the course of their lives, though from experiences from the work in the Dunkelfeld, these findings appear biased by relying on judicial convictions rather than self-reports.

As for Peter, he reported not to think about his daughter or other children that he came into contact with in a sexual way but that his sexual attraction to children was strictly limited to his fantasies and CSAI. An explanation could be the detachedness of his sexual desire that was exclusively directed to prepubertal girls and his attachment needs that were exclusively directed to adult women. Another explanation could be his rather unincisive emotional congruence with children which has been found to moderate between sexual interest in children and offending behavior in pedophilic sexual offenders (McPhail, Hermann, & Nunes, 2013), though not being clearly associated with offending behavior in non-forensic pedohebephilic men (Konrad, Kuhle, Amelung, & Beier, 2016).

There are some implications that could be drawn from the case study when it comes to the treatment of men at risk to sexually offend against children. First, it was of importance to work out Peter's major behavioral pattern which had become automatic over time. A pivotal aspect of the therapy was to understand the mechanisms behind the misuse of CSAI, as for Peter the feelings of inadequacy and inferiority. This is in line with the assumptions of the GLM (Ward & Gannon, 2006) that conceptualizes sexual offending against children as a socially inadequate attempt to meet basic human needs. Thus, the presented case underlines the idea of de-pathologizing the mechanisms leading to the abusive behavior, while simultaneously marking the use of CSAI as child sexual abuse behavior. Accordingly, most of the applied interventions and techniques could be considered non-specific as for the clinical indication. If Peter had not misused CSAI but showed other dysfunctional behaviors (e.g. substance abuse), the therapeutic procedure would have been similar. Notwithstanding, it was of utmost importance to take the pedophilic preference into account, as the associated distress and self-depreciation have to be considered maintaining conditions for the dysfunctional behavior, i.e. the misuse of CSAI. Peter himself considered the misuse of CSAI as sexual addiction. It could, however, have fallen short to treat Peter as a sexual addict as it would have neglected the origin for the addictive behavior. We would assume that a permanent change could only be achieved when considering the pedophilic preference and acknowledging the concomitant fantasies and urges as soon as possible.

Parallel, the couples interventions addressed the intimacy deficits and led on to an improved syndyastic level of functioning, which was achieved by emphasizing the importance of sexuality for the fulfillment of basic needs of acceptance, safety and comfort (Beier & Loewit, 2011). The

dimension of attachment in pedophilic men living in a relationship is thereby of special concern because the partner does not (entirely) correspond with the sexual fantasies. This sexual therapeutic approach was of specific concern for Peter since mature women were not part of his sexual fantasies. In the beginning of the therapy he described a deprived communication and sexuality in his relationship. This was reflected in his wife's ignorance of his sexual preference, his initial decision not to involve her in the therapy and his decision to take medication to reduce his sexual impulses. By opening up to her and communicating about (sexual) needs their relationship as a couple improved despite the initial unsettling. Consequently, both partners have reported a significant increase of intimacy and communication, which has made their sexual relationship more fulfilling.

Another noteworthy aspect of the treatment would be Peter's decision for temporary medication. Through the pharmacological reduction of the sexual impulses Peter was able to gain the necessary distance to understand his needs, behavioral patterns and work on consequent dysfunctional behaviors. His perceived self-efficacy could be reinforced before the termination of medical treatment. Along with his improved self-regulation and support from his wife, this allowed him to resist renewed sexual impulses.

The presented treatment course might also come with implications for pedophilic men at risk to commit contact-offenses against children. Independent of the dissexual behavior following the pedophilic preference, frustrated needs and dysfunctional behavioral patterns, it is of importance to work out these underlying mechanisms, in order to establish alternative behaviors to fulfill basic needs. As a crucial difference, however, the antiandrogen medication

should be initiated earliest possible, if the risk to sexually offend against children is considered high. This pertains particularly in the treatment of clients outside the forensic system, where they have contact to children in socially uncontrolled situations and do not have to face immediate legal consequences. In this context, the easy accessibility of CSAI via the Internet matters as it poses a particular challenge for the treatment of CSAI users. They have to resist their impulses despite the easy availability of these images and relatively low risk of detection. This requires good self-regulation skills and a strong locus of control. Therefore, an improvement of external barriers (i.e., blocking software, facilitated criminal prosecution for online child sexual exploitation) is recommended in order to minimize the risk of sexual exploitation of children through sexualized images.

Besides the clinical implications, the case presented illustrates the necessity of investigating established risk prognostic instruments with respect to the transferability of non-forensic populations and users of CSAI. Peter reached low to moderate scores in the administered risk instruments, which were mainly attributable to the ratings for sexual deviancy and sexual self-regulation deficits. Prognostic instruments that assess sexually motivated recidivism risk based on the forensic history of the client (e.g., Static-99; Harris, Phenix, Hanson, & Thornton, 2003) are not considered applicable to community samples due to the comparatively small variance with regard to previous convictions (Kuhle & Beier, 2014). Instruments assessing the recidivism risk based on dynamic risk factors could be suitable for non-forensic populations, however, the application to this setting has yet to be determined (Kuhle & Beier, 2014). Subsequent to treatment, Peter has shown a minor improvement in the STABLE-2007 that

assesses stable dynamic risk factors. This can be attributed to his improved self-regulation skills with respect to persistent pedophilic fantasies.

Overall, Peter's case underscores the usefulness of need-oriented approaches. In this context, the use of CSAI is considered a dysfunctional (and dissexual) attempt to cope with frustrated needs such as the desire for intimacy, appreciation and connectedness. It is essential to work out these individual needs with the patient (and his partner) in order to establish alternative behaviors that are both patient and needs oriented.

Finally, it should be noted that the German reporting regulations which do not include a mandatory reporting law facilitated Peter's contact to the clinic as well as the presented treatment course. As a result, the client was able to open up concerning his sexual fantasies and his (penal) use of CSAI, without having to fear judicial persecution. This could be considered a crucial component when it comes to the prevention of initial or recurrent child sexual offending behaviors including the use of CSAI, in order to motivate clients at risk to seek treatment. Outside the forensic system, a close collaboration with child care services is of crucial importance in order to prevent harm from children and warrant support.

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Table 1: Outcome data on psychometric measures for Peter

Measure/Scale	Pre-treatment score	Post-treatment score	Mean (SD) Comparison sample	Cronbach's Alpha Comparison sample	Reliable Change Index ¹ (SEM)
SDS-17 (Stöber, 1999)	9	10	-	-	-
UCLA-LS-R (Russell et al., 1989)	54	39	37.06 (10.91)	0.94	6.07 (2.19)*
SRP-III (Paulhus et al., in press) Item mean	2.27	2.28	2.10 (0.39)	0.91	0.84 (0.30)*
BMS (Bumby, 1996)	75	58	51.8 (10.93)	0.97	11.98 (4.32)*
HBI-19 (Reid et al., 2011)	83	44	66.3 (13.8)	0.95	8.55 (3.09)*
CIS-R (Wilson, 1999)	12	13	-	-	-
ADS (Hautzinger & Bailer, 1992)	Clinically significant	Clinically non-significant	-	-	-
Global Severity Index, BSI (Franke, 2000)	Clinically significant	Clinically non-significant	-	-	-
STABLE-2007 (Hanson, et al., 2007)	8	5	-	-	-

¹In order to calculate the Reliable Change Index (RCI) and the Standard Errors of the Measurement (SEM), the means, standard deviations (SD), and alpha coefficients of the standardization sample were used. For calculation, the program of the Leeds Reliable Change Indicator (Morley & Dowzer, 2014) was used.

*Indicates changes corresponding to a reliable change.

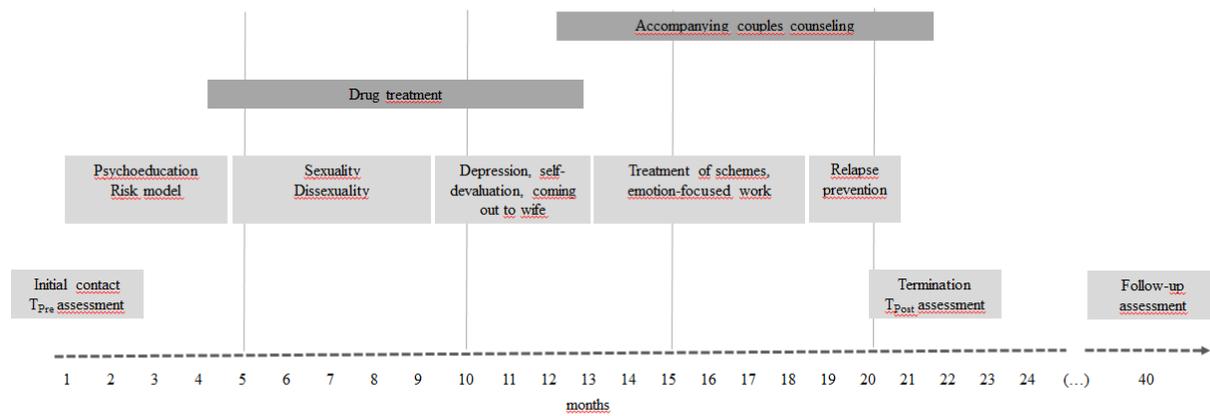


Figure 1: Schema of the therapeutic process in Peter's therapy