Insecure Parental Attachment in Pedophiles: A New Treatment Study Focusing on Intertwining Cognitive-Behavioral Therapy with Interpersonal Psychotherapy

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Abstract

This proposal focuses on demonstrating a correlation between attachment deficits and pedophilia that has been neglected in the research to date. Prior research shows that there is a link between insecure parental attachment and individuals diagnosed with pedophilia, which can be an indicator of inappropriate relationships in adulthood such as romantic relations with a child. Fifty incarcerated males who have been convicted of any sexual act involving a minor will be randomly assigned to either the standard cognitive-behavioral treatment (CBT) or CBT and interpersonal psychotherapy. They will be assessed pre- and post-treatment and over a period of 10 years. It is hypothesized that the group who receives CBT and interpersonal psychotherapy will demonstrate lower levels of recidivism than the group with the standard CBT treatment. The implications of this research study would update and correct the flaws in the current sex offender treatment being used across the country, as well as state or federal policies regarding sexual offender treatment.

Insecure Parental Attachment in Pedophiles

A study of 453 pedophiles showed that these offenders had collectively molested over 67,000 children, about 148 children per pedophile (Abel & Osborn, 1992). Statistics like this demonstrate a need for research regarding how to treat these individuals and reduce their rate of offending. This literature review will focus on pedophilia and will explore the literature regarding the etiology of pedophilia, treatment strategies, and risk of reoffending within this population. The proposal will conclude by hypothesizing that pedophilia is largely influenced from attachment deficits during childhood and an effective strategy to treat pedophilic offenders is to use a treatment method that specifically addresses attachment deficits.

Child Sexual Offenders versus Pedophiles

There is a vast difference between child sex offenders and pedophiles. Child sexual offender is a legal term that refers to anyone who has committed a sexual act involving a child, which covers a broad range of behaviors (Canter, Hughes, & Kirby, 1998). A child sexual offender may have no direct desire or love for children, but instead has a general lack of regard for others' feelings and rights, or has other motivations for their sexual offending (Canter et al., 1998).

Sexual offenders in this category are commonly called "criminal-opportunists" or "situational molesters" because they regularly exhibit antisocial behavior while engaging in many different types of crimes. Typically, child sexual offenders molest children because of their availability or because of a lack of available age-appropriate adults. These offenders may use their victims solely to gratify their sexual desires, whether the

victim is an adult or a child (Briken, Hill, & Berner, 2007; Canter et al., 1998; Seto, 2008).

In contrast, pedophilia is strictly a psychological term. The *DSM-IV-TR* defines pedophilia as recurrent sexual fantasies, urges, and/or behaviors that involve sexual activity with a prepubescent child, as well as if the individual has acted on these fantasies or urges (American Psychiatric Association, 2000). These intense, recurring sexual fantasies last over a period of at least six months and the pedophile must be at least 16 years old and at least 5 years older than the child victim (*DSM-IV-TR*, 2000). However, there is also the possibility that an individual diagnosed with pedophilia can also be legally classified as a child sexual offender after engaging in pedophilic illegal behavior and being convicted.

Theories on the Etiology of Pedophilia

Past childhood sexual trauma. One of the most common etiological theories of pedophilia is that most pedophiles have had some sort of childhood or past sexual trauma that they experienced or witnessed that can be related to their diagnosis (Briken et al., 2007; Ricci & Clayton, 2008). One study by Harvard Medical School stated that out of 200 incarcerated pedophiles, 12% had reported experience with some sexual abuse as children ("Pedophilia," 2004). Researchers theorize that the trauma of being sexually abused or witnessing sexual abuse during childhood creates a sense of loss of control in the victim; thus, the victim begins sexually offending during adulthood as a way of taking back control (Ricci & Clayton, 2008). Finkelhor and Araji (1986) suggest that the

pedophile may see himself[1] in the child, and by acting as the aggressor that once victimized him, he is overcoming the feelings of powerlessness or shame that he felt when he was a child (Briken et al., 2007).

Another possibility regarding victim-turned-perpetrator scenarios is that pedophiles use sex as a coping mechanism because of the trauma experienced during their own childhood sexual abuse, meaning that he is projecting his own emotional pain onto his victim(s) (Marshall & Marshall, 2000). Studies have shown that one in six male children who were victims of abuse will go on to repeat the cycle and commit sexual and/or violent acts when they grow up and about 80% of sexual offenders report having been abused during childhood (Craissati, McClurg, & Browne, 2002; Knight & Sims-Knight, 2004). This leads some researchers to theorize that this abuse is the causal factor as to why the victims became predators themselves.

Glasser et al. (2001) studied 747 male psychiatric patients in an outpatient psychotherapeutic service for sexually deviant individuals and offenders and discovered that 35% of the sexual offenders have been abused and 11% of the non-offenders had been abused. Similarly, Salter et al. (2003) studied 224 male sexual abuse victims for 7 to 19 years. They discovered that 12% of the 224 victims ended up becoming sexual offenders themselves (Salter et al., 2003). Although these two studies show that there are child sexual offenders who were victimized in their youth, they also show a large percentage of child sexual offenders who were not victimized. Additionally, the studies discussed do not focus specifically on pedophilia separate from sexual offending as a

[1] Although this research proposal does recognize that both men and/or women can be diagnosed with pedophilia, the male pronouns will mostly be used for the remainder of the proposal due to the fact that the overwhelming majority of pedophiles have proven to be men.

whole. This is a limitation to the studies because it is difficult to identify the extent to which these results apply specifically to pedophiles, since the study failed to separate the two populations of perpetrators.

Freund, Watson, and Dickey (1990) examined the retrospective self-reports of 344 pedophiles, non-pedophilic sexual offenders, and non-offenders. Freund et al. (1990) found that the self-reports showed that it is very likely that pedophiles, compared to the other groups, do not accurately report abuse in their own childhood and may possibly exaggerate it because they perceive that this justifies their behavior. Although some studies (e.g., Craissati, McClurg, & Browne, 2002; Finkelhor and Araji, 1986; Knight & Sims-Knight, 2004; Ricci & Clayton, 2008) indicate that a large number of offenders have been sexually victimized during childhood, research (Freund et al., 1990) also indicates that some offenders may be lying regarding prior victimization and that many offenders have never been victimized at all (James, 2006). This suggests that prior sexual victimization does not explain the sexual victimization of children for all offenders, and that other factors may be contributing to the characteristics associated with those who offend against children.

Neurological, biological, and developmental theories. The next theory to be discussed is that pedophilia is due to neurological (brain functioning), biological (physical functioning), or developmental (the standard benchmarks for growth throughout one's life) factors. This theory is very popular because if pedophilia can be explained by a defect in the brain, then it stands to reason that its underlying cause could be treated by a medical intervention (Seto, 2008).

Researchers who support this theory argue that pedophilia is a physical ailment or symptom that the individual does not choose to participate in, but rather experiences due to neurological or developmental problems (Beech & Mitchell, 2005). The University of Toronto conducted a study (as cited in Briken et al., 2007) that compared the medical histories of 400 pedophiles to the medical histories of 800 non-pedophiles and found that the pedophiles had an increased likelihood of experiencing accidents causing them to lose consciousness before the age of six. Similarly, another study conducted by Blanchard et al. (2003) examined 685 pedophilic psychiatric patients using phallometric tests, neuropsychological tests, and interviews regarding head injuries experienced to collect their data. Results were parallel to the University of Toronto's study, indicating that pedophiles more commonly experienced head injuries before turning 13 years old than did non-pedophiles, suggesting that neurological damage sustained due to injury may increase the likelihood of developing pedophilia (Blanchard et al., 2003). A study by Bremner (2008) suggests that any type of abuse during childhood can result in neurological damage, causing damage such as lesions on the prefrontal cortex of the brain. The result of this damage may be the inability to properly regulate or interpret emotions making it hard to have relationships with functioning adults (Bremner, 2008). Another theory suggests that low intelligence has occasionally been identified for causing pedophilia (Seto, 2004).

Developmental or neurological issues could also impact an individual's brain development regarding sexual desires, impulsivity, and judgment creating pedophilic urges or ideas ("Pedophilia," 2004). Researchers who argue these theories often use case studies, which only show a possible link to pedophilia rather than a direct cause (e.g.

Bremner, 2004; Briken et. al, 2007). These studies also do not address the majority of individuals with brain injuries, developmental disabilities, or lower intelligence that never develop sexually deviant desires or behaviors. This is because these studies commonly use individual case studies or small samples, rather than a larger population, which means the results are unreliable because one cannot generalize information obtained from case studies to an entire population accurately.

Conditioning. A third theory into the etiology of pedophilia is that pedophilia develops through the act of conditioning due to pornography, masturbation, early sexualization, or other methods of sexual conditioning (Finkelhor & Araji, 1986). According to this theory, pedophiles develop their preference for children through associating children with sexual desires and/or fulfillment. One way this happens is that when individuals are sexually abused as children, they are watching an adult who is stimulated sexually by children. This could lead to the victims associating sexual arousal with children (Finkelhor & Araji, 1986). If a prepubescent individual has their first consensual and pleasurable sexual experience with a prepubescent peer, then it is possible that the individual will always associate sexual excitement with prepubescent children (Finkelhor & Araji, 1986). Perhaps, for some reason, they have become emotionally blocked from moving on in their fantasies as they age (Finkelhor & Araji, 1986). The critique of this theory is that early sexualization might strengthen the already present attraction to children, but does not necessarily indicate how pedophilia was developed.

Another aspect of conditioning involves masturbation. When an individual has pedophilic fantasies during masturbation, the association between pedophilic fantasies and sexual arousal/gratification is strengthened. After the association has been

strengthened through this repetition of masturbation, the individual may want to act out his fantasies in order to gratify his desires (Marshall & Marshall, 2000; Quayle & Taylor, 2003). As with the aforementioned theory by Finkelhor and Araji (1986), this theory does not explain why the individual originally used pedophilic fantasies during masturbation, furthering support for the possibility that conditioning strengthens the pedophilic fantasies rather than causes it.

Attachment Theory. The final theory to be discussed regarding the possible etiological causes of pedophilia is the prevalence among pedophiles to have an insecure attachment with their parents. Sawle and Kear-Colwell (2001) demonstrated that pedophiles displayed higher percentages of insecure parental attachment as compared to both sexual abuse victims and those who were neither sexual abuse victims nor perpetrators. The pedophiles were usually classified as anxious-ambivalent or avoidant attachment styles. These styles mean that the pedophile have difficulty cultivating relationships with peers due to the type of attachment he had with his parents (Baker, Beech, & Tyson, 2006; Bogaerts, Declercq, Vanheule, & Palmans, 2005). Many pedophiles may be incapable of creating secure attachments with friends and are less likely to become intimate with other people compared to non-pedophiles who are capable of creating secure attachments (Bogaerts, Vanheule, & Declercq, 2005).

Many studies have indicated that sexual offenders reported high levels of neglect, rejection, and little to no warmth from their parents, as well as low levels of supervision, discipline, and consistency (Bogaerts et al., 2005; Craissati et al., 2002; Marshall & Marshall, 2000; McCormack, Hudson, & Ward, 2002). Additionally, these studies indicated that pedophiles have a much higher rate of insecure attachments in both

childhood and adulthood when compared to non-pedophilic control groups (Bogaerts et al., 2005). Further support for attachment theory is found in a study conducted by Hudson and Ward (2000). This study found that child molesters reported high rates of self-reliance, rather than reciprocal sharing and dependence with their mothers, meaning they felt unable to intimately and emotionally share with their mother (Hudson & Ward, 2000). Other studies run parallel to these findings, many stating that child molesters are more likely to be insecurely attached than other sexual offenders and non-offenders (e.g. Craissati et al., 2002; Hudson & Ward, 2000). These studies provide support for the theory that a pedophile's lack of parental warmth or attachment can be an important factor in why they developed pedophilia and why they are unable to form age-appropriate relationships.

These insecure attachments can lead the pedophile to have low self-esteem and struggle with relationships (Seto, 2008). According to McCormack et al. (2002): "child molesters have a tendency toward fearful and preoccupied attachment styles, both characterized by negative views of the self…child molesters tend to view themselves in a self-deprecating manner" (p.91). McCormack et al. (2002) goes on to argue that a pedophile's negative evaluations about himself are a likely cause for the common lack of age-appropriate relationships and friendships as an adult. Sometimes these negative evaluations of oneself also lead to a lack of ability to trust, be intimate, and engage in appropriate intimate and platonic relationships, causing a higher likelihood of interest in children (Bogaerts et al., 2005).

This experience with detachment can lead a child to grow up without knowing how to connect with people in appropriate and healthy relationships (Bogaerts et al.,

2005; Marshall, Serran, & Cortoni, 2000). Hudson and Ward (2000) mention that this difficulty to create relationships can influence other relationships in an individual's life, such as peer relationships. They reported pedophiles to have few, if any, friends growing up. Similarly, Furnham and Haraldsen (1998) showed that early childhood relationships with peers were a leading factor in the cause of pedophilia and that there was a clear link between pedophilia and issues regarding intimacy and attachment. They argued further that directly focusing on these causes in treatment might be the most effective means to reduce recidivism and should be further studied (Furnham & Haraldsen, 1998; Kear-Colwell & Boer, 2000). Baker, Beech, and Tyson (2006) state that attachment problems can cause the individual to create cognitive distortions that he is unable to distinguish from reality. These distortions make it difficult for them to create age-appropriate, intimate relationships and lead them to develop fantasies and create relationships with inappropriate persons (Baker et al., 2006). This asocial lifestyle is a very common trait in sexual offenders who are emotionally detached from others (Knight & Sims-Knight, 2004).

These results suggest that having insecure attachments make a child more vulnerable to being sexually assaulted or abused, which in turn leads the child to an earlier awareness of sexuality (Finkelhor & Araji, 1986). This early sexualization leads to higher and earlier rates of masturbation, which, when paired with fantasies of younger children and violent acts, increases the likelihood that the child will age to become a pedophile (Marshall & Marshall, 2000). Although the research between attachment and pedophilia is correlational, it emphasizes the importance attachment may have in the etiology of this diagnosis.

Risk and Recidivism in Pedophilia

Risk is the probability that a pedophile is likely to reoffend, whereas recidivism is the actual act of reoffending (Vrieze & Grove, 2010). Risk can be assessed by several different measures, depending on the researchers (Hall & Hall, 2007; Seto, 2008). For example, Seto (2008) described using a pedophile's criminal history to predict his risk in the future or other instruments like testing the level of sexual arousal to pictures of children. These instruments and assessments allow the researcher to estimate the likelihood of the pedophile reoffending.

Marshall, Jones, Ward, Johnston, and Barbaree (1991) state that clarifying the type of sexual offender is extremely important when calculating risk. Similarly, a study of 400 male participants by Greenberg, Bradford, Firestone, and Curry (2000) found that a pedophile's relationship to his victims was extremely important when assessing risk. They argued that the child molesters who were daily acquainted with, but not related to, children were more likely to reoffend than an incest child molester. Examining the sexual offender's history with the victim, or characteristics of the victim, is an important aspect to acknowledge when attempting to assess the pedophile's risk of reoffense.

In addition to identifying the offender's history and its role in his risk of reoffense, the researcher must also identify the most accurate estimate of recidivism. There is some variation regarding how to correctly calculate rates of recidivism and risk among researchers in the psychological field. Hall and Hall (2007) argue that this field lacks longitudinal research, where a pedophile is followed for many years and the researchers record whether he reoffends over that time period. Most studies only follow the offender during treatment or sometimes for a short period of time afterwards

(Bogaerts, Vanheule, & Desmet, 2006; Cohen & Galynker, 2002; Hall & Hall, 2007). Scalora and Garbin's (2003) study of 194 child molesters undergoing cognitive behavioral therapy discovered that the length of time of follow up after treatment could be a factor when estimating risk, because the researchers only followed up for around 4-5 years in their study. At this 4-5 year mark, almost 25% of the child molesters had reoffended. If followed for longer, the chances of this percentage being higher are likely (Scalora & Garbin, 2003). For example, if the offender reoffended seven years following treatment, it would not be recorded, leading to the false conclusion that the level of recidivism for this study was lower than what it actually was.

Hanson (2002) conducted a study on recidivism and age in sexual offenders. He was looking for any difference in sexual offending behavior across different ages, ranging from adolescence to elderly. Instead of taking a small sample of offenders and following them after prison to see if they offended less as they aged, he took a large sample of offenders at varying ages and compared them to each other (Hanson, 2002). His results showed that extrafamilial child molesters showed little to no reduction in recidivism until they reached 50 years old, compared to other groups of sexual offenders who shows quicker rates of reduction with age (Hanson, 2002). Similarly to the aforementioned study by Marshall et al. (1991), recidivism rates can vary by the type of offender, therefore these factors need to be accounted for when assessing risk of reoffense.

Other problems with calculating risk and tracking recidivism are that not all studies use the same measurements. Therefore, when self-reports are used to show recidivism rates, there could be inaccuracies because the offender could provide

inaccurate information (Grubin, 2008; Hall & Hall, 2007). Criminal reports could also be inaccurate because the pedophile may have committed other crimes but has not been caught. Both of these possible ways of keeping track of recidivism could result in inaccurate recidivism estimates.

Instruments used for risk and recidivism. Risk of reoffending can be measured different ways, but one of the most common measures is the *Static-2002* (Hanson & Thornton, 2000). The *Static-2002* assigns a raw score to the sexual offender to measure his risk of reoffending (Hanson & Thornton, 2000). It is heavily supported in the psychological community as being one of the most specific assessment instruments to address sexual risk (Doren, 2002). Law enforcement agencies, like the Texas Department of Criminal Justice, use this coding to determine the risk of an offender placed on probation and as a tool to inform the community about the level of risk of recidivism regarding that offender ("Texas Code of Criminal Procedure," 2006). The strength of this instrument is that it can be used on any type of male sexual offender, and that it shows the likely outcome of recidivism after release due to the offender's criminal history.

However, there are some limitations to this instrument. For example, it relies on static factors, or factors that do not change over time, which does not address any possible changes in the offender's life or habits. Also, assigning a number to an individual does not always accurately predict how they will behave because human beings are unpredictable and constantly changing (Coxe & Holmes, 2009). A coded form of static variables does not account for emotional variability and cognitive distortions in

the sexual offender (Coxe & Holmes, 2009). However, research still presents this instrument to be one of the best and most accurate measures of recidivism (Doren, 2002).

The *Abel Assessment of Sexual Interest* (*AASI*) has been used with pedophiles and has been shown to accurately differentiate between non-pedophiles and pedophiles (Abel, Jordan, Hand, Holland, & Phipps, 2001). In a study of 747 participants, the *AASI* was able to accurately differentiate admitted pedophiles and non-pedophiles (Abel et al. 2001). In another study of 57 incarcerated offenders, the *AASI* use of visual reaction time to photographs of different genders and ages clearly identified the pedophiles and their preferences compared to the penile plethysmograph, which is an instrument that measures penile growth in response to sexual thoughts (Letourneau, 2002). Compared to the penile plethysmograph, which is very invasive and requires particular tools and skills, the *AASI* is much quicker, easier to administer, and less invasive. The result of this is that the *AASI* has much fewer, if any, ethical concerns compared to the penile plethysmograph. Also, the *AASI* is currently one of the most accurate detectors of faking in pedophiles (Kalmus & Beech, 2005). The results of the *AASI* have been accepted as reliable evidence in several court cases to date (Coxe & Holmes, 2009).

There have been many risk instruments developed over the last few decades that compete with the *Static-2002* and the *AASI* (Abel et al., 2001; Hanson & Thornton, 2000), but this proposal specifically focuses on these two due to their consistency and strength. The *Static-2002* has proven valid and constant, giving reliable risk data for many previous studies (Hanson & Thornton, 2000). The *AASI* is not only consistent, but it also is able to be more accurate than other tests while also being unobtrusive and simple to administer (Abel et al., 2001).

Treatment of Sexual Offending

Treatment methods tend to focus on reducing sexual recidivism rates, however, most methods focus dually on factors other than sexual offending, like treating the pedophile's mental, emotional, interpersonal, psychological, or developmental problems. Kear-Colwell and Boer (2000) mention that results with today's treatments are much better and much more positive than what the recidivism rates were thought to be 20 years ago. Some examples of treatment methods that will be reviewed in the following section are medication used to manage emotional states or lower libido, reconditioning methods, and cognitive-behavioral therapy (CBT).

Medication. Medications are used on sexual offenders for several different purposes. Some medications are used to treat depression or anxiety in offenders but have the side effect of diminished libido. Other medications are meant to solely inhibit the hormones that produce testosterone. A common medication used is Depo-Provera (Medroxyprogesterone), a female birth control medication. When taken by a man, the medication prevents the production of certain hormones from the pituitary gland. This causes a stop in the production of testosterone by the testes. Some other anti-androgen drugs include Leuprolide Acetate, Triptorelin, Cyproterone Acetate, Androcur, and Tamoxifen ("Pedophilia," 2004). Anti-androgens are specifically designed to block specific hormones in order to stop the production of testosterone, lower libido, block androgen receptors in the body, and/or over stimulate the hypothalamus which reduces testosterone levels significantly (Seto, 2008).

Beech and Mitchell (2005) discuss the use of selective serotonin reuptake inhibitors (SSRIs) to help sexual offenders with mood disorders as well as to help

improve their interpersonal skills. SSRIs are commonly taken by individuals struggling with depression, anxiety, and other mood disorders; however, for a sexual offender, these drugs help to encourage appropriate social behavior by reducing the anxiety or other psychological problems that have blocked them from appropriate social attachments in the past (Beech & Mitchell, 2005; Seto, 2008; Stermac & Hucker, 1988). As well as the benefit of the SSRI helping with mood disorders and anxiety, it has the side effect of diminished libido which aids in sexual offender treatment by lessening the offender's physical drive to reoffend sexually (Seto, 2008).

Although some research has shown that medication can be an effective tool in sexual offender treatment, it does have its limitations. Medications can be controversial because many physicians won't prescribe it because of the side effects as well as the ethics regarding forced medications (Seto, 2008). Also, there is a limited amount of research regarding SSRIs with sexual offenders because most of the studies done are case studies, making it impractical to assume that this treatment is applicable to the larger population of pedophiles (Beech & Mitchell, 2005).

Reconditioning methods. Reconditioning methods decrease the association between arousal and children and increase the association between arousal and age-appropriate persons. Some methods for this are aversion therapy and discrimination therapy ("Pedophilia," 2004). Aversion therapy takes a negative unconditioned reinforcer, like electric shock, and follows it with a conditioned stimulus, like an image of a child (Seto, 2008). The point of this treatment is to condition the pedophile to associate negative consequences with becoming sexually aroused in response to children. Usually following aversion therapy is discriminative conditioning in which a sexual

photo of an adult is shown with positive consequences or a lack of negative stimulus (Seto, 2008). The point of discriminative conditioning is to associate positive rewards to an attraction to age-appropriate adults.

Another therapy that is used in reconditioning is orgasmic reconditioning which is meant to teach the pedophile to associate climax and ejaculations with age-appropriate sexual fantasies, hoping to reduce the sexual interest in children (VanDeventer & Laws, 1978). This can be done in several ways, including using sexual imagery and fantasies of age-appropriate adults during climax.

These therapies are meant to help the offender associate negative consequences with sexualized thoughts towards children. The flaw, however, is that reconditioning only addresses the behavior and not the cognitive distortions or causal reasons that spurred the behaviors initially. It also can be extremely invasive and sometimes cause unintended harm to the participant, like loss of libido or sexual confusion (VanDeventer & Laws, 1978). It also has often been researched through case studies, so the amount of research in the field is limited.

Cognitive-behavioral therapy. One of the most common approaches to treating sexual offending and pedophilia is cognitive-behavioral therapy (CBT). CBT combines behavioral approaches, such as reconditioning, with cognitive restructuring to attempt to change the thought process of pedophilic urges. Therapists might ask the individual diagnosed with pedophilia to explain his sexual offending and then the therapist will help him to identify the distorted thoughts (thoughts/attitudes that deviate markedly with reality; “Pedophilia,” 2004). For example, thinking that entering into a sexual relationship with a minor is acceptable is a distorted cognition that a sexual offender

could report (Craske, 2010). The reason the individual sexually offends and commits sexually deviant behaviors is that he/she is operating under these types of cognitive distortions (Craske, 2010). CBT then tries to get to the root of the behavior by examining his underlying thought processes and trying to change them, so that in turn, the behavior will change as well (Craske, 2010).

CBT uses a variety of techniques and is done slightly differently by each therapist, but contains methods such as social skills, assertiveness, coping skills training, victim empathy training, externalization (learning how the offending individual's actions look and feel to the child), relapse prevention (continual therapy and use of techniques to avoid tempting situations throughout life), identifying and restructuring cognitive distortions, and being aware of the cognitive influence on his behaviors (Abel, Rouleau, & Cunningham-Rathner, 1986; "Pedophilia," 2004; Seto, 2008; Stermac & Hucker, 1988). Treatment methods, such as CBT, are thought to work best with pedophiles because it involves the rehabilitation of the offender as a whole, not just the cessation of the deviant behavior (Hall & Hall, 2007; Marshall et al., 1991; Stermac & Hucker, 1988).

Lowering the risk, or rate of reoffending, is the goal for most treatment methods (Hall & Hall, 2007). CBT is often combined with relapse prevention treatment, which specifically addresses these risk situations and how best the offender can cope when confronted with them (Stermac & Hucker, 1988). The therapist and offender discuss possible risk situations and the best coping methods to use for that particular offender in each scenario to strengthen the offender's feeling of self-control if he ends up in that scenario (Pithers, Marques, Gibat, and Marlatt, 1983; Stermac & Hucker, 1988). Relapse

prevention helps the offender to identify strategies in which he can use to avoid sexually deviant behaviors in high-risk situations (Kear-Colwell & Boer, 2000).

CBT is one of the most popular approaches because it has been shown to help reduce recidivism rates thanks to the interventions it incorporates (Camilleri & Quinsey, 2008; Enright, 1989; Furnham & Haraldsen, 1998; Kear-Colwell & Boer, 2000). A study by Harkins and Beech (2008) examined 73 male sexual offenders undergoing CBT and determined that their level of risk was reduced after treatment. This study even compared child molesters and rapists both undergoing CBT to see if there was a difference in improvement, but results were not significantly different (Harkins & Beech, 2008).

CBT is specifically useful with patients dealing with attachment and interpersonal difficulties because it incorporates relationship building as well as confronting cognitive distortions- unrealistic thoughts (Furnham & Haraldsen, 1998). As mentioned in the previous section, insecure parental attachment is thought to be strongly associated with pedophilia and therefore, having a treatment method that can work to address these issues together is extremely important. However, Kear-Colwell and Boer (2000) argue that more of a focus is needed on this background in the client's life of issues, such as interpersonal difficulties. They state that the offender needs to fully understand how his history influences his current cognitive distortions and deviant behaviors (Kear-Colwell & Boer, 2000).

Interpersonal psychotherapy. Although CBT touches on the interpersonal difficulties that the offender struggles with, it doesn't focus as strongly on interpersonal skills training for age-appropriate relationships (Kear-Colwell & Boer, 2000). It has been clearly shown that interpersonal skills and past insecure parental attachment have a strong

influence on the offender's current state and behaviors (Horowitz et al., 1993). Interpersonal psychotherapy is a treatment style that specifically focuses on attachment problems, current and past relationships, and interpersonal skills (Weissman, Markowitz, & Klerman, 2000). Weissman et al. (2000) state that "interpersonal psychotherapy is a focused, time-limited psychotherapy that emphasizes the link between mood and the current interpersonal relations of the [patient]…" (p. 4).

Earlier studies have shown that specific interpersonal problems are associated with different attachment styles (Horowitz, Rosenberg, & Bartholomew, 1993). Horowitz et al. (1993) created a model called the *Inventory of Interpersonal Problems* that classified insecure attachment (also known as fearful-avoidant attachment) as being characteristically highly introverted, subassertive, and exploitable. They continued to describe individuals with this type of attachment classification to have low sense of self worth and a lack of faith in others. Horowitz et al. (1993) believed that these qualities made individuals with insecure attachment less likely to actively pursue appropriate relationships with others due to fear of rejection. Interpersonal psychotherapy and interpersonal skills training specifically target these cognitive distortions, like lowered self-esteem and extreme introversion to the point of influencing one's lifestyle, by teaching methods of building stronger relationships with age-appropriate partners and family as well as addressing the reasoning behind the attachment deficiencies.

Crits-Christoph, Gibbons, Temes, Elkin, and Gallop (2010) studied interpersonal psychotherapy versus cognitive behavioral therapy on 72 patients who were struggling with major depressive disorder. Results showed that participants who were receiving interpersonal psychotherapy showed outcomes of establishing stronger relationships and

the lessening of depressive symptoms compared to the CBT group (Crits-Christoph et al., 2010). Although this study did not focus on sexual offenders, but it does suggest that interpersonal therapy could address shared issues, such as social attachment.

Research Proposal

There is a neglected area in the research literature regarding insecure parental attachment in relation to pedophilia. Attachment issues have been shown to have a significant effect on future relationships (Bogaerts et al., 2005; Marshall, Serran, & Cortoni, 2000), so this proposal states that by addressing these deficiencies in pedophiles, it will help to create age-appropriate relationships instead of pedophilic behavior. CBT is a common sexual offender treatment but it lacks the aspects of interpersonal psychotherapy that directly address this deficit of attachment in pedophiles. By combining these two treatment methods and uniquely targeting attachment deficits in pedophiles, this proposal hopes to demonstrate that the use of interpersonal psychotherapy and CBT therapy will result in lower recidivism rates and enhanced interpersonal skills and age-appropriate relationships than CBT therapy alone.

Method

Participants

Participants will be 50 incarcerated male offenders who have been convicted of any sexual act involving a minor, soliciting a minor, possession of child pornography, and/or meet diagnostic criteria for pedophilia. Participants will only be selected to be part of this study if their victim(s) were under the age of 13 years old at the time of the crime to be consistent with the *DSM-IV-TR* diagnostic criteria for pedophilia (*DSM-IV-TR*, 2000). All of the participants will be male even though this study does acknowledge that pedophilia can be found in females as well. This study will not focus on juvenile sexual offenders; therefore, only offenders over the age of 18 years old will be allowed to participate.

Instruments

Static-2002. The *Static-2002* is a common tool used with sexual offenders for measuring recidivism (Doren, 2002; Hanson & Thornton, 2000). It examines the following characteristics of the offender: age at release from a criminal institution, persistence of sexual offending (prior sentencing occasions for sexual offences, juvenile sexual offence arrests, and rate of sexual offending), deviant sexual interests (non-contact sexual offences, gender of victim, age and relation to victim), relationship to victims (stranger, family, or other relation), and general criminal records (any record in criminal justice system, prior sentencing for anything, community supervision violations, years between re-offending, prior non-sexual violence sentences). Each of the items is coded with a specific score that can range from 0-3 and then tallied to create a total score that indicates the likelihood of re-offending. The total score is then interpreted as: 0-2 is low

risk, 3-4 is low to moderate risk, 5-6 is moderate risk, 7-8 is moderate to high risk, and over 9 is high risk. Since this instrument classifies the participant's risk based on each participant's past record and interests, the *Static-2002* will only be administered once at the start of treatment (Hanson & Thornton, 2000).

Abel Assessment of Sexual Interest. The second assessment tool that will be utilized is the *Abel Assessment of Sexual Interest* (*AASI*), created by Gene Abel (Abel et al., 2001). This is a recently developed measure in which sexual deviance and interest are assessed through visual reaction time (Abel et al., 2001). Participants are first given a questionnaire to assess their sexual interests. The participants then see photographs of different people of all ages (including children) in different poses. The amount of time that they choose to view each photograph is recorded. It is thought that participants will look at photographs containing individuals to whom they are attracted for longer periods of time than at photographs that contain individuals to whom they are not attracted. This tool has been specifically used with pedophiles and has been proven to accurately differentiate between non-pedophiles and pedophiles (Abel et al., 2001).

Inventory of Interpersonal Problems. The last measure of assessment that this study will utilize is the *Inventory of Interpersonal Problems* (*IIP*), designed by Horowitz, Rosenberg, Baer, Ureno, and Villasenor (1988) to measure the emotional and psychological distress that is created from interpersonal relationships in an individual's life. The therapist will be working from a questionnaire that contains lists of interpersonal problems for the therapist and participant to pick from and focus on, and then discussing whether or not the problem improved after treatment (Horowitz et al., 1988). In another study using the *IIP*, it specifically relates the interpersonal struggles to

attachment problems and shows the ability of the *IIP* to detect and define these issues (Horowitz, Rosenberg, & Bartholomew, 1993). The current study is looking at attachment deficits in pedophiles; therefore using this measurement will assess the attachment strengths and weaknesses of each participant.

Procedure

Before the study can even begin, the study proposal will be presented to the Institution Review Board (IRB) at the researcher's institution and the Prison Review Board. It will need to be successfully approved by both before the study begins to ensure that the study does not exploit or harm this population and that the study is in compliance with the ethical guidelines of the researcher's institution, the American Psychological Association, and the Prison Review Board (*DSM-IV-TR*, 2000; OHRP, 2003).

Once the researcher's institution's IRB and the Prison Review Board approve the entirety of the study, all interested participants will be asked to sign an informed consent that makes him aware of the nature of all the possible physical, mental, or emotional difficulties that may result from going through this study. This form will clearly outline that the participant might experience minimal or less risk, defined as "the probability and magnitude of physical or psychological harm that is normally encountered in the daily lives, or in the routine medical, dental, or psychological examination of healthy persons" (OHRP, 2003).

The informed consent will also acknowledge the offender's right to quit the study at anytime with no consequence. It will also stipulate that the participant's results will be kept anonymous and the results and/or publications of the study will only report group statistics, instead of individual results, to help keep the participant's involvement and

outcomes anonymous. It will also be made clear that there will be no advantages or compensation for participation in this study and the participant's will be placed into groups by random selection. If the offender does not sign the informed consent, he will not be considered for the study. The informed consent is one of the most vital parts of this study because it will identify that the study has passed the Prison Institution Review Board as being relevant to this population and posing no more than minimal risk to the prisoners who participate, as well as ensuring confidentiality.

After all possible candidates for participation have signed the informed consent, they will be interviewed to determine whether they meet the diagnostic criteria for pedophilia. If they did not sign the informed consent, then they will not be allowed to be interviewed. This is because the informed consent will explain the entire study, including the reason for the interview before participant selection. The questions in the interview will be in respect to the *DSM-IV-TR* criteria regarding the definition of pedophilia (*DSM-IV-TR*, 2000). Questions will surround the following: the occurrence, frequency, and intensity of sexually arousing fantasies of prepubescent children, the occurrence, frequency, and type of behavior or urges involving sexual activity with a prepubescent child, whether or not the participant has ever acted on his fantasies or urges, whether or not the sexual urges, fantasies, or behaviors cause distress of interpersonal difficulty to the participant, how old the subjects of his fantasies or actions are, and so on (*DSM-IV-TR*, 2000). The researcher and/or the research assistant will diagnose the participant as a pedophile based on his answer to these questions and the *DSM-IV-TR* definition. If the offender has been found to meet the *DSM-IV-TR* criteria, then he will be asked to

participate in the study. If he is not found to meet the criteria, then he will not be allowed to participate in the study.

After finalizing their agreement to participate in this study and their meeting the diagnostic criteria for a pedophile, the participants will be randomly placed into one of two groups. The first group will be treated with the standard sexual offender treatment, which is cognitive behavioral therapy (CBT). The second group will be treated with the same CBT treatment as well as interpersonal psychotherapy. Treatment will be done in a small group therapy setting with other offenders because research has shown that a less confrontational therapeutic style tends to have more positive outcomes than individual therapy, as well as the fact that relationships with others are highlighted in the group setting (Kear-Colwell & Boer, 2000). Treatment will be the last 18 months of incarceration due to the standard of incarcerated prison time (e.g. Washington Sentencing Guidelines Commission, 2004; Sentencing Guidelines Council, 2003).

Every participant will be assessed before they start treatment and an analysis will be done to determine how likely they would be to re-offend if released without treatment. They will be administered three different tools of measurements. First, they will be given the *Static-2002* to test their constant risk of re-offending based on their age, gender, crimes, and past victims (Hanson & Thornton, 2000). Second, the participants will receive the *Abel Assessment for Sexual Interest* (Abel et al., 2001). Lastly, they will end with the *Inventory of Interpersonal Problems* (*IIP*) to examine the change in their level of attachment problems and interpersonal skills throughout treatment (Horowitz et al., 1988).

After the initial testing, the participants will begin to receive treatment, based on their respective groups, by a certified mental health practitioner. The *AASI* and *IIP* will be administered every 60 days during treatment, but will stop upon their release from prison due to practical limitations. Participants will be tracked for 10 years following release and their re-arrest records will be recorded at the 6-month, 1-year, 2-year, 4-year, 8-year, and 10-year mark. Although this study does acknowledge that there are various ways to track reoffending behavior, criminal arrest records will be utilized in this study for practicality as well as being a common indicator of recidivism rates used in research (e.g. Caldwell, 2010; Miner & Dwyer, 1995). The criminal arrest records of the offenders will be closely tracked to indicate if there are any reoffending patterns among participants, as well as show the recidivism rates at each interval. Marital records of all participants will also be tracked at these intervals to indicate any possible improvements in attachment capabilities.

Proposed Analyses

Demographics. Analyses will include the standard *Statistical Package for the Social Sciences* (*SPSS*) statistical analyses. The mode will be calculated for race and type of crime committed. Measures of central tendency will be calculated for age of offender, age of victim(s), and number of crimes. Percentages of the participant's marital status and types of crime will also be calculated. Gender is not a factor, since all participants will be male.

Risk. The *Static-2002* and *AASI* will be analyzed throughout treatment regarding the participant's risk (Abel et al., 2001; Hanson & Thornton, 2000). The raw scores of all participants on the *Static-2002* will be analyzed to collect the average risk score for each

group and for the participants as a whole. The *AASI* uses a questionnaire and viewing time. Both the answers to the questionnaire and the viewing time will be compared and contrasted between the two groups at each testing time to see if there are differences between the groups and to see if the results change throughout the experiment when assessing risk.

Two independent samples *t*-tests will be used to compare the CBT and the CBT with interpersonal psychotherapy group's scores on the *AASI*. The *t*-tests at the beginning of the study will be conducted to ensure that the groups do not show a significant difference regarding their initial level of risk. This will allow the researchers to conclude that any significant differences observed after treatment can be attributed to the impact of treatment, rather than due to pre-existing differences between the two groups. A second independent sample *t*-test will be conducted at the completion of treatment to examine if the CBT combined with interpersonal psychotherapy group displays significantly lower *AASI* scores than the CBT alone group. It is hypothesized that the *AASI* scores will be significantly lower in the CBT with interpersonal psychotherapy group compared to the group that receives CBT alone.

Repeated measures ANOVAs will also be conducted for the *AASI* results, to see if the two groups showed significant differences in their *AASI* scores over the course of treatment. The ANOVA will take the *AASI* data and compare risk at the start of treatment, during treatment, and after treatment to see if there was any significant change over those three intervals. It is hypothesized that *AASI* scores will decrease over the course of treatment for both groups; however, the CBT with interpersonal psychotherapy group is expected to show a more dynamic decrease than the CBT alone group.

Attachment. The *IIP* is an interview in which the therapist will work from a questionnaire with the participant regarding interpersonal difficulties and the results of these interviews will also be contrasted between the two groups throughout the experiment at each interval to see if any change occurs or if there is a significant difference when assessing attachment strengths between the groups.

Two independent samples *t*-tests will be used to compare the CBT alone and the CBT with interpersonal psychotherapy group's scores on the *IIP*. The *t*-test at the beginning of the study will indicate whether there is a significant difference regarding the two group's initial type of attachment. This will allow the researchers to conclude that any significant changes observed after treatment can be attributed to the impact of treatment, rather than due to pre-existing differences between the two groups. A second independent samples *t*-test will be conducted at the completion of treatment to examine if the CBT combined with interpersonal psychotherapy group displays significantly higher *IIP* scores than the CBT alone group. It is hypothesized that the *IIP* scores of the CBT with interpersonal psychotherapy group will show higher levels of secure attachment after treatment compared to the group that receives CBT alone.

Repeated measures ANOVAs will also be conducted for the *IIP* results, to see if the two groups showed significant differences in their *IIP* results over the course of treatment. The ANOVA will take the *IIP* data and compare attachment types and deficits at the start of treatment, during treatment, and after treatment to see if there was any significant change over those three intervals. It is hypothesized that *IIP* results will show higher levels of secure attachment in the CBT with interpersonal psychotherapy group after treatment compared to the CBT alone group.

Marital records will also be analyzed during follow up of all participants to see if one group had statistically significant higher levels of marriage than the other group. It is hypothesized that having higher levels of secure attachment will be evident through higher levels of marriage. While these records may not fully capture whether the participant's attachment capabilities have improved, it will provide an initial idea as to one of the ways that the participants could be establishing intimate relationships with age-appropriate peers.

Recidivism. Criminal records will also be analyzed to see if one group had statistically significant higher criminal re-arrest and conviction records compared to the other group. Percentages will be calculated for each group and compared. Expected results are that the CBT alone group will have a higher percentage of re-arrest instances than the CBT and interpersonal psychotherapy group.

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