



# Pedophilia: The problem with diagnosis and limitations of CBT in treatment

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Received 11 April 2006; accepted 20 April 2006

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**Summary** This paper asserts two main points. First, there is little reason to include pedophilia among the mental disorders of the Diagnostic and Statistical Manual (DSM). The diagnostic criteria as specified in the DSM-IV-TR (2000) are both over-inclusive in that all acts of child molestation warrant diagnosis, and under-inclusive in that individuals who have not acted upon, and who are not distressed by their sexual interest in children do not meet diagnostic criteria. On both sides of this debate there are problems. A diagnosis of pedophilia seems to “medicalize” an illegal behavior, or “criminalize” fantasy; depending on the diagnostic criteria used, or the use made of the diagnosis. Secondly, the typical CBT-based relapse prevention treatment for pedophilia, which represents current best practice, is reviewed. It is suggested that this, as a stand alone therapy, is suboptimal. CBT components are necessary but not sufficient for comprehensive therapy. It is imperative that process issues are given primacy in treatment programs. The common factors literature makes it clear that the therapeutic relationship is at least as potent a factor promoting change as the system or techniques that clinicians employ. Diagnosis per se is not required for adequate treatment of these individuals. For the CBT components, some offence specific information is required but that is a far cry from true diagnosis. © 2006 Elsevier Ltd. All rights reserved.

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## Introduction

Dispassionate discussion of pedophilia is difficult and a great deal of emotion is evoked by the behavior of pedophiles. Some have suggested there is an innate biological imperative to protect our young and this should act to discourage some acts of child molestation [1]. Violation of this imperative (and social taboo) may be the source of our outrage when members of society sexually exploit children. Nevertheless, dispassionate dis-

course is required if we hope to improve our understanding of this troubling social problem. The term “pedophilia” is of Greek origin and means “child lover” [2]. This term refers to the state of adults being sexually interested in children. Ironically, most people would not consider sexual abuse as love, and some individuals who molest children are not sexually aroused by them – at least not exclusively. Pedophilia as a diagnostic label is somewhat more precise and is defined according to particular criteria.

According to the Diagnostic and Statistical Manual of Mental Disorders-4th Edition-Text Revision (DSM-IV-TR) [3], three criteria are specified to diagnose pedophilia. These are:

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- (A) Over a period of at least 6 months, recurrent, intense sexual thoughts or fantasies, or urges involving sexual activity with prepubescent children, or behavior involving sexual activity with prepubescent children (generally 13 years of age or less);
- (B) These sexual fantasies, urges or thoughts cause marked distress or interpersonal difficulty, or the individual has acted on these fantasies or urges;
- (C) The person is at least 16 years of age and at least 5 years more senior than the child in criteria A.

There are several approved specifiers available as well. These are: sexually attracted to males, sexually attracted to females, sexually attracted to both, limited to incest, exclusive type, or non-exclusive type [3, p. 572].

In the text accompanying diagnostic criteria in DSM-IV-TR, there are some noteworthy features. The paraphilias (of which pedophilia is one) are often first seen in adolescence and continue into adulthood, fantasies associated with pedophilia tend to undergo elaboration and revision over the life of the pedophile, and the course of the disorder is chronic and generally lifelong. DSM-IV-TR further posits that 8 to 10 year olds are preferred by pedophiles attracted to girls, while older children are preferred by male oriented sex offenders. In a potentially problematic intermingling of legal and medical nosology, DSM reports that recidivism rates for pedophiles attracted to males, are reportedly twice as high as for those who are attracted to females (see p. 571).

## Prevalence

Estimating the prevalence of pedophilia in the general population is an imprecise process and the DSM offers little comment on this aspect of the disorder. As pedophiles do not typically identify themselves as such, studies on virtually every aspect of pedophilia use convicted sex offenders as the sample pool, and crime statistics as a data source. Crime statistics are crude measures at best, given that reporting practices, police procedures, court interpretation, and plea bargaining arrangements differ over place and time. Epidemiological survey data can provide a different perspective on prevalence. For example, Briere and Runtz [4] surveyed male undergraduates and found that 5% admitted masturbating to fantasies of children, and 7% thought they might have sex with a child if they could be assured it would not come to light. Unfor-

tunately, this methodology has its own limitations (briefly reviewed as it relates to pedophilia in Marshall [2]).

DSM-IV-TR [3] notes that in order to make a diagnosis of any of the paraphilias, the following primary conditions need to be excluded: mental retardation, dementia, a personality change due to some other general medical condition [5], substance intoxication, manic episode, and schizophrenia. These conditions specifically are associated with decreased judgement, and increased impulsiveness. The diagnosis is not indicated if the paraphilic incident is isolated behavior and not the patient's preferred sexual pattern [3, p. 568]. These caveats are highly significant. Peugh and Belenko [6] for example, reported high prevalence of substance use among a cohort of incarcerated sex offenders. However, it is unclear from a DSM perspective what degree of use/abuse of substances would better account for pedophilic acts than pedophilia itself. Depression is notably absent from the text on differential diagnosis. This is an interesting omission in that depressive symptoms are frequently observed in men who molest children.

## Etiology

The etiology of pedophilia is unclear. As with most human behavior, its causation appears to be multi-determined. Kelly and Lusk [7] summarized how the major psychological schools account for pedophilia. For example, they reported that classical psychodynamic theory views pedophiles as being arrested at an early psychosexual stage and as typically having unresolved oedipal conflicts, while object-relations theorists would point to troubled self-object representations as causal factors. As another example, social learning theorists interpret high rates of childhood sexual victimization among pedophile samples as support of conditioning and modeling influences on later psychopathology [7].

Sociocultural theory, as interpreted by Kelly and Lusk [7], suggests numerous factors in modern society that make child molestation more likely to occur. For example, the socialization of males as dominant figures and as non-nurturing with children, the oppressed status of women/girls making victimization more tolerable to other men, generally repressive sexual norms for children, the erosion of traditional families, and fewer traditional external social controls over sexual behavior are possible disinhibiting factors for pedophilic behavior.

Neurological abnormalities have been considered as possible factors predisposing some men to

pedophilia. Blanchard et al. [8] for example, have suggested that subtle brain damage after birth (but during neurologically developmental years) may be implicated in later pedophilia. Blanchard et al. [8] found that pedophilic men self-reported head injuries before the age of 13 years more frequently than non-pedophilic men. This replicated earlier work by the same group [9]. Collectively, these two studies involved 1,891 men [8] and while the strength of correlation was quite modest ( $r = .12$ ) significance was obtained.

Maes [10] implicated several monoamine and hormone irregularities in pedophilia, any one of which may be a predisposing factor alone or in combination. Maes reported that pedophiles appear to have decreased activity at the pre-synaptic 5-HT<sub>2</sub> receptor, and increased activity (upregulation) at the same post-synaptic sites. Maes reported pedophiles tend to have lower baseline serum levels of cortisol and prolactin. The impact on downstream behavior as a result of these hormonal variations (especially in males) is unclear. Other reports have suggested that prolactin levels among sex offenders are *higher* than expected in the normal population [11]. Testosterone has tentatively been implicated in aggression, and has been recently shown to have a small, but significant, relationship predicting sexual offence severity and recidivism among child molesters and rapists [12].

In sum, there is little conclusive evidence that pedophilia has clear and direct physiological causation. Rather, contributory elements appear to promote or inhibit manifestation of this disorder. There are many who argue that sexual orientation is not a choice. The removal of homosexuality as a disorder from DSM may reflect some consensus on this point [13]. It has been posited that pedophilia, like heterosexuality or homosexuality, represents sexual arousal to a particular identifiable group, and is not voluntarily decided, but biologically determined [14]. Extending the sexual orientation argument to pedophilia is an unsettling prospect, as it could then become morally contentious to hold offenders accountable for their behavior.

Numerous studies have examined diverse variables such as family history, childhood abuse/neglect, sibship order and configuration, digit length ratios and handedness, substance use, and personality characteristics in attempts to understand how individuals come to obtain sexual gratification (or power and control) in activities with children. Positing that intimacy deficits and disrupted attachment to parents play important roles in the etiology of sexually abusive behavior, Marshall and his group have looked at numerous aspects of

psychological functioning among sex offenders [15]. Investigations have found that child molesters are lonely, have difficulty with intimacy, and have disrupted attachment bonds with other adults [16]. A sample of child molesters were found to have lower self-esteem and reported a greater degree of maternal rejection than a sample of demographically matched normal controls [17]. Ward, McCormack, and Hudson [18] found that child molesters and rapists had a variety of deficits in establishing and maintaining intimacy in their relationships. Child molesters, for example, were found to be especially sensitive to rejection by others. While these are notable findings, they do not clarify the issue of cause and effect.

In what is most certainly an issue related to style of attachment and degree of intimacy, evidence indicates that sex offenders experience higher rates of childhood abuse than the general population [19–21]. This disorder/behavior is clearly multi-determined.

## The irrelevance of diagnosis

There are numerous past and present events in the life of any pedophilic patient that have little explanatory value when viewed in isolation. Pedophilia seems to be a case where diagnosis adds little to our understanding of a patient beyond being a description of their behavior. This is a good example of diagnosis providing a "...flat and colorless picture of the client" [22, p. 180]. A true classification system should have some relationship and inclusion of etiological/evolutionary theories and principles.

There are significant problems with the DSM diagnostic criteria for pedophilia and with the accompanying text. DSM notes differences between pedophiles attracted to males versus pedophiles attracted to females [3, p. 571]. Specifically, DSM indicates that homosexual pedophiles re-offend at twice the rate of heterosexual pedophiles, but such a claim is unfounded. In fact, one recent study suggested that recidivism rates in a large sample ( $n = 354$ ) of child molesters did not differ significantly with victim gender [23]. As well, Marshall [2] noted that there is no evidence to suggest that 8–10 year olds are preferred by heterosexual pedophiles as DSM claims.

Marshall [2] highlights some of the changes in diagnostic criteria that have occurred over various editions of the DSM. The terms "pedophile" and "child molester" are now used as synonyms by the lay public and by many clinicians. This was not always the case. In earlier versions of DSM (until DSM-III-R, [24]) a diagnosis of pedophilia was

only indicated if the individual experienced recurrent, intense sexual urges toward children. Thus, an individual who may have molested many children, but denied recurrent, intense fantasies would not have been considered a pedophile. Many pedophiles deny or minimize the extent of their sexual interest in children, and the cynical observer may simply disbelieve these individuals. However clinically, pedophiles do seem to have varying degrees of investment in adult-child sexual activities. Does this mean that the diagnostic category should include qualifiers such as “moderate” or “severe?”

Probably guided by the pursuit of sample homogeneity, researchers seem to have a greater resistance to seeing pedophiles and child molesters as being equivalent. To these parties, a pedophile is primarily sexually attracted to pre-pubescent children (as per DSM criteria), while a child molester is one who has sexually assaulted a child in some way but may not, in fact, have a *primary* sexual attraction to children. There is debate as to the importance of this distinction [25]. Some have suggested that the motivations to touch children may be different for the two groups [26], and it is widely accepted that molesters with different victim types have different arousal patterns. Admission of attraction to children is typically accepted via patient self report, but denial is usually met with skepticism. Unfortunately, there is no valid “lie detector” for this including erotic preference testing (EPT) [27,28]. Penile plethysmography is one way to assess arousal patterns and involves an apparatus to measure penile tumescence when men are presented with audio and/or visual stimuli of variously aged individuals of both genders and in various sexual situations (consenting, non-consenting, in activities with adults, etc). Any result of erotic preference testing unfortunately provides the assessor with information of limited diagnostic value. If a patient fails to respond to stimuli in such a way as to suggest pedophilia, but has already committed a pedophilic act (or several) then the test result is moot. Recall that from a DSM-IV-TR perspective a pedophilic act equals the diagnosis of pedophilia. The point here is that the labels of child molester or pedophile have limited practical utility and there is no obvious rationale as to why either label should lead to different types of treatment or perhaps equally important, disposition. The truth may be that the pedophilia diagnosis actually subsumes a “continuum” of sexual response rather than dichotomous or exclusive groups.

O'Donohue, Regev and Hagstrom [29] have raised additional concerns about diagnostic crite-

ria. These authors have disputed the requirement for fantasies to persist for at least 6 months, and suggest that this temporal criteria is arbitrary in the absence of any clarification. O'Donohue et al. take further issue with field trials used to establish inter-rater reliability for diagnosing pedophilia, and doubt that an appropriate amount of research has been conducted to clarify numerous validity issues.

Based on the points raised thus far, it is reasonable to advocate for the removal of pedophilia as a mental disorder from the DSM [13]. However, one might rightly consider if there is a compromise position on this issue. If removal of the category was not an option, an improvement could be found by going back to earlier versions of DSM. Prior to DSM-IV [30] a clear sexual attraction to children (intense and recurrent fantasies) was required for diagnosis even if actual molestation was known to have occurred. Many researchers and clinicians effectively ignore diagnosis, yet many will still acknowledge that there may be something unique about the “true” pedophile versus other child molesters. This remains a throwback to early theory which identified a “fixated” pedophile as being exclusively attracted to children, and the “regressed” pedophile who only seeks out children when some incident or life stressors impel an individual toward this behavior [31]. Although not the best solution to deal with categorical ambiguity, this differentiation between pedophiles and child molesters at least recognizes that many men who molest children do not do so strictly for sexual purposes. These individuals will often cite revenge, jealousy, or a need for power and control as being very significant elements in their behavior.

Another potential improvement to DSM would be to adopt a proposition by O'Donohue, Regev, and Hagstrom [29] to interpret pedophilia strictly as a behavioral disorder and rename the diagnostic category as “pedophilia response disorder” – either chronic or acute. Thus, making the “diagnosis” strictly a behavioral description. Unfortunately, this goes against psychiatric practices and principles. Under this alternative, all acts of child molestation would be sufficient to warrant diagnosis, and vague descriptors such as “intense” and “recurrent” could be avoided.

In sum, it is advocated here that the category of pedophilia be dropped from future editions of the DSM as it appears the lines between psychopathology and legal description have become blurred. The institutions of justice and medicine both are served best when remaining as distinct from each other as possible. The criteria, at this point in time, are too broad to allow for any meaningful

discrimination between child molesters and pedophiles. They are also too narrow in that some individuals who are very aroused by adult-child sex would not be considered pedophiles so long as the arousal was ego-syntonic and had not been acted upon. This is becoming a much more relevant point with the huge increase in child pornography available on the internet. Barring the preferred outcome of removal from DSM, a revision to the definition of pedophilia is advocated so that it might be either very narrow or very inclusive.

In many situations in general medicine, diagnosis can point the clinician toward or away from a specific treatment. This is not true for pedophilia. The present treatment of choice for pedophiles is group therapy from a cognitive-behavioral therapy (CBT) orientation. In 1999, Marshall [32] commented that sex offender treatment programs from a cognitive-behavioral perspective represented the future of sex offender treatment. This appears to have been prophetic, although Marshall subsequently began to re-evaluate the limitations of this model [33]. The typical CBT treatment program involves having patients participate in psycho-educational groups where modules on various topics are presented. Relapse prevention concepts adapted from addictions therapy [34] are frequently a major component of these programs. These concepts usually involve the identification of high risk situations and the completion of behavioral chains and crime cycles. Other groups often focus on anger management, assertiveness training, human sexuality, communications, control/reduction of deviant arousal, and substance abuse.

Identifying the strength of CBT-relapse prevention treatment programs for pedophiles is easy; they have demonstrated efficacy in reducing sexual offense recidivism compared to treatment non-completers, or to some control group. Research in this area has methodological obstacles, but a number of studies now report success in lowering re-offense rates with this treatment [35–37]. With clearly defined and objective measures, CBT tends to be research friendly, and various modules can be examined to evaluate their relative contribution to positive outcome (i.e., reduction in recidivism).

Without a doubt the rise of CBT has had a major and positive influence on how sex offenders receive treatment. The CBT orientation has helped to generate a large body of literature regarding effective treatment interventions for sex offenders. Unfortunately, this dominant tradition has also hindered our understanding of what changes occur for these patients during treatment, and in understanding what aspects of the treatment experience contrib-

ute to lasting positive outcome. As traditional insight-oriented approaches have been (perhaps prematurely) reported to be less effective with sex offenders [38,39], interventions from behavioral and cognitive-behavioral perspectives have gained favour among treatment providers.

As traditional approaches have been abandoned, attention to group process principles have also been neglected. These principles are taken for granted as important in clinical work with other patient groups. The pervasiveness of the CBT movement in this field has meant that priority has been assigned to skills-acquisition, relapse prevention, crime cycles, behavioral chains, and similar psycho-educational constructs. Unfortunately, these intervention strategies overall are geared only toward symptom reduction and do not capitalize upon the host of other extra-therapeutic factors that can facilitate change [22]. Consequently, much less importance has been placed on the generation and maintenance of interpersonal relationships, and work in the affective domain [40].

Recently, some investigators have begun to reassert that group process issues are indeed relevant in the treatment of sexual offenders [41–44]. Marshall et al. [33] noted the years of adhering to the typical CBT treatment models for sex offenders while ignoring process issues has likely been in error.

Given that the offender is the treatment recipient, his experience in therapy should be a central issue. Yet, few attempts have been made to obtain the perceptions of sex offenders regarding their subjective experiences in treatment. The lay public and sometimes treatment providers, unfortunately, do not care what the sex offender thinks or how he feels about the treatment he receives. In one of the few studies to examine this subject using data provided by sex offenders, Day [45] reported that offenders in his sample found the most helpful elements of treatment were those related to interpersonal factors. Day concluded that intra-group relationships might play a more significant role in predicting outcomes than the content of the program itself. Drapeau, Körner, and Brunet [46] conducted a qualitative study of 24 pedophiles attending treatment. Similar to Day, Drapeau et al. reported that offenders' experience of the treatment staff were the most important factor in their progress. Such findings seem to confirm Bordin's [47] position and the wider psychotherapy literature that relationships, not techniques, are the key agents of change.

In virtually any psychotherapy setting the therapeutic alliance is considered fundamental. The construct of the therapeutic alliance has demonstrated



validity [48] and at its most fundamental level, the therapeutic alliance is the relationship between patient and therapist that facilitates the work of therapy. In reviewing the recent literature examining alliance and outcome, Horvath [49] reported that there are a number of variables which impact upon the strength of the alliance. Patient factors and therapist factors play key roles in the bi-directional relationship which "...provides the essential common context..." [49, p. 370] upon which therapists implement their techniques. In another recent review of therapist qualities found to promote a strong alliance, Ackerman and Hilsenroth [50] reported that both personal attributes (e.g., flexible, experienced, honest, respectful, trustworthy) and *qualities* of therapist technique (e.g., exploration, depth, reflection, supportive, affirming) are often reported in the literature as having a positive impact on the therapeutic alliance.

Given that the therapeutic alliance is considered a valid pan-theoretical construct [47,49–52] there is no reason to expect the importance of the alliance in work with sexual offenders to be diminished. In fact, there are several reasons why the therapeutic alliance may be a particularly important mechanism of change for sexual offenders.

The high prevalence of abusive experiences among sex offenders may be one reason why a strong alliance is important in their treatment. Given the negative effects of childhood abuse that have been identified in a variety of samples across a host of interpersonal and psychological domains, it seems entirely reasonable to expect pedophiles to have attachment problems, intimacy deficits, and poor relationships with others. The strength of the alliance may potentially explain a greater degree of the variance in rates of recidivism (one definition of outcome) than do the established static risk factors. Potentially, the treatment experience may provide the richest prophylactic effect for sexual offence recidivism among this group of patients.

Many elements of an ideal treatment program would be typical of cognitive-behavioral therapy. For example, group members could do a variety of written assignments such as crime cycles or substance abuse relapse chains. Such assignments would delineate thoughts, feelings, and behaviors which precede an offence or substance relapse, and are considered standard fare in sex offender treatment programs. It would be folly to eliminate elements that have some demonstrated benefit. Rather, they should be given appropriate status within an environment that offers something additional. What is more essential are the relationship dynamics which develop within the program. CBT elements should be subordinate to an interpersonal

here-and-now focus [53]. Treatment gains should mean more than an improved skills set, and symptom reduction.

The relationship between alliance and outcome among sex offenders in treatment is virtually unknown from an empirical standpoint. However, given that these patients frequently have disturbed attachment styles [54], have experienced high rates of childhood abuse [19], and often expect treatment staff to be punitive [56], the therapeutic alliance provides an opportune vehicle by which offenders can experience a wealth of new transferential learning.

Kear-Colwell and Boer [40] argue persuasively that the overall approach to the treatment of sexual offenders needs to be reconsidered. Whereas many programs advocate a highly confrontational style in this work [55], some observers have seen it as counter-therapeutic. Given that the alliance itself can be healing, and that the strength of the alliance has been found to be positively related to outcome [52,57], it is imperative that the *process* of therapy not be overlooked for this patient group.

As many offenders have been exposed to violent and dysfunctional parent figures, they often have significant impairments in establishing and maintaining satisfactory relationships with age-appropriate others. As Stukenburg [56] describes, these offenders have often become exquisitely aware of control issues, have abused that control themselves, and expect others to do likewise. The therapeutic experience can allow new learning to occur for these individuals, and in particular, a strong therapeutic alliance can allow patients to work through transference issues and experience fulfilling relationships which have been unattainable to them in the past. It may be that developing healthy relationships with treatment staff and peer group members may be a corrective bonding experience that can be generalized to all their relationships, both casual and intimate.

The most important work with these patients may be in facilitating affective learning about themselves and the relationships they have with those around them. When these patients come to believe they have personal efficacy, personal responsibility often follows. And when they learn to establish fulfilling relationships that meet universal interpersonal needs, they often improve their ability to tolerate some emotional discomfort. Abusiveness to others then becomes an increasingly unlikely response to stress. This type of change is best achieved when the primacy of the interpersonal relationship is continually reasserted, in a therapeutic environment where group

process is routinely examined. To rely solely on improving coping strategies and skills development is to treat symptoms while ignoring the patient and the source of the disorder. Ultimately, society may be better protected and offenders better served by treatment providers if relationship issues are primary in treatment programs.

In conclusion, although it may appear that these two areas, in which the current wisdom is being questioned, are disparate it is our contention that they are fundamentally connected. Diagnosis is not as important as some would like to believe, partly because an interpersonal approach to treatment is optimal. This more global perspective to treatment which highlights the poverty in relationships among this group, allows for an individualized approach on a template of core therapeutic techniques without the need for a highly specific diagnostic label.

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