Psychiatric Comorbidity in Pedophilic Sex Offenders

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Objective: The primary purpose of this research was to assess the rates of axis I and axis II psychiatric disorders, as defined in DSM-IV, in a group of pedophilic sex offenders. **Method:** Forty-five male subjects with pedophilia who were participating in residential or outpatient sex offender treatment programs were recruited to participate. Subjects were interviewed by using the Structured Clinical Interview for DSM-IV. **Results:** Ninety-three percent of the subjects (N=42) met the criteria for an axis I disorder other than pedophilia. The lifetime prevalence of mood disorder in this group was 67%. Sixty-four percent of the subjects met the criteria for an anxiety disorder, 60% for psychoactive substance use disorder, 53% for another paraphilia diagnosis, and 24% for a sexual dysfunction diagnosis. **Conclusions:** Axis I and II comorbidity rates are high in this population. Untreated comorbid psychiatric disorders may play a role in treatment failure and recidivism.

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There has been remarkably little research on comorbid psychiatric disorders in pedophilic sex offenders. In our recent review of the literature, we located only two articles on psychiatric comorbidity in sex offenders (1, 2). This is an important area for study because comorbid conditions may have an effect on treatment outcome.

The purpose of this study was to collect data on the prevalence of DSM-IV axis I and axis II disorders in a group of men who met DSM-IV criteria for a diagnosis of pedophilia. The Structured Clinical Interview for DSM-IV Axis I Disorders, Patient Edition (SCID-P) (3) (a semistructured psychiatric interview designed to diagnose axis I and axis II disorders), was performed on 45 men who met DSM-IV criteria for pedophilia.

METHOD

Subjects were recruited by one of the researchers (E.C. or F.O. or both), who met with all of the groups of sex offenders (regardless of their offense) from seven outpatient and one residential sex offender treatment program. Individuals were invited to participate in a study that involved being interviewed about psychological or emotional problems they may have experienced. Fifty-eight male subjects volunteered to participate. With the exception of one voluntary patient, all of the subjects were court ordered to participate in the treatment programs as part of their probation agreement. Ten subjects were eliminated because they did not meet the DSM-IV criteria for pedophilia. Three subjects were eliminated because they did not complete a sufficient portion of the evaluation to be included in data analysis. Therefore, 45 subjects participated in the protocol. Written informed consent was obtained after subjects were given a complete description of the study.

All subjects were interviewed by one of the authors by using the SCID-P in order to diagnose both axis I and axis II disorders. No standardized structured interview was available to make diagnoses for the sexual disorders section of DSM-IV. Therefore, two of the authors (N.C.R. and E.C.) developed a semistructured interview designed to evaluate the presence or absence of all of the disorders in the sexual disorders chapter. The questions in this interview followed the format used in the SCID-P. (Copies of the unpublished semistructured interview are available from Dr. Raymond on request.) Impulse disorder diagnoses were assessed by using a semistructured interview formatted like the SCID-P that was developed by Susan McElroy, M.D. (unpublished interview). Subjects were paid $30 for participation in the study.

RESULTS

The average age of the 45 male subjects was 37 years. Eighty-nine percent of the subjects (N=40) reported their race as Caucasian, 7% (N=3) were African American, one was Hispanic, and one subject identified himself as "other." Seventy-one percent (N=32) of the subjects had completed high school or some college. Twenty percent (N=9) had a college degree. Nine percent (N=4) had not completed high school. Twenty-nine percent (N=13) of the subjects were recruited from a residential treatment program in which they

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were not allowed to work. Twenty-four percent of the subjects (N=11) identified themselves as technical workers, and 20% (N=9) described themselves as laborers. Nine percent of the subjects (N=4) stated that they worked for small businesses, 4% (N=2) were clerical workers, one was a professional or executive, one was an administrator, one was a student, and 7% (N=3) were unemployed.

Only 7% (N=3) of the subjects were not diagnosed with any comorbid psychiatric disorders by using SCID-P criteria. Fifty-six percent of the subjects (N=25) met the criteria for five or more comorbid diagnoses in addition to pedophilia. Sixty-seven percent (N=30) of the subjects were diagnosed as having a history of mood disorder. The most common diagnosis was major depression, with over half of the group (N=25) reporting a history of this disorder. Sixty-four percent (N=29) of the subjects were diagnosed with a history of anxiety disorder. Social phobia (N=17) and posttraumatic stress disorder (N=15) were the most common anxiety disorders. Sixty percent (N=27) of the population reported a history of substance abuse. The most common substance of abuse was alcohol (51%), followed by cannabis (38%) and cocaine (18%). (For details on the prevalence of other axis I and II diagnoses, see table 1.)

TABLE 1. Rates of Axis I and Axis II Comorbid Disorders in 45 Male Pedophilic Sex Offenders[a]

	Current		Lifetime		Age at Onset (years)	
Disorder	N	%	N	%	Mean	SD
Any axis I disorder listed below	34	75.5	42	93.3		
Any mood disorder	14	31.1	30	66.7		
Bipolar	1	2.2	2	4.4	18.0	12.7
Other bipolar	1	2.2	2	4.4	10.5	0.7
Major depression	9	20.0	25	55.6	16.8	10.1
Dysthymia	4	8.9	4	8.9		
Any anxiety disorder	24	53.3	29	64.0		
Panic disorder	2	4.4	3	6.7	23.5	15.7
Social phobia	14	31.1	17	37.8	9.9	3.7
Simple phobia	8	17.8	12	26.7	12.8	8.8
Obsessive-compulsive disorder	5	11.1	4	8.9	12.0	3.9
Generalized anxiety disorder	3	6.7			10.3	2.5
Posttraumatic stress disorder	9	20.0	15	33.3	8.9	6.7
Any psychoactive substance use disorder	2	4.4	27	60.0		
Alcohol	2	4.4	23	51.1	15.9	7.1
Sedative/hypnotic/anxiolytic	0	0.0	0	0.0		
Cannabis	0	0.0	17	37.8	16.6	6.1
Stimulant	0	0.0	5	11.1	18.6	3.5
Opioid	0	0.0	2	4.4	22.3	4.2
Cocaine	0	0.0	8	17.8	24.4	4.7
Hallucinogenic/PCP	0	0.0	1	2.2	17.0	4.1
Polydrug use	0	0.0	4	8.9	21.0	8.8
Other drug use	0	0.0	3	6.7	19.0	4.4
Any psychotic disorder	1	2.2	1	2.2		
Schizoaffective disorder	1	2.2	1	2.2	13.0	
Any eating disorder	3	6.7	4	8.9		
Binge eating	3	6.7	4	8.9	20.7	10.0
Any impulse control disorder	1	2.2	13	29.0		
Kleptomania	0	0.0	4	8.9	9.3	4.6
Intermittent explosive disorder	0	0.0	3	6.7	11.0	5.6
Pathological gambling	0	0.0	5	11.1	23.4	7.7
Pyromania	0	0.0	2	4.4	8.0	
Trichotillomania	0	0.0	2	4.4	14.0	12.5
Impulse control disorder not otherwise specified	1	2.2	1	2.2	16.0	
Any additional paraphilia	15	33.3	24	53.3		
Exhibitionism	3	6.7	6	13.3	8.0	5.9
Fetishism	2	4.4	2	4.4	29.5	19.5
Frotteurism	5	11.1	7	15.6	21.6	6.0
Sexual masochism	0	0.0	0	0.0		
Sexual sadism	2	4.4	3	6.7	16.3	1.5
Transvestic fetishism	1	6.7	1	2.2	49.0	
Voyeurism	6	13.3	12	26.7	15.9	5.9
Paraphilia not otherwise specified	3	6.7	3	6.7	29.7	25.6
Any sexual dysfunction	7	15.6	11	24.4		
Hypoactive sexual disorder	0	0.0	0	0.0		
Sexual aversion	0	0.0	1	2.2	16.0	
Male erectile dysfunction	2	4.4	2	4.4	31.5	16.2

[a] Forty-five subjects completed the SCID-P interview for axis I disorders. The SCID-P for axis II diagnosis was completed by only 40 subjects because the interview was added to the study after the first five subjects had completed the protocol.

CONCLUSIONS

The most remarkable finding in this study is that 93% (N=42) of the subjects met the criteria for some axis I diagnosis in addition to pedophilia over the course of their lifetime. Only three subjects had pedophilia as their only psychiatric diagnosis. These data support the view that attention to the diagnosis and treatment of comorbid psychiatric disorders is essential to the treatment of this population. Diagnosis on all five of the DSM-IV axes should be assessed during the evaluation and treatment of pedophilic sex offenders.

Mood and anxiety disorders were the most common disorders in our population. The presence of these disorders could make it difficult for patients to respond effectively to the rigors of sex offender treatment, which often uses confrontational group therapy and cognitive behavioral therapy approaches. The same could be said for the personality disorders that were common in these subjects (i.e., obsessive-compulsive, antisocial, avoidant, narcissistic, and paranoid personality disorders). Personality disorders, particularly antisocial personality disorder, have been offered as an explanation for pedophilic behavior, even though the literature has not supported this position (2). It is important to note that in our group, 77.5% of the subjects (N=31) did not meet the criteria for antisocial personality disorder, and 80% (N=32) did not meet the criteria for narcissistic personality disorder. Previous authors have reported higher-than-expected rates of alcoholism and alcohol abuse in child molesters (re-

TABLE 1. Rates of Axis I and Axis II Comorbid Disorders in 45 Male Pedophilic Sex Offenders[a]

	Current		Lifetime		Age at Onset (years)	
Disorder	N	%	N	%	Mean	SD
Inhibited male orgasm	1	2.2	2	4.4	22.5	3.5
Premature ejaculation	5	11.1	7	15.5	23.8	9.8
Nonparaphilic compulsive sexual behavior or sexual disorder not otherwise specified	3	6.7	9	20.0	19.6	4.8
Any axis II diagnosis	24	60.0				
Cluster A	7	18.0				
Paranoid	7	17.5				
Schizotypal	0	0.0				
Schizoid	1	2.5				
Cluster B	13	32.5				
Histrionic	0	0.0				
Narcissistic	8	20.0				
Borderline	5	12.5				
Antisocial	9	22.5				
Cluster C	17	42.5				
Avoidant	8	20.0				
Dependent	5	12.5				
Obsessive-compulsive	10	25.0				
Passive-aggressive	5	12.5				

[a] Forty-five subjects completed the SCID-P interview for axis I disorders. The SCID-P for axis II diagnosis was completed by only 40 subjects because the interview was added to the study after the first five subjects had completed the protocol.

viewed in reference 4). In our population of pedophiles, 51% (N=23) met the criteria for a lifetime history of alcohol use disorder, and 44% (N=20) met the criteria for a substance use disorder other than alcohol. Thirty-three percent of this group of pedophiles (N=15) met the criteria for at least one other paraphilic diagnosis. With regard to exhibitionism, frotteurism, and voyeurism, we made these diagnoses even if the focus of these behaviors was directed primarily at children. We used a liberal interpretation of this statement in DSM-IV: "if the individual's sexual preferences meet criteria for more than one paraphilia, all can be diagnosed" (p. 525). Future studies could focus more on the details of the differential diagnosis of these disorders. Lack of progress in treatment is often attributed to poor motivation, inattentiveness, resistance, and denial. In light of the findings presented here, it seems likely that unrecognized psychiatric conditions contribute to the difficulties that individuals face when they try to engage in the process of therapy and in completing therapeutic tasks. These findings call for taking comorbid disorders into consideration when individualizing treatment within sex offender treatment programs and for the appropriate use of pharmacotherapy in addition to psychotherapy. It seems reasonable to assume that sex offenders would benefit from the treatment of comorbid psychiatric disorders and the appropriate use of pharmacotherapy.

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