Psychopathology and Personality Traits of Pedophiles

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In This Report:

Because of recent scandals, pedophilia is one of the few psychiatric disorders widely known to the general public. Classified in DSM-IV and DSM-IV-TR as a paraphilia, pedophilia is characterized by persistent sexual attraction to prepubescent children. Although patients with pedophilic tendencies are generally seen by specialists in sexual disorders, many other clinicians are likely to encounter such patients as well. This article provides a general overview of the current literature on the psychology and psychopathology of pedophilia so that clinicians who encounter pedophilic patients will be better prepared to make an assessment and decide on the appropriate course of treatment. Moreover, a better understanding of people who are sexually attracted to children is critically important to protect against the severely destructive effects of childhood sexual abuse.[1,2]

CHECK POINTS

- ✓ Pedophiles commonly experience their sexual urges as ego-syntonic. To justify their behavior, they frequently rationalize, minimize, and normalize their sexual interaction with children, sometimes to the point of delusional ideation.
- ✓ Childhood sexual abuse appears to play an important role in the development of pedophilic tendencies. Nevertheless, childhood sexual abuse is neither necessary nor sufficient for the development of sexual attraction to children. Childhood abuse histories may be more characteristic of "true" pedophiles than "opportunistic" ones.
- ✓ Full assessment of pedophilia is best performed with multiple modalities and sources of information. The most common objective methodology involves plethysmographic measures, in which erectile response to targets of different ages and genders is recorded.
- ✓ Treatment of pedophilia is most effective when it is multimodal, long-term, and perhaps, court mandated. Cognitive-behavioral treatments can be used to reduce pedophilic sex drive, to increase age-appropriate sexual and affiliative behavior, and to strengthen inhibition of pedophilic behavior. In cases in which the risk of recidivism is high, anti-androgen or other hormonal treatments may be indicated.

Diagnosis

DSM-IV and DSM-IV-TR define pedophilia as "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving activity with a prepubescent child or children (generally 13 years or younger)." These feelings, urges, or behaviors must persist for at least 6 months. The DSM-IV criterion that such urges must cause clinically significant distress or functional impairment was amended in DSM-IV-TR, such that recurrent pedophilic fantasies or arousal need not be experienced as distressing. This correction reflects the ego-syntonic nature of many pedophiles' sexual desires and/or behavior.[3,4]

According to DSM-IV, pedophilia can be diagnosed in the absence of any pedophilic behavior. Nonetheless, because of the potential legal risks of self-reporting pedophilic inclinations, the majority of pedophile research is conducted with participants who are identified by their behavior, most often via their contact with the criminal justice system.

There are 2 problems inherent with this research pool. For one, convicted or arrested sex offenders might differ considerably from pedophilic individuals who have not acted on their urges or who have acted on them but have not been caught. Second, not everyone who sexually molests a child is actually a pedophile; that is, such a person may not have a persistent sexual attraction to

prepubescent children.[5] Despite these difficulties, current research does reveal sufficiently consistent patterns to provide a basic overview of common psychological features associated with pedophilia.

Male and female pedophiles

Most sexual offenders against children are male, although female offenders may account for 0.4% to 4% of convicted sexual offenders.[6,7] On the basis of a range of published reports, McConaghy[8] estimates a 10 to 1 ratio of male-to-female child molesters. However, most researchers assume available estimates underrepresent the true number of female pedophiles.[9] Several reasons for this have been proposed, including a societal tendency to dismiss the negative impact of sexual relationships between young boys and adult women as well as women's greater access to very young children who cannot report their abuse.9 Because of the low number of females in pedophile samples, most of the studies discussed below will be drawn from exclusively male samples.

Pedophilia subgroups

The most important diagnostic issue for clinicians who encounter a possible pedophile is the danger the patient may pose to children, although DSM-IV does not directly address this issue. Several subgroups are listed under the DSM-IV diagnosis of pedophilia:

- Individuals who are sexually attracted to males, females, or both sexes
- Those whose behavior is limited to incest
- Persons who are attracted only to children—exclusive versus nonexclusive

Although not listed in DSM-IV, the distinction between true and opportunistic pedophiles is possibly of greater diagnostic importance.[10,11] Related terms include fixated versus regressed pedophiles or preferential versus situational pedophiles.[8,11]

True pedophiles are those who show persistent and focused sexual attraction to prepubescent children. They show specific arousal to pedophilic stimuli on physiological measures of sexual arousal and have repeated sexual encounters with or recurrent sexual urges toward children. Opportunistic pedophiles have less of a focused sexual attraction to children. Their sexual engagement with children may depend on circumstances, such as the availability of a child victim, disinhibition secondary to substance abuse, or difficulty in connecting with an adult sexual partner.[8,10,11]

There is some controversy whether this distinction reflects distinct categories or a continuum.[7,11] Clearly, it suggests that people who molest children may have distinctly different motivations. For example, true pedophiles may be motivated more by abnormal sexual desire while opportunistic pedophiles may be better characterized by failure to inhibit their impulses.[11] Consequently, the distinction between true and opportunistic pedophiles may be important when considering the often conflicting findings on various psychological features within pedophile research. Perhaps more important, research supports the notion that "true" pedophiles present a higher risk of recidivism.[5,10,11] Thus, this distinction may be worth addressing in DSM-V.

It is critically important for clinicians to understand that not all pedophiles are the same; in fact they may differ widely. In essence, clinicians should evaluate whether attraction to prepubescent children reflects a long-standing, deviant sexual drive or a more short-term, circumscribed problem that developed in response to circumstances or to comorbid psychopathology. Treatment and prevention implications as well as the risk to the public vary accordingly because research suggests that "true" pedophiles pose the greatest risk of recidivism.[5,10,11]

Psychological features of pedophilia

Different psychological features give clues to the mechanisms underlying pedophilic behavior and offer potential treatment targets. More specifically, the person who sexually molests children has both impaired motivation and impaired inhibition. Possible motivational factors include social anxiety and the "abused-abuser theory." Possible inhibitory factors include impulsivity, cognitive distortions, and psychopathy. In addition, neurobiological abnormalities may pertain to either motivational or inhibitory dysfunction. All of these factors may come into play in any one person, but individual pedophiles may differ widely in their psychological profile.

Deviant motivation

Pedophiles have been hypothesized to seek sexual relations with children in response to social anxiety, poor self-confidence, or other personality traits that inhibit appropriate sexual relations with adults. While some studies have documented the presence of elevated levels of cluster C personality disorder traits, poor self-esteem, and impaired assertiveness, it is unlikely that these traits are specific to pedophilia.[12,13] There is also the problem of the direction of causality.

In our own recent study of pedophilic persons, narrative data revealed that some turn to children in

response to their impaired interpersonal skills. Others reported feelings of shame, low self-esteem, and social avoidance as a result of their pedophilic urges.[14]

The abused-abuser theory offers another model of pedophilic motivation. This suggests that a pedophile's own history of childhood sexual abuse predisposes him or her to pedophilic tendencies. Indeed this is the one proposed etiological factor that has received robust support in the literature. Estimates of the incidence of childhood sexual abuse in pedophiles' histories range from 40% up to 100%.[15,16] Female offenders might have an even higher incidence of childhood sexual abuse.[17] Moreover, pedophilic offenders have a higher incidence of childhood sexual abuse than do sexual offenders against older age-groups and nonsexual offenders.[15,18] Finally, in a randomly selected sample of men living in the community, men who had reported multiple events of sexual contact in their own childhood were almost 40 times more likely to report having sexual contact with children 13 years and younger than men who reported no sexual abuse in childhood (0.2% vs 7.7%).2

Thus, childhood sexual abuse appears to play an important role in the development of pedophilic tendencies. The underlying mechanism for this is not clear. Psychological processes, such as identification with the aggressor and normalization of adult-child sexual activity have been proposed.[19] We have suggested that abuse sustained during early childhood may result in neurodevelopmental abnormalities that predispose to pedophilic sexual desire.[12]

Nonetheless, most studies suggest that a sizable proportion of pedophiles were not abused as children.[12] While this might reflect underreporting because of denial and/or inadequately processed emotions about past traumas, the data suggest that childhood sexual abuse is neither necessary nor sufficient for the development of sexual attraction to children.[1,2] However, it is also possible that childhood abuse histories are more characteristic of "true" pedophiles than "opportunistic" ones.

A number of studies have investigated the neurobiological or neuropsychological correlates of pedophilia. Some studies have shown lowered IQ in pedophiles compared with healthy controls.[20] Cortical abnormalities in frontotemporal regions have also been documented using MRI, positron emission tomography, CT, and electroencephalography, as have subcortical abnormalities in the amygdala and related limbic structures.[12,21-23]

We can speculate that frontal dysfunction may underlie disinhibition while temporolimbic abnormalities may relate to abnormal motivation via aberrant sexual arousal patterns. However, not all studies have documented such impairment and the neurobiological and neuropsychological literature has been contradictory.[23] In our study of 20 pedophiles and 24 demographically matched healthy controls, we found no difference on tests of executive function despite highly significant differences on personality measures.[12]

Impairment in inhibition

With regard to inhibitory dysfunction, 3 areas to consider include impulsivity, cognitive distortions, and psychopathy. Impulsivity can impede inhibition via inadequate consideration of consequences, cognitive distortions through misunderstanding of the implications of the pedophilic behavior, and psychopathy through inadequate concern with the harm done to others, particularly young victims. Considerable data point to high levels of impulsivity or impulse control disorders within pedophile samples.[13,24] Nonetheless, these findings are not consistent and may reflect comorbid psychopathology in those pedophiles with the most severe psychopathology and/or those most likely to get caught. In addition, the findings may characterize pedophiles on the opportunistic side of the spectrum.

In the 1967 study by Gebhard,[25] the majority of pedophilic crimes (70% to 85%) were premeditated rather than impulsive. Likewise, in our study, pedophiles displayed lower scores on an impulsivity scale than a group of opiate-addicted controls. Moreover, the pedophiles' scores were virtually indistinguishable from those of healthy controls.14 The relatively high prevalence of pedophiles who maintain demanding jobs with high levels of responsibility, such as pedophile priests, also argues against a central role of impulsivity.[26] Thus, impulsivity may characterize some pedophiles but not all.

One finding that has robust support is the tendency toward grossly distorted thinking.[3,4,12] Pedophiles commonly experience their sexual urges as ego-syntonic. Presumably in an effort to justify behavior that is widely socially condemned, pedophiles frequently rationalize, minimize, and normalize their sexual interaction with children, sometimes to the point of delusional ideation. Relatedly, several studies have noted high levels of schizotypal and other cluster A personality traits in this population.[12,27]

Finally, engaging in sexual activity with children violates strongly held taboos as well as criminal law. Thus, we can predict that the participation in child sexual abuse may be associated with elevated psychopathic traits. Indeed, many studies have supported this finding.[12-14] Nonetheless, the degree

of psychopathic traits appears to vary across subgroups. A study of pedophilic priests found that this subgroup had lower levels of psychopathy than a sample of nonclerical pedophiles.[26]

In sum, research shows highly consistent evidence for cognitive distortions and sexual abuse histories, fairly consistent evidence for psychopathic traits, and mixed evidence for avoidant personality traits, impulsivity, and neurobiological or neuropsychological impairment. Future research is needed to address the extent to which:

- These traits pertain to either motivational or inhibitory dysfunction
- They are characteristic of true versus opportunistic pedophiles

Consequently, when evaluating a pedophilic patient, clinicians should consider the level of comorbid impulsivity, social inhibition, neurocognitive dysfunction, psychopathic traits, and cognitive distortions. These traits may give a fuller picture of motivating factors as well as impediments to the inhibition of pedophilic urges.

Assessment

Because pedophiles are not always truthful, full assessment of pedophilia is best performed with multiple modalities and multiple sources of information. When the criminal justice system is involved, examination of court records is critical. Likewise, objective measures of sexual response styles are often necessary because pedophiles routinely minimize their pedophilic tendencies.

The most common objective methodology involves plethysmographic measures, in which erectile response to targets of different ages and genders is recorded.[5] Measures of galvanic skin response and respiration rate can also accompany plethysmographic measures. The Abel Assessment for Sexual Interests (AASI) offers an alternative measure of observable behavior, recording visual reaction time to a range of images.[28] The AASI also comes with a lengthy self-report questionnaire. Two other self-report instruments, the Clarke Sexual History Questionnaire–Revised and the Multiphasic Sex Inventory, contain validity scales to detect lying.[5]

Treatment

Although, pedophilia is commonly seen as treatment-resistant, much research suggests this is not the case. Maletzky and colleagues[7] reported a treatment failure rate of only 9% over a 20-year period with pedophiles in comprehensive and (frequently) court-mandated treatment. Nonetheless, given the severe consequences of any relapse and the possibility of relapse even decades after the original assessment, clinicians who encounter a patient with pedophilic tendencies would be well advised to consult with a specialist in sexual disorders or even refer the patient to a specialty clinic. Unfortunately, there are far fewer specialty centers than are needed. The Association for the Treatment of Sex Abusers (ATSA) (www.atsa.com), however, can be a useful resource.

Treatment of pedophilia is most effective when it is multimodal, long-term, and perhaps court mandated.[7] Cognitive-behavioral treatments have been used to reduce pedophilic sex drive, to increase age-appropriate sexual and affiliative behavior, and to strengthen inhibition of pedophilic behavior. Associative conditioning techniques such as covert sensitization and aversive conditioning, as well as plethysmographic biofeedback and masturbatory satiation are used to reduce pedophilic arousal.[5,7,29]

With plethysmographic feedback, pedophilic patients can be provided with objective evidence of their sexual arousal patterns and of the effectiveness of any intervention to reduce pedophilic arousal. This can help cut through the denial and minimization that is such a problem with this population. More recent approaches have emphasized a relapse-prevention model, based on an addiction model of pedophilia.[5] Training in interpersonal skills, assertiveness, and empathy are also used in order to enhance relationships with adults.

Finally, confrontation of denial, particularly in group format; cognitive restructuring of cognitive distortions; and training in empathy for victims are all used to strengthen inhibition of pedophilic behavior.[3] Given the high rate of childhood abuse in pedophiles' own histories, exploration of their own abuse and its relationship to their adult pedophilic behavior is also warranted.

In cases in which the risk of recidivism is high and danger to the public is of considerable concern, anti-androgen or other hormonal treatments may be indicated.[29,30] The anti-androgen agent cyproterone acetate is widely used in Europe and Canada but is not available in the United States. Hormonal agents such as medroxyprogesterone and luteinizing hormone-releasing hormone (LHRH) analogues are also used. LHRH analogues, such as leuprolide, triptorelin, and goserelin, are long-acting and can be given via injection.[5,29,31] Because these treatments reduce global and not just pedophilic sex drive, treatment adherence may pose a serious problem and may depend on external pressures, such as court-mandated treatment.

SSRIs such as fluvoxamine, fluoxetine and sertraline have also been used to treat pedophiles. With a

more favorable adverse-effect profile than anti-androgens, treatment adherence with SSRIs may be less of an issue. A few studies have shown some efficacy.[29,31] It is unclear, however, whether these work through reducing depression, reducing compulsive behavior, or reducing general sexual function.

Conclusion

Because of the many legal and ethical complications involved, some clinicians may choose not to treat individuals with pedophilia. It is nonetheless important for all clinicians to be familiar with the basic literature on pedophilia because these patients do present in a wide range of clinical settings. Moreover, given the high incidence of childhood sexual abuse and its pernicious, long-lasting effects, high-quality research, assessment, and treatment of pedophilia are of great public importance. Luckily, current techniques are promising. With better public support, there is opportunity for significant advances in the treatment and prevention of this disabling and destructive disorder.

Check Points

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Drugs Mentioned in This Article
Cyproterone (Cyprostat)
Fluoxetine (Prozac, Sarafem, Symbyax)
Fluvoxamine (Luvox)
Goserelin (Zoladex)
Leuprolide (Lupron, others)
Medroxyprogesterone (Depo-Provera)
Sertraline (Zoloft)
Triptorelin (Trelstar)

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