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Psychological and Legal Aspects of Treating Sexual Offenders with Pedophilic Disorder: A Clinical Case Report

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Abstract

Sexual offenses are among the most strongly condemned prohibited acts, and those whose victims are minors evoke particularly strong social outrage. Such crimes violate fundamental human rights, such as freedom and dignity, and cause serious physical and emotional consequences for the victims. Pedophilia is a psychosexual disorder classified as a paraphilia, characterized by persistent and intense sexual preferences toward children who have not yet reached puberty. From the perspective of psychology and law, pedophilia poses a serious threat to the safety and well-being of children; therefore, taking effective therapeutic and rehabilitative actions toward individuals with such tendencies is crucial.

This article presents the case of a homosexual pedophile who underwent a comprehensive therapeutic and rehabilitative process in a closed institution. The process included cognitive-behavioral therapy, interventions aimed at changing cognitive schemas, and impulse control techniques. After completing therapy at the residential center, the patient continues outpatient treatment, which is an essential element of prevention and monitoring of risky behaviors. The case study allows for an analysis of the effectiveness of the applied therapeutic methods, their impact on controlling deviant behaviors, and potential challenges related to social reintegration of individuals after therapy. The article also discusses legal and ethical aspects of therapy and the dilemmas associated with the rehabilitation of perpetrators of sexual offenses against minors.

Keywords: pedophile, homosexuality, sexual preference disorder

I. Sexual preference disordered of the homosexual pedophilia type.

Sexual preference disorders, known as paraphilias, are persistent experiences of recurring, intensified sexual urges and fantasies involving, for example, objects or activities, accompanied both by acting on these urges and by experiencing distress as a result. (Beech et al., 2016; Konrad et al., 2015; Krueger et al., 2017)
An atypical stimulus is necessary for arousal and full sexual satisfaction. The rigidity of these behaviors, however, becomes dangerous. It must be remembered that sexual preference disorders do not have a clearly defined etiology. Deviance, in contrast, refers to a deviation from a norm (unspecified), and not every deviation constitutes pathology. (*Stanowisko Polskiego Towarzystwa Seksuologicznego w sprawie leczenia przestępców seksualnych*, b.d.).
Pedophilia (from the Greek *paidos* and *philia*, literally meaning "love for children") is a psychosexual disorder, a type of paraphilia, in which sexual satisfaction is achieved through contact between an adult and prepubescent or early pubescent children. (Ames & Houston, 1990; *Encyklopedia Erotyki*, b.d.; Tenbergen et al., 2015)
From the perspective of psychology and medicine, pedophilia is a diagnosable disorder in the ICD-10 classification. To diagnose pedophilia, the general criteria for sexual preference disorders must be met. ICD-10 F65 includes:

- the preference has been present for at least 6 months,
- the person experiences recurrent, intensified sexual urges and fantasies involving unusual objects or activities,
- the person acts on these urges and experiences significant distress,
- a persistent or dominant tendency toward sexual activity with one or more prepubescent children.

Finkelhor developed a theory based on research and observations on child sexual abuse. He emphasized that preventing child sexual abuse requires eliminating four specific conditions, particularly through education and social awareness regarding child protection:

- **Emotional congruence** – why the adult has an emotional need to relate to a child

- **Sexual arousal** – why the adult becomes sexually aroused by a child
- **Blockage** – why alternative sources of sexual and emotional gratification are not available
- **Disinhibition** – why normal prohibitions fail to deter the adult (*Child Sexual Abuse: Finkelhor's Precondition Model Revisited | Office of Justice Programs*, b.d.; Finkelhor, 1984; Finkelhor & Araji, 1986)

The integrated theory of the etiology of sexual offending assumes that pedophilia is the result of biological, environmental, and situational factors. Biological predispositions shape the development of human sexuality—temperament forming the foundation for pedophilic tendencies. Environmental factors highlight sexual pathology as an effect of parental attitudes, attachment patterns, and social conditions, shaping personality traits and social competencies. Sexual development is influenced throughout life by parents, peers, and social institutions, with emphasis on childhood and adolescence. Situational factors determine the final behavior, especially under the influence of stress, alcohol, or drugs, which can impair behavioral control. Etiological factors constituting the Pathways Theory in unrelated offenders include:

- a persistent pattern of age-discrepant sexual relations,
- personality disorders related to behavioral control,
- deficits in social competencies,
- disturbances in sexual development.

Empirical research conducted by Professor Maria Beisert on 96 male offenders unrelated to the victims demonstrated that family factors play a key role in the development of pedophilia. An insecure attachment style and negative parental attitudes toward sons were present in 75% of cases. More than half showed an anxious attachment style. Social competence deficits significantly increased the risk of developing pedophilia. (Kotlarska-Michalska, 2011) Based on age preferences, pedophilia subtypes include:

- **Nepiophilia (infantophilia)** – sexual attraction to children up to age 5
- **Pedophilia** – sexual attraction to prepubescent children
- **Hebephilia** – sexual attraction to early pubescent children (ages 11–14)
- **Ephebophilia** – sexual attraction to adolescents aged 15–19

Nepiophilia, pedophilia, and hebephilia are legally prohibited. (Aggrawal, 2008; Tenbergen et al., 2015)
DSM-5 defines pedophilia as the presence, for at least 6 months, of sexual fantasies, urges, or behaviors involving sexual activity with prepubescent children. The perpetrator must be at least 16 years old and at least 5 years older than the victim, and the choice of the child must be persistent and dominant. (*Diagnostic and statistical manual of mental disorders*, 2013)
Groth, Hodson, and Gary distinguish two types of pedophiles:

- **Fixated pedophile** – someone who, since adolescence, perceives children as the most attractive sexual objects;
- **Regressed pedophile** – someone who turns to children when adult partners are unavailable. (Groth & Birnbaum, 1978, 1979)

Pedophilic acts may involve exposure, masturbation in the child's presence, touching genitalia, and sexual intercourse. Importantly, such acts may be committed not only by pedophiles but also by individuals who have difficulty finding adult sexual partners. (Hall & Hall, 2007; Łucka, b.d.)

Under Polish law, pedophilia refers to prohibited sexual acts involving minors (Penal Code Art. 200). (*Internetowa baza tekstów prawnych OpenLEX*, b.d.). This term refers to the act committed, not the perpetrator's psychological condition. Notably, the term "pedophilia" does not appear explicitly in the Polish Penal Code.

II. Child sexual abuse and trauma.

According to the World Health Organization, sexual abuse involves engaging a child in sexual activity that he or she cannot fully understand or consent to, and which violates the laws and social norms of the society. (Dayal et al., 2018; *Indicator Metadata Registry Details*, b.d.; Mathews & Collin-Vézina, 2019)
It occurs between a child and an adult or between children when there is a relationship of power, dependency, or development disparity. The goal of the activity is the gratification of the other person.
Such activity may include:

- persuading or forcing a child to take part in illegal sexual activities,
- exploiting a child for prostitution or other unlawful sexual practices,
- using a child in the production of pornographic materials.

Children who are sexually abused often struggle in adulthood with sexual trauma, including depressive and anxiety disorders, and post-traumatic stress disorder. Abuse interferes with normal sexual development and may cause physical injuries. (Beisert & Izdebska, 2012; Chen et al., 2010; Hailes et al., 2019)

III. Trauma and it's effects on later life and offending.

The consequences are wide-ranging and multidimensional. They affect how a person perceives themselves, their body, their sexuality, emotions, relationships with others, and functioning in the world. Adults may suffer from anxiety disorders, depression, or eating disorders. They often have low self-esteem and encounter difficulties in interpersonal relationships and sexual functioning. They may experience fear, guilt, helplessness, anger, and depressive symptoms. Sexual symptoms may include hypersexualized behavior, premature sexual knowledge, and adult-like sexual behaviors. Other behaviors include antisocial tendencies, difficulties forming peer relationships, and self-harm. Repeated trauma may lead to complex PTSD. (Briere & Elliott, 1994; Izdebska, b.d.; Kendall-Tackett et al., 1993)

IV. Case description of a homosexual pedophile.

The man is well-oriented to person, place, and time. He does not show psychotic symptoms. His intellectual functioning is sufficient for understanding social rules and legal norms. However, he has a low sense of guilt and shallow emotional life. Experts diagnose him with homosexual pedophilia.
He displays narcissistic and infantile personality traits, emotional immaturity, and impaired emotional–motivational functioning. He has difficulties controlling emotions, is emotionally excitable, and tends to manipulate others with premeditation. He exploits the trust and innocence of his victims.

Raised by both parents until age six; father later formed a new family. He grew up in a conservative religious household, was an average student, and did not complete military service due to multiple convictions for offenses against minors.
He considers his father's departure a major turning point in life. He experienced adaptation difficulties, impulsive and manipulative behavior, peer submissiveness, and aggression when mocked for not having a father. He was called "gay" for playing with girls. At age 10 he was sexually abused by a man he did not know. He also experienced coercive sexual acts from peers. He relieved tension via masturbation and, at age 13, began viewing pornography with friends. Images of heterosexual sex disgusted him. He had minor romantic contact with female peers.
His first intercourse was with a girl. He had multiple long-term romantic relationships but experienced premature ejaculation. He visited a prostitute once but did not repeat it. He reported suicidal thoughts and a suicide attempt related to work and financial stress.
He had two children. His wife divorced him after he disclosed his homosexuality. He felt affection for her and achieved sexual satisfaction. Coming from conservative families, they maintained traditional roles.
He increasingly masturbated, directing his sexual drive toward underage boys. He possessed child pornography.
In prison he had fantasies about his victims. Experts say pedophilia is incurable; therapy can reduce, but not eliminate, deviant urges. Sexological therapy in prison did not produce lasting insight. He denied having a disorder.
Before current detention he identified as heterosexual; therapy helped him admit his homosexuality. He completed a one-year sexological therapy program in prison.
He spent four years in a high-security forensic psychiatric facility, complied with rules, helped others, participated in therapy, and stayed in contact with his mother and brother.
He committed multiple sexual acts against individuals under 15.
Experts concluded he has homosexual pedophilia. He relates to young boys because he perceives them as similar to himself emotionally. His behavior shows extreme lack of empathy and manipulativeness. He exploits minors to fulfill his sexual drives.
In therapy, he initially rationalized abuse as an attempt to give "fatherly love," later recognizing this as seduction. He made therapeutic progress in social skills, accepted himself as bisexual, expressed remorse, acknowledged wrongdoing, and declared a desire for a family with a mature woman.
Experts assessed his risk of reoffending as low. The court changed the preventive measure from inpatient treatment to outpatient therapy with probation supervision.

V. Conclusions.

The primary goal of treating sexual offenders is to prevent them from reoffending against victims, thereby reducing recidivism. („(PDF) The Effectiveness of Treatment for Sexual Offenders", 2025)
Treatment focuses on developing effective control over sexual impulses so that individuals are able to refrain from prohibited behaviors that violate another person's sexual autonomy. Treatment should be provided not only to offenders with diagnosed sexual preference disorders, but also to all sexual offenders whose risk of recidivism is moderate or high. The foundation of treatment is psychological therapy (individual or group), and pharmacotherapy may also be introduced. Pharmacotherapy aims to reduce androgen levels, thereby decreasing sexual desire, arousal, and associated sexual behaviors. (Harrison et al., 2020; Khan et al., 2015; Richer & Crismon, 1993)

Salter's Deviant Cycle describes how social, psychological, and emotional factors may lead to the gradual adoption of deviant behaviors. The entire process is viewed as cyclical and may recur throughout an individual's life.
The stages of the deviant cycle according to Salter include:

- Deviant arousal (fantasies accompanied by masturbation)
- Apparently unimportant decisions (AUID) or deliberate intent
- High-risk factors
- Selection of the target
- Planning and deviant fantasies
- Grooming or use of force
- Sexual assault
- Ensuring secrecy
- Guilt or fear (Saleh, 2004)

Within the population of offenders, cognitive distortions—false or distorted thinking—are common and particularly dangerous because they increase the risk of reoffending. They allow offenders to avoid responsibility for part or all of their criminal actions. By fully or partially denying that anyone was harmed, offenders may continue to commit crimes and avoid therapeutic assistance, thus avoiding confrontation with difficult or painful issues that intensify criminal behaviors.

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