A STUDY OF PERSONALITY PATTERNS IN HOMOSEXUAL AND HETEROSEXUAL PEDOPHILES

by

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A Thesis Submitted to the Faculty of Graduate Studies and Research of McGill University in Partial Fulfillment of the Requirements for the Degree of Doctor of Education

Department of Educational Psychology and Counselling
McGill University
Montreal, Quebec, Canada

May 1988

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Abstract

This pilot study was designed to collect and analyze a broad range of descriptive data on out-patient pedophiles. Eighteen males, with at least one legally charged pedophilic offense (excluding incest) participated in the research. Seven of the subjects sexually molested a male child (homosexual pedophiles) and eleven subjects sexually molested a female child (heterosexual pedophiles).

Subjects were administered the Millon Clinical Multiaxial Inventory (MCMI) and the Narcissistic Personality Inventory (NPI). Subjects and their therapists also participated in a structured interview which sought data on psycho-social and offense variables.

Analysis of the MCMI results found that when profile configurations were compared, the homosexual group showed higher mean sub-scale elevations, a more cohesive pattern of sub-scale elevations, and significantly higher sub-scale scores for Passive-Aggressive personality as a feature. The heterosexual group shared Avoidant/Dependent features of personality with the homosexual group but individual profile configurations were much less homogeneous in sub-scale elevations. The analysis of the NPI results found no significant difference between the groups. A comparison of the structured interview data for the groups

strongly suggests that homosexual offenders are more structured in their pedophilic interest than heterosexual offenders.

The results are discussed in relation to the validity of the fixated/regressed model for homosexual and heterosexual pedophiles, respectively. The relationship between personality, aetiology of pedophilic behavior, and offense pattern is considered. Implications and suggestions for future research are outlined.

Résumé

Cette étude pilote visait à recueillir et à analyser un large éventail de données descriptives relatives à des patients pédophiles en clinique externe. Dix-huit hommes, ayant à leur compte au moins une accusation pour acte de pédophilie (excluant l'inceste), ont participé à cette recherche. Parmi ces sujets, sept ont molesté sexuellement un enfant de sexe masculin (pedophiles homosexuels) et onze sujets s'en sont pris à un enfant de sexe feminin (pedophiles hétérosexuels).

Ces sujets ont été soumis au "Millon Clinical Multiaxial Inventory" (MCMI) ainsi qu'au "Narcissistic Personality Inventory" (NPI). Les sujets et leurs thérapeutes ont aussi participé à une entrevue exhaustive, laquelle visait à obtenir des informations sur les variables psycho-sociales et les accusations.

L'analyse des resultats du MCMI a démontré que quand on comparait les configurations de profil, les homosexuels présentaient une moyenne plus élevée à l'échelle de graduation, une courbe plus cohésive, et des résultats définitivement plus elevés au niveau d'un caractère Passif/Agressif comme trait saillant de la personnalité. Le groupe hétérosexuel partage avec le groupe homosexuel les caractéristiques d'une personnalité de type Évitement/Dépendance, mais les configurations de profil au niveau des individus sont beaucoup moins homogènes. L'analyse des

résultats du NPI n'a pas montré de différence significative entre les deux groupes. Par contre, une comparaison des données recueillies lors des entrevues indique clairement que les contrevenants homosexuels sont plus déterminés dans leur penchant à la pédophilie que les contrevenants hétérosexuels.

Les résultats sont discutés en relation avec la validité du modèle fixation/régression pour les pédophiles homosexuels et hétérosexuels respectivement. La relation entre personnalité, étiologie du comportement pédophilique et type d'offense est considérée. Enfin, nous soulignons des hypothèses et des recommandations susceptibles d'être utiles à la recherche future.

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ACKNOWLEDGMENTS

This study would not have been possible without the support of the staff at the McGill Clinic of Forensic Psychiatry. I am particularly indebted to Dr. Renée Fugère, Director, for finding the time to support this project in the midst of administrative duties, court appearances, and caseload demands. Her clinical expertise was an invaluable contribution to this work. I am indebted to Dr. Bruno Cormier for devoting his life's work to the study of offenders, which made it possible for me to also find my life's work.

I would like to express my deep appreciation to Dr. William Talley, Counselling Program, Department of Educational Psychology and Counselling, Faculty of Education, McGill University. As my thesis advisor, Dr. Talley provided guidance and support from the proposal stage of this research to the editing of the final manuscript. His non-judgmental approach to the topic of this research was a great support to me personally.

I wish to thank Dr. Socrates Rapagna, Department of Educational Psychology and Counselling, for his expert counsel in the statistical analyses of these data. In addition to countless office hours spent on this research, he generously gave of his personal time.

I also wish to thank Dr. Ted Maroun, Department of Educational Psychology and Counselling, for his reading of this manuscript and his comments as a scholar in human sexuality. The collaboration of Dr. Pierre Lagier, Bureau d'intervention psychosociale, Montreal, on the development of French versions of the testing instruments helped make the data collection possible.

I am grateful to Ms. Angela Bolt, M. Ed., for her efforts as my research assistant. Her perseverance in collecting these data throughout difficult scheduling problems is to be commended. I am also indebted to Ms. Agathe Genois for her careful attention and patience in typing this manuscript.

Quality work depends not only on the support of a technical team, but also on the support of friends and family. I would like to express my gratitude to Dr. Schamborzki, whose determination in her own endeavors served as my example. I wish to thank the future Dr. Mann for her conviction that the title "Dr." belongs in front of both of our names.

Finally, appreciation is extended to the Research Grants Committee of McGill University for the provision of funds to defray the expense of this research.

Chapter I

Overview of the Field

Introduction

The study of pedophilia (literally defined as "love of children") has become a major concern of mental health professionals as public attention has focused on the sexual abuse of children. Clearly, the public is unwilling to accept sexual relations between adults and children, and yet it is equally clear that such interactions continue to happen. It is estimated that one-fourth of female children have some sexual experience (broadly defined) with an adult male before they are fourteen; this is probably an underestimate due to the hesitancy of victims to disclose such experiences, and it excludes the (male) victims of homosexual pedophiles (Finklehor, 1979; Kinsey, Pomeroy, & Martin, 1953; Mohr, Turner, & Jerry, 1964). Statistics for the sexual abuse of children reveal an increase from 4,327 reported cases in 1977 to 22,918 cases in 1982 (American Humane Association data cited in Finklehor, 1984).

The practice of pedophilia can be traced back to Ancient Greece where sexual/love relationships between pre-pubescent boys and girls and adult males were commonplace.

> Pederasty was a means of raising Greek soldiers in accord with government specifications. Just as each prepubescent girl had to marry a man 15 to 20 years her senior, so each male child of noble family had to take an adult male lover. Pederasty was the prime mode of the boy's education. A boy of 12 would be courted with male admirers openly vieing for his attention with gifts, poetry, flattery, and even cash. Once a suitor was approved by the father, the lucky man was permitted to possess the boy by rape. Upon completion of the ritual, the adult was responsible for perfecting the boy's body and mind, use of weapons, horsemanship, execution of duties, and obedience to authority. (Garcia, 1987)

These relationships were held in high esteem as the adult male served as a valued mentor to the boy, and the relationship ended as soon as the boy showed signs of beard growth (Durant & Durant, 1939).

Although historical contexts have existed where sexual relations between adults and children were valued, today this is certainly not the case. Adults who act upon their sexual interest in children are seen as deviant and such actions constitute a criminal offense throughout North America.

In the last decade, public attention has been focused with renewed interest upon this problem (see "Disturbing End of A Nightmare", in Time, Lamar, 1985). In 1977, an organization calling itself the "Pedophile Information Exchange" (PIE) gained media attention with their stated desire to change the legal age of sexual consent for children, and their attempts to present pedophilia in a more positive light. PIE wants the age of sexual

consent lowered to age 4. Other organizations have followed this quest for acceptance. As Garcia (1987) writes,

> The really dedicated pedophiles form networks with each other through mailing lists, pen pals, newsletters, and lobbying efforts. Hermes, one such underground newsletter, gives erotic accounts of pedophilic adventures. NAMBLA, the North American Man-Boy Love Association, not long ago accused the FBI of launching a witch-hunt against their organization. According to Bill Andriette, their spokesman, NAMBLA is "political and educational with a libertarian, humanistic outlook on sexuality". The Rene Guyon Society of Los Angeles is more blunt, "Sex by eight or else it's too late" is their motto. (p. 139)

As Cook and Howells (1981) have theorized, perhaps the individuals involved believed that the sexual revolution had liberalized the social climate to the extent that pedophilia would no longer be seen as "deviant" but only as an alternative sexual lifestyle.

Sexual offenses against children arouse horror on the part of the public and consequently much of what the public believes about pedophiles is clouded in emotionality. If society is to address the problem in a responsible manner, it is first necessary to answer, empirically and objectively, some very basic questions.

Cook and Howells in Adult Sexual Interest in Children summarize these basic questions and ask,

> ... what sort of adults are sexually interested in what sort of children; and why; what effect does their interest have on the child; how might their interest be measured; and how might their interest be redirected ? (1981, p. viii)

In this research, the author will first acquaint the reader with the answers that exist for the above questions by providing a focused summary of current knowledge. Drawing from this framework, the author will concentrate attention upon the differences between homosexual pedophiles (male victim/object) and heterosexual pedophiles (female victim/object). The objective of this research will be to determine whether some of these differences may be related to different personality structures of heterosexual and homosexual pedophiles. The author's interest is related to both the "why" and the "how might this interest be measured"; it is her belief that the level of sexual interest in children varies systematically and predictably in the homosexual pedophilic population as contrasted with the heterosexual pedophilic population, and that this variation can be related to differences in personality.

This section will orient the reader to the many dimensions of pedophilic behavior and the resultant issues involved in doing research with this population.

The study of those who commit criminal offenses of any sort is first and foremost feuled by the desire to protect society.

When the offense committed is a sexual act and where a child is the object, the desire to protect is particularly acute.

While studying an offender after the fact can not protect the child who has already become a victim, knowledge of the offender can protect victims of the future. We know that the abused often become abusers (Gaffney, Lurie, & Berlin, 1984; Groth & Burgess, 1979; Prendergasts, 1979), and like any psychopathology which shows an intergenerational transmission (Cooper & Cormier, 1982; Gaffney et al., 1984) the cycle must be broken[1].

Incidence

How widespread are pedophilic offenses ? This is quite difficult to know as there are several problems inherent in trying to determine incidence. While numerous researchers have tried to estimate the incidence (Badgley, 1984; Finkelhor, 1979; Fritz, Stall, & Wagner, 1981; Russel, 1983; Sedney & Brooks, 1984), clear information on the number of pedophilic offenses is difficult to isolate as statistics on sexual offenses against children often fail to differentiate incest (intra-familial) from pedophilia (extra-familial). Clearly, there has been an increase

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[1] This is not to say that we study offenders in isolation; to understand a criminal act we must study both the offender and his object. Victimology studies inform us that there are two parts which make the whole (Viano, 1976).

in reporting by victims of sexual offenses, with estimates on the amount of children having experienced an unwanted sexual advance or behavior from an adult ranging from 7.7% to 38% for females, and 4.8% to 8.6% of males before age eighteen (Pelletier & Handy, 1986). The author is purposely vague in using the terminology "an unwanted sexual advance or behavior" as these statistics reflect a broad range of offenses. Offenses of varying severity are often classed together. An incident which results in a charge for an adult may range from fondling a child through his clothing, to forcing anal intercourse on a child repeatedly over the period of a year.

A third problem in estimating the incidence of pedophilia (in Quebec particularly) is the result of a change in the law. Until 1982, a pedophilic offense could have resulted in a charge of "gross indecency", "contributing to the delinquency of a minor", "rape", or "sodomy". Pedophilic offenses might have resulted in these charges, but non-pedophilic offenses might have also resulted in some of these charges. For example, "contributing to the delinquency" may be the charge resulting from someone who shares drugs with a minor, so that tallies of these charges include, but are not limited to, pedophilic offenses Further, after 1983, the classing of sexual offenses was changed to a broad category of "Sexual Assault" - which can include offenses against minors and adults. In criticizing this

law and its confounding effect on researchers, Renner and Sahjpawl (1986) have written that,

> The decision by Statistics Canada to alter reporting procedures at the time this new law was introduced has excluded the opportunity for a proper evaluation of a major piece of social legislation. (p. 413)

Some researchers have tried to assess the problem by collecting data on the average number of offenses per pedophile. Abel, Mittelman, and Becker (1985) have written that in a sample of 232 pedophilic offenders the average number of victims per pedophile was 75.8. Yet there is a problem in assuming this statement validly represents all pedophiles. This sample was composed of volunteers who responded to newspaper advertisements offering treatment without prosecution. It is likely that these individuals were people with a fixed sexual interest in children and consequently they would have a relatively high number of victims as a group. In fact, the "average duration of deviant arousal... was 12 years" (Abel et al., 1985, p. 190). In addition, 50% of these subjects had multiple deviations (such as exhibitionism and voyeurism). Some pedophiles have a developmental history of multiple deviations (including, for example, exhibitionism, voyeurism, and fetishism), but research leads one to conclude this is less than 50%. Groth, Longo, and McFadin (1982) found roughly 25% of their sample had committed other paraphiliac behavior, while Abel himself found that the

initial paraphiliac behavior and first legal offenses of his pedophilic sample were 75.85% pedophilia only. Whether the same percentage of offenders continue other behavior in addition to pedophilia is unknown. Yet, these findings suggest that his group was somewhat "loaded" with polymorphous sexual offenders, who may be a distinct class of pedophile.

His statistics probably represent the damage done by well-structured pedophiles. While we do not know the percentage of the total pedophile population which falls into this category, research suggests this may be roughly half of those with like charges (Groth & Birnbaum, 1978).

A final problem in estimating incidence concerns the varying ages which in law constitute a minor for the purpose of sexual consent. While in Quebec a minor is someone 16 or under, in the United States the present range is from 11-18 years. "The age selected seems to be an arbitrary matter, the product of legislative compromise" (Kourany, Hill, & Hollender, 1986).

Problems in Assessment and Legal Dispensation

Should pedophiles go to jail ? While society may react with a resounding "yes!", the problem of "what to do" with the individual is not so simple. Let us examine the problem of assessment as it relates to treatment and legal dispensation. In a very basic way, if the assessment criteria used for legal

dispensation are the number of prior offenses and the likelihood of recidivation, it would seem obvious that an individual with three prior pedophilic offenses (separated by years) is likely to recidivate, and if we wish to protect the victim(s), we should lock him behind bars to keep him away from society. But is prior history leading to judgments regarding future recidivation enough ? The following section will underscore the difficulties in making such a decision. The nature and context of the act, the degree of victimization, the financial cost to society, the ability to control through out-patient treatment or deprivation of liberty, and (if we are to see ourselves as humane) the social and psychological limitations of the offender should all be taken into account.

It is not always clear what is the best treatment of the individual, both with a view toward protecting society and a desire to "help" the offender. The balance between the two is tenuous yet strongly tied together. If we can successfully treat the pedophilic individual, we are at the same time protecting society from his abuses.

Clearly, we must know enough about pedophilia to determine what is the best specific treatment for each individual and the best dispensation of each case. Let us examine some of the criteria the professional community uses in psychological assessment and recommendations for sentencing. The list is not

meant to be exhaustive, nor is it presented in order of importance.

1. Likelihood of recidivation.
2. Prior offenses.
3. Degree of violence in the act.
4. Degree of trauma to the victim.
5. Nature of the actual sexual act.
6. Degree of sexual disturbance (well-structured vs. regressed from normal adult sexuality).
7. Degree of psychological disturbance.
8. Life-stressors at the time of the offense.
9. Disinhibitors (alcohol, drugs) active at the time of the offense.
10. History of sexual abuse in the offender's background.
11. Intellectual capacity of the offender or organicity.
12. Physiological disturbance (e.g., epilepsy leading to violent impulses, diabetes leading to sexual impotence).
13. An escalating offense record (sexual crimes of increasing severity).
14. Polymorphous sexual behavior (exhibitionism, voyeurism, rape, in addition to pedophilia).
15. Social network of the offender (married? loner?)
16. Other (non-sexual) criminal history.
17. Actions as ego-syntonic vs. ego-dystonic (shame and remorse or cognitive defense of actions).

To illustrate just how complicated the issues surrounding pedophilia are, let us use one of the above items, the "degree of sexual disturbance", and consider it in the five cases below. If no differentiation is made between offenders it may seem an obviously correct statement to say that all pedophilic offenders are sexually disturbed.

Berlin (1986) has written an excellent article which presents five different sexual offenders (rapes in this case, although one offender raped children) to illustrate the point that "... rape is not a diagnosis, and we do not diagnose a

patient by looking solely at his behavior" (p. 11). One can say the same for pedophilia - it describes a behavior, but hardly the individual. In the DSM-III (American Psychiatric Association, 1980), pedophilia is an Axis I diagnosis which,

> ... simply means that a person is sexually attracted to children and as a result of that attraction may have great difficulty coping. It does not tell us whether or not there are other aspects of character, temperament or personality that also need to be seen as having psychiatric importance.. some individuals who commit sexual offenses can be said to have antisocial personalities. But that is not inevitably so, nor is it necessarily something that is obvious on the face of it. For example, many people might assume that anyone who has sex with a child must necessarily be somehow characterologically flawed. They may or they may not be. (Berlin, 1986, p. 11)

A pedophile may or may not be characterologically flawed or sexually disturbed. The following five brief cases and ensuing comments may make the above statement easier to understand. The cases concern five different offenders who have committed the same crime. Again, these men have all committed rapes. There is no equally illustrative work with pedophiles but the principles can certainly be extrapolated. All of the examples are summaries of Dr. Berlin's case discussions in the article, "Interviews with Five Rapists" (1986).

Case I : The Career Criminal Who Rapes. This is an individual with a long and varied criminal history starting in his youth, who recently committed his first rape. He is a man who had a habit -- pattern may be a better word -- of taking what he wanted

when he wanted it. He is a person who wanted sex, was not in a position where he could have it consentually with a particular woman, and so he took it from her. He is not someone who is psychotic, and there is probably nothing wrong with his sexuality. He has a long history of satisfying his needs with a total disregard for the impact of that satisfaction on others. It is difficult in a sense to know how to treat such an individual; it is a matter of his having to develop social responsibility (conscience).

Case II : The Angry Rapist. This individual has no prior criminal record; he committed a single rape. He once shot off his foot to avoid entering the army at his mother's insistence. He is an individual who all his life did not know how to deal with frustration and he had pent-up feelings. He had been building a home for his wife. Just at the time they were supposed to move into this dream home, his wife announced she was having an affair with her boss, and was going to leave him and move into the home with her employer. He does have what might be called temperamental or characterological problems, but not of an anti-social sort; he is a person who all his life has had great difficulty dealing with frustration and asserting himself in a constructive way. In a nutshell, the treatment for him is to anticipate the buildup of anger and allow him to be defused in a sense before it reaches the point where it explodes causing problems for himself or for other people. He is not on Depo-Provera. He does not need his sexual drive lowered. He does not need anti-psychotic medications. He is probably a person with an anti-social personality with personality vulnerabilities.

Case III : The Psychotic Rapist. The patient believed he was a religious figure. The patient committed a series of rapes, but had no prior criminal record. He did have, however, a record of two previous psychiatric hospitalizations. All rapes were committed during a 3-4 week period when he was floridly psychotic. He appears to have had several episodes where he was mentally ill in this way, but with good recovery in-between. The impression is that he probably has a diagnosis of manic-depressive illness: such individuals can be restored to normal functioning. As long as he is monitored closely, as long as he is educated about the early warning signs of slipping into this kind of illness, as long as he is willing to take medicines that are necessary and be hospitalized during vulnerable times, one should feel confident that this man could live in the community without posing a significant danger to others.

At this point in his article, Berlin writes, "In none of these cases, by the way, do I feel that the rapes had anything to do with unusual sexuality" (1986, p. 28).

Case IV : The Maturationally Limited Rapist. Typically, this is a person with an I.Q. in the high 70s, who seems very limited, and is really coping in life from the perspective of a little child in terms of his mental maturity. Secondly, he seems to have a very strong sexual drive and might have difficulty controlling it even if he were less limited. He is someone who has gone around raping. His rapes have often been of young children. He is a person for whom we need to be very, very, concerned. Lowering sexual drive seems to help somewhat, so this is done but the stakes here are just too high to gamble with. Therefore, in addition to that, perhaps he needs to be in a structured and supervised setting. A prison is probably not an answer. This isn't somebody who is criminally motivated, purposely doing wrong with disregard for other people. On the other hand, people could suffer. He needs, perhaps indefinitely, to be in a state hospital, to take Depo-Provera, to be under supervision, to do the things that patients in state hospitals can do -- but to be seen as a limited individual with strong sex drives who may not be able to live in society unsupervised.

In introducing the next case Dr. Berlin writes,

> There are many sex offenses involving behavior which have nothing whatever to do with so-called sexual deviation, rather, behavior exibiting sexual desires that are just the same as our own. However there are some people for whom the rape seems to be very much tied into the singular kinds of sexual desires they experience. For example, the average male is simply not tempted to have sex with a 4-year old boy, yet we do see individuals who are in no way attracted to adults, and have to recurrently fight off the attraction to become involved sexually with a 4-year old boy. The point is that sexual desire for human beings is not an abstract concept. We desire sex within a certain context, a particular relationship, in particular ways, with particular sorts of people. (1986 p. 33)

Case V : The Paraphilic Rapist. Only after his father raped his girlfriend when he was 16, did he begin to realize that this was wrong. He has committed many rapes. This young man was molested by his father. He was, in fact, taught to rape by his father. In this example, the patient was highly turned on sexually by raping. It's not that he couldn't have consenting sex. It's that he's constantly having to fight off the urge to rape because raping is such a sexual turn on for him. It's like an addiction. Patient 5 is someone whom we would consider to be a compulsive, or sexually driven rapist. The problem isn't that he is anti-social, that he commits other kinds of crimes. The problem isn't that he's psychotic or out of touch with reality. He is certainly not limited intellectually. The mainstays of treatment with him are first, to give him a medicine to lower the intensity of these urges that he experiences to rape -- (Depo-Provera)-- and secondly, to develop a trusting relationship with him so that, if he were in the community and feeling urges to do this, that he would come in time for help before he acted out. Finally, the counselling is also intended to help him develop some strategies for successfully resisting acting on those temptations in the same way that alcoholics may go to AA and try to learn strategies for resisting their particular kinds of temptations.

It is hoped at this point it is quite clear that, similar to the rape cases described by Dr Berlin, pedophiles (as another group of sexual offenders) may or may not be sexually disturbed. They may or may not be characterologically disturbed. They may or may not be emotionally disturbed, intellectually impaired, or organically damaged.

There may be a career criminal who as a result of his anti-social, uncaring character decides to force sex upon his girlfriend's attractive 12 year old daughter -- resulting in a pedophilic charge. There may be an individual unable to handle anger, who regresses from a normal adult sexual preference structure under overwhelming (for him) life stresses and

loneliness to fondle his next door neighbor's daughter--resulting in a pedophilic charge. There may be an individual who rapes children during a psychotic episode. There may be a slightly retarded, immature individual who can only relate sexually to young children, because he is like one himself. There may be an individual, who like the paraphilic rapist, is solely aroused by children as sexual objects, and fights urges like an addiction. Finally, there may be an individual who has a pedophilic offense for reasons different from any of the above.

Assessment, diagnosis, treatment, and legal dispensation of pedophilic offenses are necessarily complex and individualized issues. As the cases above illustrate, the correct treatment and sentencing recommendations may have nothing to do with the severity of the act, or the culpability of the offender. (It was the slightly retarded man who, appropriately, was likely to be institutionalized for life.)

As Dr. Berlin writes at the conclusion of his article,

> I hope that I can persuade you that rape is not a diagnosis, rather a behavior that may reflect a variety of diagnostic conditions and psychodynamic issues. I think that when we subdivide the behavior into smaller and more homogeneous kinds of groupings, and study those groups, that we will advance farther along the path of medical and humanitarian progress. (1986, p. 41)

General Statement of the Problem

Echoing Dr. Berlin, the present research was pursued optimistically with the hope of contributing something to the study of these groupings among pedophilic offenders. The general interest of the author was to try to discover whether there are any classes of shared characteristics in the offenders that would allow them to be placed into "smaller and more homogeneous groupings".

More specifically, because data on social adjustment, sexual interaction in an offense, offense patterns, recidivism, and treatment prognosis consistently differ for homosexual and heterosexual pedophiles (see Chapter II), it is hypothesized that the degree of sexual interest in children varies systematically and predictably in groups of homosexual pedophiles as contrasted with heterosexual pedophiles[2]. The problem is to discover why this may be case. Are there relatively stable differences in the backgrounds of homosexual and heterosexual pedophiles that could explain their different offense profiles ?

Were this found to be the case it would be most useful as a theoretical guide to direct questions about the aetiology of pedophilia. Could one constellation of characteristics be

[2] The degree of sexual interest in children will vary systematically for groups, not for every individual.

related to homosexual pedophilia, and another be related to heterosexual pedophilia ?

If a random group of pedophiles is divided into "high-acting-out" (well-structured, fixated pedophilia) as differentiated from "low-acting-out" (weakly-structured sexual interest in children), would these two groups share any intra-group similarities in psycho/social background ? Would these intra-group similarities also serve to distinguish heterosexual offenders from homosexual offenders ? Or is there in fact no difference between these groups ?

These are some of the general problems of inquiry that concern this research, and the field as a whole. More specifically, the researcher was also interested in examining whether or not there is a relationship between a specific trait of personality (narcissism in this case) and homosexual pedophilia, and the opposite -- a null relationship between heterosexual pedophiles and narcissism. These specific hypotheses and the reasoning behind them will be discussed in later sections. The general problem(s) this research attempts to address concern(s) the relationship(s) between personality traits and different groups of pedophiles.

Limitations of Pedophilic Research

This section will discuss some of the broad limitations that operate when studying pedophilia. Specific limitations on the design of this research and their effects on the interpretation of results will be discussed in the method and results sections, respectively.

One of the contextual limitations results from choosing to research an area which concerns behavior that is both sexual and illegal; inevitably, compromises must be made. The most obvious problem concerns the validity of self-report data gathered from offenders; are they telling the truth ? Not only is there a request for information that the subjects may receive "punishment" for giving, the offenders are asked about their sexuality, and worse, about their abnormal sexuality.

On the surface, there would seem to be an incentive (even if only face-saving) for the offenders to conceal or diminish the degree of illegal/abnormal behavior. Since this is a limitation that goes hand in hand with choosing to study this population, should we choose not to research because we cannot create guarantees of validity ? As researchers, we can only try to establish an atmosphere where it is advantageous, rather than a disadvantage, for the patient to be as honest as possible.

In this research, several steps were taken to minimize any disadvantages, and to maximize the advantages of sincerity.

First, all subjects were tested after having pled, or been found guilty of their offense, so that there was no legal incentive to deny. The large majority of subjects were tested post-sentencing. Those who weren't, were tested after the assessment for sentencing was completed - they had not yet received sentence due to postponements, and other matters. The psychiatric work however had been done. All subjects received code numbers, were tested anonymously (having given informed consent), and were aware that the research concerned group results, rather than those of the individual. Further, the clinic from which the sample was drawn has a positive reputation among offenders in Quebec (it has been in existence for 32 years) such that staff there are not generally perceived as adversary, but supportive. Because clinic staff and the research assistant were quite accustomed to working with sexual offenders, the attitude of staff toward offenders is not colored by a negative countertransference, often a problem when untrained staff work with sexual offenders. Rowan and Rowan (1985), in their article concerning the development of a treatment program for pedophiles, have written that,

> In evaluating our own performance as a staff, there appears to be a need for treatment professionals to discuss their own attitudes, feelings, and responses to their pedophilic patients and also a need to provide inservice training to on-ward staff so that they may be more comfortable with and therapeutic toward sex offenders. (p. 64)

Whether the clinic staff established an atmosphere of mutual trust to the point where every offender was completely honest can never be determined, and this study was done within this limitation. The author feels fairly confident that subjects were truthful. One of the more interesting (and unexpected) results that may support this feeling concerns the data gathered in the structured interviews. Offenders were asked 1) the number of legal offenses and 2) the number of clinical offenses (not legally charged) each had committed. In an attempt at cross-validation, the subjects' workers were also asked 1) the number of legal offenses and 2) the number of uncharged offenses the subject had committed. One might expect that the professional staff would estimate more clinical offenses than the offender would admit to; in fact, however, in cases where the offender/staff answers didn't match, the offender admitted more clinical offenses than the professional staff was aware of.

The author would like to make an additional point concerning the honesty of sexual offenders and negative professional attitudes. Berlin writes,

> ...there are many areas where we as physicians believe people when they say they are having a hard time controlling themselves. Certainly, people are trying to stop smoking and yet they go out and buy a pack of cigarettes premeditatedly. Yet, when they tell us they're struggling and need help, we tend to believe that and try to help them. If they're trying to keep from overeating, we tend to appreciate that that's

> possible, and try to help them. Compulsive hand washers come, and they say they can't stop doing this. We believe them and try to help them. But if someone says they're trying to resist the urge to expose themselves, or resist their desires to have sex with children or, certainly, if they say they're trying to resist the urge to commit rapes, our attitude is : who are they trying to kid ? They're just trying to beat the rap. Let's get them off to prison where they belong. (1986, p. 40)

A second problem in choosing to research this population is its small numbers. The researcher was interested in testing pedophiles seen on an out-patient basis. As explained previously, the actual size of the pedophilic population is unknown, but when one excludes (as in this study) imprisoned offenders and those charged with incest, and is required to obtain informed consent the available population is certainly limited[3].

Some possible sample members in this study were also lost due to illiteracy -- over the period of testing (roughly one year) six individuals were unable to be tested because reading skills were not sufficient for them to undergo the written testing, which requires an eighth grade reading level. This, of course, skewed the group somewhat by eliminating the bottom rung

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[3] The incarcerated would have different qualities as a group, due to the selective process of imprisonment. It is likely one would find a greater number of polymorphous sexual offenders with long histories of disturbance and pedophilic offenders with other (violent) criminal histories. They cannot be considered representative of the general pedophilic population.

of the education ladder. It was felt that an oral administration of the psychometric testing would affect the comfort level of the respondent to an extent that made this undesirable. It is difficult to determine whether the extent of illiteracy in the prospective sample is representative of the pedophilic population in general; the clinic staff expressed the feeling that this was an unusual occurrence to the extent that it was seen here, while some research reports low-normal IQs are over-represented in pedophile samples (Hucker, Langevin, Wortzman, & Bain, 1986).

A third general limitation of this research concerns instrumentation. There is a lack of instruments specifically designed for research with pedophilies and sex offenders, in general. Specific instruments for testing are not widely available, because the field is relatively new and research interest has been primarily in the past ten years. The research instruments that have been developed center on assessment of pedophiles by phallometrics. Freund (1967a, 1976), Groth (1983), and Abel et al. (1985) have done much to improve the area, having designed versions of testing where the patient's penile tumescence is monitored when exposed to a variety of normal and deviant sexual stimuli (typically presented in films, slides, or audiotapes). There seems to be some confusion as to what form of stimuli (visual or audio) best discriminates sexual interest. For example, Marshall, Barbaree, and Christophe (1986) found that pedophiles responded more to children than did incest offenders

when verbal descriptions of sexual interaction were used. In a study by Murphy, Haynes, Stalgaitis, and Flanagan (1986) both groups responded more to children than adults when audiotaped descriptions were used, but with slide stimuli pedophiles showed more response to children than the incest offenders. The best method would be that which could find differences between offender groups; it is not clear at present which forms of stimuli are better. Further, the way penile changes are recorded may have an impact on the results.

There has also been controversy about how measurements should be ascertained. Langevin (1985) writes, "The measurement of penile volume and circumference changes are the two general techniques in phallometry. The two share at best a 50% relationship" (p. 180). Penile volume has been generally accepted as "... a more sensitive description of sexual preferences" (Earls & Marshall, 1983, p. 342). Phallometric testing is a good method of assessing sexual interest to specific stimuli as it eliminates most error due to subjective response[4]. It is particularly useful in conjunction with interview, or to confront a subject who shows physiologic arousal, but denies it in the interview. Often, reactions to a specific stimulus are recorded phallometrically, while the subject declares he "feels" no

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[4] Some males can exert voluntary control over their erections, and it is not clear whether erections have a linear relationship to arousal (see Farkas, 1978).

sexual interest or arousal. The ideal format for the assessment of sexual anomalies in general would include, as primary factors, phallometry, sex history, and gender identity. Second stage information would ideally include a full hormone profile, a CT scan, information and testing on alcohol and drug use, criminal record and history of aggression, and tests of psychopathology (Langevin, 1985, p. 188). However,

> It is important to note that erotic preference is really a hypothetical construct existing inside the subject's head. One may infer it from overt acts, but ultimately one must ask the person what his preferences are. In our own data we found that approximately 85% of our cases are readily categorized as having one preference or another using the criterion of erotic preference. These results are similar to those generated by phallometry... verbal report has the advantage of requiring very little equipment. One can use a standard comprehensive interview or a sex history questionnaire. (Langevin, 1985, p. 181)

While phallometrics may be the research instrument of choice, it would have been difficult, if not impossible, for this researcher to obtain the necessary expertise, equipment, and agreement from subjects and staff to attach offenders' penises to gauges and take measurements.

In assessing pedophilic interest, the second best approach was taken, i.e., information was sought through a variety of methods that could serve to substantiate one another. Full case histories (comprehensive interviews) were taken from both the

subject and his worker (separately), files containing a variety of reports and legal information were used, and written testing (with hidden agenda and built in validity scales) was employed. Information was gathered in this way in the areas of sexual history, gender identity, alcohol and drug use, criminal record and aggression, and psychopathology. The specifics of this method are covered in the method section.

The fourth problem embedded in the context of this research relates to the specific assumptions being tested. The researcher was interested in testing the relationship between pedophilic interest (fixation) and narcissism. Both of these concepts belong to the analytic school, both are largely abstract and concretely unmeasurable. Yet both exist as conceptual formulations used by professionals (not only among the analytic community) in the assessment and treatment of patients.

The author is aware that "the validity of psychoanalytic theories of pedophilia is dependent on the validity of the particular psychological mechanism and processes that the theories subsume" (Howells, 1981, p. 64). The author realizes it is impossible to validate empirically such analytic concepts as fixation, Oedipal Complex, narcissism and the like, and in fact the evidence in support of these ideas is weak (Eysenck & Wilson, 1973). However, as theory instructive to thinking, they serve well, and help the clinician make sense of his experience, i.e., they "fit" and give some theoretical structure to what seems to

go on in the office with a patient. Because of the above, and because the study of pedophilia is still at the discovery stage where theory generation is all important (Resnikoff, 1978), no further explanation will be made for generating research from empirically untestable concepts. One must do the best possible within the prescribed limitations when attempting to combine abstract theory and concrete research practice.

Finally, as research was conducted in the context of dissertation work, unlimited funds were not available, and unlimited time for completion was not desirable. While the above may detract from the ideal for research, it is realistic, as Millon (1986) says in responding to critics of some of his research, to realize that,

> "Real" research (not something contrived in non-clinical settings or drawing upon likeminded or uniformly trained observers as a means of creating spuriously high, if not illusionary, interjudge reliabilites) does not require that we control for every possible "bug" one might conjure up, but rather that we work with diverse clinicians and representative patients in a project that controls for relevant confounds. Is it possible to find an empirically flawless and fully generalizable study dealing with diagnostic issues ? Hardly! Can one carry out a credibly reliable, plausibly generalizable, and reasonably useful study ? Of course! (p. 206)

Because of the above embedded limitations this research should be primarily considered a pilot study, whose purpose is to contribute to the direction of future research.

Research Questions

1) Is there a relationship between homosexual object choice in pedophilia and exclusive (fixed) interest in children, and inversely, a relationship between heterosexual object choice and non-exclusive sexual interest in children?

2) If there is a relationship between homosexual object choice in pedophilia and exclusive (fixed) interest in children and a relationship between heterosexual object choice and non-exclusive sexual interest in children, can this exclusivity (fixation) be demonstrated in terms of differences between the personality traits and/or structures of homosexual and heterosexual object choice pedophiles?

3) Can it be shown that the sex of object choice of homosexual pedophiles and of heterosexual pedophiles produce mutually exclusive groups in terms of personality traits and/or structure?

4) Is the trait of narcissism significantly more evident in homosexual pedophiles (as measured by the MCMI and NPI) than in heterosexual pedophiles as measured by the same instruments?

Definition of Terms

It should be understood at the outset that there is no agreed upon definition of pedophilia. Most of the difficulty in definition concerns the distinction between using the term inclusively or exclusively (Finklehor & Araji, 1986). They write,

> In using the term inclusively, many investigators have applied pedophilia to any sexual contact with or interest in a child however transitory this behavior may have been (Friedman, 1959; Mohr et al., 1964). Others, however, such as the current DSM-III (American Psychiatric Association, 1980) have reserved the term only for a condition where an adult has an enduring, and often exclusive, sexual interest in children. (p. 146)

Freund (1981) provides a definition resembling the perspective of the American Psychiatric Association. He defines pedophilia as,

> ... a sustained erotic preference for children (within the age range up to and including 11 or 12) as compared to this subject's erotic inclination toward physically mature persons, and under the condition that there is free choice of partner as to sex and other attributes which may co-determine erotic attractiveness. (p. 161)

This definition eliminates situational pedophilia and as a diagnostic definition it establishes clear criteria to be met; yet while so pure as to be ideal, it is not always operational. It is a problem for clinicians because it is so highly specific as to exclude many individuals who are considered by practitioners to be pedophiles. For example, a middle-aged married man who, while under stress, commits a first pedophilic act with a girl of six or seven would not be considered as exhibiting "... a sustained erotic preference...", rather he is viewed by practitioners as having temporarily regressed from a normal sexual adjustment with his wife.

Finklehor and Araji (1986) further make the point that "... if pedophilia is reserved for only exclusive-type offenders, it leaves no term to apply to the broader phenomenon of sexual contact in general between adults and children" (p. 146). They prefer to define pedophilia "... as occuring when an adult has a conscious sexual interest in prepubertal children" (p. 146). They infer this interest when there has been some sexual contact with a child, or when the adult has masturbated to fantasies involving children. While they are correct in stating that, "This definition recognizes that a person may have a very strong sexual interest in children and be blocked only by circumstances from acting on it directly" (p. 147), it is dangerous to infer pedophilia from the use of pedophilic fantasy. While women might find it sexually exciting to fantasize about rape (and may masturbate to this fantasy), it is unlikely they wish this fantasy to be translated into behavior. The issue probably depends on whether fantasies of children are used exclusively.

The appropriateness of the various definitions may depend on the level of inquiry. While there are pros and cons to each definition, perhaps the "exclusive", or theoretically pure definition (such as Freund's), is best used for research theory formation and conceptual discussions and is appropriate for diagnosis and labeling as used by the American Psychiatric Association. The "inclusive" and broader definitions are best suited to clinical practice. Of the inclusive definitions, the

author finds preferable the definition in use at the McGill Forensic Clinic, which, although loose, is more useful; specifically, a pedophile is, "A person who seeks sexual satisfaction with an immature sexual object" (Cormier, Note 1).

It is suggested that the exclusive and inclusive definitions may be better applied to the distinction between "fixated" and "regressed" pedophiles, respectively, and in fact they may be describing the same thing. Howells writes, "A distinction is made between offenders whose behavior is the product of a deviant sexual preference for children, and those whose behavior is situationally induced and occurs in the context of a normal sexual preference structure" (1981, p. 76). In research supportive of this distinction, Swanson (1968) classified approximately 75% of his study sample as having a normal sexual orientation. The important aetiological situational factors he lists are, "... marital disruption, loss of a sexual partner through the wife's illness or work requirements, the use of alcohol, and multiple life stresses" (1981, p. 77).

Groth (1978) chooses the term "regressed" to title Swanson's situational offender; his continuum spans from the "fixated" to the "regressed". For him, the fixated offender is one who "... shows a primary or exclusive attraction to children from adolescence throughout the life span... (he) avoids adult sexual contacts where possible, and sexual thoughts and fantasies center on children" (p. 6). He defines the regressed offender as one

who becomes involved with a child when there is " .. some challenge to his sexual adequacy or threat to his competency as a man" (p. 9). His situational factors include "... precipitating events such as physical, social, sexual, marital, financial and vocational crises to which the offender fails to adapt" (p. 9).

Howells (1981) feels that the term "situational" is preferable to "regressed" as he questions whether it is clear that these offenders are in fact "regressing" to a (developmentally) earlier form of sexual expression, that is, immature sexual behavior previously engaged in but later outgrown. Further study by Groth has, in fact, tended to support his notion (Groth & Birnbaum, 1978). In this later study, an analysis of 175 pedophiles determined that 83 were fixated, and 92 were regressed. If marriage can be assumed to indicate the existence of a normal sexual preference structure, the different rate of marriage in these two groups is striking: while 75% of the regressed group had been married, in the fixated group, 88% had never married.

Before offering the operational definitions used by the author to make sense of the exclusive/inclusive and fixated/regressed definitions of pedophilia, a few words need to be said about what constitutes a "child" or "immature sexual object". Freund (1981), in the above definition, defines a child according to "... gross somatic features...", i.e., the absence of secondary sexual characteristics such as pubic hair for boys and

girls, breast development for girls, etc. Establishing a chronological cut-off point is extremely difficult because we know that some 11-year-olds can appear fully developed, while a 16-year-old can appear to be twelve. This has been a problem for researchers who must use records of age, records which define a child as anyone who is a legal minor, (i.e., under sixteen in Quebec), and is further complicated by the fact that boys mature more slowly than girls. Perhaps the average 14-year-old boy is more equivalent to the average 12-year-old girl. Due to this pervasive lack of clarity, usually clinicians simply make a judgment call, and in practice ask the patient to describe the preferred appearance of his objects. While hardly ideal, this usually results in greater clarity than accepting chronological age at face value, and as the only factor that separates a "child" from an "adult".

There are similar problems in attempting to distinguish a hebephile from a pedophile. Hebephilia is essentially the same as pedophilia but differs in that it is "....a sustained erotic preference (under the same conditions of free choice) for pubescents, 11-12 to 13-14 for female objects[5], and 15-16 for male objects" (Freund, 1981, p. 161). Again, the best approach to this problem is to ask for a description from the patient and to classify accordingly, rather than by chronological age of the

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[5] Nabokov's Lolita is an excellent literary example of this interest (1955).

child. An extensive search of the current literature reveals that the term hebephilia is rarely used, perhaps falling out of favor due to the difficulties in specifying the distinction.

Due to all of the above confusion over the correct definition of pedophilia, the author prefers to offer operational definitions for use in this research project.

Fixated Pedophile. As used here, the term "fixated pedophile" will refer to the exclusive type of pedophilic offender. As Groth (1978) has defined it, the fixated offender shows a primary or exclusive attraction to children from adolescence throughout the life span, avoids adult sexual contacts where possible, and his sexual thoughts and fantasies center on children. In assessment to determine fixation, a variety of factors combine which contribute to this judgment. Some of these include the age at which the patient was first attracted to children (if he was first attracted to children at age 14 as compared to age 40), the strength of his sexual fantasies concerning children, the age of the patient at his first pedophilic offense (age at which he first acted on his fantasies), the number of legal offenses, and the number of clinical offenses. It is possible to be considered "fixated" using this operational definition without the patient having committed any clinical offenses, for example, if other criteria such as an early first attraction and strong fantasies, coupled

with a lack of adult contacts (pedophilic social profile) are met.

Regressed Pedophile. As used here, the term "regressed pedophile" will signify its inclusive sense, i.e., referring to someone who "... seeks sexual satisfaction with an immature sexual object" (Cormier, Note 1) outside of an enduring sexual preference for children As Groth (1978) explains, the regressed offender becomes involved with children when there is some challenge to his sexual adequacy or threat to his sense of competency as a man. This offender has engaged in adult sexual and social relationships, and his history will reveal a period of life stress (be it due to physical, social, sexual, marital, financial, or vocational crises) that preceded the pedophilic offense.

Episodic Pedophile. The term "episodic offender" is borrowed for operational use here from criminology; in criminology it describes an offender who has more than one offense, but whose offenses are separated by long periods of law-abiding behavior (Cormier et al., 1964; Cormier & Boulanger, 1973). The "episodic pedophile" therefore is one who may have two or more offenses separated by long periods of "normal" adult sexual adjustment. He occupies a middle-ground between the fixated and the regressed; while not strictly "fixated" on

children as sexual objects because he can find satisfaction in adult sexual relationships, under periods of stress he will habitually seek out children, indicating some degree of a structured sexual interest. Distinguishing an episodic pedophile from a fixated pedophile is not always easy; the clinician must use his judgment based on a thorough knowledge of the patient's history. For example, if clinicians are presented with an individual who has three pedophilic offenses at age intervals of 28, 42, and 60 (separated by a sexual relationship with his wife), how can it be argued that he is not actually a fixated pedophile (psychodynamically) who only guarded against his pedophilic desires during the in-between periods ? Largely it is done by looking very carefully at the periods between his offenses. If his marital relationship was actually a healthy one -- the clinician would likely interview his wife -- and fantasies about children are absent, he would probably be classified as "episodic". If marital adjustment was poor, or sexual fantasies concerning children continual, he might be diagnosed differently. It can be seen that the number of offenses is hardly sufficient to diagnose the individual.

In the current research, the term "episodic pedophile" will be used mostly for discussion purposes.

Chapter II

Review of the Literature

Focus of the Review

There is a dearth of recent research in the study of pedophilia. To underscore this point, consider that a computer search accessing 7 databases (med-line, psychological abstracts, psycalert, psycinfo, excerpta medica, CA search of the American Chemical Society, and Scisearch) found only 13 articles published during the entire year of 1987.

This section will focus on a review of the literature related to the aetiology of pedophilia. This is not artificially limiting as almost all research on pedophiles can be related to aetiology. There are several reasons for choosing to concentrate on this area. First, it is the area most relevant to the research focus of this study; in asking about the role of psychosocial characteristics in pedophilia, we are looking (ideally) for a correlate which may explain the behavior of certain pedophiles. Second, while there are many literature bases which would be relevant to this research (normal sexuality, criminality, victimology), covering them all would be simply unmanagable, and could detract from a cognizant focus. Third, by

choosing to focus on aetiology, implications for the assessment and treatment of pedophiles will be clear without having to enter specifically into the (vast) area of treatment modalities. Literature on the treatment of pedophiles will be examined in the context of the discussion.

While concentrating for the most part on theories of aetiology, we will first look at the general characteristics of pedophiles to dispel any pre-conceived impressions the reader may have from their portrayal in the media, and to provide a groundwork from which to examine the various theories which attempt to explain the origins of their behavior. Secondly, we will examine the differences which exist between heterosexual and homosexual pedophiles as groups, and relate these differences to theories of aetiology.

Who Are Pedophiles ?

Perhaps the most commonly held stereotype (and most erroneous) is that of the "dirty old man". "Indeed, the molester is most commonly a respectable, otherwise law-abiding person, who may escape detection for exactly that reason" (Lanyon, 1986, p. 177). The mean age of pedophiles is approximately 35; only 4% of pedophiles are over age 60 (Bernard, 1975; McCary, 1973; Mohr et al., 1964). Groth et al. (1982) have found two cluster groups, ages 16 and 31.

While it is unlikely they are old, there is no doubt that pedophiles are overwhelmingly male. As regards the possibility of female pedophiles, Plummer (1981) writes,

> I suspect there is a considerable degree of adult female to child sexuality. Most of this however, is hidden because of the expectations of the female role which simultaneously expect a degree of bodily contact between woman and child, and deny the existence of sexuality in women. (p. 227)

While Finkelhor and Araji (1986) have written that, "There have been virtually no studies of female offenders..." (p. 146), the Report of the Committee on Sexual Offenses against Children and Youth (Badgely, 1984) contains eight case studies of convicted female offenders. From these case studies it would seem clear that female offenders differ radically from males charged with the sexual assault of a child.

> In five of the eight case studies, the convicted female offender had been involved with male accomplices, usually a husband, a common-law partner or friend. The accounts suggest that in most instances, the woman complied with the wishes of her male accomplice(s) in sexually assaulting young victims. In the other three cases, one woman was mentally ill, one had been a victim of incest, and one had a consensual affair with a male adolescent. (Badgely, 1984, p. 846)

Recently, a number of cases have appeared in the press wherein female caretakers in day-care centers have been charged

with sexual abuse (e. g., The McMartin Pre-School; Note 2). It is hoped that once these are legally resolved[6], a study will be made of the women involved to see if they follow a similar pattern of cooperation with males (similar to Badgely's findings), or may be in fact acting on their own desires. At present, it is safe to say that females charged with pedophilia represent less than 2% of the pedophilic population.

The earliest attempt to collect and norm data drawn from a population of pedophiles in a value-free manner was a study conducted at the Clarke Institute of Psychiatry in Toronto over twenty years ago. Mohr et al.'s classic phenomenological study, Pedophilia and Exhibitionism (1964), presented data gleaned from intensive study of 247 male pedophiles and relevant court, police, and correctional records. While much has been learned since then (and in some ways not very much), his study is considered a classic; Mohr is to pedophilia what Kinsey is to normal sexuality.

He found that there is a tri-modal distribution of age, i.e., three clusters of ages for pedophiles, and that these age

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[6] In the McMartin Pre-School case, charges have been dropped against five of the women, after some had wasted in jail for over two years. The school has closed and the defendants were professionally and financially ruined. Charges are still being laid against one male teacher and his mother. It would seem based on present evidence that the five women and the school were the victims of hysteria (Note 3).

groupings correspond with different offense patterns and demographic/psycho-social backgrounds. The basis for the age clusters in his work was the "age of onset", namely, when did the pedophilia first appear in the chronological development of the offender?

These three age clusters of pedophilic offenders were as follows :

1) The Adolescent Group (cluster age 15-24). This group is characterized by delayed development in psychosexual functioning - in short, they are immature.

2) The Middle-Aged Group (cluster age mid- to late 30s). This, according to Mohr, was the largest group of the pedophilic population. They are characterized by regression to an immature partner following social and sexual failure. The child is, psychodynamically speaking, a "surrogate" for the adult partner.

3) The Senescent Group (mid-50s to early 60s). In these individuals, offenses are seen as a response to social isolation and loneliness; in addition, organic deterioration due to aging may be a factor.[7]

While these three sub-groupings may describe certain offenders of today, they are accurate only for a segment of the pedophilic population. Each of these above categories describes an individual who is not a fixated pedophile. For example, if we

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[7] Hucker and Ben-Aron (1985) do not feel that dementia and pedophilia are causally related in the elderly. Nevertheless, it may be a factor for some individuals.

see an offender in the middle-aged group, he may be characterized by a regression to an immature partner, or he may be someone who has always been attracted to children and has only acted out for the first time in his thirties. An adolescent offender may be socially immature and therefore seek an experience with a child or he may be at the beginning of a lifelong exclusive interest in children as sexual objects. (Some adolescent offenders, with maturity, may "grow out of it".)

Mohr's three age groupings can therefore better be applied to regressed offenders, who have no previous clinical or legal offenses, and who have evidence in their histories of an adult-to-adult sexual preference. In the case of the adolescent offender, the waters are muddy; as in most psychopathology seen in adolescence we must wait and see what develops. This may be a transient disturbance, or the first appearance of chronic disturbance. Clinically, with the adolescent, one would spend a good deal of time looking at the onset and strength of pedophilic fantasy, other paraphilic behavior, and background history likely to lead to abnormal sexuality (e.g., Was he sexually abused as a child?).

A recent study by Gene Abel et al. (1985) gives one a very different view of pedophiles from that of Mohr's work. At the New York State Psychiatric Institute he gathered data from 411 paraphiliacs (rapists and child molesters) who were all volunteers protected by a dense system of confidentiality.

> The data on 232 child molesters whose victims were less than 14 years of age show that they made ~~55,250~~ attempts, had 38,727 completions, and had perpetrated these acts on 17,585 victims. On the average, each offender had attempted 238.2 child molestations and had completed 166.9 molestations on 75.8 victims. (p. 193)

It is obvious that Mohr's descriptions of age clusters hardly apply to this group.

Abel's work, like Mohr's, is accurate only for a specific segment of the pedophilic population. As mentioned in the previous chapter, because Abel solicited his population from newspaper advertisements with guarantees of confidential free treatment, the individuals he attracted had somewhat different characteristics than random sample pedophilic groups.

Again then, who is a pedophile ? Is he an individual constantly on the prowl for a new victim, having committed multiple offenses ? Or is he, as Mohr's work suggests, someone whose only sexual interest in a child is as a transitory surrogate when he has failed with adults ? He may be either. The author has found no studies which attempt specifically to determine the percentage of fixated vs. regressed pedophiles although Groth and Birnbaum (1978) have classed a sample using these constructs. There have been some estimates, but statistically this percentage is as yet unknown. The clinical experience of this author over a three-year period of receiving

outpatient referrals (at the Forensic Psychiatry Clinic in Montreal) suggests that one in three patients sent for assessment fits the label "regressed". The higher number of well-structured pedophiles coming through the door may reflect a bias in the way individuals are charged, rather than an accurate reflection of population trends.

Since these two differing profiles have such a large impact upon any discussion of the characteristics of pedophiles (as they may have little in common), it is best to first discuss the few common factors.

As a group, pedophiles are not violent. "In a number of widely cited studies undertaken in Canada, the United Kingdom and the United States, it has been concluded that child sexual offenders rarely, if ever, physically injure victims" (Badgely, 1984, p. 791). The public tends to associate pedophilia with the sensationalist cases involving violence; while they compose about 10-15% of all child sexual abuse cases, they garner much of the publicity (Lanyon, 1986).

Groth, Hobson, and Gary (1982) class these individuals as "child rapists" rather than pedophiles and believe they are similar to rape offenders, not pedophiles. Physical force in pedophilia should be distinguished from non-physical and psychological methods for coercion of victims (i.e., bribery, psychological coercion, or threat of force). There is a difference between physical and psychological harm to victims.

The findings of clinical medical research reports on child sexual abuse (including incest) suggest that, of the young patients who had been medically examined, seven in eight had not been physically injured (Badgely, 1984, p. 656). While murders that are sexually motivated abound (of children and adults), murder is a pathological process unto itself, and sadism is a separate psychological feature.

The use of physical force is usually not necessary. As an adult, the offender has an advantage from the start. He is usually someone who genuinely likes children and can often establish a warm relationship. An often-seen pattern is for the pedophile to "parent" the child who is lacking attention at home. He is always happy to see the child, spends time playing with him/her; one of the author's patients took his "kids" to the library to get library cards! In some cases these attentions may be from genuine caring; in others, gifts, candy, and favors are used as bribery to goad the child into allowing touching. Some may be strict "business" transactions in which the offender goes to a park and offers ten dollars for some 12-years-olds to show him their penises.

> Some child molesters who have rewarded children for participation in sexual acts with them are approached by these same children who request further sexual acts (so they can be paid)... as a consequence (they) become involved with sexual activities initiated by the child. (Abel et al., 1985, p. 202)

Again, a large amount of social involvement with children is more typical of the well-structured pedophile, but the point is made that most men who are sexually involved with a child (fleetingly or as a preferred partner) usually like children and have no wish to physically harm them. They would prefer a consensual relationship. When they cannot have a consensual relationship, some pedophiles will resort to the use of threats. Data on the use of threats and force are practically non-existent. The Badgley report (1984) gives findings that between 50.9%-62.0% of convicted sexual offenders against children used threats or force. However, this is practically meaningless for pedophiles as data were collected using incarcerated offenders (systematically biased), the report did not differentiate between threats and force, and no distinction was made between incest and pedophilic offenders. Clinical experience of the author and her colleagues suggests the use of force is rare, and when it occurs it typically involves some form of physical restraint. Threatening the victim about disclosure is probably common.

In addition to not wishing to harm them, many fixated pedophiles live up to their name (as in "lovers of children") by engaging in occupations that nurture children. In Sex Offender Profiling by the FBI, Dietz (1985) writes,

> ...if the offender is hypothesized to be an organized, homosexual pedophile, one of his expected attributes is that he has an occupation (e.g., selling ice cream, teaching, or pediatrics) or a hobby (e.g., coaching a boys team, leading a boys group, or photographing children) that brings him into frequent contact with boys. (p. 215)

One may argue that this is the case because the pedophile wishes to have an easy pool from which to pick his victims. It is also true that they derive much emotional satisfaction from interacting with children. If the pedophile did not exceed the boundaries of appropriate physical contact (did not sexualize the relationship), his involvement with the child could be viewed positively (for the child, not necessarily for him). Children and their parents usually like the neighbor who is so nice to all the children in the neighborhood; often parents willingly relinquish childcare responsibilities to such an adult. Victims are often emotionally deprived at home and "needy" for the caring (artificial or otherwise) he supplies.

The capacity of most pedophiles to relate well to children, and to derive and provide emotional satisfaction, is probably related to another common factor among all pedophilic offenders. While not negating the existence of genuine nurturing needs of males, it would seem from multiple studies, that pedophiles are usually immature and lack appropriate social skills. They often lack the social skills necessary to form and maintain relationships with adults (Bancroft, 1978; Barlow, 1974; Fisher,

1969; Fisher & Howell, 1970; Freund et al., 1974; Patch & Cowden, 1974; Panton, 1978; Peters, 1976; West, 1977). If adults are threatening for the pedophilic socially, children are just what he needs. This lack of social skills has appeared as a factor in many theories of aetiology. (It will be discussed later in this regard.)

One researcher has questioned this finding. Langevin (1985) states that his research has not found pedophiles to be unassertive and afraid of women.

> ... pedophiles who are also presumed to be heterosexually inadequate personalities were found in our current research to have had a considerable amount of sexual experience and pleasure with the adult female. (p. 183)

This is an interesting finding which needs further explanation because it would surely be unlikely that a well-structured (fixated) pedophile would derive any satisfaction from an adult female sexual interaction. His finding may relate again to the problem of differences between fixated and regressed pedophiles; the regressed pedophile will by definition have a history of an adult sexual relationship; the fixated often will have never had such experiences (be they heterosexual or homosexual). In support of social skills deficits in pedophiles, Langevin (1985) writes that, "One feature does recur in clinical

cases of sexual anomalies in general, and that is introversion" (p. 183).

Clinically, the pedophilic patient (fixated or regressed) presents a picture of social isolation. While the degree of isolation may vary in relation to the fixated/regressed continuum, even those individuals who have families and friends, and who actually have a good amount of contact with other adults, fail to establish intimacy. The regressed pedophile who seeks a child object because he is isolated from his wife and is unable to speak of his stress to a friend is a typical example. The fixated pedophile is more likely to avoid adult contacts of any form.

Langevin (1985) makes a good point in discussing the introversion seen among this group when he writes, "In short, their introversion may not be an inadequacy but disinterest and nothing more" (p. 183). While introversion and social skills deficits may or may not play a role in aetiology (to be discussed in a later section), it is clear that almost all pedophiles have some deficits in these areas.

The third factor generalizable to the majority of pedophiles concerns the form of sexual activity they engage in with children.

> Most child molesters (84.9%) have a hands-on experience (usually fondling, oral sex or less frequently, vaginal or anal intercourse); 13.4% expose

> themselves to children; 0.9% are attracted to particular parts of the child, such as a fetish for boys' feet; 0.4% are voyeurs of children; and 0.4% have first contact with a child during a sadistic attack upon a child. (Abel et al., 1985, p. 195)

The majority of hands-on experiences take the form of fondling and/or masturbation, the pedophile wishing to touch and be touched by the child. In cases of oral sex and the less frequent vaginal or anal intercourse, the child victims are likely to be older. There are some differences between groups of homosexual and heterosexual pedophiles in sexual activity engaged in (see Differences Between Groups in Chapter II), but fondling alone accounts for 60% of heterosexual pedophiles activity, and fondling and masturbation for 57% of homosexual pedophiles' activity (Mohr et al., 1964). It is much more likely that a pedophile will fondle a child than attempt intercourse with him/her. In the Montreal Child Sexual Abuse Study (1977-ongoing) 80.4% of the children had had their genitals touched and 10.7% had been a victim of sexual intercourse; for the adolescents the proportions for these acts were 31.9% and 44.9%, respectively (Badgely, 1984).

In summary, for <u>most</u> (though not all) pedophiles three things are true : they are not violent, they have difficulty in adult relationships, and they usually engage in "lower" or "childlike" forms of sexual activity with their young victims. Aside from these general truths, the differences between sub-

types of pedophiles (on the fixated/regressed continuum and the heterosexual/homosexual continuum) are so vast that they must be individually discussed in the third section of this chapter.

Theories of Aetiology

Research on the aetiology of pedophilia seems to be characterized by a small and stable group of researchers. Poorly done research and a paucity of research seems to be the norm, with the exception of four or five individuals who have devoted their life's work to this area.

As pedophilia is a heterogeneous disorder, there can be no single theory which explains the behavior of all. The few researchers doing quality work in this area tend therefore to try to design models incorporating several workable theories of aetiology into a framework. We can then selectively apply a specific theory from this framework to the individual offender, based on a "goodness of fit". As can be expected, this means that the evidence supporting one particular theory seems strong for certain offenders and weak for others. Likewise, evidence in support of theory "A" may be equally correct for offender "A", and wrong for offender "B".

The problem is best addressed by dividing pedophiles into smaller and more homogeneous groupings. But yet another difficulty appears because we do not really know what

characteristics should be used as markers for distinguishing these (homogeneous) groups from one another. For example, a few of the salient characteristics that can be used to group offenders could include :

1. age clusters
2. first offenders/multiple offenders
3. violent/non-violent
4. homosexual/heterosexual object choice
5. fixation/regression
6. multiple paraphilias/"pure" pedophilia

Another confounding problem concerns the sixth item above. While the cases used in the current study were "pure" pedophiles in legally charged offenses, about half the cases presenting at clinics come with multiple sexual anomalies (Langevin, 1985), and so a theory must attempt to "sift out" individuals who are pedophilic from those who have pedophilic behavior appearing as part of a history of paraphilic disturbances (for example, someone with three sexual assaults, one against a child). As is obvious, the task of developing explanations for pedophilia is not an easy one.

The best attempt at synthesizing theories and relating them to specific individual pedophilic outcome is seen in the recent work of Finklehor and Araji (1985, 1986). They felt that research on the aetiology of pedophilia

> ...could be categorized as trying to explain one of

> four factors : (a) why a person would find relating sexually to a child to be emotionally gratifying and congruent; (b) why a person would be capable of being sexually aroused by a child; (c) why a person would be frustrated or blocked in efforts to obtain sexual and emotional gratification from more normatively approved sources; and (d) why a person would not be deterred by the conventional social restraints and inhibitions against having sexual relationships with a child. (1986, p. 148)

Further, they address a "goodness of fit" when they write,

> It is possible that some theories, such as ones based on emotional congruence, may be better able to explain male-object pedophilia while other theories, such as blockage-type explanations, may be better able to explain the female-object type. (1985, p. 33)

Using these four factors they produced the table reprinted below. Discussion here will concentrate on the "individual" level of explanation; the social/cultural factors which may play a role in pedophilia are interesting, but better left to the realm of sociology and anthropology.

Explanations of Pedophilia

Theory type	Level of Explanation: Individual	Level of Explanation: Social/Cultural
Emotional congruence	Arrested development Low self-esteem Symbolic mastery of trauma Identification with aggressor Narcissistic identification	Male socialization to dominance
Sexual arousal	Arousing childhood experience Traumatic childhood sexual experience Operant conditioning Early modeling by others Misattribution of arousal Biological factors	Child pornography Eroticization of children in advertising
Blockage	Oedipal conflict Castration anxiety Fear of adult females Traumatic experience with adult sexuality Inadequate social skills Marital disturbance	Repressive norms about masturbation, extramarital sex
Disinhibition	Impulse disorder Senility Alcohol problem Psychosis Situational stress Failure of incest avoidance mechanism	Cultural toleration Pornography Patriarchal prerogatives

For the sake of clarity, the author will discuss the four factors in reverse order, beginning with disinhibition. This factor seeks to explain why some pedophiles are not constrained by the social norms which prohibit having sex with children;

inhibitors are either overcome, or not felt by the individual. Alcohol is a well-known disinhibitor; it's use is present in roughly a third of offenses (Rada, 1976). In Abel et al.'s sample of 232 child molesters, about 30% reported that drinking alcohol increased their arousal toward children (1985)[8]. The use of alcohol or drugs is probably more common among the "regressed" offender for whom sex with children is ego-dystonic; the very fixated individual needs no disinhibitor. As previously discussed, researchers have found alcohol use is more often a factor in female object offenses (Gebhard, Gagnon, & Pomeroy, 1967; Rada, 1976; Stokes, 1964). Clearly, individuals with paraphilic disturbance of any sort should be treated for alcohol abuse if present.

The presence of psychosis in an offender is sometimes seen in isolated cases, but it is rare. The person who commits a pedophilic offense in the course of bizarre behavior related to a psychotic episode is unlikely to be diagnosed as pedophilic (assuming no prior history exists). While it certainly accounts for the presence of some pedophilic behavior, as an aetiological factor its importance is negligible. Again, in Abel et al.'s sample, no psychopathology was found in 59.9% of the child molesters; "... many of the offenders have no psychopathology

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8 Normal males, who show no arousal to rape cues, do so when intoxicated (Barbaree, Marshall, & Lanthier, 1979).

other than paraphilia... schizophrenia is rare in this group" (1985, p. 196). (Anti-social personality was seen in 11.6% of the offenders, and a small percentage had hysterical personalities or other psychiatric diagnoses.)

Senility is a factor worth pursuing when faced with a first-time offender in the appropriate age bracket. Organic deterioration due to aging, or neurological impairment should be assessed through testing (Karpman, 1954; Mohr et al., 1964; Storr, 1965). Like psychosis, it may account for the presence of pedophilic behavior in certain individuals; as already described however, only 4% of offenders are over age 60, a fact which severely limits the application of senility as an important determinant.

Poor impulse control has been seen by some theorists as characterizing pedophiles (Gebhard et al., 1967; Groth et al., 1982). This factor would seem logical if one considers that they would not be pedophiles if they were able to control their impulses. As a factor in aetiology it is insufficient. While a problem needing redress in treatment for pedophiles, impulse control (or lack thereof) plays a role in many types of offenses having nothing to do with pedophilia. In addition, many pedophilic offenses are planned rather than impulsive (Gebhard et al., 1967). It is better viewed as a factor possibly present in all acting-out behaviors, rather than pedophilia per se.

Situational stress can be seen as a factor which lowers inhibition, and it's presence is well-documented in the clinical histories of certain pedophiles. It is more often a factor for the "regressed"; Swanson (1968) in fact uses the term "situational offender" to refer to this group. It is likely that a primary factor in the aetiology of pedophilia among regressed offenders is stress - due to the loss of a partner or job, among other stressors. The loss of sexual prowess is also often a factor, for example in the case of an individual suffering from impotence due to diabetes, or secondary complications from medication.

As discussed above, while not all heterosexual pedophiles belong to the "regressed" group, most regressed offenders are heterosexual, choosing female objects. Stress, as an aetiological factor (of importance particularly to this group), must be examined in light of the ability of the female child to serve as a surrogate for an adult female, because "... most heterosexual offenses are committed by males who in fact erotically prefer adult females...". Freund, McKnight, Langevin, & Cibrini (1972) tested the hypothesis that males with non-deviant erotic preferences are prone to react in a sexual way to female children. They write,

> In previous studies (Freund, 1967 a,b), there was support for the hypothesis that males who were charged more than once with a heterosexual pedophilic offense

> (incest excluded) usually sexually reacted more to female children than to adult females. The picture was different in those cases where no recidivism had occurred. This latter fact is in accord with the findings of Mohr (1964) and Gigeroff et al. (1968) that most heterosexual hebephilic and pedophilic offenses, especially when there is no recidivism, are probably committed by men who do not erotically prefer female children or pubertal youths to mature females. These sexual offenses may be considered surrogate activity which, under special circumstances, occurs when the most preferred object, i.e., an adult female, is unavailable either chronically or in certain crucial situations. Such a position assumes that not only pubescent females but also female children are to some degree generally attractive to males who are non-deviant in their erotic preferences. (1972, p.120)

He tested a random sample of "normal" males on their response to slides of nude persons (four age categories of each sex, each category represented by six pictures) by measuring penile volume changes on a phallometer. He found that, "With males who have no deviant object preferences, clearly positive sexual reactions occur to 6-8 year-old female children" (p. 132, emphasis added).

The ability of the female child to serve as a surrogate for an adult female suggests that situational stress, for some forms of pedophilia, may not "cause" a deviant erotic preference to occur; but rather, that stress may lead them to choose a partner within the range of his "normal" sexual preference hierarchy when the top member of this hierarchy (the adult female) is unavailable. The unavailability of the adult female can be the "stressor" in and of itself, either through marital disruption,

or through intrapsychic problems of the individual which cause him to feel that adult females are unavailable to him. That children can serve as surrogates is also supported by a study which compared pedophiles and incest offenders (Murphy et al., 1986). In erection responses to slide stimuli, pedophiles showed more response to children than to adults, while incest offenders (who had been sexually involved with a child) showed a greater response to slides of adults. The notion of the incest victim as surrogate is well-known (Stern & Meyer, 1980).

The notion of the surrogate is not limited in application to the disinhibition factors that are discussed by Finklehor and Araji (1986). It has equal importance to the second group of factors they title blockage. This group of theories seeks to explain "... why some individuals are blocked in their ability to get their sexual and emotional needs met in adult heterosexual relationships" (p. 153). The author would prefer that the word heterosexual is omitted here, as blockage may operate equally for heterosexual and homosexual persons. They may be correct in limiting this to heterosexuality, as regression to a child following blockage is unknown (as discussed previously) for adult homosexuals (androphiles). However, the homosexual pedophile may, conceivably, have never had the desire to develop an adult homosexual relationship due to several of the factors they include.

The first of these factors is marital disturbance. This is self-explanatory. Inadequate social skills, as the second factor in this group, have been sufficiently discussed in previous sections thus no further expansion is needed. Suffice it to say that many pedophiles are "... timid, unassertive, inadequate, awkward, even moralistic types with poor social skills who have an impossible time developing adult social and sexual relationships" (Finklehor & Araji, 1986, p. 153).

A "traumatic experience with adult sexuality" and "fear of adult females" are common-sense reasons why an adult may choose a non-threatening, immature object. Yet they are so general as to have little value for researchers. Clinically however, in an adolescent heterosexual pedophile seen at the first offense, this can be sufficient explanation. Mohr et al.'s (1965) definition of the adolescent offender as one who "... is characterized by delayed development..." often summarizes this individual. He may have been impotent in his first sexual attempts, or simply extremely shy, unattractive to his peer, and sexually curious. Of course, deciding that the disturbance is transient and likely to be outgrown (with supportive counselling) requires ruling out a myriad of factors which may indicate the beginning of pedophilic fixation.

Finklehor and Araji have placed theories based on Oedipal dynamics under this heading, although they may also belong under the heading emotional congruence (see page 50). A fear of adult

women may result (if one has an analyst's perspective) from intense conflicts about the mother, castration anxieties, and the like. Empirical studies of this idea are negligible; such an explanation tends to come from the analyst treating a lone pedophilic patient, and authors writing of such cases do not do empirical research. While the concepts may be instructive, Fenichel (1945), Gillepsie (1964), and Hammer and Glueck (1957) would have little to offer for treatment implications save many years on the couch. More contemporary researchers have not tried to test these ideas; clinicians may use them to conceptualize.

The next category of theory types, Sexual Arousal, would seem to be directly related to the fixated pedophile. While the regressed individual may use a child as a surrogate for the ideal partner, the fixated find that the child is the ideal partner.

There are some theorists who have expressed the opinion that sexual arousal has little to do with pedophilia. Those arguing this point of view stress the importance of non-sexual components in pedophilia, i.e., that the pedophile's interest in children stems from a need for mastery and control, dominance, and other interpersonal dynamics that motivate relationships (Hammer & Glueck, 1957; Sgroi, 1982; Stoller, 1975). While there is no doubt that for some pedophiles these factors may be most important,

> Even the most conventional kind of sexual interaction

> between a husband and wife is filled with many non-sexual motives, such as the desire for power, possession, affiliation, and confirmation of adequacy as a male or female. The presence of non-sexual motives does not make pedophilia... a non-sexual behavior. (Finklehor & Araji, 1986, p. 151)

These factors may more appropriately be discussed when examining theories based on the emotional congruence of pedophiles and their objects (following this section). That certain pedophiles are clearly sexually aroused and attracted to the physical characteristics of children (hairless bodies, delicate features) is documented (Groth et al., 1982).

Several theories seeking to explain how a pedophile comes to find children sexually arousing are drawn from the social learning school. The first is the notion of classical conditioning (Pavlov, 1929). The idea is that in childhood play where children masturbate together (Kinsey et al., 1948), the sexual response/gratification is first experienced while in the company of other children, and the pedophile becomes conditioned to the presence of children as an excitant. However, the majority of adults engaged in sex play with other children when they were young, but most do not become conditioned in this way.

If these experiences do serve to condition some individuals who become pedophiles, it is likely that the experience was paired with some strong emotional cues that are incorporated into fantasy by the individual. This fantasy is then used in

subsequent masturbatory repetitions, which strengthens the importance of the original stimulus experience. For example, "... any feature of the experience that makes it prominent in the person's awareness - great pleasure, embarrassment, or shame- will make it likely to come to attention in the course of masturbation" (Finklehor & Araji, 1986, p. 151).

This explanation is particularly plausible when one looks at the extent of sexual victimization seen in the childhood backgrounds of pedophiles. Researchers have found unusually high amounts (Gaffney et al., 1984; Gebhard et al., 1967; Groth & Burgess, 1979). Prendergasts (1979) found 90% of convicted sexual offenders (not exclusively pedophiles) had histories of sexual trauma. Trauma can take the form of passive trauma (over-exposure to sexual talk and thoughts, witnessing adult sexual activities) or active trauma, such as being the victim of sexual abuse. Gaffney et al. (1984) found twice as many pedophiles as non-pedophilic controls were molested in childhood. Further, he questioned whether there is familial transmission of pedophilia. "Pedophilia was found in five of 33 families of pedophiles. Pedophilia was found in one of 21 families of non-pedophilic paraphiliacs. ... four of the non-pedophilic paraphiliac families had a sexual deviancy not involving pedophilia" (p. 547). While 18.5% of the sexually disturbed (pedophilic and non-pedophilic) sample had family members with sexual deviancy, it is interesting to note that pedophilia was more often seen for pedophiles and

non-pedophilic disturbance was more often seen for other paraphiliacs[9].

It is fairly easy to believe that the experience of abuse serves to facilitate imprinting or conditioning deviant sexual fantasies, which may be strengthened through masturbatory repetition. Howells (1981) suggests that modeling may be more important than conditioning. That is, in pedophiles who were victimized as children, having the adult model of someone who finds children sexually stimulating is the factor of importance.

Another contribution from the social learning school related to pedophilic sexual arousal is that of Misattribution Theory (Schacter, 1964). This concerns the cognitive labeling (intra-individual) of sexual arousal. Simply, the idea here is that the individual has incorrectly "labeled" children as an erotic stimulus. For example, the physiological arousal not elicited by an erotic stimulus may be labeled erotic; conversely, arousal elicited by an erotic stimulus may be labeled (by the individual) as non-sexual. Howells (1981) mentions that children elicit strong reactions in adults, i.e., we feel "protective", "parental", "affectionate", and these feelings can potentially be mis-labeled, or mis-attributed by the pedophile, as sexual love. Finklehor and Araji have developed this idea further stating,

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[9] These results would be more interesting if we had a base rate for the percent of sexually deviant members in all families.

> Thus, perhaps certain socialization experiences or subjectively felt sexual deprivation may prompt individuals to label any emotional arousal as a sexual response. Once having labeled a response as sexual, they may find ways to reinforce it through repetition and fantasy and thus come to have a much more general sexual arousal to a child in particular or children in general. (1986, p. 152)

Another area of research with promise for understanding deviant sexual arousal are studies of biological factors such as hormone levels or chromosomal make-up. Physiological abnormalities have been noted in pedophiles (Berlin, 1982; Hucker et al., 1986). One of the more interesting of these studies concerns testosterone levels in sex offenders that are non-violent. (Testosterone has typically been studied only in violent sexual offenses.) Gurnani and Dwyer (1986) found in a study of non-violent outpatient child sexual offenders that,

> ... not only are testosterone levels.. significantly lower than control subjects but that all of them (N=23) had testosterone levels in the low to below normal range. This finding accords with the results of a Toronto study ...in which lower than normal testosterone levels were found... (p. 43)

While data on the relationship between testosterone levels and sexual behavior are inconclusive (Brown, Monti, & Corriveau, 1983) research in this area is worth pursuing. It may be that the pedophile with deficient social skills lacks the testosterone necessary for asserting himself in (threatening) adult sexual

relationships. One is reminded also of Freund's (1987) study on physical aggressiveness and feminine gender identity (see page 81). He asserts that his findings suggest that physical unaggressiveness, rather than feminine gender identity is the "... lowest common denominator of homosexual male types" (p. 31), and as such endocrinological research is potentially relevant for the study of homosexual pedophiles.

Studies of treatment with anti-androgens -- testosterone is an androgen -- and progestogens show that they are useful in decreasing libido (Bradford, 1983; Cooper, 1986; Money, 1987), but they are relatively useless for pedophiles as most are not hypersexual, and hormonal substances cannot influence the direction of sexual interest, i.e., interest in children. Looking for theories of aetiology in these areas therefore may only have a bearing on the predisposition of an individual to deviant sexual behavior, rather than a specific interest in children.

Wincze, Bansal, and Malamud (1986) studied MPA (another anti-androgen) in a controlled setting with three chronic pedophiles. They found that subjective arousal was lowered, nocturnal penile tumescence amplitude decreased, but that subjects were still capable of genital arousal to strong erotic stimulation. They concluded that, "MPA may have the effect of decreasing overall erectile responsivity but not the capacity for

full erection in the presence of specific arousing stimuli" (p. 304).

One recent case study suggests that cyprotone acetate (another anti-androgen), combined with behavioral conditioning, may be used not only to lower deviant interest, but to change the direction of interest. Bradford and Pawlak (1987) used this approach successfully with a sadistic homosexual pedophile where the prognosis was extremely poor because organicity played a role.

In general, theories derived from biological factors may be useful for treatment, but do not as yet help to explain why an individual finds children arousing.

Studies of brain pathology also hold promise for the future. Scott, Cole, McKay, Golden, and Liggett (1984) administered the Luria-Nebraska Neuropsychological Battery to three groups of sexual offenders: a) forcible assault of a post-pubescent male or female (rape), b) non-violent assault against a pre-pubescent child (pedophiles), and c) normal controls. Sadly, these authors did not specify whether the pedophile group was composed of heterosexual offenders, homosexual offenders, or both. They excluded all subjects who might have been expected to show neurological abnormalities, e. g., history of seizures or head trauma. They found that, "The subjects arrested for molestation of pre-pubescent children performed worse on all scales... than those subjects arrested for rape" (p. 1116). Further,

discriminant analysis correctly classified 64% of the pedophile group using the battery results. Overall, "In the pedophiles group, 36% met the criteria for diagnosing brain dysfunction, 29% performed in the borderline range, and 36% were neuropsychologically normal" (p. 1117).

Hucker et al. (1986) administered neuropsychological test batteries to pedophiles and controls and found that the pedophiles were significantly more impaired on all measures. Heterosexual and homosexual pedophiles scored lowest of all groups on I.Q. measures (X=93.5). The pedophiles (total group) showed 52% CT abnormalities, compared to 17% of the controls. In all "..., 67% of the pedophiles showed some brain abnormality" (p. 445), and they showed more neurological impairment when age, I.Q., and education differences were eliminated. Left temporo-parietal pathology was particularly noted for the pedophilic group. This is the only recent published study of brain pathology in pedophilia that exists, and it is hoped it will not be the last. Both studies certainly suggest that cerebral dysfunction is a factor for some, though not all, offenders.

The final theory type proposed by Finklehor and Araji (1986), emotional congruence, groups into one category theories which try to explain the offender's behavior by looking at why he finds it emotionally satisfying to relate sexually to a child. (The reader will note that the theories here are discussed in reverse order. See page 53.) "Emotional congruence" is an apt

term as researchers working from this perspective hold the assumption that the pedophile is emotionally a child. "Pedophiles experience themselves as children, they have childish emotional needs, and thus they wish to relate to other children" (Bell & Hall, 1976, p. 195).

Many theorists espousing this idea come from the analytic school. The idea that pedophiles have arrested psychological development is a theme which runs through all the theories; differences lay only in the interpretation of what caused development to stop. From each different view on the cause comes a like view of what the child/object offers to the pedophile.

Howells (1981) summarized the contributions of the psychoanalytic school which have particular merit for the study of pedophilia. They are essentially three. First, that "perversions" such as pedophilia occur out of avoidance of anxiety-ridden adult sexuality (due to arrested development and low self-esteem). Second, that there are important non-sexual components in sexual behavior, i.e., the need for coping, mastery, control, competence, and dominance. Finklehor and Araji (1986) suggest through their inclusion of "symbolic mastery of trauma" and "identification with the aggressor" that these needs may be an important dynamic for pedophiles with a history of childhood abuse. Thirdly, and as listed by Finklehor and Araji, the psychoanalytic school has contributed the concept of

narcissism as an underlying motivational dynamic or drive for pedophilic behavior.

The first of these, that pedophilia may stem from the avoidance of anxiety-ridden adult sexuality, finds support from many areas; both from clinical descriptions of pedophiles as isolated and avoidant of adults in their general living (see Mohr et al., 1964, p. 45-57) and from all the studies of social skill deficits in pedophiles (Bancroft, 1978; Barlow, 1974; Fisher, 1969; Fisher & Howell, 1970; Freund, 1974; Pacht & Cowden, 1974; Panton, 1978; Peters, 1976; West, 1977).

The second contribution, concerned with the non-sexual components of sexual behavior' has been discussed in relation to pedophilia by several researchers (Lambert, 1976; Rosen, 1979; Stoller, 1975). Howells (1981) has adapted Stoller's (1975) theory of sexual deviance where the pedophilic "fantasy" serves as a "... scene of symbolic mastery over childhood-induced psychological traumas..." (p. 58). As Finklehor and Araji (1986) point out, this same process has also been called "identification with the aggressor" (p. 148). The desire to regain a feeling of mastery and power on the part of pedophiles seems logical, especially when we consider this in light of data on the general social inadequacy of pedophiles and the history of childhood sexual abuse seen in this population.

Nevertheless, both of the above ideas (avoidance of adult sexuality and the need for mastery) are of limited use in

explaining the development of pedophilia. These two factors may be equally likely to produce an individual who rapes elderly women. Their implications are likely more useful for treatment, than as factors that are both necessary and sufficient in the aetiology of sexual interest in a child.

It is for these reasons that the third contribution from the psychoanalytic school, that of the role of narcissism, held particular interest for this researcher. The idea has been proposed that pedophiles, simply stated, are confusing themselves with their object. They are the child who is the victim, and by "loving" the child, they are coping with their own histories of emotional deprivation as children. This idea appealed to the researcher for two reasons. First, it would account for the specific choice of a child as an object. Second, if narcissistic inversion is the psychodynamic "glue" which holds the fixed offender to the child, it would explain why fixation or "true pedophilia" is seen more often in offenders picking same-sex objects (homosexual pedophiles).

Several authors have discussed the importance of the pedophile's identification with childhood. Bell and Hall (1976) speak of an "infantile personality" and "childhood preoccupations" in their pedophilic population. Fraser (1976) and Roth (1952) contend that pedophilia is dependent on narcissism, a love for the child the adult once was. Kraemer

(1976), Gordon (1976), and Storr (1964) express similar beliefs. Howells writes,

> ... many pedophiles' involvement with children occurs in the context of an idealization of the characteristics of childhood. It is not uncommon, clinically, to find pedophilic persons who are fascinated with, and attracted by, the qualities of childhood. Such qualities may not be physical or sexual but of a more general nature. (1981, p. 65)

The author's clinical experience supports this view, particularly for homosexual pedophiles on her caseload who have spoken of the "goodness", "innocence", and "purity" of their objects.

How does one "choose" an object to love? Freud wrote,

> Psychoanalysis informs us that there are two methods of finding an object. The first ... is the 'anaclitic' or 'attachment' one, based on attachment to early infantile prototypes. The second is the narcissistic one, which seeks for the subject's own ego and finds it again in other people. This latter method is of particularly great importance in cases where the outcome is a pathological one. (1905/1953, p. 145)

The psychiatric dictionary (Hinsie & Campbell, 1970) gives a general definition of narcissism which defines it as "... a form of auto-eroticism characterized by self-love" (p. 487). The authors explain that "... in psychoanalytic psychology, narcissism is a stage in the development of object relations...

(where)... the infant is ... ignorant of any sources of pleasure other than himself and does not differentiate between the breast (or other objects) and the self ... the breast is thought of as part of his own body" (p. 487). Further, "When applied to the adult, the term narcissism implies a hypercathexis of objects in the environment and/or a pathologically immature relationship to objects in the environment" (p. 488).

In homosexual pedophilia, where offender and victim are the same gender, the "hypercathexis" occuring would be that of the "self" of the offender, for the "object" which is the child. While Freud did not write specifically about pedophilia, in his treatment of homosexuality[10] (1905/1953), he explores the function of the (primary) narcissism described above. He uses the word "inverts" to describe homosexuals and writes,

> In all cases we have examined, we have established the fact that the future inverts, in the earliest years of their childhood, pass through a phase of very intense but shattered fixation to a woman (usually the mother), and that, after leaving this behind, they identify themselves with a woman and take themselves as their sexual object. That is to say, proceeding from a basis of narcissism, they look for a young man who resembles themselves and who they may love as their mother loved them. (1905/1953, p. 56)

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[10] Freud's theory of homosexuality may reflect the anti-homosexual bias that long dominated European history (Friedman, 1986).

How does the theory inform us that one "gets stuck" in, or develops, the position of inversion stemming from narcissism? Without going into detail (as to do so would require a re-explanation of the whole theory of psychoanalysis), let us simply state that the individual has "chosen" (albeit not consciously) a way to resolve his Oedipal Complex. Greater clarity regarding this concept is found in Fenichel's The Psychoanalytic Theory of Neurosis (1945) in which he wrote that in homosexuality the "... Oedipus is resolved by assumption of the negative Oedipal attitude characteristic of the opposite sex" (p. 334). That is, the child no longer has to deal with the threat, the guilt and anxiety, generated from wanting to kill the father because of desire for the mother if he assumes the position of the female child. To manage through the "intense but shortlived fixation to mother" they change position psychically and "identify themselves with a woman" (Freud, 1905/1953, p. 56).

The individual is looking for a non-threatening substitute for his Oedipal strivings.

> Having identified himself with his mother, he behaves as he previously wished his mother to behave toward him. He chooses as love objects young men or boys who, for him, are similar to himself, and he loves them and treats them with the tenderness he had desired from his mother. While he acts as if he were his own mother, emotionally he is centered in his love object, and thus enjoys being loved by himself. This type of development produces 'subject homoerotic' individuals who actively seek younger persons as objects... who represent themselves... most often they

> behave very tenderly toward their object. (Fenichel, 1945, p. 322)

Hinsie and Campbell (1970), in summarizing aspects of Freud's theory of homosexuality, state that after the process of identification with the mother,

> ... if his fixation is predominantly narcissistic, he will choose young men or boys as love objects who represent himself, and he loves them in the way he wanted her to love him. These are 'subject homoerotic' persons, one of whose conditions of love is often that the homosexual object be of the same age as the person himself when the change into overt homosexuality occurred. (p. 350)

Given this grounding in psychoanalysis, let us review the few analytic writings specific to pedophilia.

In The Death of Narcissus, Fraser (1976) expresses the view that narcissistic inversion is at the core of pedophilia. He relates this to the childhood family situation of the pedophile which necessitates this form of resolving the Oedipal crisis. The pedophile is in childhood deprived of love from his mother, and has either an absent father or one who is psychologically absent because he is hated. The healthy resolution of the Oedipal conflict depends upon a final identification with the father, but because of father absence, the child is unable to do so. The second option would be to identify with the mother as a model, but he is unable to do this either because of distance or

inability to relate to her. The solution according to Fraser is to substitute himself as the love object : "He narcissistically remains in love with the child he then was. This is impossible so he must project his love onto children of a similar age to his lost child, who thus become love objects for him" (1976, p. 20).

This is somewhat different in terms of a causal chain from Freud's theory of the "invert", but of course, has the same result. Fraser offers this theory for pedophilia in general, although it seems clear that it makes sense only for homosexual pedophilia ("the boy he once was") and not for heterosexual pedophilia, where the object choice is a female.

This theory would seem to find mixed support when we examine the family backgrounds of homosexual pedophiles. Mohr et al. (1964) found that for homosexual pedophiles the father was not generally perceived as being "close", and this need for a closer relationship was often expressed by the offender. This same group showed a highly positive relationship to mother (through self-report); this tended to be idealized.

Kraemer's The Forbidden Love (1976) is written from a Jungian perspective. Narcissism is again seen as the root of pedophilia, with the causal chain differing from other writers. He believes the narcissism results from the "narcissistic relationship" between mother and child. Specifically, the mother is extremely narcissistic and so views the child as an extension of herself; consequently the child receives excessive love and

develops a narcissistic attitude. In light of the above regarding homosexual pedophiles' self-reports of relationship with mother perhaps this is a possibility, although clearly we need to know much more.

In general, data concerned with parental relationships of pedophiles show no greater degree of disturbance, disruption, deprivation, or pathology than in other populations with serious social/psychological disturbance, in which makes it difficult to view them as any more than a contributor to general pathology, rather than specific sexual disturbance.

Bell and Hall (1976) have written about an in-depth single case study of a pedophile. They feel that the pedophilia was largely an expression of the patient's child-like level of functioning. While their patient exhibited maternal dependence, gender identity confusion, and a poor relationship with father, they felt "... these activities can best be understood as an expression of an inadequate, infantile personality ... his molestations ... were probably ... a continuation of his childlike preoccupations and conducted from a child's point of view" (p. 195).

In summary, the relevance of narcissistic inversion in homosexual pedophilia has been used by clinicians to explain the offender's emotional congruence with his victim, but no research results exist to support these ideas.

Differences Between Groups

The pedophilias are a heterogenous group of disorders. The "common factors" cited are basically useless in contributing to a better understanding of pedophilia as they concern extremely general descriptions of behavior. Other than the assumed difficulty in adult relationships (obvious if they choose children as sexual partners), these general factors are no different than statements we can make about adult-to-adult sexual relationships. Most adults are not violent and prefer consensual sexual relationships, and most adults engage in forms of sexual activity that are commensurate with the needs/desires of their partner. (Pedophiles generally seek immature forms of sexual expression, e.g., fondling, with their immature partners.) To describe adult-to-adult sexuality by such broad "generally true" statements would hardly lead to comprehensive understanding. The same is true for pedophilia.

While every case must be considered individually, the heterogeneous nature of pedophilia can be broken into smaller, more homogeneous groupings by the use of two dimensions on which we locate the offender. The first is a continuum which spans varying degrees of the strength of sexual interest in children, the starting point being the weak interest of the regressed

offender, spanning to the exclusive interest of the fixated offender. The second dimension which separates some pedophiles from others depends on the sex of the object. A homosexual pedophile chooses male children. A heterosexual pedophile chooses female children.

Research indicates that heterosexual and homosexual pedophiles share group characteristics which differentiate them from one another. Pedophiles who have no gender preference are labeled "undifferentiated". While important to research, this group tends to be insignificant due to their small numbers. They account for only 2-4% of all pedophiles, and are much more pathological (Fitch, 1962; Frisbie & Dondis, 1965; Mohr et al., 1964; Nedoma, Mellan, & Pondelickova, 1971). Much like normal adult sexuality, gender preference is largely fixed and rarely varies[11].

What is the relative percentage of heterosexual pedophilia as compared to homosexual pedophilia? The Badgely report found that, "... of convicted male offenders having single victims, four in five (80.1%) had committed heterosexual offenses, and one

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[11] Some pedophiles are charged with an offense against both a boy and girl, but these are not "undifferentiated" pedophiles as there is a clear gender preference expressed. Usually these cases involve a brother and sister, or both genders, because the children happened to be together. Researchers collecting statistics should be careful in assuming an offender is "undifferentiated" based on an arrest record showing male and female victims.

in five (19.9%) had committed a homosexual offense" (1984, p. 842). However, these statistics included incest offenses, which would greatly elevate the proportions of heterosexual as compared to homosexual offenses. Langevin (1983) found three-fourths choose female victims exclusively, and about one-fourth choose male victims. A study by Gebhard, Gagnon, Pomeroy, and Christenson (1965) was analyzed by Freund, Heasman, Racansky, and Glancy (1984); they found a proportional prevalence of 32% more homosexual than heterosexual offenders.

Another study of adolescent pedophilic offenders found 59% of the sample had male victims, 35% had female victims, and 6% had both (Saunders, Awad, & White, 1986). These researchers noted however, that the high percentage of homosexual offenders may differ "... according to whether they are pedophiles or young homosexuals... experimenting in an attempt to clarify their gender identity" (p. 548).

In Freund's (1984) own population (N=457) the proportional prevalence of offenders against male children was 36%. It would seem that the homosexual pedophiles comprise roughly a third of the pedophilic population. This is particularly interesting if we consider, as he did, how this relates to the prevalence of homosexuality among the non-pedophilic population. Researchers agree that among a "normal" population, homosexuals comprise no more than 4-5% (Kinsey et al., 1948; Whitham, 1983). Freund intelligently argues that this discrepancy signifies that the

development of partner sex preference and partner age preference are not independent; if there were no relationship it would be expected that the same amount of homosexuals would be found among the pedophilic population as among the general population, i.e., 4-5%. A question to be discussed later is why so many more pedophiles than non-pedophiles choose male objects. Let it be clear to the reader that these figures have nothing to do with adult-to-adult homosexuality; homosexual pedophiles rarely show any attraction or previous sexual experience with adult males (Freund & Langevin, 1976; Freund, Watson, & Rienzo, 1987; Groth & Birnbaum, 1978).

Freund and Blanchard have continued to investigate the prevalence of homosexuality in pedophilia. In a recent study (1987) they compared groups of heterosexual and homosexual offenders who were pedophilic, hebephilic, or both, and who had either one offense or were recidivist offenders. Significantly more of the heterosexual offenders had a single offense, while significantly more of homosexual offenders were recidivist. Freund points out that this "... is the opposite of what one would expect given the higher chances of multi-case offenders being caught" (p. 212), (i.e., it would be expected that more recidivist offenders than non-recidivist offenders would be seen in either group). This offers additional support to the contention that most heterosexual single-case offenders are not pedophilic. Further, he found that for subjects who had offended

against both a child and an adolescent the proportions were much smaller in the heterosexual as compared to the homosexual group. Freund writes that this may suggest, "... offenses against male early adolescents are considerably more often related to homosexual pedophilia than offenses against female early adolescents are related to heterosexual pedophilia" (1987, p. 263).

Another recent study by Freund and Blanchard (1987) shows further evidence of the dissimilarity between non-pedophilic homosexuals (androphiles) and homosexual pedophiles. The purpose of the study was to investigate "... whether there exist developmental differences between men erotically attracted to male vs. female children that would parallel already known differences between men erotically attracted to male vs. female adults" (p. 25). They choose the study of physical aggressiveness in childhood and feminine gender identity as a number of retrospective studies have consistently found androphiles differ on these measures, i.e., less aggressivity and more feminine gender identity (Evans, 1969; Harry, 1982; Saghir & Robins, 1973, Thompson, Schwartz, McCandless, & Edwards, 1973; Whitham, 1977; Whitham, 1980).

The homosexual group had three individual populations of choice : pre-pubescent, pubescent, and physically mature partners. The heterosexual group was also broken into three groups for analysis; those who preferred pre-pubescent partners,

a control group who preferred normal sexual interaction with adult partners, and a group who preferred adult partners but who were not normal in preferred sexual activity, (e.g., exhibitionism, obscene phone calls, sadism). In a previous study no difference in (recalled) gender identity was found between homosexual and heterosexual pedophiles (Freund; Scher, Chan & Ben-Aron, 1982). He reconfirmed his earlier findings, that is, that, while the homosexual groups all tended to be unaggressive in childhood, only those homosexuals who preferred adult partners showed statistically significant levels of feminine gender identification in childhood[12].

Again, the notion that homosexuals who engage with adult partners present a greater risk for children is unfounded because they are a different population from homosexual pedophiles.

Most research suggests that the heterosexual/homosexual and fixated/regressed dimensions may not be entirely orthogonal. In essense, homosexual pedophiles tend as a group to be fixated, whereas heterosexual pedophiles tend as a group to have the majority of group members belonging to a regressed model.

The bulk of the evidence suggesting a link between homosexual pedophilia and fixation comes from studies of

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[12] Gender identity confusion has been noted for pedophiles in a study by Johnson and Johnson (1986); see footnote on page 88.

recidivism, assuming that the fixated pedophile will be more likely to have a recurring offense pattern. These differences in rates of recidivism were noted as early as thirty years ago. The 1957 British Study of Sexual Offenders found that "there is a marked difference between the proportion of sexual recidivists in the heterosexual class (12%) and the homosexual class (23%)" (Radzinowicz, 1957). The Toronto Forensic Clinic Study (1956-1959) found that exhibitionism has consistently the highest recidivism rate, "... followed by homosexual pedophilia with a recidivism rate of from 13-28%. Heterosexual offenses against children show about half this recidivism rate, varying from 7-13%" (in Mohr et al., 1964, p. 156). A 1965 U.S. Study of Sexual Offenders done by the Kinsey Institute found that "... the rate of recidivism varied in relation to whether heterosexual (33.1%) or homosexual (53.4%) offenses had been committed" (Gebhard et. al , 1965, p. 811). This last study used incarcerated offenders, which would explain the generally higher recidivism rates for both groups than that noted in studies using clinic populations; six in seven incarcerated offenders have previous convictions for sexual offenses (Searle, 1974, p. 18).

The 1974 Canadian Report on Sexual Offenses Against Children (also drawn from incarcerated offenders) makes this summary. "Recidivism varied in relation to the types of offenses committed, respectively 21.5% heterosexual offenders; 39.5% homosexual offenders; and 52.4% offenders having multiple victims" (in Badgely, 1984, p. 854). (The author assumes that

"multiple" refers here to the undifferentiated offenders who, as mentioned above, are very small in number [2.4%] and more polymorphous in sexual disturbance.)

Researchers such as Fitch (1962) and Frisbie and Dondis (1965) have found homosexual pedophiles have previous convictions and higher reconviction rates. Nedoma et al. (1971), Groth and Birnbaum (1978), and Quinsey (1978) all suggest that homosexual pedophiles have a more enduring preference for children than do heterosexual pedophiles, and they rarely report any attraction to adult males.

Additional strength for a relationship between homosexual pedophilia and fixation (and the opposite) is found in many areas other than recidivism statistics. The history of sexual trauma in the early development of the offender indicates that "... twice as many of the 'fixated' type offenders (who are also more commonly male object) had been victimized compared with the 'regressed' type offenders" (Finklehor & Araji, 1985, p. 25). Gebhard et al. (1967) found evidence of poor parental relationships for male object, but not for female object offenders.

Homosexual offenders are more likely to choose strangers as victims, whereas heterosexual offenders are more often known to their victims (e.g., friends of family, neighbors) which supports a theory of "ease of access" for the (regressed) heterosexual pedophile (Mohr et al., 1964; Groth & Birnbaum, 1978). "Overall,

only one in four offenders (26.9%) was a stranger, with this type of relationship being more common when boys than girls had been victims" (Badgley, 1984, p.851). The homosexual offender actively seeks his object in an unknown child; perhaps the heterosexual offender would be unlikely to offend were a child not conveniently nearby.

There are differences in the nature of the sexual act itself between the homosexual and heterosexual groups. As a preface however, it should be clear to the reader that before we can understand a sexual act, we must remember the importance of distinguishing the act itself from the intention, or directionality, of the act. For example, an adult male who exposes his genitals to a child can have different intentions; exposing can be the final aim for gratification (in which case he would be diagnosed an exhibitionist, not a pedophile) or it can be done with the intention of being fondled as the final aim.

Heterosexuals and homosexuals differ both in the act itself and the intentionality of the act. Whereas by and large penetration and intercourse are rare in all pedophilic activity (Mohr et al., 1964), for the heterosexual the majority of sexual acts are like the sexual play that children engage in, i.e., showing, looking, fondling, and being fondled, and there is clearly no intention on the part of the offender to do anything else (Gagnon, 1965; Mohr et al., 1964; Kinsey et al., 1948). There is an underlying assumption here that fondling is a

childlike form of sexual expression when it is the only sexual behavior engaged in.

In homosexuals however, the acts are basically the same as they are with adult partners with the exception of anal intercourse (Mohr et al., 1964). Fondling accounts for only 9% of the sexual acts of homosexual pedophiles (masturbation accounts for 48%) as compared to 60% of heterosexual pedophiles' activity (Mohr et al., 1964).

As regards intentionality, only 6% of the heterosexual offenders had intentionality of orgasm, whereas 50% of the homosexual group sought orgasm (Mohr et al., 1964). It is fairly clear that homosexual pedophiles seek a truly sexual experience with a child to a much larger degree than heterosexuals; it is not a great leap of logic to suppose that sexual behavior of the homosexual group reflects a greater degree of fixation on children as sexual objects.

Studies by Gebhard et al. (1967), Rada (1976), and Stokes (1964) have shown that alcohol is more often a factor in offenses committed by female-object, rather than male-object, pedophiles. This can be interpreted to mean that alcohol acts as a disinhibitor for the heterosexual pedophile, while the homosexual (fixated) pedophile is less likely to need a disinhibitor as his actions are ego-syntonic.

While some things are known about the difference in behavior exhibited, little is known about how they may differ from one

another intra-psychically. If we are to assume that homosexual pedophiles are more fixated, and hence, more truly "pedophilic", then it becomes important to look at the psychological profile of this group and how it may relate to their greater fixation. Fitch (1962) found "... some associations between homosexual object choice and traits of immaturity and sociopathy". Frisbie and Dondis (1965) found homosexuals more likely to be classified as "sociopathic", but this tells us little; twenty years ago homosexuals of any type were considered to be pathological.

As in the rest of the field, there have been few empirical psychodiagnostic studies. Objective personality measures of pedophiles have relied largely on the use of the Minnesota Multiphasic Personality Inventory (MMPI). Levin and Stava (1987) have discussed the limitations of the MMPI as applied to this population. They point out that it is not the ideal instrument for assessing personality as it was actually designed as a device to assess psychopathology. "The test was originally constructed in an empirical manner to distinguish various groups, defined in terms of psychiatric diagnosis, from a normal sample and from each other" (p. 59). The use of the MMPI as a personality test in the following studies represents a shift away from the use intended in its design.

Aside from the limitations of the MMPI, much of the research fails to provide adequate control groups (using college students as controls, for example), and it does not differentiate between

types of child molesters (violent/non-violent, hetero/homo, among others) in the data analyses.

Armentrout and Hauer (1978) and Panton (1978) found a (two-point) 4-8-code to be the mean profile for sex offenders against children (psychopathological deviate and schizophrenia). Panton found incest offenders had a mean profile code of 2-4 (depression and psychopathic deviate). A later study by Panton (1979) found that incest offenders had a higher scale 0 code (social introversion) than did non-incest offenders. These results are questionable as the researchers reported means without modes, and the mean profile is not necessarily the most frequently occurring. Panton's (1978) study used only heterosexual offenders.

Langevin, Paitich, Freeman, Mann, and Handy (1978) used the MMPI to test the assumption of confused gender identity in pedophiles[13]. The expectation of a higher scale 5 score (masculinity-femininity) was not confirmed. Quinsey, Arnold, and Preusse (1980) found no differences between the MMPI profiles of child molesters, rapists of adults, and non-sexual offenders. He

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[13] Johnson and Johnson (1987) also reported gender confusion in child molesters, based on the results of House-Tree-Person tests. Aside from the limitations of projective instruments and questionable inter-rater reliability, they did not differentiate offense characteristics, and they used college students as controls.

did not differentiate the child molester group in the analysis along homo/hetero or incest/non-incest lines.

Hall, Maivro, Vitaliano, and Proctor (1986) have done one of the few methodologically correct pieces of research using the MMPI. The objective was to assess group differences. They included the important offender characteristics in their analysis (male/female victim, incest/non-incest, force/no force, rape [penetration]/non-rape, and younger/older age of victims) by using chi-square, ANOVA, MANOVA, and multivariate regression.

They found that the MMPI failed to differentiate among offenders using the above offense characteristics. It is quite unlikely that these groups have no differences. Like Armentrout and Hauer (1978) and Panton (1978) they found a 4-8 mean (and modal) profile code for the entire sample. Incest offenders had a 2-4 profile code. They point out however, that this code was present among only 7% of the entire sample, and was not significantly more frequent than several other two-point codes.

> The observations that 67% of the sample had more than two MMPI clinical scales significantly elevated and that only 13% of the sample had only two significant clinical scale elevations are evidence that scale elevations in addition to scales 4 and 8 should not be overlooked in the interpretation of the MMPI profiles of sexual offenders against children. (p. 496)

Results also suggested that scale 5 code elevations (masculinity-femininity) were higher for offenders with male

victims than offenders of female children, and that there was an inverse relationship between victim age and offender disturbance. These differences were of "minimal magnitude" (p.496). The authors concluded that,

> The MMPI is of limited clinical utility in assessing and differentiating such patterns among populations of men who have sexually assaulted children. (1986, p. 496)

Research using instruments other than the MMPI have also contributed limited results. Fisher (1969) and Fisher and Howell (1970) used the Edwards Personal Preference Schedule in an incarcerated population. They found, irrespective of sex of victim, that the sample had a high need for abasement and low need for achievement, change, and autonomy. Homosexual and heterosexual comparisons found heterosexuals were high on deference and low on heterosexuality and aggression. Homosexual child molesters were elevated on succorance and nurturance. Langevin et al. (1978) used Catell's 16-PF to study eight types of sexual offenders. He found that "the incestuous and homosexual pedophilic groups scored significantly less assertive than almost everyone else" (p. 232). Wilson and Cox (1983) used the Eysenck Personality Questionnaire in research. The pedophile group had higher scores on introversion, and they found a significant relationship between introversion and preference for

younger children. Figia, Lang, Plutchik, and Holden (1987) compared heterosexual non-violent offenders against children to violent (non-sexual) offenders using seven different psychometric instruments. While few items were found to differentiate the groups they concluded that, "Sex offenders, however, are more socially anxious, fearful of criticism, and inclined to express their hostility in an indirect manner..." (p. 221).

Lanyon (1986) summarizes what testing research has to tell us about pedophilia.

> No consistent findings emerge from these and similar studies except to support the view that molesters' sexual identification is not significantly feminine and that they tend to be somewhat more shy, passive, and unassertive than average. (p. 178)

Perhaps the strongest piece of evidence that can be used to make the link between homosexual object choice and fixation is the age of <u>onset</u> of pedophilic behavior. The logic is that the earlier one engages in pedophilic fantasies and behavior in the chronological lifespan (the earlier the pathology appears), the more fixed, or enduring, the sexual preference is likely to be.

What do we know about the age of onset of the paraphilias in general? A few studies have looked at the initial paraphiliac behavior of adult offenders (Abel et al., 1985; Longo & Groth, 1983). Results indicate not only an early age of onset, but that

the initial behavior differs between groups of rapists and child molesters.

Longo and Groth (1983) studied the histories of adult pedophiles and rapists for juvenile sexual offenses. A pilot study for this research showed that for both groups 37% had a history of exhibitionism, 45% had a history of voyeurism, and 62% had a history of both. The mean age of first appearance was 16 years for exhibitionism and 13 years for voyeurism. A trend was also seen in that voyeurism was more common for rapists and a history of exhibitionism was seen more often in child molesters.

Psychoanalysis contends that exhibitionism and voyeurism are related to castration anxiety. Using this framework one may see why some pedophiles engage (or engaged in) all these behaviors. In exhibitionism, reassurance of not being castrated is given from the victim's shocked reaction to the sight of the penis. In voyeurism, the analytic view contends that the voyeur is attempting to recreate the (primal) scenes from childhood that aroused the castration anxiety, and through repetition, somehow master them (Bak & Stewart, 1974). In some pedophiles then, the impulse to touch the genitals of boys and girls (search for the female phallus) may be a similar attempt at reassurance.

In the later study by Longo and Groth (1983), (N=231, 128 pedophiles), histories showed that as juveniles, pedophiles engaged in compulsive masturbation more often than rapists (35% vs. 28%), exhibitionism more often than rapists (28% vs. 18%),

and that voyeurism was more common for the rapists (23% pedophiles, 31% rapists[14]). These trends mirror the adult behavior of the offenders as masturbation is commonly seen in pedophilic offenses but not in rapes, and voyeurism often precedes rapes but rarely pedophilic offenses.

> While it is apparent that the majority of sexual offenders do not show an escalation of sexual crimes in their histories, a significant number of offenders, at least one out of every three, show some evidence of progression from non-violent sex crimes during adolescence to more serious sexual assaults as adults ... of these behaviors, most tend to be more prominent in the histories of child molesters as compared to rapists. (1983, p. 154)

The authors go on to suggest that clinicians take adolescent referrals for these offenders seriously. While these behaviors are often a part of normal sexual development for adolescents, "normal" activity of this kind is "... generally discreet and with consenting peers" (p. 154).

Abel et al. (1985) also collected data on the initial paraphiliac behavior of pedophiles (N=411). As he expected, most individuals diagnosed pedophilic started with child molestation activity (75%), but 12.9% began with exhibitionism, 3.4% with

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[14] Rapists also reported this had been accompanied by aggressive rape fantasies, while the pedophiles did not.

rape, and 3.0% started as voyeurs. Again, exhibitionism was often seen in the histories of adult pedophiles.

Nearly 42% of the total sample had deviant arousal by age 15, and 57% by age 19. "The earliest onset paraphilia was homosexual pedophilia; 53% reported arousal by age 15, 74% by age 19" (p. 196, emphasis added). While they start early, they also "finish" later; the Badgely report (1984) found that "... homosexual offenders on average, were older than heterosexual offenders" (p. 855), and they go on to state that the type of offense (homo or hetero) is more important than prior convictions in accounting for age groupings among convicted offenders.

In summary, research evidence from diverse studies strongly suggests that sex of object choice has a relationship with the degree of fixation. Separating a random group of pedophiles based on hetero/homo object choice may also provide groupings of fixated and regressed pedophiles. While there are certainly fixated pedophiles in both groups, the fixated heterosexual pedophile may comprise, based on an educated guess, no more than 20% of the total heterosexual group. It might be argued that 80% of the homosexual group is fixated. However, Groth and Birnbaum (1978) have reported roughly a 50-50 distribution of fixated/regressed offenders.

The notion of regression does not seem to apply to the homosexual group. There is no clinical case, either in the author's experience or in the literature, in which an adult-to-

adult homosexual has "regressed" under stress to a surrogate object choice of a child. The author's clinical experience and that of her colleagues tends to support the notion that homosexual pedophiles are more fixated and hence more difficult to treat, the clinical picture usually being drawn as "an isolated, immature, narcissistic individual who avoids adult contacts of any form" (Markus, Note 4).

The following chapters present the method and results of this research, which lend additional support to the assertion that sex of object and degree of fixation are correlated.

Chapter III

Method

This section contains a description of the procedures used to carry out this study. Information on the type of subjects included in the study, the instrumentation used to assess them, and the procedure for doing so are outlined.

Subjects

The sample population (N=18) was drawn completely from the Forensic Psychiatry Clinic of McGill University in Montreal. This is an out-patient clinic for the assessment and treatment of offenders serving the greater metropolitan Montreal area[15]. Patient offenses range from shoplifting to murder and the clinic has a reputation of expertise in the assessment and treatment of sexual offenders. The clinic receives referrals from all arms of the judicial system. Patients can be referred for both assessment and/or treatment (pre-trial and pre- and post-sentencing) from the services of probation and parole, private and legal-aid lawyers, and the courts, and occasionally there are self-referrals. At the time of this research, this was the only

[15] The clinic also occasionally receives case referrals from out-of-province, although none is represented in this sample.

out-patient clinic with this particular expertise operating in Quebec. Total new case referrals for all patients (not limited to sexual offenders) numbered 190 (17 consultations, 173 for legal/psychiatric processing) from January to November 1986 (unpublished annual report of McGill Forensic Clinic). The clinic is staffed by two psychiatrists, one social worker, and a variety of graduate and undergraduate students from related disciplines. There were 3,276 patient visits during this period.

One must keep in mind that the sample population (pedophiles) is not available in large numbers, even under the best of circumstances. When the inclusion criteria are implemented, available subjects are even fewer. The actual sample members were all in fact initially referred either by the Probation Service, or by their lawyers for the purpose of obtaining pre-sentence reports. The criteria for the inclusion of subjects were essentially simple and as follows:

1) Subjects must be adult males who were legally charged with the sexual assault of a minor, where the minor was not a member of the offender's nuclear family. (This served to exclude incest cases.)

2) The subject was agreeable to participate in the research, having given informed signed consent.

3) The subject was capable of undergoing the testing session, i.e., not illiterate (8th grade reading level) or actively psychotic.

All subjects were adult males ranging in age from 19 to 55. The sample was divided between subjects with grade school

educations and high-school graduates. Occupations of these subjects were commensurate with education levels and were either unskilled and semi-skilled, except one subject who worked as a professional. I.Q. testing shows that pedophiles are similar to the general population with a slight skew toward the lower end of the intelligence scale (Mohr et al., 1964; Langevin et al., 1978). The number of pedophilic offenses (legal and/or clinical) varied from a single offense to five or more. Some subjects had spent time incarcerated for an offense; many had not, generally having received as sentence a period of probation. Some subjects were married, others were not; some had children while others were childless. Subjects also varied with respect to the absence or presence of a previous psychiatric history and history of treatment received (for pedophilic as well as other disorders). In short, sample members constituted a heterogeneous group in relation to all surface characteristics outside of a legally charged pedophilic offence.

Instrumentation

Three instruments were used as the testing battery; two are standardized psychometric tests. The third instrument is a questionnaire specifically devised for the structured interviews with the subjects and the professional staff.

The first of these instruments is the Millon Clinical Multiaxial Inventory hereafter referred to as the MCMI (Millon, 1983). This is a 175-item forced-choice (true/false) inventory yielding an assessment of personality and psychopathology. The MCMI has eight basic personality subscale outcomes : schizoid (asocial), avoidant, dependent (submissive), histrionic (gregarious), narcissistic, anti-social (aggressive), compulsive (conforming), passive aggressive (negativistic). It also includes scales of pathological personality syndromes (schizotypal [schizoid], borderline [cycloid], paranoid), a lie scale, and nine clinical symptom syndrome scales (see Appendix C). For all of the above subscales, scores above 74 indicate the presence of the characteristic or syndrome as a feature of personality, while scores above 84 indicate the characteristic or syndrome corresponds to the "highest" clinically judged prevalence rate of the personality or symptom syndrome. Thus, in this study a 10-point scoring range (75-85) is considered in the analysis of results. (See the explanation on page 127.)

In "A Review of the Millon Clinical Multiaxial Inventory", Greer (1984) writes that the MCMI

> ... can be depicted as a major clinical rival or, at least, addendum to the MMPI. It has several assets : (a) short administration time (20 to 30 minutes); (b) linkage to comprehensive clinical theory and construction rather than a purely empirical construction; (c) coordination with DSM-III; (d) differentiation of personality from acute psychiatric

> symptomology; (e) pathological severity clearly delineated in the structure of the scales; (f) norms based largely on psychiatric rather than normal subjects; and (g) scores based on base-rate data which are not based on the assumption of normal distribution of clinical syndromes. Its construction is in short impeccable and radically different from previous instruments. (p. 263)

This instrument was chosen by the researcher because it offers personality subscales, is DSM-III derived, and is based on norms for a psychiatric, rather than a "normal" population (Dr. Millon, the author, was a member of the task force that developed the DSM-III). Because of the above, it was felt to be a stronger instrument for use in this research than the better-known Minnesota Multiphasic Personality Inventory. (See the discussion of the MMPI limitations in Chapter V.)

The second of the instruments is the Narcissistic Personality Inventory, hereafter referred to as the NPI (Raskin & Hall, 1979; Note 5). This is a 54-item forced-choice (true/false) inventory (see Appendix D). It is based on the DSM-III definition of narcissistic personality disorder, which combines an "exaggerated sense of self-importance" with "a lack of sustained positive regard for others" (American Psychiatric Association, 1980, p. 317). This inventory may be split into two halves if there is a need for two forms, although in this research the full scale was administered to each subject. (Spearman-Brown split-half reliability coefficient for the 54

items is .86.) While this is a fairly new instrument and validity is not clearly established, it was chosen for inclusion in the battery as it is the only psychometric instrument available to specifically test for narcissism. Raskin and Hall (1979) found correlations between this instrument and the narcissism subscale of the MCMI to be r = 0.66 (.001) in a psychiatric population. This mid-range correlation suggests that each instrument is measuring something in common as well as something not shared by the other, but there are no better scales available.

The third instrument used in the data collection is a questionnaire designed by the researcher with the aim of guiding the interviews with the subjects and the professional staff. It does not yield a score as it serves simply to collect information. The questionnaire sought information on the usual demographic variables (age, education, profession) as well as a variety of information believed to be relevant for use in the analysis of data gathered from the MCMI and the NPI.

The latter included such items as history of treatment received for pedophilia and sentencing history. Concerning the quality of the relationship between the offender and the child, subjects were asked the age of the child (in the last offense, if multiple offenders), how long the child had been known to them, if they felt they had been "in love" with the child, the length of the relationship, the type of sexual activity engaged in,

whether they viewed the child as consenting, and if they had ever used physical force to obtain sexual relations with a child (see Appendix E). They were also asked if they themselves had ever been sexually abused.

It should be recalled here that these same questions were asked of the professional staff in the later interview to control for those subjects who might not answer honestly. The level of agreement was actually quite high and it would seem that most subjects were in fact honest in their responses.

Procedure

Each subject was asked for his participation, either by the assessing psychiatrist or therapist, depending upon what clinical status the patient occupied and what staff member was most familiar to him. The general nature of the request was to the effect that the clinic was "... doing research on patients like yourself so that we can better help patients that come to us in the future." The patients were not informed of the specific nature of the research, but the words, "... patients like yourself" (or "with charges like yourself"), were included in the request so that the individual would not be rudely shocked during the interview when asked questions about his pedophilic offense(s). If a patient asked for more specific information, he was told that the research was concerned with people "who have

charges like yourself". Some patients therefore may have entered testing with a general idea that the research was concerned with pedophilia. Since only the questions in the interview following the psychometric testing (comprised of general personality questions) were directly concerned with pedophilia, it was felt unlikely that a "pre-knowledge" of this sort would have an effect on outcome. Patients were not familiar with any details of the purpose of the research.

Patients were also informed that participation in the research entailed paper and pencil testing to be followed by a short interview, that it would take roughly one hour of their time, and that the results were absolutely confidential. They were informed that the research was not concerned with them as individuals, but only with group results, and that their individual results could not be released to anyone (not even their therapist), without their written consent. (This information was also on the consent form that each subject signed; see Appendix A.) If a patient wished to know his individual results he was told he would have to write a letter to the researcher stating his request. Some patients expressed an interest in doing this, altough as yet no letters have been received.

When a patient arrived for the testing session, the same information was repeated to him before he signed the consent form.

A female graduate student (who had been an intern at the clinic the previous year and hence was comfortable working with pedophiles) greeted the patient and accompanied him into a small office at the clinic. Test administration was always carried out on an individual basis. The research assistant would then read the standardized instructions printed on the Millon Clinical Multiaxial Inventory to the patient, and the patient would proceed. Following completion of the MCMI, the research assistant would read the standardized instructions appearing on the face of the Narcissistic Personality Inventory (the name did not appear on the cover), and the patient would proceed. Test administration was always done in this order; first the MCMI, followed by the NPI.

Following completion on the NPI, the research assistant conducted a structured interview with the patient, asking the questions that appeared on the questionnaire and checking the appropriate boxes in accordance with patient response. The patient did not see the questionnaire form. At the end of the questioning, the assistant gave the patient the opportunity to make additional comments, or to respond to anything he felt was important and had not been addressed. She noted comments on an area of the questionnaire left blank for this purpose. In addition to the benefit of eliciting data in an unstructured fashion, it was felt that this would provide a chance for the patient to "have his say" and would place closure on the testing

session. The length of time for completion varied from forty minutes to one hour and twenty minutes, never exceeding one and one half hours.

The same structured interview (with a duplicate questionnaire) was conducted by the research assistant with the clinic staff member (either the assessing psychiatrist or the treating worker) who was most familiar with the patient. This was done in order to elicit the worker's view of the patient, and for cross-validation purposes as the data were gathered from patients' self-report. The staff member was also given the opportunity to make comments (which were noted) at the end of the structured interview.

In summary, the procedure was relatively simple. Each patient was tested on a one-to-one basis, first completing the MCMI, followed by the NPI, and then participating in a short structured interview. The same interview was then conducted with the patient's worker.

Statistical Analyses

Due to the descriptive nature of this work, the approach taken is phenomenological and similar in spirit to an ethnology. This did not preclude the application of objective statistical procedures which allowed more precise description of the groups. To clarify the following, the statistical analysis relevant to

each research question is discussed in the manner indicated below. The analyses listed were performed using the SPSSX Information Analysis System (1986).

> 1) Is there a relationship between homosexual object choice in pedophilia and exclusive (fixed) sexual interest in children, and inversely, a correlation between heterosexual object choice and non-exclusive sexual interest in children?

Because fixed sexual interest is not a clear and distinct variable in and of itself, this question was addressed by collecting a variety of sociodemographic and relevant offense data using the structured interview questionnaire given to subjects and clinic staff. These data are presented in Tables 1-20. The data were organized into separate frequency distributions for the homosexual and heterosexual groups, and visually compared. It was expected that a relationship would be found between homosexual object choice and fixed sexual interest in children, and inversely, that non-exclusive sexual interest in children would be related to heterosexual object choice. If these expectations were valid, one of the expected outcomes of the offense data would be a higher frequency of clinical offenses (offenses not legally charged) in the homosexual group as compared to the heterosexual group. Another example of the group differences expected would concern the age of onset of pedophilic fantasy. The homosexual group would be expected to report this

onset earlier in their chronological development than subjects in the heterosexual group. If these assumptions are valid, the data should reflect group differences that parallel what is expected, given the clinical pictures of fixated and regressed offenders discussed in Chapter II. Because fixation and non-exclusive sexual interest in children are not single distinct variables, this question is answered inferentially through the integration of a broad range of descriptive data.

2) If there is a relationship between homosexual object choice in pedophilia and exclusive (fixed sexual interest in children and a relationship between heterosexual object choice and non-exclusive sexual interest in children, can this exclusivity (fixation) be demonstrated in terms of differences between the personality traits and or structures of homosexual and heterosexual pedophiles?

This question was addressed by testing subjects using the Millon Clinical Multiaxial Inventory. ANOVA was used to compare the subscale elevations of the homosexual and heterosexual groups. It was expected that differences would be found between the profiles of the homosexual and heterosexual groups. This question was also addressed by analyzing the proportions of subscale elevations over the established cut-off scores. The homosexual and heterosexual groups were separately compared to the MCMI's normative group. As the assumption made in the first research question is that homosexual and heterosexual pedophiles are clinically distinct groups, it was expected that unspecified

differences would be found with respect to the manner in which these two groups compared to the MCMI's normative sample.

> 3) Can it be shown that the sex of object choice of homosexual pedophiles and of heterosexual pedophiles produces mutually exclusive groups in terms of personality traits and/or structure?

This question was addressed in a manner similar to the one described above. The MCMI subscale elevations of the homosexual and heterosexual groups were compared using ANOVA. The proportions of each group's subscale elevations (over the established cut-off scores) were compared with the MCMI's normative group.

It was expected that significant differences would be found in the profiles of the two groups (question 2), and that these differences would be consistent for all heterosexual and homosexual subjects. In other words, the personality profiles of individual subjects in the two groups would not overlap. The comparison of the proportions of subscale elevations were expected to find that heterosexual subjects would not differ significantly from the MCMI's normative sample, but homosexual subjects would differ, further indicating that the groups are distinct from one another. No assumptions were made concerning the expected proportion differences between the homosexual group and the MCMI's normative sample, other than that in general the homosexual group would exceed the base rates of certain subscale

elevations established in the MCMI's normative population (i.e., they would be more disturbed in some areas). (The heterosexual group was not expected to be more disturbed than the normative sample.)

> 4) Is the trait of narcissism significantly more evident in homosexual pedophiles (as measured by the MCMI and NPI) than in heterosexual pedophiles as measured by the same instruments?

This question was addressed in the same manner as questions two and three. The results of the homosexual and heterosexual groups on the Narcissistic Personality Inventory and the narcissism subscale of the Millon Clinical Multiaxial Inventory were subjected to ANOVA, and the proportion of scores above the established cut-off were compared.

The analysis of variance was expected to find that the homosexual group had significantly higher scores than the heterosexual group on the NPI and the narcissism subscale of the MCMI. A comparison of proportions was expected to find that the heterosexual groups either did not differ significantly from the normative groups of these instruments, or differed by exhibiting lower mean subscale elevations than the normative samples. The homosexual group was expected to show proportionately more elevation than the normative groups on the NPI and the narcissism subscale of the MCMI.

CHAPTER IV

Results

Introduction

This study investigated several areas of inquiry. First, the researcher was interested in discovering if homosexual pedophiles as a group are more fixed in their sexual preference for children than heterosexual pedophiles. If data were collected on a number of relevant offense variables and homosexuals and heterosexuals grouped separately, would the results indicate that heterosexual and homosexual pedophiles differ in terms of exclusivity of sexual interest in children?

Second, the researcher was interested in learning whether or not the expected group differences in exclusivity of sexual interest in children could be related to personality differences between the homosexual and heterosexual groups. Would the two groups differ in their psychological profiles?

Third, if the two groups did differ in their psychological profiles, could it be shown that sex of object choice (homosexual or heterosexual) produces mutually exclusive groups in terms of personality traits and/or structure?

Fourth, the researcher was interested in learning whether or not homosexual pedophiles exhibited narcissism as a feature of personality to a significantly greater degree than heterosexual pedophiles. Would narcissism scores obtained by psychometric instruments distinguish the two groups from one another?

In addition to the specific research questions, the researcher had a general interest in discovering any trends that would indicate more clearly how pedophiles differ from non-pedophilic individuals, and from one another, particularly in personality and psychosocial history.

This section contains the results of this inquiry. These results should be considered primarily as preliminary because the sample size was small (N=18).

This chapter begins with general information on the sample, then proceeds to data specifically related to the offense and pedophilic history, both for the total sample and for the sub-populations of homosexual and heterosexual pedophiles. These are the data relevant to the first research question.

The next sections concentrate on data gleaned from the Millon Clinical Multiaxial Inventory[16]. These are the data relevant to research questions two, three, and four. Data here

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[16] Both English and French versions of this instrument were employed, depending on the subject's native language. The reader is directed to Appendix F where English and French subscale scores are presented.

are again studied in terms of the total group, and in a comparison of the homosexual and heterosexual sub-populations. The significance level for inter-group comparisons has been set for all analyses at .05. Data concerned with how the research sample differed in performance on the Millon Clinical Multiaxial Inventory (from the psychiatric population on which the instruments' actuarial tables are based) are also presented. This comparison is presented both in terms of the whole research sample, and the sub-populations of homosexual and heterosexual pedophiles.

General Characteristics of the Group

For all the following tables, HM signifies homosexual pedophiles and HT signifies heterosexual pedophiles. As indicated in Table 1, the population was well distributed over all age groups, with a clustering between the ages of 30-40. The mean age for the sample was 34.5.

Table 1

Age

Age	Total	HM	HT
16-21	1	0	1
21-25	2	1	1
26-30	1	0	1
31-35	5	2	3
36-40	3	1	2
41-45	1	0	1
46-50	2	1	1
51-55	3	2	1

Table 2 shows that educational levels were limited to the primary and secondary levels, with no sample members having progressed past secondary school. As seen in Table 3, professional levels varied, but sample members tended to occupy the lower levels of professional attainment. There was a marked difference between the sub-populations as five of the heterosexuals were skilled or above, whereas none of the homosexuals had progressed past the semi-skilled.

Table 2

Education

	Total	HM	HT
Primary	9	4	5
Secondary	9	3	6
University	0	0	0
University+	0	0	0

Table 3

Vocation/Profession

	Total	HM	HT
Unskilled	6	3	3
Semi-skilled	7	4	3
Skilled	4	0	4
Professional	1	0	1

As Table 4 indicates, the majority of the population was in treatment at the time of the study. This was of course expected because sample members were drawn from an out-patient clinic.

Table 5 is interesting in that the majority of the sample had not received treatment for their pedophilia prior to that received at the clinic. There was a difference between the sub-populations in treatment history. None of the homosexual pedophiles had ever sought or received treatment for pedophilia, whereas nearly half of the heterosexuals had previously been in treatment.

Table 4

Subject's Treatment Status

	Total	HM	HT
In treatment	14	5	9
At Assessment	2	1	1
Post-Treatment	2	1	1

Table 5

Incidence of Treatment Prior to Clinic

	Total	HM	HT
Yes	5	0	5
No	11	6	5
For other problems	2	1	1

Table 6 shows that less than half of each group had been incarcerated for a pedophilic offense. It should be noted that none of the sample members had ever been incarcerated for a non-pedophilic offense. Data collected from the files (not presented here) indicated that three heterosexuals and one homosexual had been legally charged with a single offense of break and entry or robbery. These were not concomitant to the pedophilic charges, those charges having appeared much earlier in the subjects' histories. No other criminal offenses appeared in the histories, i.e., they are not a criminalized population.

Table 7 shows that just over half the total group had been married or had lived with a woman for at least one year. There was a difference seen in the rate of marriage between the sub-populations. Whereas 63.6% of the heterosexual group had been married, over half the homosexual group had never married (57.1%).

Table 6

Incidence of Incarceration for Pedophilic or Other Offenses

	Total	HM	HT
Yes	7	3	4
No	11	4	7
Other Offense	0	0	0

Table 7

Rate of Marriage or Common-Law Marriage Lasting More Than 1 Year*

	Total	HM	HT
Yes	10	3	7
No	8	4	4

* Gathered from case histories.

Offense Related Characteristics

The results of Table 8 have little significance if one views only the total population. The age of first sexual attraction is evenly distributed. Roughly half the sample members first experienced sexual attraction to a child before age 21, and roughly half were attracted at some point in adulthood.

The difference between the homosexual and heterosexual subgroups shows a much less even age distribution. Among the homosexuals, 85.7% were first attracted to a child before age 21. Almost exactly the opposite situation exists in the heterosexual group, where 81.8% were first attracted to a child after age 21, i.e., in adulthood. Homosexual pedophiles would seem to experience an attraction to children (age of onset) at an earlier point in their development than heterosexual object-choice pedophiles.

Table 8

Subject's Age at First Sexual Attraction to a Child

Age	Total	HM	HT
12	1	1	0
13-16	5	4	1
17-21	2	1	1
22-30	5	1	4
31-40	4	0	4
41-50	1	0	1

Table 9 reflects the fact that all sample members had at least one legally charged pedophilic offense as a requirement for inclusion in the study. More legal charges were incurred by the homosexual group. This number was greater due to the four individuals with multiple charges. There were no heterosexuals in the two highest categories.

A larger difference between the sub-populations might have been obscured by the researcher's failure to distinguish between those individuals having 2-3 legal charges stemming from the same pedophilic episode (two children, for example) from those having two or three clearly separate episodes resulting in legal charges.

Table 9

Incidence of Legal Offenses

# Offenses	Total	HM	HT
1	9	3	6
2-3	7	2	5
4-5	1	1	0
5 +	1	1	0

As seen in Table 10, ten subjects (more than half) of the total population of 18 had committed pedophilic acts in addition to the one for which they had been charged. Within this half however, six of the subjects were homosexuals and four were heterosexuals. Six of the seven homosexual pedophiles had clinical offenses (85.71%), whereas only four of eleven heterosexuals (36.36%) had committed such offenses.

This difference is more marked when viewing those with five or more clinical offenses. None of the heterosexuals occupied

this category, while more than half of the homosexual group was found there.

The same difficulty noted previously may have served to obscure a more distinct intergroup difference, as the two homosexuals and four heterosexuals who reported 2-3 clinical offenses may have been reporting what was part of the same episode as the legal offense, but for which they were not charged.

Table 10

Incidence of Clinical Offenses*

# Offenses	Total	HM	HT
None	8	1	7
2-3	6	2	4
5 +	4	4	0

* Not legally known or charged.

As shown in Table 11, more than half (11/18) of the pedophiles in this sample preferred older children with a cluster shown between the ages of 7-12. This is in accord with the findings of other research (Badgely, 1984).

One can notice some difference in age preference between the sub-populations. Six of the seven homosexual offenders (85.71%) chose children over 10, whereas more than half of the heterosexuals (54.54%) chose children under age 10. There are

many variables which may play a role in the age of the victim chosen by either group, and they will be discussed in the final chapter.

Table 11

Age of Child in Last Offense

	Total	HM	HT
0-3	0	0	0
4-6	2	0	2
7-9	5	1	4
10-12	6	4	2
13-15	5	2	3

The results in Table 12 indicate that in both the total population (77.7%), and in the homosexual and heterosexual groups, (85.71% and 72.72%, respectively) the offender was known by the child. If this sample is representative of the larger pedophilic population, the scenario of the pedophile molesting a complete stranger is uncommon. One sixth (16.6%) of this sample did so, and one homosexual subject was known to have contracted for pay with children he met (for the first time) in a park. Excluding him would place only 11% of the sample in the category "unknown before offense". Why this 11% is comprised of heterosexuals (and whether this is indicative of a trend) is unknown. This is an unexpected finding.

Table 12

Degree of Relationship
Between Offender and Child

	Total	HM	HT
Unknown before offenses	3	1	2
Familiar by sight	1	0	1
Known slightly	2	2	0
Well-known	12	4	8

Table 13 would seem to suggest that pedophilic relationships continue over a period of time, and are usually not limited to an isolated sexual encounter. Over half of the total sample (55%) had relationships lasting from a few months to more than one year. This was true for both the sub-populations, with no difference seen between them. Exactly one third (33.3%) of the total sample was involved with the child on only one occasion.

Table 14 indicates a small percentage of offenders (16.6% of the total group) felt they were "in love" with the child. The percentage of homosexual subjects who felt they were in love with the child/victim was 28.57%. The percentage of heterosexual subjects who felt they were in love with the child/victim was 9.09%.

Table 13

Length of Relationship

	Total	HM	HT
Only at Offense	6	3	3
Few weeks	2	0	2
Few months	6	3	3
One year	3	1	2
Year +	1	0	1

Table 14

Subjects Expressing They Were "In Love" With Child

	Total	HM	HT
Yes	3	2	1
NO	15	5	10

As discussed in the literature review, the most common form of sexual activity in pedophilia involves fondling and masturbation. In Table 15, 65% of all responses are found in these two categories. Some difference is seen between homosexual and heterosexual subjects, where the responses in these categories were 57.1% and 69.2%, respectively. As the table shows however, pedophilic sexual activity takes on as many forms as adult sexual activity.

Types of sexual activity in offenses are usually related to the age and sex of the child. This will be examined in the discussion chapter.

Table 15

Type of Sexual Activity In Last Offense*

	Total	HM	HT
Fondling	8	3	5
Masturbation	5	1	4
Intercourse	2	0	2
Oral sex	4	2	2
Anal sex	1	1	0
All of above	0	0	0

* Subjects were allowed to check more than one.

Table 16 shows that both in the total population and the sub-groups, children were more often than not seen by the pedophile as consenting to sexual activity. "Consent" is probably only aquiescence as children cannot be considered capable of giving informed consent. Roughly one-third of each group felt the child had not consented. The responses in Table 16 and Table 17 should be viewed in tandem. Table 17 shows how subjects responded when asked if they bribed (with money, candy) or tricked (sex play in context of a "game", for example) the child in order to get him/her to cooperate. Four of the heterosexuals did not see the child as consenting (see Table 16),

yet none of them indicated they had bribed or tricked the child (see Table 17), or used physical force (see Table 18).

Table 16

Subjects Who Saw Child as Consenting

	Total	HM	HT
Yes	10	4	6
No	6	2	4
Not sure	2	1	1

Table 17

Subjects Who Bribed or Tricked Child

	Total*	HM	HT
Yes	3	3	0
No	14	3	11

* One subject did not answer.

As shown in Table 18 (and as supported in the literature review in Chapter II) most pedophiles do not use physical force with their victims; however, they may cause psychological damage (Gold, 1986). The two (11.1%) homosexual pedophiles who did use force used it in the form of physically detaining the child. One of these individuals had sadistic features. Unfortunately, a

separate question was not included in the research on the use of threats.

Viewing Tables 17 and 18 together would suggest that homosexual pedophiles use more active forms of coercion (bribe, trick, force) than do heterosexuals, but this is not conclusive. A cross-tabulation would be necessary to confirm this statement. The literature (Badgely, 1984) suggests that physical force or violence is more accurately predicted, and increases proportionately among non-sexual recidivists having committed a sexual offense (i.e., criminalized individuals).

Table 18

Incidence of Physical Force Used In Last Offense

	Total	HM	HT
Yes	2	2	0
No	16	5	11

* One subject did not answer.

Table 19 and Table 20 support the idea that the abused become the abusers. Viewing these two tables in conjunction with data from the files indicates that several subjects were both sexually abused by strangers and were victims of or exposed to incest in the family. Only six of the 18 sample members (three heterosexual, three homosexual) were neither abused nor exposed

to incest; i.e., fully two-thirds of the sample had a childhood history that was somehow sexually anomalous.

In comparing the homosexual and heterosexual groups, it would seem that the form of childhood sexual disturbance differs. Table 20 seems to indicate incest more frequently in the background of heterosexuals than homosexuals (63.6% [7/11] as compared to 14.28% [1/7], respectively), and abuse by a member outside the family (Table 19) is seen slightly more among the homosexuals (42.8% [3/7]) than the heterosexuals (36.3% [4/11]).

It was observed that case history data show that the seven heterosexual subjects who were exposed to incest (Table 20) were in some cases (but not in all) the victims of sexual abuse outside the family. Thus, it must not be assumed that all the subjects who were not victims of extra-familial abuse were victims of intra-familial abuse, or vice versa.

Table 19

Patient Sexually Abused as Child*

	Total	HM	HT
Yes	7	3	4
No	11	4	7

* Does not include incest victims.

Table 20

Incidence of Incest
in Patients' Family of Origin

	Total	HM	HT
Yes*	8	1	7
No	10	6	4

* Six of these were themselves the victim.

Testing Results

To aid the reader in understanding these tables, the following is excerpted from the Millon Clinical Multiaxial Inventory manual (Millon, 1983). A sample profile report is found in Appendix C.

> Separate scales are used to determine the pattern of traits comprising the basic personality structure (Scales 1-8), and the greater level of severity in that structure (Scales S,C,P). In like manner, moderately severe clinical syndromes (Scales A,H,N,D,B,T) notably those of a "neurotic" form, are separately and independently assessed from those with parallel features, but of a more "psychotic" nature (Scales SS,CC,PP). (p.2)
>
> Base rate (BR) scores of 74 were set for all scales as the cutting line above which scale percentages would correspond to the clinically judged prevalence rate for "presence" of personality or symptom features.

> Similarly, base rate scores of 84 were set for all scales as the cutting line above which scale percentages would correspond to the clinically judged prevalence rate for the "highest" or most salient personality or symptom syndrome. (p.11)

The reader will note that these two base rate cutoff scores are specifically indicated in the table titles when relevant.

The results of an analysis of variance presented in Table 21 show no difference between the groups on any of the subscales with the exception of Passive-Aggressive, in which the mean for the homosexual group (79.71) was significantly higher than the mean for the heterosexual group (57.40). In addition, only the homosexual group had mean scores above or equal to 75 (the base rate cutoff) for certain personality patterns indicating they were features of the group. The group mean for Avoidant was 82.28, for Passive-Aggressive was 79.71, and a mean of 76.14 was discovered for the homosexual group on the Dependent subscale.

There were no heterosexual group subscale means above or equal to 75. A rank ordering of the means shows a slighty different constellation for the total sample (Avoidant, Dependent, Passive-Aggressive), the homosexual group (Avoidant, Passive-Aggressive, Dependent) and the heterosexual group (Dependent, Avoidant, Anti-social). Clearly, the dominant personality patterns common to these pedophiles were Avoidant/Dependent.

Table 21

Millon Clinical Multiaxial Inventory *

Table of Means, Standard Deviations, and Significance for Basic Personality Pattern

Subscale	TOTAL		HM		HT		df	F	p
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD			
Schizoid	62.94	20.85	64.14	26.18	62.10	17.72	1	00.03	00.84
Avoidant	72.94	19.35	82.28	16.20	66.40	19.36	1	03.14	00.09
Dependent	71.94	24.40	76.14	20.37	69.00	27.54	1	00.33	00.56
Histrionic	55.88	20.74	56.85	15.81	55.20	24.43	1	00.02	00.87
Narciss-istic	62.64	18.23	64.00	14.00	61.70	21.40	1	00.06	00.80
Anti-Social	63.00	25.69	58.42	25.73	66.20	26.54	1	00.36	00.55
Compulsive	49.88	17.03	42.42	16.54	55.10	16.12	1	02.49	00.13
Pass./Agg.	66.58	18.90	79.71	19.51	57.40	12.38	1	08.38	00.01**

* All the following statistics are based on N=17 because one subject had an invalid MCMI report. His inclusion would have served to elevate all heterosexual scores.

** Significant above chosen level of .05.

While the mean group scores shown in Table 21 lead one to believe that only the homosexual group shows disturbed features of personality (i.e., had a mean scale elevation over or equal to 75), Table 22 and Table 23 show that in fact many individual sample members (both heterosexual and homosexual) had scale elevations indicating dysfunctional personality features. The most striking of these are the frequency distributions for a Dependent-Submissive personality pattern. Approximately 70% of both the total sample and the sub-groups had individual scores above or equal to 75 on this sub-scale.

Table 22

Millon Clinical Multiaxial Inventory

Basic Personality Pattern *

% = 85

Basic Personality Pattern	Total Freq.	Total %	HM Freq.	HM %	HT Freq.	HT %
Schizoid	4	(23.50)	3	(42.85)	1	(10.00)
Avoidant	6	(35.20)	3	(42.85)	3	(30.00)
Dependent	8	(47.00)	4	(57.14)	4	(40.00)
Histrionic	1	(05.80)			1	(10.00)
Narcissistic	3	(17.60)	1	(14.28)	2	(20.00)
Anti-Social	2	(11.70)			2	(20.00)
Compulsive	0					
Pass./Agg.	4	(23.50)	4	(57.14)		

* = 85 indicates clinically judged prevalence rate for the highest personality syndrome.

Table 23

Millon Clinical Multiaxial Inventory

Basic Personality Pattern*

% = 75

Basic Personality Pattern	TOTAL Freq.	TOTAL %	HM Freq.	HM %	HT Freq.	HT %
Schizoid	8	(47.05)	5	(71.42)	3	(30.00)
Avoidant	8	(47.05)	5	(71.42)	3	(30.00)
Dependent	12	(40.58)	5	(71.42)	7	(70.00)
Histrionic	2	(11.76)	0		2	(20.00)
Narcissistic	5	(29.41)	2	(28.57)	3	(30.00)
Anti-Social	8	(47.05)	3	(42.85)	5	(50.00)
Compulsive	0		0		0	
Pass./Agg.	5	(29.41)	4	(57.14)	1	(10.00)

* = 75 indicates clinically judged prevalence rate for presence as a feature.

As evidenced by the previous tables (21, 22, 23), both groups showed elevations on the subscales Dependent and Avoidant more frequently than on other subscales. Table 24 shows, however, that elevations on the Passive-Aggressive subscale appeared frequently (but only) in the homosexual group. Additionally, the distribution of subscale elevations seen in Table 24 suggests that the homosexual group evidenced a greater degree of personality disturbance (i.e., more often had these subscales elevated over 85). Table 24 also suggests that homosexual group members were more homogeneous than heterosexual subjects in the type(s) of disorders exhibited.

Table 24

Millon Clinical Multiaxial Inventory Individual Subject Profiles Showing the Three Highest Personality Subscale Elevations ≥ 85

(For Homosexual Subjects)*

HM Subjects	Individual Subscale Profiles	HM Subjects	Individual Subscale Profiles
s1.	Passive-Aggressive Avoidant, Narcissistic	s5.	Dependent, Passive-Aggressive=Avoidant, None
s2.	Passive-Aggressive= Avoidant, Dependent, None	s6.	None, None, None
s3.	None, None, None	s7.	Dependent, None, None
s4.	Passive-Aggressive, Avoidant, Dependent= Schizoid		

* Presented in descending order (Table 24 continued on page 132)

Table 24 (concluded)

(For Heterosexual Subjects)*

HT Subjects	Individual Subscale Profiles	HT Subjects	Individual Subscale Profiles
s1.	Avoidant, Dependent, None	s7.	Dependent, None, None
s2.	Avoidant, None, None	s8.	Anti-Social, None, None
s3.	Dependent, None, None	s9.	Avoidant, Dependent, Schizoid
s4.	None, None, None	s10.	Anti-Social, Narcissistic, None
s5.	Narcissistic, None, None	s11.	Avoidant=Dependent=Passive-Aggressive**
s6.	Histrionic, None, None		

* Presented in descending order
** Invalid MCMI report

Table 25 results show that there was no significant difference between the homosexual and heterosexual groups in the extent of pathological personality disorder. None of these disorders could be considered a feature of the group(s); there were no means equal to or above 75.

Table 25

Millon Clinical Multiaxial Inventory
Table of Means, Standard Deviations, and Significance
for Pathological Personality Disorder

Subscale	TOTAL		HM		HT		df	F	p
	X	SD	X	SD	X	SD			
Schizotypal	58.94	09.17	59.85	05.66	58.30	11.27	1	0.1120	0.7425
Borderline	60.82	11.20	64.57	10.96	58.20	11.15	1	1.3617	0.2615
Paranoid	66.76	15.70	66.14	14.81	67.20	17.08	1	0.0175	0.8965

Table 26 and Table 27 indicate that 6 (35.29%) of the sample members had borderline or paranoid features of personality (evenly distributed between both groups).

Table 26

Millon Clinical Multiaxial Inventory
Pathological Personality Disorder
% ≥ 85

PPD	Total		HM		HT	
	Freq.	%	Freq.	%	Freq.	%
Schizotypal	0	(00.00)	0	(00.00)	0	(00.00)
Borderline	0	(00.00)	0	(00.00)	0	(00.00)
Paranoid	3	(17.60)	1	(14.28)	2	(20.00)

Table 27

Millon Clinical Multiaxial Inventory
Pathological Personality Disorder
$\S \geq 75$

Disorder Type	Total		HM		HT	
	Freq.	%	Freq.	%	Freq.	%
Schizotypal	0	(00.00)	0	(00.00)	0	(00.00)
Borderline	2	(11.76)	1	(14.28)	1	(10.00)
Paranoid	4	(23.52)	2	(28.57)	2	(20.00)

The analysis of variance presented in Table 28 shows that no significant differences were found in symptom syndromes for the homosexual and heterosexual populations. A rank ordering of the means, however, reveals a rather cohesive pattern of syndromes; for the total sample, anxiety, drug abuse, and dysthymic symptom syndromes ranked highest, in that order. In the homosexual and heterosexual groups the orders change, but the symptoms remain constant. The rank order of the means in the homosexual group was anxiety, dysthymic, and drug abuse. The rank order of means in the heterosexual group was drug abuse, dysthymic, and anxiety.

These results indicate that the homosexual and heterosexual pedophiles in this study are basically a homogeneous group in terms of the clinical symptom syndromes presented.

Table 28

Millon Clinical Multiaxial Inventory

Table of Means, Standard Deviations, and Significance for Clinical Symptom Syndromes

Variables	TOTAL		HM		HT		df	F	p
	X	SD	X	SD	X	SD			
Anxiety	71.11	24.41	81.57	19.73	63.80	25.60	1	02.36	00.14
Somatoform	62.17	11.62	65.71	14.18	59.70	09.45	1	01.11	00.30
Hypomanic	55.82	26.32	57.28	23.93	54.80	29.11	1	00.03	00.85
Dysthymic	69.58	17.70	75.42	14.38	65.50	19.34	1	01.32	00.26
Alcohol Abuse	60.05	15.48	61.14	17.02	59.30	15.21	1	00.05	00.81
Drug Abuse	70.35	17.85	72.85	16.36	68.60	19.48	1	00.22	00.64
Psychotic Thinking	63.35	05.70	66.00	03.00	61.50	06.51	1	02.86	00.11
Psychotic Depression	59.17	05.19	61.85	06.36	57.30	03.40	1	03.69	00.07
Psychotic Delusions	66.88	13.80	67.28	11.78	66.60	15.67	1	00.00	00.92

Table 29 and Table 30 show frequency distributions for individual sample members who scored sufficiently high ($\geq$ 75) to permit stating that a clinical symptom syndrome was a feature of personality. Similar to Table 28, it can be seen that the population peaks on the subscales are anxiety and dysthymic. Drug abuse was more common in the heterosexual population although this is of clinical interest rather than statistical as a significant difference was not found. There were no real

differences in symptoms between the groups.

Psychotic thinking and psychotic depression were not seen in any individual members, while psychotic delusions were present as a feature in 23.52% of the sample.

Table 29

Millon Clinical Multiaxial Inventory

Clinical Symptom Syndromes

% ≥ 85 *

Clinical Symptom Syndrome	Total		HM		HT	
	Freq.	%	Freq.	%	Freq.	%
Anxiety	5	(29.40)	3	(42.85)	2	(20.00)
Somatoform	1	(05.80)	1	(14.28)	0	(00.00)
Hypomania	1	(05.80)	0	(00.00)	1	(10.00)
Dysthymia	3	(17.60)	2	(28.57)	1	(10.00)
Alcohol Abuse	1	(05.80)	1	(14.28)	0	(00.00)
Drug Abuse	2	(11.70)	1	(14.28)	1	(10.00)
Psychotic Thinking	0	(00.00)	0	(00.00)	0	(00.00)
Psychotic Depression	0	(00.00)	0	(00.00)	0	(00.00)
Psychotic Delusions	2	(11.70)	1	(14.28)	1	(10.00)

* Frequencies in the total group column reflect the absence of two homosexual subjects and one heterosexual subject with no scale elevations over or equal to 85.

Table 30

Millon Clinical Multiaxial Inventory

Clinical Symptom Syndromes

% ≥ 75

Clinical Symptom Syndrome	Total		HM		HT	
	Freq.	%	Freq.	%	Freq.	%
Anxiety	7	(41.17)	4	(57.14)	3	(30.00)
Somatoform	3	(17.64)	2	(28.57)	1	(10.00)
Hypomania	1	(05.88)	0	(00.00)	1	(10.00)
Dysthymia	7	(41.17)	4	(57.14)	3	(30.00)
Alcohol Abuse	2	(11.76)	1	(14.28)	1	(10.00)
Drug Abuse	6	(35.29)	2	(28.57)	4	(40.00)
Psychotic Thinking	0	(00.00)	0	(00.00)	0	(00.00)
Psychotic Depression	0	(00.00)	0	(00.00)	0	(00.00)
Psychotic Delusions	4	(23.52)	1	(14.28)	3	(30.00)

Comparison of Sample Subscale Elevations to MCMI Base Rates

In this section the research sample scores are compared to the MCMI base rates established my Millon in his research sample. The base rates employed represent the percent of Millon's normative sample who scored over or equal to 75 on the different subscales. The obtained sample proportions were compared to the

base rate of the normative group. A significant difference between the research sample group and the MCMI normative group in the percent of individuals obtaining a score of or above 75 (showing the variable as a feature for the individual) is established when z-scores exceed plus or minus 1.96 for the .05 level of confidence.

As illustrated by the z-scores in Table 31, both the homosexual and heterosexual groups had a significantly larger percentage of subjects who scored equal to or above 75 on the subscales Dependent and Passive-Aggressive, when compared to Millon's sample.

Only the homosexual group showed a significantly larger percentage of subjects who scored equal to or above 75 on the subscales Avoidant and Schizoid when compared to Millon's population.

The heterosexual group alone showed a significantly larger percent of subjects who scored 75 or above on the Anti-social subscale when compared to Millon's sample.

The results of this comparison of proportions would seem to indicate that the normative sample and the research sample exhibit different psychological profiles.

Table 31

Comparison of Sample Subscale Elevations to MCMI Base Rates

Basic Personality Pattern

% ≥ 75

	Research Sample % ≥ 75		Norm % ≥ 75	z	
Variables	HM	HT*	MCMI BR***	HM	HT
Schizoid	57.10	30.00	12.00	3.668**	0.570
Avoidant	71.40	30.00	28.00	2.557**	0.141
Dependent	71.40	70.00	35.00	2.019**	2.320**
Histrionic	00.00	18.20*	27.00	-1.609	-0.657**
Narcissistic	28.60	27.30*	11.00	1.488	1.727
Anti-Social	42.90	45.50*	12.00	1.864	3.419**
Compulsive	00.00	00.00	24.00	-1.486	-1.777
Pass./ Agg.	57.10	10.00	25.00	1.961**	2.340**

* The sample member who was excluded from the previous results did not place above 74 on these subscales; so N=11.

** Significant above chosen level of .05

*** Base rates were established by Millon using both males and females. The research sample was male only, but Millon does not offer a male-only base rate. Subject's sex is factored into the original test scoring.

Table 32 shows that no significant differences were found between the research sample and the normative sample on any of the pathological personality disorder scales. This indicates

that as a group the research sample did not show severe personality disorder to a greater extent than the normative sample.

Table 32

Comparison of Sample Subscale Elevations to MCMI Base Rates

Pathological Personality Disorder

% ≥ 75

Variables	% ≥ 75 HM	% ≥ 75 HT	% ≥ 75 MCMI BR	z HM	z HT
Schizotypal	00.00	00.00	17.00	-1.197	-1.501
Borderline	14.30	10.00	24.00	-0.600	-1.036
Paranoid	28.60	20.00	13.00	1.227	0.658

The z-score results shown in Table 33 on the clinical symptom syndromes subscales show that both the heterosexual and homosexual groups had a significantly lower percentage of members who scored equal to or above 75 on the psychotic depression, psychotic thinking, and hypomanic measures when compared to Millon's sample.

The homosexual group showed no other significant differences from the normative sample on the clinical symptom subscales. The heterosexual group, by comparison, had a significantly higher percentage of members who scored equal to or above 75 on the drug use subscale when compared to Millon's sample.

Table 33

Comparison of Sample Subscale Elevations to MCMI Base Rates

Clinical Symptom Syndromes

% ≥ 75

Variables	% ≥ 75 HM	% ≥ 75 HT	% ≥ 75 MCMI BR	z HM	z HT
Anxiety	57.10	30.00*	32.00	1.423	-0.135
Somatoform	28.40	10.00*	17.00	0.817	-0.589
Hypomanic	00.00	10.00*	07.00	-2.295**	-2.351**
Dysthymic	57.10	30.00*	43.00	0.753	-0.830
Alcohol	14.30	10.00*	16.00	-0.122	-0.517
Drugs	28.60	40.00*	11.00	1.488	2.930**
Psychotic Thinking	00.00	00.00	05.00	-1.919**	-2.406**
Psychotic Depression	00.00	00.00	07.00	-2.295**	-2.877**
Psychotic Delusions	14.30	27.30	04.00	-1.097	-0.679

* A sample member with an invalid MCMI report was excluded; therefore, the scores are based on N=10.

** Significant above chosen level of .05.

Table 34 indicates that an analysis of variance found no significant difference between the Narcissistic Personality Inventory scores of the homosexual and heterosexual groups. Tables 22 and 31 show no significant differences in narcissism

between the homosexual and heterosexual groups as measured by the subscale of the MCMI.

The results of a two-tailed t-test do, however, indicate a significant difference between the research sample scores as compared to the scores of the sample used in setting the norms for this instrument (NPI). The research sample mean of 15.70 shown in Table 34 was compared to the normative sample mean of 20.92. A t-test statistic of -08.33 was obtained. This indicated that the research sample scored significantly lower than the normative sample on this measure. On the MCMI, z-scores showed that the research sample was not significantly different from the normative population on the narcissism subscale.

Table 34

Narcissistic Personality Inventory

Table of Means, Standard Deviations, and Significance

(For the normative sample, M = 20.92; SD = 8.23)

Var.	TOTAL		HM		HT		df	F	p
	X̄	SD	X̄	SD	X̄	SD			
NPI	15.70	07.06	16.71	04.64	15.00	08.53	1	0.2311	0.6376

Summary of Findings

General and Offense Characteristics. The results for the total group were as follows: 1) The average age of sample members

was 34.5; 2) Educational and professional levels were generally low; 3) Less than half of the sample (41.17%) had spent any time incarcerated for a pedophilic offense; 4) They are not a criminalized group; there was no history of incarceration for other offenses; 5) Most of the sample members (77.7%) knew the child prior to the offense; 6) Just over half of the sample members (55.5%) had relationships with their victims that lasted from a few months to more than one year; 7) Only 16.6% of sample members were "in love" with their victim; 8) Of the sample, 65% engaged in fondling and/or masturbation with their victims; 9) Two-thirds (66.6%) of the sample members viewed the child as consenting to the activity; 10) The use of physical force against the victim was rare (11.1% of sample members); and 11) Two-thirds (66.6%) of the sample members experienced a sexually anomalous childhood.

The comparative results for the homosexual and heterosexual groups were as follows : 1) Homosexual pedophiles were less likely to have received treatment for their pedophilia (0.0%) than heterosexuals (41.66%); 2) Homosexual pedophiles were first sexually attracted to children considerably earlier in their developmental histories than heterosexual pedophiles; the majority (85.7%) of the homosexual group reported sexual attraction to a child before age 21 whereas the majority (81.8%) of the heterosexual group reported sexual attraction to a child occurred after age 21; 3) The homosexual group had more legal

charges of pedophilia than the heterosexual group, (i.e., 28.5% had three or more legally charged offenses), whereas none of the heterosexual group members had more than three legal charges; 4) Individuals in the homosexual group had more clinical (non-charged) pedophilic offenses (85.71%) than individuals in the heterosexual group (36.36%); 5) Only members of the homosexual group had five or more clinical offenses; 6) More of the homosexual subjects (85.71%) chose victims over age 10 than the heterosexual subjects (45.46%); 7) More homosexual group members (50.0%) used bribes or tricks to gain their victim's cooperation than heterosexual offenders (0.0%); 8) Only subjects belonging to the homosexual group (two) used physical force with their victims; 9) As children, more members of the homosexual group (42.8%) were sexually abused themselves by strangers (extra-familial) than heterosexual subjects (36.3%); 10) More members of the heterosexual group (63.6%) were themselves sexually abused as children or were witness to sexual abuse by a family member (intra-familial) than the homosexual subjects (14.28%); 11) Fewer members of the homosexual group (42.9%) had married or cohabitated with a female for a period of at least one year than heterosexual subjects (63.6%).

Basic Personality Pattern. The results for the total group were as follows: 1) Score elevations equal to, or surpassing the "highest" clinically judged prevalence rate for a dysfunctional

personality pattern subscale, were seen in 82.35% of the individual sample members, that is, 82.35% of the sample members were above the cutting line or base rate (BR) of one or more subscales established for the MCMI; 2) The presence of a Dependent-Submissive personality pattern was seen in 70% of the sample members; 3) Dominant personality patterns for the sample (as a whole) were Avoidant and Dependent; and 4) The sample as a whole scored significantly higher than the MCMI's normative sample on the subscales Dependent ($z = 2.019$ and 2.320 for the homosexual and heterosexual groups, respectively) and Passive-Aggressive ($z = 1.961$ and 2.340 for the homosexual and heterosexual groups, respectively).

The results for the homosexual and heterosexual groups were as follows : 1) The homosexuals showed, as a group, significantly higher ($p=00.01$) subscale scores for Passive-Aggressive personality as a feature; 2) There were no other statistically significant differences in the personality patterns of sample members when compared by sex of object; 3) When analyzed by sex of object, only the homosexual group showed elevations of means indicating Avoidant ($M=82.28$), Passive-Aggressive (79.71), and Dependent ($M=76.14$) were features of personality; 4) As a group, the homosexuals had more scores over 85 than the heterosexuals, and the pattern of scale elevations was more homogeneous; 5) When divided by sex of object and compared to the normative sample, the homosexual group showed

significantly more Schizoid (z=3.668), and Avoidant (z=2.557), features; and 6) When divided by sex of object and compared to the normative sample, the heterosexual group showed significantly more Anti-Social (z=3.419) features.

Pathological Personality Disorder. The results for the total group were as follows: 1) No group means were above 74 indicating that pathological personality disorder was not present as a feature of the group; and 2) Six individual sample members (35.29%) showed borderline or paranoid features.

The results for the homosexual and heterosexual groups were as follows : 1) There was no significant difference between the homosexual and heterosexual groups in pathological personality disorder, and 2) The six individual sample members showing pathological personality disorder as a feature were evenly split between the homosexual and heterosexual groups.

Clinical Symptom Syndromes. The results for the total group were as follows: 1) The most frequently noted symptom features for sample members were Anxiety (41.17%), Depression (41.17%), and Drug abuse (35.29%), and 2) Psychosis was not noted as a feature of the sample; psychotic delusions as a feature were seen in 23.52% of the individual sample members.

The results for the homosexual and heterosexual groups were as follows : 1) There were no statistically significant differences found in the symptom features of the homosexual and

heterosexual groups, and 2) When divided by sex of object and compared to the normative sample, the heterosexual group showed significantly more drug use.

Narcissistic Personality Inventory. The results for the total group were as follows: 1) The research sample showed significantly lower scores on this instrument than the normative sample, and 2) NPI scores did not indicate that narcissistic personality was present in the sample.

The results for the homosexual and heterosexual groups were as follows : 1) There was no significant difference seen in the NPI scores of the homosexual and heterosexual groups.

CHAPTER V

Discussion

Introduction

In the first chapter of this paper, the author presented a summary of the basic questions concerned with pedophilia. Cook and Howells (1981) asked,

> ... what sort of adults are sexually interested in what sort of children; and why; what effect does this interest have on the child; how might their interest be measured; and how might their interest be redirected? (p. viii)

The research findings of this inquiry concentrate on the first question, namely, what sort of adults are sexually interested in children? Answering this question of course has implications for the others because it may provide insight about the nature of adults who are sexually interested in children, and how this interest may be redirected. In trying to determine what sort of adults are pedophilic one also touches on the question of measurement. How can these factors that enter into pedophilia be identified and measured?

One of these factors the author has discussed at great length is the pedophile's preference for a male child or a female

child. The major assumption made by the author, and which was used to guide this study, was that a strong preference for immature sexual partners (fixed interest in children) would be coupled with a preference for male objects. Inversely, female objects would be more often chosen by those individuals who did not exhibit a pattern of fixed preference for immature partners.

Overall, the results of this study suggest that this assumption is valid[17].

As this was assumed to be the case at the formulation of this work, the next assumption the author set out to research was whether this pattern could be linked to consistent differences in personality patterns between these two groups.

Overall, the results of this pilot study suggest that this may be the case. Two personality patterns, Dependent and Avoidant, were shared by the homosexual and heterosexual groups, but a third form of personality disorder, Passive-Aggressive, frequently occurred and was limited to the homosexual group. This suggests either one of two things. Passive-Aggressive personality disorder may distinguish and be unique to homosexual pedophiles, or, a combination of personality disorders (Dependent, Avoidant, Passive-Aggressive) represents the picture of the fixated pedophile, who is more commonly homosexual. This

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[17] For groups, not every individual.

combination may also be seen in those (few) heterosexual pedophiles who fit the fixated, rather than the regressed, model.

As the assumption was made that personality would differ, it was expected that a specific difference would be seen; i.e., that homosexual pedophiles would be more narcissistic than heterosexual pedophiles. This was not found to be the case. This finding does not mean that this avenue of thought should be discarded because it is likely that the instruments used herein were inadequate for testing this idea.

The following section will consist of a discussion of the above ideas with the objective of determining whether they confirm, deny, or expand upon what is already known.

General and Offense Characteristics : Additional Support for the Fixated/Regressed Model

Importance of the Model. The relationship between pedophilic interest and victim gender preference found in this study draws together and confirms the diverse findings of other researchers who have remarked on this correlative relationship (Badgely, 1984; Fitch, 1962; Frisbie & Dondis, 1965; Groth & Birnbaum, 1978; Mohr, 1964; Quinsey, 1978; Radzinowica, 1957). While this relationship has been suggested for some time, researchers continue to treat these variables (sex of object/degree of interest) independently, and excepting

specialists, clinicians receiving these cases are largely unaware that they should look for and generally expect differences in their heterosexual and homosexual patients.

Researchers are probably correct in treating these variables as if they are orthogonal, but even though it is known that they "overlap" the extent of this phenomenon is undetermined. This and other research suggests the overlap is high - perhaps high enough to predict with some accuracy different offense patterns for these groups.

Clinicians however are missing much if they remain unaware of this relationship. It would better serve assessment and treatment to operate from the assumption of a correlative relationship (in the expected directions) between these variables, and then look for the exceptions, than to make no assumption at all. Essentially, this suggests one use this as a theory to guide clinical work, and does not suggest it be treated as fact because individual cases will vary.

The data for this correlation (Hm/fix:Ht/reg) are more persuasive for homosexual pedophiles than heterosexual pedophiles. This could be better stated by operating from the assumption that a homosexual pedophile probably will show a history of fixed interest, and a heterosexual pedophile may but more likely will not. The patient may be assessed against these expectations.

For example, on first interview with a homosexual patient, the author would be more apprehensive in believing his denial of

any history of pedophilic fantasy, than if the same denial or absence of fantasy were expressed by a heterosexual offender. This is not to say that the author would not pursue all of the relevant information with each patient to her satisfaction, but it does imply that there is a model of an expected clinical picture against which one can compare and contrast the individual patient. It was the use of this model that led the author to study the personality patterns of the groups.

Age of Onset. Researchers have most often cited statistics showing that homosexual offenders have higher rates of recidivism (legal and clinical charges) than heterosexuals in support of the idea that homosexual offenders have a more enduring preference for children. While this was also found to be the case in this research, the author places more emphasis on those "markers" that appear early in the developmental history of the offender. The most striking example of these is the different age homosexual and heterosexual subjects report for the onset of pedophilic fantasy. The individuals in the two groups report almost opposite experiences; the majority of homosexual offenders (85.7%) report they were first attracted to a child in adolescence, while almost the same amount of heterosexual offenders (81.8%) report that the first time they experienced attraction to a child was in adulthood. If one can assume that patterns of enduring sexual behavior are first expressed in adolescence (Van Wyk & Geist, 1984; Whitham, 1983), and that early disturbance equals a more primary disturbance (Freud,

1905/1953), the "age of onset" factor is perhaps the most important for differentiating fixation from a situational or regressed model.

Clinically, if faced with a heterosexual offender with three legal charges, and a homosexual offender with only one legal charge, it would be most important to ascertain the onset of pedophilic interest. The homosexual may report pedophilic fantasy starting at age 14, while the heterosexual offender may report these ideas started occurring two years previous. This changes the clinician's direction of thought from initial assumptions about fixed interest being based only on the face value of number of offenses.

Childhood Sexual Abuse. A second "marker" which appears early in the developmental history of pedophilic offenders is sexual victimization in childhood. The presence or absence of sexual abuse fails to distinguish homosexual and heterosexual pedophiles (or fix/reg), as two-thirds of each group in this sample were victimized. (Some studies [Finklehor, 1979] place this figure at 90%.) The results of this study suggest however that the form of sexual victimization in childhood may co-vary with a heterosexual or homosexual orientation. While the sample here was quite small and results must be considered in light of this, it was noted in this study that sexual abuse experiences of heterosexual offenders were more often intra-familial (63.6%) while intra-familial abuse was relatively rare for homosexual offenders (14.2%).

A return to the case histories of sample members[18] showed that intra-familial abuse generally took the form of brother/sister incest (most frequent), followed by being the witness to father/daughter incest, mother/son incest or aunt/nephew incest. The case histories of the homosexual group reveal that extra-familial abuse was more common and almost invariably took the form of a male adult abusing the male child, although some subjects had experienced abuse by both sexes.

In a sense, the gender preference choice of the offender parallels the childhood abuse experience. Heterosexual offenses may show a more "incestuous component" (drawn from early experience) while in homosexual offenders the childhood experience is "more" pedophilic. As we know that in heterosexual incest activity the victim is viewed as a surrogate for the unavailable adult female (Stern & Meyer, 1980; Mrazek & Bentovim, 1981), this is similar to those theories of pedophilic aetiology which suggest the female child is a surrogate for the (regressed) heterosexual offender. It is interesting then that incestuous experiences are more often seen in the histories of heterosexual offenders. This may have implications as a marker to be used for the placement of offenders on a continuum spanning fixed

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18 Case histories are not presented herein as it was thought that some of the information relevant to the individual's clinical picture could identify him. Subjects were told that this was a study of groups, not individuals.

preference for children to engaging children as surrogates. The author has found no studies attempting to trace this pattern.

In this vein, future research should attempt to determine if heterosexual offenders who are fixated (do not "match" the expected picture) were the victims of both intra- and extra-familial abuse. As this study did not presuppose this trend, data were not broken down carefully enough to test this relationship. In the future, analysis should be carried out using the hetero/homo subdivision and attempt to determine the relative frequencies of intra-familial abuse by a male, intra-familial abuse by a female, extra-familial abuse by a male, and extra-familial abuse by a female to determine if any group differences exist. It would also be most interesting to study those fixated offenders of either group who were never abused to determine if any common factors exist among them. Whether intra- or extra-familial sexual abuse is a factor which may differentiate, or simply whether abuse by a male instead of a female adult is more important (and simply parallels the intra-extra dimension) is at present unknown. In a study of non-pedophilic homosexuals (androphiles) who had experienced incest, the only form of incest reported was male-to-male (Simari & Baskin, 1982). In light of the above, this suggests that the sex of the abuser may be the primary factor related to a heterosexual/ homosexual orientation rather than the intra-and extra-familial factor.

The two "markers" considered above are essentially suggesting that aspects of the patient's sexual history are more important in the assessment of fixation than the current observed behavior of the patient. Naturally, these are interdependent, but many clinicians (and persons responsible for sentencing offenders) err in failing to give the correct weight to the patient's sexual development, too often relying on his recent behavior.

Legal and Clinical Offenses. The other data found in this study to support a correlation between homosexual pedophilia and fixation are drawn from the subject's offense behavior. As mentioned previously, homosexual offenders have more legal charges, more clinical offenses, were the only sample members with more than 5 clinical offenses (two of these individuals had more than 200), used bribes and tricks more often than heterosexual offenders, and used force in pedophilic behaviors.

There is little to be said concerning the frequency of legal and clinical offenses as the import is obvious.

Threat and Force. The use of threats and force bears closer scrutiny, however. Groth et al. (1982) has suggested that the term "child molester" should only be applied to those individuals who use psychological pressure on the victim, and the harm done to the child is psychological rather than physical. In this sample, two individuals used physical force. That these two offenders were intent on sexually abusing the victim is obvious and implies a stronger need for the act to take place, than seen

in those subjects (heterosexual and homosexual) who either did not find force necessary or did not wish to use it.

As mentioned previously, data on the use of threats and force are often carelessly gathered. Distinctions must be made between those offenders who : 1) threaten the child psychologically ("I'll tell your parents"); 2) who threaten to physically harm the child but do not; 3) threaten force with weapons; 4) force a child by detaining him/her; and 5) use physical force (assault) because the victim's fear/pain is satisfying to him.

The two subjects who used force in this sample were quite different from one another. One used physical force to detain the victim (tieing his hands), and when the child continued to cry he released him. The second subject handcuffed and slapped the victim as well as threatening physical harm and seemed to derive satisfaction from the child's pain, that is, sadistic features were in evidence. This person could have been clinically classed as a "child rapist".

The Badgely report (1984) on sexual offenses against children in Canada found that in all sexual offenses against children (not limited to pedophiles) harm to the victim due to the use of physical force by the offender was seen in 8.8% of offenders having no previous convictions, 10.7% of sexual recidivists, and 18.4% for victims of non-sexual recidivists. Further, 7.8% of homosexual offenders' victims suffered physical injury, and 13% of heterosexual offenders' victims suffered

physical injury (p. 840). Let the reader be reminded that these statistics were gathered from convicted and incarcerated offenders and included incest offenders and child rapists. Badgely concluded that "... a prior criminal record of any kind is a more accurate measure of the likelihood of violent sexual acts being committed than whether offenders had only previously committed sexual offenses" (p. 841).

If incest offenders and those individuals who should be classed as child rapists were excluded, these figures would certainly be much lower. Yet the public continues to believe that adults who commit sexual acts with children physically harm them. Previous research, as well as this study, does not support this belief.

Further, in a study of heterosexual pedophiles who were measured phallometrically while listening to audiotapes, Marshall et al. (1986) found "... decreasing or inhibited arousal to descriptions of assault compared with descriptions of threat or force" (p. 434). While their study did not include homosexual pedophiles, it would seem to indicate, particularly when coupled with other available evidence, that assaulting or physically harming a child is not the desire of pedophiles, and additionally it generally "turns them off". As the author has continued to make the point that heterosexual offenders as a group are not as "truly" pedophilic as homosexual offenders, one would of course have to test this idea in a homosexual group. Still, studies such as the many included in the Badgely report lead one to believe

that, as a group, even fixated pedophiles have no wish to physically harm their victims.

That pedophiles should be aroused when listening to descriptions of threat and force situations (vs. assault) does not necessarily mean they find threat and force sexually exciting. It may be that these descriptions are similar to what happened in some of their offenses, and hence listening to them reactivates the arousal they felt in general during the offense. That is, it is not known if arousal to descriptions of force is due to the use of force itself, or due to the similarity of the threat/force situation to the offender's experience. Marshall et al. (1986) did find that the greater the number of victims, the greater the use of force during offending. Force may be rare in pedophilic offenses, but when it occurs one would be likely to find a fixated offender.

Premeditation. The finding that homosexual offenders used bribes and tricks more frequently in their offenses than heterosexual offenders again suggests that they were more intent on "having their way". (In fact, no heterosexual offenders reported their use, and this was confirmed in the therapists' reports.) Circumstantially, this implies that the homosexual offenders taking this approach were more structured in carrying out what they wished to do, i.e., it suggests pre-meditation on their part.

The notion that homosexual offenses are more often pre-meditated and heterosexual offenses less so has also been

discussed in relation to the choice of a stranger as a victim. Groth and Birnbaum (1978) found in their sample that homosexual offenders are more likely to choose strangers, and this trend was also mentioned by the Badgely report (1984). Groth and Birnbaum suggested that as heterosexual offenders more often choose a friend, relative, or neighbor's child as a victim, this supports a theory of "ease of access" for the heterosexual (regressed) offender. This suggests that the (fixated) homosexual offender pre-meditates his offense and actively seeks an unknown victim. The heterosexual acts while he is under life stress and a child happens to be nearby.

In the sample for this research, the results do not support this finding as approximately the same number of heterosexual and homosexual offenders knew the victim fairly well (77.9%). This finding may differ from the other studies noted because the homosexual sub-group was too small to present an accurate picture of the larger population. Yet most other differences noted in studies of homosexual and heterosexual offenders were also seen here, so that even this small group seems in many ways representative. The author would like to suggest that although both homosexual and heterosexual offenders know their victims[19], perhaps the reason they know their victims differs.

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[19] Gold (1986) found that only 12.2% of a sample of adults who were sexually abused as children were abused by a stranger.

One plausible possibility is that homosexual offenders get to know children as a part of laying the groundwork for later getting them to cooperate in sexual activity, whereas the heterosexual offender knows the child due to a situational proximity, and later the child becomes the object of the offense. In the future, this could be better assessed by asking homosexual and heterosexual offenders if pedophilic fantasies were present when they first met the child, or whether fantasies started only some time after knowing the child. Unfortunately, this research was not refined enough in data collection on this measure in order to draw any well-founded conclusions.

Alcohol and Drug Use. Similar to the hypothesis of "ease of access" for the situational (heterosexual) offender, research has found that alcohol use is more common for heterosexual offenses and acts as a disinhibitor, while its low use in homosexual offenses suggests that no disinhibitor is needed; that is, the activity is ego-dystonic for the heterosexual offender (Gebhard, 1967; Rada, 1976; Stokes, 1964). The finding of this study on this measure did not agree with the researchers cited above in that no difference in alcohol use was seen in the two populations. Perhaps the above is supported herein in a more contemporary sense, because, to some extent, drugs have taken the place of alcohol.

While no statistically significant difference in the sub-populations was seen for drug use, it was more common in the heterosexual population. Drug abuse was first in a rank order of

the means on the clinical symptom syndrome scales for the heterosexual population, while it appeared third for the homosexual group. Further, z-scores on this measure showed that the heterosexual population's greatest difference from the MCMI's normative sample was in drug use, and this was statistically significant. The homosexual group was not significantly different from the normative sample. While this cannot be assumed to represent greater use of drugs during the offense in this group, it certainly suggests that (if it were assessed more carefully) one might find this to be the case.

Age of victim. The next offense characteristic to be discussed is the age of the victim. Since Mohr et al.'s early work of 1964, the peak age of all child victims of sexual offenses by adults has consistently been found to be 11 years. This may be because some characteristics of the child at this age are attractive to offenders (pre-pubertal bodies). Also, older victims make better witnesses for convictions and are therefore over-represented in studies using convicted offenders, and children of this age are beginning to explore sexuality themselves (e.g., playing sex games with peers). As such they are also more likely to engage in sexual exploration with adults who are interested in this behavior.

A few researchers have commented about differences in the ages of victims chosen by homosexual and heterosexual pedophiles. Some (Badgely, 1984) suggest that homosexual offenders choose younger children than heterosexuals while others suggest the

opposite, i.e., homosexual offenders choose older children as victims than do heterosexual offenders (Freund, 1987). In this study, homosexuals chose older children (age 10 or above) more often (85.7%), while heterosexual offenders more often chose children under age 10 (54.5%). That the heterosexual group finding was not as strong as the homosexual group result can probably be explained by the existence of two peak ages for female victims: either under 10 or ages 13-16. In fact, three of the heterosexual offenders had victims between the ages of 13 and 14, and could be considered hebephiles. The Badgely report (1984) included incest offenders in their heterosexual population. This would raise the mean age of victims of heterosexual offenders since female incest victims are typically pubertal and post-pubertal, similar to the second peak age. As such, the results of this study and those found by Freund (1987) probably better represent the homosexual pedophile.

Why would this difference be found? One can use the fixated/homosexual: regressed/heterosexual theory so frequently discussed as the genesis for explaining this behavior. If the homosexual pedophile seeks a peer/partner in his object (as he cannot do with adults) the desire for a relationship with the child is present. While he desires sexual activity, he also wants to satisfy other emotional needs through the relationship. Remember that "... theories based on emotional congruence may be better able to explain male-object pedophilia while other

theories, such as blockage explanations, may be better able to explain the female-object type" (Finklehor & Araji, 1985, p. 33).

It is difficult to develop a relationship that is satisfying on these levels if the child is very young. The older child (8-12) is more in a position to supply the emotional requirements of a fixated pedophile; a 4- or 5- year- old does not have the emotional maturity needed to be a "partner" for the offender[20]. Additionally, be reminded that for adult-to-child sexual offenses a relationship exists between the age of the child and the form of sexual activity engaged in. This is an age-appropriate relationship (the word "appropriate" being used loosely here) as intercourse and "higher" forms of sexual expression are rarely seen in young victims and these sexual behaviors increase proportionately with the age of the child. The homosexual offender who truly seeks sexual satisfaction with his object would be more likely to obtain it with an older child who may not be as passive.

For the same reasons as above, a study of the (few) heterosexual offenders who are fixated would likely reveal that they, in addition, prefer older children (hebephilic), as in the

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[20] Wilson and Cox (1983) suggest that there is a relationship between choice of younger victims and the introversion of the offender. Those offenders who are pathologically disturbed may pick young children; however, psychopathology is rare in pedophilic offenders.

"Lolita" type of clinical picture[21].

Perhaps fixated offenders of either group are in reality more hebephilic than pedophilic. Although usually set at a higher age, in Freund's 1987 research he chose age 11 as the cut-off between hebephiles and pedophiles. This is probably more appropriate than the broader range he has used in earlier work (1981), and analysis of pedophile populations using this cutoff would be interesting to see in the future.

Based on what is known about the clinical picture of the regressed heterosexual offender, one can postulate as to why the younger child may be a more "apt" victim. The offender is not interested in a relationship with the child (as much as the fixated offender), and as such, he may not need to have a victim who can offer a degree of mutuality. He also does not have the intention of a full sexual relationship; the desire to fondle and/or masturbate while looking is more easily accomplished with a younger (passive) child. He also does not have the cognitions of the fixated pedophile who may wish to "educate" the child about sexuality, e.g., in the "North American Man-Boy Love Association" way of thinking (Garcia, 1987).

In drawing on the idea that "... blockage explanations may be better able to explain the female-object type" (Finklehor &

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[21] This is not to suggest that regressed heterosexuals would never offend with older girls; the proximity of the victim is probably more important than the age for this group.

Araji, 1985, p. 33), the heterosexual offender's "blockage" is acute in his lifespan, as compared to the chronic blockage seen in the fixated offender that results in his "emotional congruence" with the child. While power needs are present for both types of offenders, the acute failure of the regressed individual suggests his need to regain feelings of power are also more acute, and hence he may pick the least powerful (younger) object.

In all, these ideas suggest that if proximity were not also a factor, the regressed offender's needs are better met by a passive victim, or "inanimate" object.

A final note on the age of victims concerns the ability of pedophiles to discriminate age cues satisfactorily. Marshall et al. (1986) mention that in their clinical work they have found that dull-intelligence offenders "... are unable to discern cues to age even in clothed females where the cues are more pronounced" (p. 436). In light of the recent findings of neurological impairment in pedophiles, some of these individuals may not be capable of judging the age of their objects, rather than exhibiting an age preference.

Marriage. The last finding in this section meriting discussion in the context of fixation/regression is the rate of marriage in the sample groups. As mentioned in the literature review, Groth and Birnbaum (1978) divided their sample into fixated and regressed offenders and found that 88% of the fixated

group never married and 75% of the regressed group had. This would be an expected result, implied by the fixation/regression model. As this author has continued to insist that fixated offenders are usually homosexual and vice-versa, it was expected that female-object offenders would show a much higher rate of marriage or cohabitation than male-object offenders[22].

While in fact more of the heterosexual group had married or cohabitated (63.6%), just less than half of the homosexual group had also done so (42.8%), a much higher rate than expected. A sharper contrast between the groups may have been obscured by the fact that slightly more of the heterosexual group was under age 30 and less likely to have married yet, but further, a look at the case histories of the married/cohabitated homosexuals revealed that the above figure is somewhat misleading.

In fact, only one of these individuals had actually been legally married, and he was divorced in large part due to conflict with his wife over his episodic pedophilia. The other two homosexual subjects had cohabitated with women who had children, and the sons of these women became the victims of the offenses. This suggests that the motivation for cohabitation (or for involvement with the woman altogether) may have been to gain

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[22] Not because male-object offenders are androphiles, as they are not.

access to the children[23]. Properly, perhaps these individuals should not have been included in the figure of homosexual married subjects. Their exclusion would show that the true amount of married subjects in the group was one (14.28%), and his marriage did not endure. Given the above, the findings of marriage, viewed in terms of homosexual and heterosexual sub-groups, may be similar to those found using fixated and regressed groups (Groth and Birnbaum, 1978).

Testing : Shared Personality Patterns Within the Group

Basic Personality Pattern. The finding that 82.35% of the sample members had at least one personality subscale on the MCMI elevated over the base rate (85) indicates that personality disorder of one form or another characterizes the group. While this is probably true, it is doubtful that the extent of Axis II personality disorder in the group is that high. Recently, criticisms have been made that the MCMI is programmed to generate an Axis II diagnosis for almost all patients (Piersma, 1987).

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23 In the heterosexual group, two offenders victimized children of their girlfriends, but it seems they became victims due to their proximity. The relationships were "reasonably" solid until one individual was rendered impotent due to diabetes (after which he offended), and the second offended following his own circumcision and his girlfriend's surgery which prohibited intercourse while she recovered. While these offenders may also have married for proximity to the children, the background data suggests this was not the case.

This was well-suited to the needs of this research as the discussion of personality in pedophilia required a "finding" for all subjects; however, caution is advised in assuming that 82.35% of these subjects primarily have personality disorders. The results of Piersma's work found that clinicians diagnosed personality disorders "... much less frequently than did the MCMI" (1987, p. 482).

That 70% of the sample members scored sufficiently high to indicate the presence of dependent-submissive personality features may also have been effected (in the extent of) by the above problem. Criticism has also been made regarding the convergent validity between the MCMI and DSM-III on some specific personality scales (i.e., that they are measuring the same factors), but the subscales Avoidant/Dependent are seen as the scales that have strong convergent validity (Widiger & Sanderson, 1987). That a Dependent-Submissive personality pattern is characteristic of the total group (coupled with Avoidant, also frequently occuring) seems an accurate finding. The instrument (MCMI) was strong on these scales, Dependent and Avoidant, and this turned up in all the different analyses. These personality "styles" agree with the clinical descriptions of pedophiles in the literature.

> personality disorders comprise a network of perceptions, interpersonal behaviors, and affective responses which tend to perpetuate one another in a pervasive and enduring pattern. (Antoni, Levine, Tischer, Green, & Millon, 1986, p. 65)

What exactly are the Dependent and Avoidant personality patterns? Millon (1983) sees the dependent individual as, "Characterized by an inadequate and fragile self-image, social passivity, and deficits in autonomy and assertiveness" (p. 51). The DSM-III (American Psychiatric Association, 1980) describes the dependent personality as a person who: a) passively allows others to assume responsibility for major areas of life because of inability to function independently; b) subordinates own needs to those of person on whom he depends in order to avoid any possibility of having to rely on self, and c) has low self-confidence, sees self as helpless, stupid (p. 326) Widiger and Sanderson (1987) see the dependent syndrome measured by the MCMI as "...someone who exibits excessive dependency, isolation anxiety, low self-confidence, low initiative, submissiveness and abdication of responsibilities" (p. 230).

The avoidant person is seen by Millon (1983) as, "Reflecting a personality pattern characterized by social anxiety and withdrawal, self-alienation, and depressive affect" (p. 51). The DSM-III (American Psychiatric Association, 1980) describes avoidant personality disorder as: a) hypersensitivity to rejection; b) unwillingness to enter into relationships unless given unusually strong guarantees of uncritical acceptance; c) social withdrawal, distances self from close personal attachments and engages in peripheral social and vocational roles; d) low self-esteem, devalues achievements and is overly dismayed by personal shortcomings (p. 324). Widiger and

Sanderson (1987) see the avoidant person as "... shy, anxious, dysphoric, alienated, hypersensitive to rejection, and lonely" (p. 230).

It is easy to see why individuals characterized by these features would gravitate toward children. The low self-confidence and passivity found in both personality styles would indicate that emotional needs be fulfilled by non-threatening objects, and children best supply the "strong guarantee of uncritical acceptance". This has already been discussed in great depth in relation to the aetiology of pedophilia, and that finding that pedophiles are passive socially and suffer low self-esteem is nothing new. Low initiative and the inability to function independently would predict the (low) educational and vocational achievement of this sample. These findings basically reiterate those of clinical studies in which pedophiles are seen as "... timid, unassertive, inadequate, awkward, and have an impossible time developing social and sexual relationships" (Finklehor & Araji, 1986, p. 153).

What is "new" about these results is how they differ in degree from personality assessments of pedophiles made by means of the MMPI. In summarizing MMPI findings, Lanyon (1986) writes that pedophiles are "... somewhat more shy, passive, or unassertive than average" (p. 178). This would seem a great understatement; they are in fact substantially more shy, passive, or unassertive than average. This difference in degree of disturbance is probably due to the finer discrimination offered

by the MCMI; the MCMI may be a better tool than the MMPI for assessing personality in some populations.

Scale elevations of pedophiles on the MMPI have consistently found mean point codes of 4-8-2, or some combination thereof. Without entering into a lengthy discussion of MMPI interpretation, these codes can be clustered according to Axis II diagnoses personality disorders and they include Avoidant, Dependent, Compulsive, and Passive-Aggressive personalities (Vincent, Castillo, Hauser, Stuart, Zappata, Cohn, & O'Shanick, 1983). While no compulsive features were seen in any individual subject, Dependent, Avoidant, and Passive-Aggressive features were recurring for individuals in the sample. The similarity of these findings to other MMPI studies (Armentrout & Hauer, 1978; Hall et al., 1986; Panton, 1979; Quinsey, 1980) indicates that this outpatient sample is quite similar to other pedophilic research populations. Additionally, researchers comparing the MCMI and MMPI have found that "... the two instruments were highly correlated... and have conceptually similar factor structures" (Sexton, McIlwraith, Barnes, & Dunn, 1987, p. 388).

One of the shortcomings of much MMPI research with sex offenders has been the use of mean profiles in reporting results; they may exist for the group but not really describe the individuals in the group. For example, in the work done by Hall et al. (1986), scales 4 and 8 were elevated for 44% of his sample, however only 7.1% of the sample had an actual 4-8 point code. "Although scales 4, 8, and 2 were the three elevated

scales in the mean profile of the sample, no individual MMPI profile in the sample had these three clinical scales elevated exclusively" (p. 495). While this sample was similar to his work in that "most of the sample was characterized by multiple scale elevations" (p. 495), Table 24 presents individual scores that show ten sample members (58.8%) had either Avoidant, Dependent, or both subscales elevated ($\geq$ 85). The number of individual profiles showing Avoidant, Dependent, or both scales elevated ($\geq$ 85) exclusively was five (29.4%).

Pathological Personality Disorder, Clinical Symptom Syndromes, and z-scores. Pathological personality disorder was not a feature of the group and this agrees with the findings of other researchers (Langevin et al., 1978; Abel, Becker, & Skinner, 1983). That six sample members showed borderline (1 homosexual, 1 heterosexual) or paranoid (2 homosexuals, 2 heterosexuals) features is actually less than expected as these features are related to the types of personality disturbance seen. Clinical symptom syndromes seen in the group are also compatible with the personality patterns found.

For example, the borderline subscale gauges, among other things, "marked dependence anxiety" and a "self-condemning conscience" (Millon, 1983, p. 53), which are seen in the dependent person or the passive-aggressive person whose interpersonal ambivalence struggles between "dependent acquiescence" and "assertive independence" (1983, p.5). Likewise

the symptoms of anxiety, depression, and drug abuse are experienced, congruent to the above struggles. The paranoid subscale as defined by Millon reflects "... such characteristics as an edgy and vigilant mistrust, provocative interpersonal behavior, and mini-delusional cognitions. ." (1983, p.5) and would be congruent with aspects of such personality patterns as anti-social ("hostile affectivity") and passive-aggressive ("interpersonal contrariness"). These personality types were present in the sample. In addition, we may expect to see paranoid traits in those fixated subjects who have rigid cognitive belief systems that allow them to view pedophilia positively, and who realize that society opposes this belief system. Again, all of the above would be expected to generate anxiety and underlying depression which the individual may try to self-medicate with drugs.

It is almost surprising therefore that only two subjects (1 heterosexual, 1 homosexual) had scale scores over or equal to 85 on any of the pathological personality syndromes; these two individuals were both paranoid.

The z-scores presented in Table 31 show that the sample scored significantly higher than the MCMI normative sample on the Dependent and Passive-Aggressive subscales. The between-groups analyses will show that the samples elevation on the Passive-Aggressive subscale was a function of the homosexual group's high scores, and therefore this will be discussed in the between-groups section.

Are the Findings Unique to Pedophiles?

The findings of this research and the studies cited above offer a relatively uniform picture of how pedophiles differ from "normals". One must be careful, though, in assuming that this characterizes pedophiles per se and not other types of sexual offenders as well.

For example, Langevin et al. (1978), in trying to discover some personality factor unique to pedophilia predicted that pedophile groups (heterosexual and homosexual) would score significantly higher on the Social Introversion (Si) scale of the MMPI than a multiple deviant group consisting of rapists, toucheurs, voyeurs, frotteurs, fetishists, and transvestites. While the means for the pedophile groups were somewhat higher, it was not established that they were significantly higher than the multiple deviant group.

Quinsey et al. (1980) carried out similar research using persons grouped into the following offense categories: homicide of a female, arson, rape, sexual contact with a child, and property offenses (excluding armed robbery). There were no differences found between the pedophiles and any other group. Panton, as early as 1958, used the MMPI on groups of assault, robbery and burglary, property theft, white collar crimes, rape, and a "sex perversive" group, and likewise found no statistically significant differences.

Further, given that the link has been made between homosexual pedophilia and fixation, these syndromes of personality may be more related to some aspect of homosexuality rather than the choice of an immature object[24]. Personality patterns in androphiles may be similar, albeit not as dysfunctional, and this study would have benefitted from the inclusion of an androphilic control group. A brief look at MMPI studies of androphiles (which have largely concentrated 20 years ago on finding high-point codes which discriminate homosexuals and heterosexuals), may either support or refute this train of thought. Dean and Richardson (1966) found the most frequently occuring high-point codes in a homosexual sample were 5-9, 5-8, 5-2, 5-7 and 5-4. While the masculinity/feminity code (5) always appears, the 2-4-8 codes noted in groups of sexual offenders are also present. Zucker and Manosevitz (1966) in critisizing Dean and Richardson's work, found three major high-point codes : 5-9, 5-8 and 5-2 Again, although different, the 2-8 code is present. While these findings are far from equivalent to that seen in sex offender groups, there are some shared features that suggest researchers investigate similarities and differences between androphiles, homosexual pedophiles, and heterosexual (fixated) pedophiles. Similarities may only be a function of these groups' shared social "deviance" and associated problems, or, while

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24 Freund's (1987) recent work on the prevalence of homosexuality in pedophilia also suggests this.

androphiles (ego-syntonic) are not characterized by personality disorder, there may be shared personality characteristics. Homosexual pedophiles do not seem to share the masculinity/femininity (code 5) elevations of androphiles, and Freund's work (1987) found that gender identity did not discriminate homosexual and heterosexual pedophiles.

Some authors have suggested that it is futile to look for personality correlates to criminality (Reppucci & Clingempeel, 1978), and the above studies would perhaps support this opinion. Intuitively, it is very hard to believe that the deficits in personality noted in clinical practice with sexual offenders are not somehow related to their crimes. The author is more comfortable in believing that methodological problems and inadequate instruments (the MMPI for one) are more at the root of the failure to distinguish between offense groups, than to accept that there are no personality features which may distinguish them from one another. It would be interesting to replicate the studies of Langevin, Panton, and Quinsey using the MCMI which is specifically designed to provide personality measurements.

In summary, the within group results basically replicate the findings of other research, which shows that pedophiles are generally dependent and/or avoidant in their interaction with the world. This may or may not be unique to pedophilia. Little light is shed on the aetiology of the disorder as these personality features may relate to either of the aetiological streams discussed by Finklehor and Araji (1986), that is,

"emotional congruence" (due to low self-esteem) or "blockage" (fear of adult females).

It is hoped that the following section will prove more interesting as the between-groups analysis assumes different aetiological factors for the sub-populations.

Distinguishing Patterns of Personality and Their Possible Relationship to Fixation and Regression

In the beginning of this paper, the author suggested that narcissism scores obtained on the NPI and MCMI would be elevated in the homosexual group and low in the heterosexual group. This result was expected as it was the author's contention that homosexual pedophiles (who are usually fixated) develop their interest in children due to a reparative process of narcissistic inversion. This notion was explained and discussed in relation to the aetiology of pedophilic fixation in Chapter II. However, no difference was seen between the groups on this measure either in the NPI or MCMI results. In fact, both groups showed significantly less elevation on this measure in the NPI results when they were compared to the normative sample of the instrument. The lack of the expected finding in this regard may be due to an improper choice of instruments for measuring this feature or it may be that the author's hypothesis is incorrect.

Both the NPI and MCMI were chosen by the author because they were the only objective scales found that specifically test this

feature. Both instruments measure narcissism in accord with the DSM-III definition of narcissistic personality. Millon (1983) defines the individual as "... characterized by interpersonal exploitiveness, pretentious self-assurance, and a deficit social conscience..." (p. 51). The DSM-III criteria for Narcissistic Personality Disorder are: a) grandiose sense of self-importance, b) preoccupation with fantasies of unlimited success, power, brilliance, beauty or ideal love, c) exhibitionism, d) cool indifference or rage to criticism or defeat, and e) two of the following disturbances in interpersonal relationships: entitlement, exploitiveness, overidealization and devaluation, or lack of empathy (American Psychiatric Association, 1980, p. 317).

While some of these criteria may seem relevant to pedophiles and their relationships with children (exploitiveness, overidealization), they have limited relevance for measuring the presence of narcissistic inversion as an interpersonal dynamic "style". Narcissistic inversion is an unconscious process. Therefore projective instruments may have been a more useful choice than the MCMI or NPI. Because of the above limitations this hypothesis is better considered as yet untested, rather than negated with certainty.

While narcissism scores were not found to distinguish the homosexual and heterosexual groups, other scale scores appear to have done so. The homosexual group mean elevation on the subscale Passive-Aggressive was significantly higher than the heterosexual group. Not only did the homosexual group show this as a feature

($\geq$ 75), but four subjects scored Passive-Aggressive as part of their two highest scale elevations ($\geq$ 85). In fact only five of the seven homosexual subjects had scale elevations over 85, and four of these five were on the Passive-Aggressive subscale. This is a pilot study and while these data are suggestive, confirmation would be necessary using a larger sample. Intuitively, this pattern seems unlikely to be random error. Even given that the MCMI may "over-diagnose" personality disorder, it would have done so equally for the groups and, as such, would not produce the noted differences. Not one heterosexual subject showed a Passive-Aggressive scale elevation $\geq$ 85.

What is the Passive-Aggressive personality? Millon informs us that this person exhibits: a) labile affectivity; is frequently irritable, easily frustrated and explosive b) behavioral contrariness; reveals gratification in demoralizing and undermining the pleasures of others; c) discontented self-image; feels misunderstood, unappreciated and demeaned; 4) deficient regulatory controls; expresses fleeting thoughts and impulsive emotions; 5) interpersonal ambivalence; conflicting and changing roles in social relationships, particularly dependent acquiescence and assertive independence; uses unpredictable and sulky behavior to provoke edgy discomfort in others (1983, p. 5). The DSM-III (1980) offers the following diagnostic criteria : a) resistance to demands for adequate performance in both occupational and social functioning; b) resistance expressed

indirectly through at least two of the following : procrastination, dawdling, stubborness, intentional inefficiency, "forgetfulness"; c) as a consequence of a and b, pervasive and long-standing social and occupational ineffectiveness; d) persistence of this pattern even under circumstances in which more self-assertive and effective behavior is possible (American Psychiatric Association, 1980, p. 329).

Widiger and Sanderson (1987) inform us that there is some difference between Millon's and the DSM-III's view of the Passive-Aggressive personality; while the "... DSM-III version is defined around the single trait of passive resistance to external demands... Millon's version is broader..." (p.230). Millon himself has acknowledged this, and feels that his version better encompasses the "... broad range of characteristics reported in both the theoretical and research literature..." (in Widiger & Sanderson, 1987, p. 230).

How could this be related to the behavorial patterns seen in this group? It certainly is congruent with the lower educational and vocational achievement seen in the homosexuals as compared to the heterosexuals, i.e., the "pervasive and long-standing social and occupational ineffectiveness". It also suggests greater social impairment; where the heterosexuals fail in social relationships due to patterns of avoidance and dependence, the passive-aggressive (homosexual group) shows these traits but is somewhat more antagonistic; i.e., "behavioral contrariness", "deficient regulatory controls", and "sulky behavior". This is

in accord with the findings of Figia et al. (1987), who found that the tendency to express hostility in an indirect manner differentiated sex offenders from violent offenders. In all three of these personality patterns, the devalued self-esteem rests on "controlling" significant others (Passive-Aggressive, Dependent), or avoiding intimacy with them (Avoidant).

In relation to the aetiology of pedophilia, one cannot say that some aspect unique to passive-aggressives results in the choice of an immature object. Looking overall at the between and within groups results however, some inferences can be made about how homosexual and heterosexual pedophiles differ and why one group may have a more fixed interest in children.

Table 24 shows that the heterosexual group was much more heterogeneous in the specific subscale elevations exhibited. Individual heterosexual subjects showed Narcissistic, Histrionic, Anti-social, as well as Avoidant (only) and Dependent (only) subscale elevations. The homosexual group showed much less variation in scale results, and elevations fell in clusters of Passive-Aggressive, Avoidant, and Dependent. These three personality patterns can be considered separate parts of a syndrome.

Work done by Vincent et al. (1983) has shown that Axis II disorders can be grouped into clusters. The first cluster includes paranoid, schizoid, and schizotypal personalities. The second cluster includes histrionic, narcissistic, anti-social, and borderline personalities. The third cluster includes

avoidant, dependent, compulsive, and passive-aggressive personalities (1983, p. 830).

Individual subjects in the heterosexual group could either be placed in the second or third cluster, while homosexual offenders belong exclusively to the third cluster.

The third cluster would seem to be the "lowest common denominator" of all subjects. It was seen exclusively in the homosexual/fixated group, and aspects of this cluster were seen in some, but not in all heterosexual offenders, who may or may not be fixated. It is speculated that those heterosexual individuals belonging to cluster three may approximate the fixated model since they share characteristics with the fixated homosexual group. Heterosexual subjects not showing this cluster profile may belong more in a regressed model. Heterosexuals showing some aspects of this cluster (Dependent-Avoidant only, for example) may be predisposed in terms of personality "style" to fail in social, vocational, or sexual roles and hence choose immature objects when the dysfunctional aspects are "acute", i.e., the regressed offender. Offenders showing aspects, but not all personality patterns of this cluster profile, which are chronically dysfunctional, may become episodic pedophilic offenders.

Further, the 4-8-2 MMPI profile codes are included by Vincent et al. (1983) as codes which belong to the third cluster. These codes represent the mean profiles of sexual offenders against children (pedophiles and incest offenders) in the work

done by Armentrout and Hauer (1978), Panton (1978), and Hall et al. (1986). While these researchers have not presented results showing that the 4-8-2 code is seen more frequently in homosexual or recidivist offenders one may guess that a more refined analysis may illuminate this pattern.

The author suggests therefore that a personality syndrome including Dependent, Avoidant, and Passive-Aggressive scale elevations characterizes fixated pedophiles. This syndrome will frequently appear in homosexual offenders, and will appear less frequently, or less powerfully[25], in the heterosexual offenders. This should probably be coupled with the absence of compulsive personality as the sample results show that it was not present for any individual member. Pedophiles are not conforming individuals.

In many ways, this is a restatement of what clinicians working with pedophiles have known, and researchers have suspected but been unable to illuminate due to insufficient analysis between groups, or through the use of instruments that are not sensitive enough to personality distinctions. This personality syndrome may be related to theory types offered in explanations of aetiology.

The following model of the relationship between personality pattern, offense pattern, and aetiology is not intended as a

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25 For example, a regressed offender may show the cluster profile as a feature ($\geq$ 75), but not as dominant ($\neq$ 85).

system of classification of offenders. Pedophilic offenders should not be classed as fixated or regressed based on the results of psychometric testing. It is presented simply as a model of the possible interaction between personality, offending pattern, and aetiological explanation. It suggests expected outcomes on the MCMI if we are able to clearly classify and separate groups of fixated, episodic, and regressed offenders. It offers an hypothesis of the correlations between types of personality patterns, types of offense patterns, and aetiological theory types based on the synthesis of this study's preliminary research results. This research was not designed to fit individual subjects into this model, but suggests that future research may use this model in attempts to refine the relationship between personality and pedophilia.

The Relationship Between Personality Pattern, Offense Pattern, and Aetiology

Offense Pattern	MCMI Personality Profile	Theory Type
Regressed	1 subscale elevation either Narcissistic, Histrionic, Anti-social, Schizoid, Dependent, or Avoidant only 2 subscale elevations where one is Dependent, Avoidant, or Passive-Aggressive	Blockage Situational blockage due to life stresses coupled with aspects of a dysfunctional personality style.
Episodic	2 subscale elevations where both are of the following three : Avoidant, Dependent, Passive-Aggressive OR 3 subscale elevations where 2 are of the following three : Avoidant, Dependent, Passive-Aggressive	Here offenders experience blockage which is more chronic than acute due to dysfunctional aspects of personality. When coupled with acute life stresses this results in periods of emotional congruence with children.
Fixated	3 subscale elevations including the following three in any order : Avoidant, Dependent, Passive-Aggressive 3 subscale elevations where the order from highest to lowest is as follows : Passive-Aggressive, Avoidant, Dependent	Emotional Congruence due to chronic personality disturbance. The offender is congruent to a child.

Summary of Discussion

The major points made in the author's discussion of this study's results are :

1) There is a relationship between homosexual object choice in pedophilia and exclusive (fixed) interest in children, and inversely, a relationship between heterosexual object choice and non-exclusive sexual interest in children. The use of the fixated/regressed model for homosexual and heterosexual offenders, respectively, is valid and useful both clinically and theoretically.

2) Exclusive and non-exclusive sexual interest in children may be demonstrated in terms of differences in personality traits and/or structures. Fixated pedophiles of either a homosexual or heterosexual orientation may consistently exhibit a "cluster" of personality features; i.e., Passive-Aggressive, Avoidant, and Dependent. The presence of this cluster might produce mutually exclusive groups in terms of exclusive or non-exclusive sexual interest in children. The strength of this cluster may have a relationship to the aetiology of this interest.

3) Sex of object choice of homosexual and heterosexual pedophiles does not produce mutually exclusive groups in

terms of personality traits and/or structure. Heterosexual and homosexual pedophiles who have either an exclusive or non-exclusive interest in children share specific dominant personality characteristics; i.e., Avoidant and Dependent features of personality.

4) We do not know if the cluster of personality features (Passive-Aggressive, Avoidant, Dependent) that may distinguish fixated pedophiles from those with non-exclusive sexual interest in children, is unique to pedophilia. This may also be shared by other classes of offenders, or related to a shared group characteristic other than offending, such as some aspect of homosexuality.

Implications for Treatment

The following section does not present a review of the literature relevant to the treatment of pedophilia. The purpose of this brief section is to present the reader with an overview of the treatment techniques that are used with pedophiles, and to discuss the differential application of these techniques within the context of the findings of this research.

Having read until now, the reader may feel that the author would suggest that the treatment of pedophiles concentrate on addressing dysfunctional personality disorder. In fact, this is not the case. Treatment should ideally be tailored to each

individual. Regressed and fixated offenders may have different treatment needs.

As Dr. Berlin (1986) pointed out in his discussion of rapists, sexual offenders may or may not be characterologically, sexually, intellectually, or organically disturbed.

This study has shown that many pedophiles are characterologically disturbed, and they are probably disturbed in other areas as well. Is it reasonable to attempt to change the personalities of this group? Hardly so, as personality is rather difficult to change and save for many, many years of analytic psychotherapy (which may or may not be successful) it is not known how to go about instituting such changes.

The regressed offender whose disturbance is acute rather than chronic may be helped in individual psychotherapy. He has temporarily regressed from adult-to-adult sexuality to adult-to-child sexuality due to overwhelming life stresses. Individual psychotherapy can help relieve his stress by release to his therapist, examine the areas of interpersonal dysfunction (e.g., encourage him to talk to his wife), and generally make him aware of his personality vulnerabilities so that he may develop more effective coping. He can first practice new interpersonal skills in therapy, and it is hoped he will later transfer them to his outside life. Speaking about his offense to a non-judgmental therapist may have a great impact on his wellness as these offenders are often sickened with guilt, remorse, and shame due to the nature of their offense.

The fixated offender on the other hand, has a chronic problem. Even if he wishes to stop offending to avoid the legal consequences of his actions his only sexual interest is in children. Such offenders can sometimes be controlled through individual therapy because they must answer to a therapist each week, but they will still experience the desire to offend, and some time after therapy ends, they probably will offend again. Since treating the characterological disturbance is difficult if not impossible, it is more effective to concentrate treatment efforts on changing the external behavior.

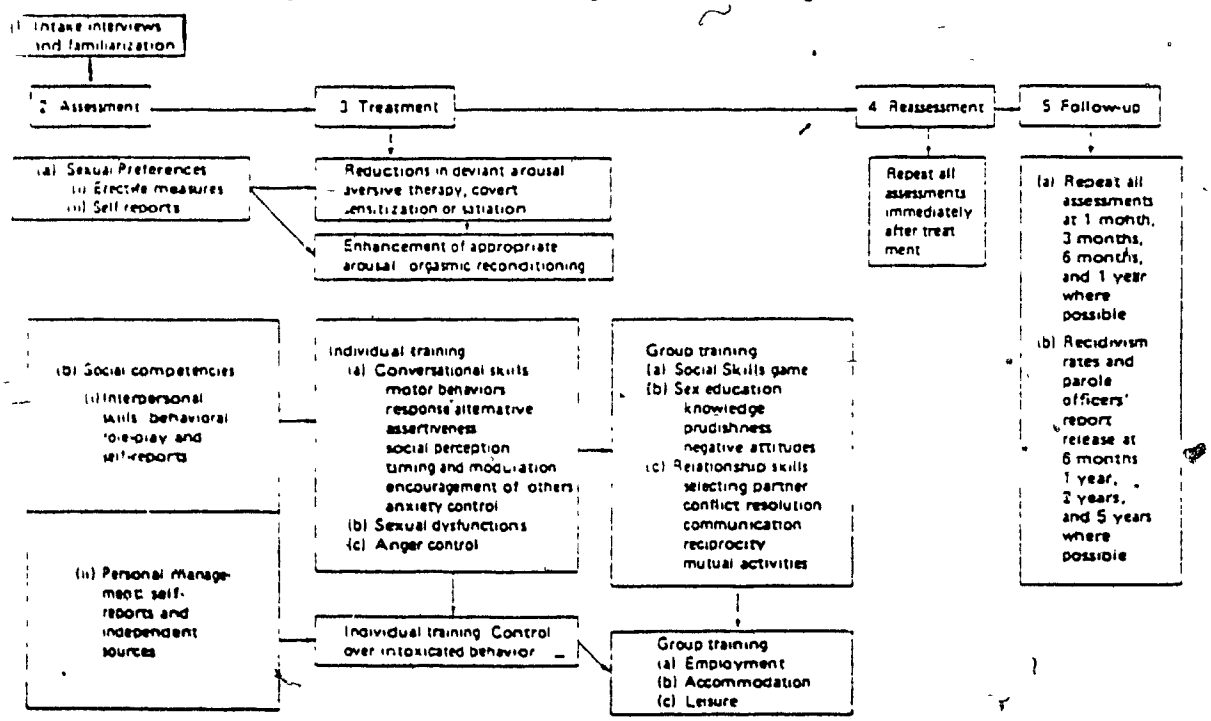
> There are two major views in the literature as to how sexually deviant behavior is best conceptualized. The traditional view... has two basic premises: a) that all sexually deviant behaviors are theoretically and etiologically similar, and b) that they represent a single type of psychopathology, specifically a form of character disorder... because sexual pathology is viewed as a character disorder, the behaviors have been regarded as highly resistant to change, so treatment is lengthy and is based on restructuring of the character. The second major view of sexual deviations is a more recent development and has its roots in the relatively atheoretical, elemental behavioral approaches to human disorders. The behavioral or functional view does not imply that... they are free of character disorder or other psychopathology... (but this)... does not necessarily require treatment for the sexual problem to be alleviated. (Lanyon, 1986, p. 176)

The author prefers to conceptualize pedophilia in the traditional view, but embraces the functional view, particularly for the treatment of fixated offenders. This is not to say that behavioral techniques should not be applied with regressed

offenders (if available), but the basic premise of behavioral work with sex offenders is to eliminate the deviant sexual preference. Regressed offenders, by definition, do not have this problem as the victim is a surrogate for an adult female. Behavioral techniques applied to this group may negate the ability of the child to serve as a surrogate, which is of course helpful.

Abel et al. (1985) have proposed a comprehensive model for treatment of sexual offenders which, in the author's opinion, is the best in existence.

TABLE 1
Progression of Patients Through Behavioral Program



From Marshall, Earls, Segal, and Darke, 1983.

Parts of the model may be more important for some individual offenders, and less important for others. It is presented briefly.

The problem of decreasing deviant arousal is addressed by three methods: aversive therapy, covert sensitization, or satiation. The first, aversive therapy, exposes the patient to the preferred (deviant) stimuli and pairs this with a mild electrical shock. Covert sensitization is essentially an internal aversive technique where the deviant stimulus is imagined by the patient and paired with (patient generated) aversive images. Covert sensitization is also used to re-condition pre-offense behavior. The patient imagines the feelings and thoughts he experiences prior to committing an offense and pairs them with aversive images. This is especially important as it " .. sensitizes the offender to those behaviors early in the chain of events that led to his paraphilic acts" (Abel et al., 1985, p. 201). Masturbatory satiation (Marshall, 1973; Marshall & Barbaree, 1978) has the patient masturbate for one hour (regardless of ejaculation and without resting) while freely verbalizing all of his deviant fantasies. This is useful as an at-home management technique as well, where the patient tape records his verbalizations for later presentation to his therapist (Abel & Annon, 1982).

In patients with particularly poor impulse control or violent arousal patterns where the techniques above may not be

enough, chemical intervention, such as with Depo-Provera or the major tranquilizers may be indicated.

The second facet of the model attempts to increase non-deviant arousal through orgasmic reconditioning to appropriate stimuli. The patient may be provided with audiotapes, slides, films, and other audio-visual materials. This is particularly important to fill the "gap" left from the extinction of deviant arousal; he must develop appropriate arousal patterns or he may revert to earlier behaviors.

Other facets of the program teach social skills through role rehearsal and modeling, address cognitive deficits used by the offender as a rationale for his behavior (such as feeling they are educating the child about sexuality), treat drug or alcohol use which may increase the arousal of the offender toward the deviant object, and offer sex education and treatment for specific sexual dysfunctions.

Although the author believes that the aetiology of pedophilia is related to dysfunctional personality features, these methods (which pay no attention to this) are effective and can be accomplished in a relatively short period of time. Programs based on this model, such as the one in operation at Institute Philippe Pinel in the Montreal region, require a two-year stay. The author has purposefully covered the area of treatment briefly as it is only tangentially related to the study of personality and pedophilia. Interested readers are directed

to the work of Abel, Becker, and Skinner (1983); Abel, Mittleman, and Becker (1985); Berlin and Heinecke (1981); Marshall (1973); and Marshall and Barbaree (1978).

In closing, a few words should be said about the utility of incarceration of pedophiles. Incarceration in penitentiary may make society feel better but it is a false feeling of relief. In the first place, less than one-third of convicted sexual offenders are incarcerated (Defrancis, 1969; Badgely, 1984). Incarceration without treatment does nothing to alter a deviant pattern of arousal, and studies of recividism following imprisonment do not support a deterrent effect (Badgely, 1984). It is also extremely expensive for society to support the (imprisoned) offender and his dependents. Pedophilic offenders should be treated as out-patients (with treatment a condition of probation supervision), except in those cases where depriyation of liberty coincides with a period of incarceration in a treatment program, or the offender is intellectually or organically impaired to the extent that he cannot follow a treatment program.

Recommendations for Future Research

Having offered a review of the research literature on pedophilia in Chapter II, it should be clear that much greater interest must be directed toward amplifying the base of knowledge

that exists for all forms of paraphilic behavior. Pedophilia in particular suffers from neglect; this is ironic as the literature on the victims of childhood sexual abuse has exploded in the past ten years. Judging from the preponderance of published work the study of incest and rape is stylish, the study of pedophilia is not. Nor is it particularly stylish to study exhibitionists, fetishists, voyeurs, toucherists, and those with courtship disorders. These may be relatively minor offenses in terms of their impact on the victim, but approximately one-third of offenders engaging in these behaviors progress to more serious offenses. The author draws attention to all the paraphilias to ask why, if we are concerned with the victims of sexual offenders, do we not realize that we should be concerned with the offender himself?

The suggestion that the present study be replicated with improvements requires research on other paraphilias to evaluate the importance of any findings. If these results were replicated in a larger sample; how do we know that they are unique to pedophilia? Might not the same results be found in exhibitionists? Any factors common to pedophilia that are meaningful must also be distinct from the other paraphilias. Again, the author's first suggestion for future research is that more people initiate research in this area.

In terms of the present study, there are many improvements that can be made. First, an exact replication with a larger

sample should be done to confirm that heterosexual and homosexual groups differ in personality profile. If the tri-scale constellation is seen (Passive-Aggressive, Avoidant, Dependent), more extensive work with the following improvements should be undertaken. These improvements are:

1) Add control groups of androphiles, a mixed paraphilic group excluding pedophiles, violent sexual offenders against children, non-sexual offenders, and a mixed (non-offender) psychiatric population. This is to ensure that the profile constellation is a correlate of pedophilia rather than homosexuality (even if some heterosexual offenders show similar profiles), sexual offenders in general, non-sexual offenders, or psychiatric patients.

2) Separate and contrast the profiles of the pedophilic group against the others along the following dimensions: heterosexual/homosexual, recidivist/first offender, force/non-force, "pure" pedophilia vs. pedophilia with history of exhibitionism, voyeurism, and other non-aggressive offenses, age of the victim, and type of preferred sexual activity (penetration vs. fondling, for example).

3) A secondary study wherein knowledgable clinicians, without awareness of the profile reports, class offenders as fixated/episodic/regressed and the resultant groups' profiles are examined to see if they follow the expected pattern of subscale

elevations. (This assumes the profile results suggest a pedophilic profile constellation.)

What if we found a personality syndrome common to and unique for pedophiles? This may have little impact on clinical work as good clinicians already understand this, and effective treatments take a functional view of this disorder. It may have significant impact in terms of its relevance to future research, particularly in the largely uncharted area of physiological studies. Scott et al. (1984) and Hucker et al. (1986) have found neurological deficits, Gurnani and Dwyer (1986) have found suggestions of testosterone deficits, and it may be that there are biochemical disturbances which underly personality dysfunction. Knowing exactly what types of dysfunctions define the group would be most helpful to focus studies of physiological deficits. Brain studies are an especially promising area of research, particularly considering that more and more forms of psychiatric disturbance have been found to have such correlates as knowledge has increased.

Recent advances in brain-imaging (such as heat or blood flow mapping) permit research in conjunction with phallometric assessment of arousal patterns. Conceivably, future research in the area may show that personality features seen in pedophiles are a function of biochemical imbalance and may be ameliorated by medication.

Another area of research that is virtually a vacuum is the role cognitions may play in sexual interest in children. That pedophiles seem to have special cognitive distortions about children has been alluded to (Howells, 1981). They may also hold distorted views of adult females. While some of these may be the result of rationale for pedophilic behavior, they may also pre-exist this behavior and hence play a role in aetiology as well. We know essentially nothing of the cognitive attributes of pedophiles.

Finally, research on adolescent paraphiliacs needs immediate attention. We know that for some adolescents these behaviors are part of a temporary developmental disturbance, while for others they are not outgrown (Saunders et al., 1986). We cannot determine which individuals will continue such behaviors and what factors distinguish them from those who stop. Longitudinal studies of such adolescents would certainly contribute to better understanding. If prevention is the best cure, we must be capable of successfully treating these behaviors at their earliest appearance.

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Appendix A

Consent Form for Participation in Research

I, _____, herein state that I am a voluntary participant in the research being conducted by the McGill Forensic Psychiatry Clinic.

I certify that my participation as a subject in this study has been explained to me, and I am aware that it consists of paper and pencil testing to be followed by a short interview. I understand that my results will be kept absolutely confidential and cannot be communicated to either myself or a professional outside of the McGill Forensic Psychiatry Clinic without my written authorization.

Signature _____

Date _____

Witness _____

"THE MILLON CLINICAL MULTIAXIAL INVENTORY",
BY THEODORE MILLON.
INTERPRETIVE SCORING SYSTEMS,
NATIONAL COMPUTER SYSTEMS,
P.O. BOX 1294,
MINNEAPOLIS, MINNESOTA.
55440.

```
***** MILLON CLINICAL MULTIAXIAL INVENTORY ****    DSM-III REPORT     ***FOR PROFESSIONAL USE ONLY***
*
* NAME: SAMPLE       TM           M            VALID REPORT      WEIGHT FACTOR = -2          01/21/82  *
* CODED SUMMARY= 2 3 1 8 **- * 7 + - ≠ 6 4 5   //S **C * //A D H **//- //                              *
*                                                                                            001 0002  *
*******************************************************************************************************
* SCALES    * SCORE *                   PROFILE OF BR SCORES                  * DSM-III (MILLON) DIAGNOSIS*
*           *RAW  BR*               35      60         75        85        100                           *
*********+***+***+***+------------+-------+---------+---------+---------+****************************
*          ]1 ] 25] 98]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX ] SCHIZOID (ASOCIAL)          *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*          ]2 ] 31]109]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX AVOIDANT                    *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*   BASIC  ]3 ] 26]108]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX DEPENDENT (SUBMISSIVE)      *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*PERSNLTY  ]4 ]  3]  1]X           ]       ]         ]         ]         ] HISTRIONIC (GREGARIOUS)    *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*PATTERN   ]5 ]  4]  1]X           ]       ]         ]         ]         ] NARCISSISTIC               *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*          ]5 ]  3]  1]X           ]       ]         ]         ]         ] ANTISOCIAL (AGGRESSIVE)    *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*          ]7 ] 25] 60]XXXXXXXXXXXXXXXXXXXXX         ]         ]         ] COMPULSIVE (CONFORMING)    *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*          ]8 ] 18] 86]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         ] P. AGGRESSIVE (NEGATIVSTC) *
*********+***+***+***+------------+-------+---------+---------+---------+****************************
*PATHLGCL  ]S ] 37]104]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX SCHIZOTYPAL (SCHIZOID)      *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*PERSNLTY  ]C ] 28] 78]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      ]         ] BORDERLINE (CYCLOID)       *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*DISORDER  ]P ]  8] 36]XXXXXXXXXXXXX       ]         ]         ]         ] PARANOID                   *
*********+***+***+***+------------+-------+---------+---------+---------+****************************
*          ]A ] 28]110]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX ANXIETY                     *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*          ]H ] 27] 88]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       ] SOMATOFORM                 *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*          ]N ]  5] -2]X           ]       ]         ]         ]         ] HYPOMANIA                  *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*CLINICAL  ]D ] 29]105]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX DYSTHYMIA                   *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*SYNDROME  ]B ] 11] 64]XXXXXXXXXXXXXXXXXXXXXXX       ]         ]         ] ALCOHOL ABUSE              *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*          ]T ]  9] 23]XXXXXXXX    ]       ]         ]         ]         ] DRUG ABUSE                 *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*          ]SS] 17] 71]XXXXXXXXXXXXXXXXXXXXXXXXXXXX  ]         ]         ] PSYCHOTIC THINKING         *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*          ]CC] 15] 71]XXXXXXXXXXXXXXXXXXXXXXXXXXXX  ]         ]         ] PSYCHOTIC DEPRESSION       *
*          +--+---+---+------------+-------+---------+---------+---------+----------------------------*
*          ]PP]  7] 64]XXXXXXXXXXXXXXXXXXXXXXX       ]         ]         ] PSYCHOTIC DELUSION         *
*********+***+***+***+------------+-------+---------+---------+---------+****************************
```

NPI

[redacted] Date _____

Sex_____ Age _____ Education _____ Occupation _____

Instructions: The NPI consists of a number of pairs of statements with which you may or may not identify. Consider this example: A "I like having authority over people," versus B "I don't mind following orders." Which of these two statements is closer to your own feelings about yourself? If you identify more with "liking to have authority over other than people" than with not minding following orders", then you would choose option "A".

You may identify with both "A" and "B". In this case you should choose the statement which seems closer to your personal feelings about yourself. Or, if you do not identify with either statement, select the one which is least objectionable or remote. In other words, read each pair of statements and then choose the one that is closer to your own feelings. Indicate your answer by drawing a circle around the letter ("A" or "B") that precedes that statement. Do not skip any items.

1. A I am fairly sensitive person.
   B I am more sensitive than most other people.

2. A I have a natural talent for influencing people.
   B I am not good at influencing people.

3. A Modesty doesn't become me.
   B I am essentially a modest person.

4. A Superiority is something that you acquire with experience.
   B Superiority is something you are born with.

5. A I would do almost anything on a dare.
   B I tend to be a fairly cautious person.

6. A I would be willing to describe myself as a strong personality.
   B I would be reluctant to describe myself as a strong personality.

7. A When people compliment me I sometimes get embarassed.
   B I know that I am good because everybody keeps telling me so.

8. A The thought of ruling the world frightens the hell out of me.
   B If I ruled the world it would be a much better place.

9. A People just naturally gravitate towards me.
   B Some people like me.

10. A I can usually talk my way out of anything.
    B I try to accept the consequences of my behavior.

11. A When I play a game I don't mind losing once in a while.
    B When I play a game I hate to lose.

12. A I prefer to blend in with the crowd.
    B I like to be the center of attention.

13. A I will be a success.
    B I'm not too concerned about success.

14. A I am no better or no worse than most people.
    B I think I am a special person.

15. A I am not sure if I would make a good leader.
    B I see myself as a good leader.

16. A I am assertive.
    B I wish I were more assertive.

17. A I like having authority over other people.
    B I don't mind following orders.

18. A There is a lot that I can learn from other people.
    B People can learn a great deal from me.

19. A I find it easy to manipulate people.
    B I don't like it when I find myself manipulating people.

20. A I insist upon getting the respect that is due me.
    B I usually get the respect that I deserve.

21. A I don't particularly like to show off my body.
    B I like to display my body.

22. A I can read people like a book.
    B People are sometimes hard to understand.

23. A If I feel competent I am willing to take responsibility for making decisions.
    B I like to take the responsibility for making decisions.

24. A I am at my best when the situation is at its worst.
    B Sometimes I don't handle difficult situations too well.

25. A I just want to be reasonably happy.
    B I want to amount to something in the eyes of the world.

26. A My body is nothing special.
    B I like to look at my body.

27. A Beauty is in the eyes of the beholder.
    B I have good taste when it comes to beauty.

over

28. A I try not to be a show off.
B I am apt to show off if I get the chance.

29. A I always know what I am doing.
B Sometimes I'm not sure of what I am doing.

30. A I sometimes depend on people to get things done.
B I rarely depend on anyone else to get things done.

31. A I'm always in perfect health.
B Sometimes I get sick.

32. A Sometimes I tell good stories.
B Everybody likes to hear my stories.

33. A I usually dominate any conversation.
B At times I am capable of dominating a conversation.

34. A I expect a great deal from other people.
B I like to do things for other people.

35. A I will never be satisfied until I get all that I deserve.
B I take my satisfactions as they come.

36. A Compliments embarrass me.
B I like to be complimented.

37. A My basic responsibility is to be aware of the needs of others.
B My basic responsibility is to be aware of my own needs.

38. A I have a strong will to power.
B Power for its own sake doesn't interest me.

39. A I don't very much care about new fads and fashions.
B I like to start new fads and fashions.

40. A I am envious of other people's good fortune.
B I enjoy seeing other people have good fortune.

41. A I am loved because I am lovable.
B I am loved because I give love.

42. A I like to look at myself in the mirror.
B I am not particularly interested in looking at myself in the mirror.

43. A I am not especially witty or clever.
B I am witty and clever.

44. A I really like to be the center of attention.
B It makes me uncomfortable to be the center of attention.

45. A I can live my life in any way I want to.
B People can't always live their lives in terms of what they want.

46. A Being an authority doesn't mean that much

48. A I am going to be a great person.
B I hope I am going to be successful.

49. A People sometimes believe what I tell them.
B I can make anybody believe anything I want them to.

50. A I am a born leader.
B Leadership is a quality that takes a long time to develop.

51. A I wish someone would someday write my biography.
B I don't like people to pry into my life for any reason.

52. A I get upset when people don't notice how I look when I go out in public.
B I don't mind blending into the crowd when I go out in public.

53. A I am more capable than other people.
B There is a lot that I can learn from other people.

54. A I am much like everybody else.
B I am an extraordinary person.

Appendix E

Questionnaire

Data	Coding	Column Number
1) Name _____		1-2
2) I. D. Number		
3) Card Number		3-4
4) Language anglo...1 franc...2 other...3		5
5) Status in treatment....1 at assessment...2 post-treatment..3		6
6) Age 16-21...1 41-45...6 21-25...2 46-50...7 26-30...3 51-55...8 31-35...4 56-60...9 36-40...5 60+....10		7-8
7) Ed. Level primary.....1 secondary...2 some university..3 university+..4		9
8) Profession unskilled.....1 semi-skilled..2 skilled.....3 professional..4		10
9) Viewing all clinical offenses, is this person: homo ped.....1 hetero.....2 undiff.....3		11
10) Has he been in treatment for pedophilic behavior before? yes.....1 no.....2 other (not ped)....3		12
11) For how long? years_____ months_____		13-16

Data	Coding	Column Number
12) Of what type?* indiv. psy. ther.....1 behavioral.....2 group.....3 chemical (hormones).4 * If more than one of the above, enter appropriate numbers.		17-21
13) Has he been in prison for a related offense? yes..... 1 no..... 2 Charge _____		22
14) If yes, length of sentence: years_____ months_____		23-26
15) When did he first feel attracted to a child? before age 12.....1 13-16.....2 17-21.....3 31-40.....5 41-50.....6 50+.....7		27
16) How many legal offenses does he have? * none.....0 one.....1 2-3.....2 4-5.....3 5+.....5 * 2 offenses, within the same episode counts as one.		28
17) How many uncharged (clinical) offenses has he committed? one.....1 2-3.....2 4-5.....3 5+.....4		29

Data	Coding	Column Number
18) Age of Child (last offense): 0-3.....1 4-6.....2 7-9.....3 10-12.....4 13-15.....5		30
19) Was the child: - unknown to you before offense....1 - familiar by sight only.....2 - known slightly (spoken before)...3 - well known to you (spent time together, was relative, baby-sitting, etc.).....4		31
20) Were you "in love" with this child? (Emotionally attached to) yes.....1 no.....2		32
21) How long did this relationship last? - only one time (during offense)...1 - a few days.....2 - a few weeks.....3 - several months.....4 - one year.....5 - more than one year.....6		33
22) What type of sexual activity did he engage in? (actually happened) fondling, touching.....1 masturbation.....2 intercourse.....3 oral sex.....4 anal intercourse.....5 all of the above.....6		34-35
23) What type of sexual activity would he like to engage in? (in fantasy, w/o limits) fondling, touching.....1 masturbation.....2 intercourse.....3 oral sex.....4 anal intercourse.....5 all of the above.....6		36-37

Data	Coding	Column Numbe
24) Did you view this child as consenting and/or enjoying this sexual activity? yes.....1 no.....2 not sure...3		38
25) Did you have to bribe or trick this child to agree to engage in sexual activity? (buy presents, give money, etc.) yes.....1 no.....2		39
26) Did you ever use physical force with this child? yes.....1 no.....2		40
27) With other children? yes.....1 no.....2		41
28) Was he sexually abused as a child? (excluding incest) yes.....1 no.....2		42
29) Did incest occur in his family? (Patient or other as victim) yes.....1 no.....2		43
30) Is there anything you would like to add or comment on that we have not asked? (patient or therapist)		
31) Interviewer's Comments:		

APPENDIX F

Table 35

Millon Clinical Multiaxial Inventory

Table of Means, Standard Deviations, and Significance

French and English Subjects

(N = 18)

Variables	TOTAL		French		English		df	F	p
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD			
Schizoid	63.77	20.53	62.46	21.19	67.20	20.59	1	0.183	.6745
Avoidant	74.77	20.32	73.76	20.79	77.40	21.13	1	0.109	.7454
Dependent	74.05	25.32	71.38	28.63	81.00	13.47	1	0.505	.4873
Histrionic	56.16	20.15	57.15	22.17	53.60	15.50	1	0.106	.7486
Narcissistic	61.77	18.07	58.46	19.28	70.40	11.97	1	1.635	.2192
Anti-Social	62.50	25.01	61.53	25.98	65.00	24.98	1	0.065	.8015
Compulsive	48.61	17.38	48.46	16.52	49.00	21.55	1	0.003	.9552
Pass./Agg.	68.72	20.45	67.30	19.12	72.40	25.61	1	0.213	.6502
Schizotypal	59.66	09.41	60.23	10.01	58.20	08.49	1	0.159	.6948
Borderline	61.61	11.37	64.40	12.07	60.53	11.40	1	0.401	.5351
Paranoid	67.44	15.50	64.00	13.78	76.40	17.70	1	2.514	.1324
Anxiety	73.05	25.07	71.30	26.42	77.60	23.26	1	0.217	.6476
Somatoform	64.61	15.28	63.69	16.46	67.00	13.05	1	0.160	.6939
Hypomanic	58.61	28.14	56.15	32.88	65.00	07.17	1	0.342	.5663
Dysthymic	70.55	17.65	72.07	16.18	66.60	22.63	1	0.333	.5715
Alcohol Abuse	61.44	16.13	63.92	16.15	55.00	14.71	1	1.112	.3073
Drug Abuse	70.94	17.50	71.61	20.45	69.20	06.41	1	0.065	.8020
Psychotic Thinking	63.77	05.81	63.46	06.75	64.60	02.40	1	0.131	.7219
Psychotic Depression	59.11	05.05	58.23	03.63	61.40	07.73	1	1.459	.2445
Psychotic Delusions	66.44	13.51	64.46	12.64	71.60	15.83	1	1.007	.3305

A French language version of the MCMI was developed for use in this research. The small number of subjects in the sample did not allow a more refined analysis of the validity of the translated version. The table above does show that no significant differences were found in the subscale elevations of the French and English groups. Further, French subjects were asked if they had any difficulty with any part of the test; subjects did not express problems.