Pedophilia Among the Paraphilias: Symptomatology and Treatment of The Pedophile

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Abstract

Paraphilia refers to the set of sexual behaviors best known by the names of sexual perversions or deviations. Paraphilias are classified into: exhibitionistic disorder, fetishistic disorder, frotteuristic disorder, pedophilic disorder, sexual masochism disorder, sexual sadism disorder, transvestism disorder, and voyeuristic disorder (APA, 2013). In pedophilic disorder, the object of sexual arousal is the child. In the past in the time of the ancient Greeks and Romans, the term pedophilia was understood as an educational or pedagogical form. At present there is a view of the pedophile as a "sick person," in fact as argued by Aguglia and Riolo (1999), the pedophile is a psychiatric patient "not only because he violates children in body and mind, but also because of a whole series of personality traits, if not overt clinical forms, that make him a sick person and therefore to be treated, despite the fact that he is not always conscious of illness." There has long been discussion and research for the purpose of identifying the mechanism through which the perverse sexual desire of the pedophilic type came to be formed. In order to better understand the nature of this sexual perversion, some authors (Ward et al., 1995) have related pedophiles' intimacy problems to different attachment styles, others have given more weight to experiences learned throughout the life span (Kaplan et al., 1995), and others have also considered the psychobiological perspective. Finally, in terms of therapeutic treatment, there are physiological treatments such as surgical castration, chemical castration, and drug therapy and cognitive behavioral psychotherapy are also used.

Keywords: pedophilia, crimes, victimology, society, psychotherapy.

I. Introduction

The term Paraphilia is derived from the Greek: para (deviation) and filia (source of attraction) and indicates that which constitutes sexual attraction (situation, object) thus, the set of sexual conduct best known by the names of sexual perversions or deviations. Some of these abnormal forms of sexuality are prosecuted by law, as they may involve the overpowering of the will of the other, even to the involvement of non-consenting persons. The goal is to achieve sexual arousal and pleasure (Kaplan, 1992). To be diagnosed with a paraphilic disorder, the DSM-5 requires that people with this interest experience it with personal distress, not resulting simply from social disapproval; or have a sexual desire or behavior that involves psychological distress, injuries or the death of another person; or a desire for sexual behavior involving other people unable to give valid consent or involved without their knowledge. Paraphilias are classified into: exhibitionistic disorder, fetishistic disorder, frotteuristic disorder, pedophilic disorder, sexual masochism disorder, sexual sadism disorder, transvestism disorder, voyeuristic disorder. (Andreoli, Cassano, Eselver, 2002). So-called Paraphilias not otherwise specified are also present, which include: phone scatology, clismaphilia, urophilia, coprophilia, zoophilia, necrophilia, etc. Such paraphilias are considered "minor" because they are much rarer to justify the use of a specific class. When such activities become a priority and replace ordinary sexual contacts, then they fall into a framework of "abnormality (Simonelli, Petruccelli, Vizzari, 2000). First and foremost, the problem of pedophilia is more a psychological-social problem than a strictly medical one. Suffice it to say that in ancient times, relationships between adults and minors were permissible, codified within a defined cultural framework, certainly different from today's. Given that pedophilia is a complex phenomenon in which both clinical and legal evidence are involved, it is essential that these two areas work synergistically. Today, however, the treatment and prevention aspect is often put on the back burner in the face of greater interest in the punitive aspect. In fact, the use of treatment is secondary to legal pressures that situate such a solution as the only alternative to prison for obtaining parole. Most pedophiles accept treatment at legal services only to avoid jail time. Therefore, it would represent a good

start to the approach if the clinician decides to postpone treatment until later, when the case has had a legal resolution (Gabbard, 1994). The pedophile is also difficult to treat because usually the perversions are ego attuned, so that only a fraction of treatment requests occur spontaneously on the part of the person concerned, and when they do almost always, these individuals are driven by anxiety or depression related to the perversion. The major objection to this proposal has been that those who refuse to cooperate cannot be treated. Some research has shown, however, that psychotherapies of involuntary abusers have achieved results even without the patient's initial full motivation. In Italy since the 1990s, work has begun in this direction and excellent results have also been obtained through the acceptance of an explicit link between the judicial and therapeutic contexts. According to this current of thought, if therapy instead of repression were favored, the economic costs would certainly be very high, since highly specialized therapists are needed, but they would always be lower than the costs that society has to pay for the costs of detaining these subjects and also their probable recidivism would be lower. It turns out to be necessary and fundamental, a cultural and social commitment to confront the omertà, passive acceptance and indifference to the phenomenon of Pedophilia. This is possible only if we begin to combat pedophilia properly and above all by admitting that to date it has not yet been studied enough. This is what Andreoli (2003) argues that "society, and the scientific community within it, has always tried to exorcise this problem either by denying that it exists, or by trying to relegate it to the realm of monstrosities, that is, those cases that are so rare and aberrant that they do not even merit systematic study. This phenomenon is not only continuously and increasingly increasing, but is also increasingly developing and evolving thanks to the new technologies at our disposal. Recent news events show how, thanks to the new communication technologies, the phenomenon of pedophilia has multiplied the spaces of expression by preserving anonymity and fostering exchanges between pedophiles from all over the world. This new dimension of pedophilia is based on the exchange of child pornography, attempts at online solicitation of minors, and the creation of pedophile sites. There are numerous images, in fact, depicting minors partially or fully nude, where it is mostly the attitudes or the environments in which they are portrayed, which recall the sphere of sexuality. The use of the network, therefore, has enabled the pedophile to collect and exchange pornographic material more easily. The entry of pedophilia and child pornography into the Internet is part of the characteristics of cybercrime, representing one of the main criminological emergencies. It seems interesting, therefore, to highlight how the new communication technologies have not only expanded the frequency and consequences of criminal realities, but have also affected the socialization processes of users, thus favoring the expression of their sexual deviance. Pedophiles build, here, ad hoc sites, thanks to which they have the opportunity to meet, interact and communicate with subjects with the same interests and sexual deviance. The feeling of security resulting from the guarantee of anonymity and the absence of inhibitory brakes normally present in real life are characteristics of those phenomena of seduction and grooming of minors known by the term grooming, a process of socialization within which the abuser tries to familiarize himself with younger people by sharing their hobbies, interests, communicative languages in order to grab their trust and prepare the way for eventual sexual abuse.

II. Pedophilia in history

The term pedophilia which comes from the Greek pais, child, and philìa meaning love could be understood as an educational or pedagogical form. Pedophilia spread between the 4th and 6th centuries B.C. in Sparta and Athens. A distinction must be made between pederasty understood as a sexual relationship of an adult and a minor between the ages of twelve and eighteen, which is considered licit and recognized as a pedagogical-educational form; and pedophilia understood as sexual relations with children under the age of twelve, which is illegal and reprehensible. Protecting childhood was a constant concern of the Athenians. According to their legislation, if the minor had not reached the age of 12, he who engaged in sexual relations of any kind with the minor always committed an illegal act. Very severe penalties were provided for adults who wandered inside the buildings reserved for minors. The pagan world, on the other hand, failed to understand the human identity and dignity of the child and could not comprehend it, since it assumed that the child, was not a person and therefore did not enjoy the various rights. This conception led to contempt and all forms of abuse toward children (Bonafiglia, 2003). In the Middle Ages, marriage between a 10-year-old girl and an old man was not an exception, even though the law set 12 years of age, the minimum age for marriage. Pedophilia could not be spoken of because of the ethical-religious beliefs of the time, but the practice of apprenticeship in the homes of strangers, which facilitated the possibility of sexual contact between adults and children, was widespread. The beauty of the child and adolescent body, often reproduced in works of art, its smoothness, facilitated the sensuality of relationships, and the desire for possession, including bodily possession, of beauty.

III. Pedophilic Disorder according to the DSM-5

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) includes pedophilia within the category of those disorders that psychiatric terminology refers to as "paraphilias."

Relative to pedophilia, the diagnostic criteria given by the APA (American Psychiatric Association) reported in DSM-IV and unchanged in DSM-5 are as follows: a) during a period of at least 6 months, recurrent, intensely sexually arousing fantasies, sexual urges or behaviors involving sexual activity with one or more prepubescent children (usually 13 years of age or younger); b) the fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in the social, work, or other important areas of functioning; c) the person is at least 16 years old and at least 5 years older than the child or children in criterion A. The age of onset is in adolescence, although some subjects report not experiencing arousal toward children until middle age. Pedophilia can be classified into severe, when there is marked discomfort with paraphilic urges but they are not enacted; moderate, when the drive is enacted occasionally; and severe, when patients repeatedly enact their paraphilic urges. The pedophile's sexual activities may be limited to undressing the child and looking at him, showing off, masturbating in his presence, gently touching and caressing him. In severe cases, he subjects the child to oral-genital intercourse, vaginal or anal penetration, using varying degrees of violence. As

argued by Aguglia and Riolo (1999) it appears, therefore, clear that the pedophile is a psychiatric patient "not only because he violates children in body and mind, but also because of a whole series of personality traits, if not overt clinical forms, that make him a sick person and therefore to be treated, despite the fact that he is not always conscious of illness."

IV. The origins of pedophilic behavior: theoretical contributions

There has long been discussion and research for the purpose of identifying the mechanism through which the perverse sexual desire of the pedophilic type came to be formed. Some authors (Ward et al., 1995) have related pedophiles' intimacy problems to different attachment styles, identifying three main types of molesters: a) the anxious-resistant, with low self-esteem, continually seek the approval of others. They feel secure in the presence of a partner who can be controlled (such as a child in need), while with adults they are incapable of establishing emotional relationships. They nurture and court children and rarely employ coercive means; b) the avoidant-threatening, present a strong desire for contact along with fear of rejection, so they avoid intimate relationships with adults perceived as rejecting them. These individuals enact abuse using force and little empathy; c)
the avoidant-avoidants, seek relationships that require as little social contact as possible and as little emotional openness as possible. Compared with avoidant-thymers, they are characterized by a greater degree of hostility and aggression that can lead to violent and sadistic coercive behavior. According to learning theory, experiences during adolescence could result in perverse sexual conduct: these if not properly corrected can develop into adulthood, becoming an integral part of the subject's personality (Kaplan et al., 1995). Moving on with the analysis of the phenomena that may have influenced in the onset of paraphilic behavior, the psychobiological perspective must also be considered, since a high percentage of these subjects exhibit post-traumatic symptoms. Some studies, conducted since 2002, have linked childhood brain trauma with the development of pedophilia. Ray Blanchard et al. of the University of Toronto, comparing the histories of 400 pedophiles with those of 800 non-pedophiles, found that the former had a much higher rate of traumatic incidents with loss of consciousness before age six. The authors, therefore, concluded by stating that their work did not prove a causal link between traumatic injuries and the development of pedophilia, but it could have been hypothesized that the presence of a congenital defect, predisposing to altered sexual orientation, would also have made them more vulnerable to accidents. Some studies have focused on the role of serotonin, which would be able to control the abnormal sex drive. It appears, in addition, that there is, at some stages of sexual behavior, an involvement of dopamine.

V. Treatment of the pedophile

Regarding physiological treatments, there is surgical castration (currently in use only in Germany and the Czech Republic), which consists of the surgical removal of the testicles, in men, or the ovaries, in women. According to Vittorino Andreoli (2003), surgical castration is not useful because the sexual act does not necessarily require either erection or penetration. Chemical castration (used in the U.S., Canada, and Europe, but not in Italy) is another practice that falls under pharmacological treatment options. In contrast to surgical castration, this one relies on taking hormone-based drugs with the goal of reducing testosterone levels in the blood, resulting in a reduction in deviant sexual fantasies. The subject must, however, be forced to take these substances for a long time to achieve an effective and lasting effect, and this can cause irreversible physical injury. Incidentally, the effectiveness of this type of treatment is still uncertain, as it primarily acts by reducing activation at the genital level, but not on the mental aspects related to sexual desire. As for drug therapy, the aim is to reduce libido and sexual arousal. Specifically, drugs are divided as follows (Catanesi and Dell'Erba, 2002):
1.Substances with a direct hormonal effect: Estrogens, LH agonists (triptorelin),
2.Antiandrogens: cyproterone acetate, medroxy-progesterone acetate;
3.Psychoactive drugs: Neuroleptics, Benzodiazepines, Antidepressants;
4.Others: Propanol, Reserpine, Spironolactone.
Other drugs such as neuroleptics do not seem to possess great antilibid efficacy, while cases of patients treated effectively with fluoxetine have been reported, albeit with limited success (Stein et al., 1992). Their use stems from the idea of an involvement of the serotonergic system on the control of aggression, which often underlies paraphilic behavior.

VI. Cognitive-behavioral psychotherapy

The initiation of therapy for paraphiliacs often takes place involuntarily, often the law requires it because therapy is essential to have parole, in these cases successful treatment is really difficult. Any therapy achieves its goal only when the person undergoing it is voluntary and consenting, and only when patients are able to fully accept responsibility for their actions and the harm they have caused. Over the years, the sex offender has been seen as a sick person who must be treated. The goal of these intervention programs is for modification of deviant sexuality to occur, while taking into account that it is often associated with behavioral and cognitive distortions, by identifying two basic goals: to reduce sexual arousal in relation to "unusual" practices or partners; and to promote or enhance sexual arousal in relation to appropriate practices or partners. Several techniques, often combined, can be used for this purpose:

1. masturbatory conditioning.
2. covert sensitization (Cautela, 1960).
3. aversion therapy (Marshall, Barbaree, 1990).

The purpose of the Masturbatory Conditioning technique is to replace deviant fantasies in the subject with non-deviant fantasies. For example, the pedophile uses a diary in which he writes typical deviant masturbatory fantasies. With the help of the therapist, he or she will have to work out and write down a nondeviant fantasy that still allows orgasm to be achieved through masturbation. When there is a deviant fantasy, the subject should not masturbate, but verbally express all the modifications he can imagine of this deviant fantasy or practice, so that the orgasm that will follow (with masturbation) will be related to the nondeviant fantasy. Concealed Awareness involves helping the abuser to imagine a scene that might stimulate him or her to reoffend and to imagine unpleasant consequences immediately afterwards, such as, for example, arrest. Finally, aversive therapy involves correlating arousing and deviant as well as unacceptable behaviors with an unpleasant physical experience (e.g., an electric shock or an unpleasant odor such as ammonia) (Accorsi, Berti, 1999). A variant of this technique is the one proposed by Serber referred to as "shame therapy": the pedophile is invited to enact his deviant behavior in the presence of the therapists' aides, who are appropriately instructed to taunt and disapprove of the subject.

Conclusions

Sexual perversions are a topic that is often under-explored in the scientific and field literature. However, sexuality is a fundamental component within the lives of human beings and is very often ignored and seen as taboo. Like any other pathology, paraphilias require treatment in order to reduce the effects of the pathology on the sufferer. For example, therapeutic treatment of pedophiles and Sex-Offenders in general can yield positive results if due consideration is given to both the subjective and objective difficulties of these therapies and their costs. Prevention understood in therapeutic terms of treatment, can be effective only for subjects consenting to treatment and aware of their pathological sexuality (Accorsi, Berti,1999). Therapeutic goals consist of the pedophile recognizing his or her problem, taking responsibility for his or her actions, remodeling his or her attitude toward both sexuality and aggression, and gaining awareness that sexual abuse is a compulsive act that must be controlled. The issues that therapist and patient will have to deal with are: sex education, understanding sexual abuse, the impact of sexual abuse on the victim, resocialization of the individual taking into account interpersonal relationships, control of aggression; personalized "techniques" to avoid abuse. The growing consensus of psychiatrists seems to indicate that no single therapy taken individually is effective for all paraphilias, and that tailored approaches are needed for each individual (Schwarz,1987). Gabbard (1994) assumes that therapist expectations must be modest because, regardless of the type of therapy, paraphilic patients are notoriously difficult to treat. Therefore, before psychotherapy can be considered, which in any case should take place in the prison environment, it may be useful for the prospective patient to receive even individual treatment that, following behaviorist principles, pursues certain therapeutic goals, such as: helping patients overcome their denial, helping them develop empathy for their victims, identifying and treating deviant sexual arousal, identifying social deficits and coping skills that are inadequate, and avoiding situations that are particularly challenging for them. It can be concluded that these types of programs, in order to prevent recidivism, help the pedophile understand and recognize, behaviorally, the psychological and situational variables that expose him or her to the risk of committing the crime again. The pedophile should be helped to recognize the factors that trigger the cognitive, affective and behavioral alterations that drive him to abuse.

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