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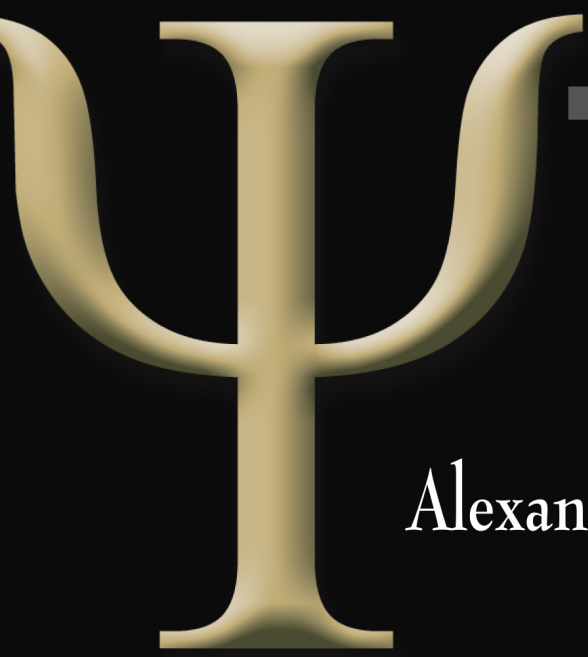

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PREFACE

Advances in Psychology Research. Volume 141 first summarizes the literature on social cognition and its neural correlates in children and adults with ADHD, focusing on emotion recognition, theory of mind, empathy, moral cognition and social decision-making.

Following this, the authors explore the environmental/chemical-associated peripheral blood gene expression profiling of autism spectrum disorder, providing an explanation for the molecular mechanisms of environmental chemicals on autism spectrum disorder.

A quantitative study is conducted to provide empirical evidence of the relationship between altruistic leader behavior and innovation success, using radical innovation as an explanatory variable.

In addition, this compilation aims to validate a scale designed to measure authentic moral pride for children aged 10-16. Participants also completed an adaptation of the Empathy Index for Children and Adolescents.

The authors go on to analyze three-year productivity data (2014-2016) from clinical psychologists assigned to U.S. Army behavioral health clinics to examine patient care productivity standards. A simple computational model compares standards from the Department of the Army, the Veterans Health Administration, and the Defense Health Agency.

The influence of psychosocial and clinical factors, as well as insight, on attitude and adherence to medication in patients with psychosis is explored through a clinical case study.

The services available for support and employment opportunities for individuals with serious mental illness are reviewed. Serious mental illness is defined as a diagnosable mental health disorder that "leads to serious functional impairment, which substantially interferes with or limits one or more major life activities".

The closing study examines the main characteristics of a male Italian child molester, aged 50 years old, through a semi-structured interview based on the central child molester theories and possible intervention strategies.

Chapter 1 - In the traditional diagnostic criteria of attention deficit and hyperactivity disorder (ADHD), the emphasis given to inattention, impulsivity and hyperactivity symptoms cloud over other deficits that are important for a deep understanding and treatment of the disorder. Such is the case of social cognition impairments. In this chapter, the authors summarize the literature on social cognition and its neural correlates in children and adults with ADHD. The authors consider neurophysiological research and behavioral/neuropsychological studies assessing social cognition in ADHD. In particular, the authors focus their review in studies on emotion recognition, theory of mind, empathy, moral cognition and social decision-making. The authors emphasize the variability in the degree of social cognition impairments in ADHD and compare them between other comorbid disorders. Finally, the authors address the pharmacological and non-pharmacological treatments employed for social cognition impairments in ADHD. More generally, the authors analyze the extent to which social cognition research can help to understand this multidimensional disorder from a more ecological point of view, especially considering the relevance and impact of establishing fulfilling interpersonal relations.

Chapter 2 - There are compelling evidences that environmental chemicals contribute to autism spectrum disorder (ASD) through genetic influences. The present study was to explore the environmental chemical associated peripheral blood gene expression profiling of ASD. ASD associated chemical-gene interactions were collected from the Comparative

Toxicogenomics Database (CTD, http://ctdbase.org), and the GSE18123 gene expression profile in Gene Expression Omnibus (www.ncbi.nlm.nih.gov/geo/) was downloaded and used to find the differently expressed genes (DEGs) in peripheral blood gene expression profiling on ASD children. The common genes (CGs) were extracted and gene function enrichment analysis was performed. The functional molecules in protein-protein-interaction (PPI) networks were identified and gene regulation was also analyzed. Totally 12 up-regulated CGs and 324down-regulated CGs were found for DEGs and CTD genes. Functional enrichment analysis indicated that 20 biological processes (BP) including protein metabolic and modification process, and gene expression related processes with FDR < 0.001. KEGG pathway showed only Osteoclast differentiation, HIF-1 signaling pathway, Endocytosis, Adherens junction, Spliceosome, pathways in cancer and Thyroid hormone signaling pathway with $P < 0.05$. The BPs and pathways were confirmed again in the followed identification of the functional molecules in the 12 modules of PPI networks. Some proteins in each module were predicted. Nine transcriptional factors and over 60 miRNAs were found significantly associated with the 399 CGs. The authors' findings may provide new insights to explain the molecular mechanisms of the environmental chemicals on ASD through peripheral blood gene profiling in Children.

Chapter 3 - The devolopment of successful innovations is paramount to compete in the long term. Therefore, academics are interested in the study of the antecedents of innovations in order to promote them. Leadership style is one of the factors that may contribute to the development of successful innovations. However, recent organizational scandals have spured interest in new leadership styles or behaviors based on human values. Altruistic leader behavior is one of the behaviors which has gained attention in recent years and it is a key variable in this research. A quantitative study has been conducted to provide empirical evidence of the relationship between altruistic leader behavior and innovation success, using radical innovation as an explanatory variable. 143 Spanish companies participated in this longitudinal study, providing data at two different moments in time: 2010 and 2015. The conceptual model was empirically validated, confirming that

the relationship between altruistic leadership and innovation success is fully mediated by radical innovation. Practical implications are discussed.

Chapter 4 - The aim of this study was to validate a scale designed to measure authentic moral pride (AMP) for children aged between 10 and 16. The total sample group comprised 351 participants (195 girls and 156 boys). The mean age was 12.25 with a standard deviation of 1.24. In addition to completing the scale, participants also completed an adaptation of the Index of Empathy for Children and Adolescents (Bryant, 1982; Spanish adaptation by Del Barrio, Aluja, & García, 2004), the Prosocial Behavior Questionnaire (Weir & Duveen, 1981), the Guilt, Alfa Pride and Beta Pride Scales of the Test of Self-Conscious Affect for Children (Tangney, Wagner, Burggraf, Gramzow, & Fletcher, 1990) and Rosenberg's Self-Esteem Scale (Rosenberg, 1965). The results of the Confirmatory Factor analysis carried out confirm both the convergent and divergent validity of the scale.

Chapter 5 - This study analyzes three-year productivity data (2014-2016) from clinical psychologists assigned to U.S. Army behavioral health clinics to examine patient care productivity standards. A simple computational model compares established productivity standards from the Department of the Army, the Veterans Health Administration, and the Defense Health Agency. Current U.S. Army workload standards far exceed other relevant competing models, and workload standards overall are significantly higher than current productivity rates. Active duty military psychologists show significantly lower productivity than civilian psychologists working in the same setting. Turnover rates for civilian psychologists also significantly impact overall productivity. Implications for policy and practice are discussed, with a proposed model to maximize clinical efficiency rather than individual care metrics.

Chapter 6 - *Introduction.* Medication adherence is a dimensional and dynamic variable. Psychosocial, clinical and medication factors as well as insight determine attitude and adherence to medication. *Objective.* To analyze the influence of psychosocial and clinical factors, as well as insight, on attitude and adherence to medication in patients with psychosis. *Material and methods.* Clinical cases study from inpatients (n = 55) diagnosed with psychosis. Attitude to medication was assessed through the *Drug Attitude*

Inventory (DAI-10). Medication adherence was assessed using information provided by family members, clinicians and medical records. Patients' psychosocial and clinical factors, as well as psychosis symptoms, were examined with the *Positive and Negative Syndrome Scale* (PANSS). Depressive symptoms were explored with the *Beck Depression Inventory* (BDI 13 items), cognitive impairment with the *Screen for Cognitive Impairment in Psychiatry* (SCIP), insight with the *Scale Unawareness of Mental Disorders Brief Version* (SUMD-BF) and cognitive insight with the *Beck Cognitive Insight Scale* (BCIS). *Results.* Female patients have higher medication adherence, as well as patients who show less positive psychotic symptoms, more depressive symptoms, insight and higher cognitive self-reflection capacity. *Conclusion.* Medication adherence in patients with psychosis is related to the symptomatology, insight and cognitive self-reflection capacity.

Chapter 7 - This chapter reviews services available for support and employment opportunities for individuals with serious mental illness (SMI). SMI is defined as a diagnosable mental health disorder that leads to, "serious functional impairment, which substantially interferes with or limits one or more major life activities". The services the authors discuss include: assertive community treatment, supportive housing, vocational and employment services, clubhouses, recreational therapy, and peer support. These services are in the context of the recovery model as they apply to SMI.

Chapter 8 - Risk and protective factors characterizing child molesters are heterogeneous. However, there are common elements among people who commit sex crimes. The aim of this chapter is to show the main characteristics of a male Italian child molester, aged 50 years old, through a semi-structured interview based on the main child molester theories and the possible intervention solutions based on the etiology. The first section will be characterized by the interview; while the main theories on child molesters will be discussed in the second section. The interview investigates the following areas: relationship with his parents, infancy, his sexual education, self-image, criminal onset and his perceptions about the offence and of children. Qualitative analysis shows specific core categories: mother, father, sexual education, self-perception, sexual offending and children. A detailed

study of these categories shows that the participant perceives his mother as sadistic, while his father as submissive and repressed. He reports to have suffered from psychological abuse from his mother and repressive sexual education from his father, who forbade him to masturbate. As an adolescent, he experienced social difficulties with his peers, and he began to show sexual interest in children, until his first offence and arrest in adulthood. He perceives adults as sexually terrifying and he wants to save children from adults' sexual repression. The categories emerged represent some of the main common characteristics of child molesters and may be useful for future interventions on this category of offender. The last section will be dedicated to the interventions.

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Chapter 8

CHILD MOLESTER PROFILE: THEORIES AND INTERVENTIONS BASED ON AN ITALIAN CASE REPORT

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ABSTRACT

Risk and protective factors characterizing child molesters are heterogeneous. However, there are common elements among people who commit sex crimes. The aim of this chapter is to show the main characteristics of a male Italian child molester, aged 50 years old, through a semi-structured interview based on the main child molester theories and the possible intervention solutions based on the etiology. The first section will be characterized by the interview; while the main theories on child molesters will be discussed in the second section. The interview investigates the following areas: relationship with his parents, infancy, his sexual education, self-image, criminal onset and his perceptions about the offence and of children. Qualitative analysis shows specific core categories: mother, father, sexual education, self-perception, sexual offending and children. A detailed study of these categories shows that the participant perceives his mother as sadistic, while his father as submissive and repressed. He reports to have suffered from psychological abuse from his mother and repressive sexual education from his father, who forbade him to masturbate. As an adolescent, he experienced social difficulties with his peers, and he began to show sexual interest in children, until his first offence and arrest in adulthood. He perceives adults as sexually terrifying and he wants to save children from adults' sexual repression. The categories emerged represent some of the main common characteristics of child molesters and may be useful for future interventions on this category of offender. The last section will be dedicated to the interventions.

Keywords: sexual offending, children, family, psychotherapy

INTRODUCTION

Child sexual abuse is defined as a range of cohercitive and violent behaviors towards minors. These behaviors include rape, sodomy, oral sex, masturbation, forced strokes and kisses, acts of exhibitionism and voyeurism. Studies on the demographic, personalities and environmental characteristics of child molesters indicate that they are a heterogeneous population, but they present some common characteristics: negative experiences in childhood such as neglect, violent and dysfunctional families, separation from parents and placement away from home, experience of

sexual, physical and psychological abuse, academic and behavioral problem and psychopathology, deviant sexual interests, cognitive distortions, interpersonal deficit and personality disorders or traits (Becker, Kaplan and Tenke 1992; Hunter and Becker 1997; Hunter, Hazelwood and Slesinger 2000; Mallie et al. 2011).

The phenomenon was studied according to two categories of interpretation: *Single Factor Theories* and *Multifactor Theories.* The first category of theories focuses on specific factors which influence the child molester behavior and define it in a deterministic manner. For instance, the biological approach takes into account only the sexual arousal as determinate in the offending, ignoring the cognitive and psychological factors (Abel et al. 1977). The second category of theories analyzes the child molester behavior from a wide perspective, taking into account the interaction between individual, family and environmental factors in sexual offending. According to the Multifactor Theories, sexual deviant behavior begins during adolescence and could continue over time. It may derive from abusive experiences during infancy, associated with maltreatment in family and a repressive or violent environment (Hall and Hirschman 1992). This behavior may involve child molestation and rape in late adolescent and adulthood and it often represents the exorcism of a trauma suffered. The offender identifies himself with the aggressor and reexperiences the sexual abuse in the role of perpetrator in order to reduce his anxiety and to counteract the traumatic experience. This sexual abuse may be also subconscious and derived from a dissociation operated by the victim. This mechanism of dissociation leads the person to split his identity in two parts: (a) victim, according to the trauma suffered in his past and (b) perpetrator in the current situation (Cashwell, Bloss and McFarland 1995; Rasmussen, Burton and Christopherson 1992). Thus, sexual offending is often a way to regain self-esteem and control during adulthood (Marshall, Laws and Barbaree 1990).

Regarding the evolutive trajectories and the onset of sexual crime, Moffitt' person-oriented approach (Lahey, Moffitt and Caspi 1993) describes two typologies of developmental trajectories in sexual offending; one is called "life course persisters – LCPs" in which individuals transgress

throughout their entire life cycle and the other is called "adolescent limited -AL offenders" in which individuals commit sexual offence only during adolescence. In this theory, Lussier and Blokland (2014) suggest that in the group of "adolescent limited- AL offenders," deviant behaviors appear late, around 14 years old, after which, the level of sexual transgression decreases rapidly becoming extinct at the end of adolescence, with only 2% of recurrence in adulthood. In the second group, called "life course persisters – LCPs," the deviant sexual behaviors start at an early age, with a peak at 12 years; and the level of activity decreases from that point forward, but very slowly, and then reappears around the age of 30. These considerations suggest that for the AL group, sexual offense is connected to the development and is extinguished during adulthood; while the LCP group is characterized by specific individual and personal factors, not connected to the process of adolescence identity construction and is more likely to remain stable beyond the evolutionary phase, entailing a high risk of committing sexual crimes.

Finally, according to the studies cited above, sexual crimes become a re-enactment of sexual abuse victimization in punitive families and a way to manage stress events. Consequently, child molesters perceive the world as a dangerous and destructive place that threaten their psychological integrity, thus they react accordingly using violence and coercion.

METHODS

An interview was conducted with the aim to investigate the main critical issues in the development of a child molester released from the Correctional Facility. The participant was asked to sign a consent form verifying that the participation is voluntary and confidential. The interview, recorded and transcribed, was analyzed according to the following steps: (a) the first text reading with the aim to assess the general content of the interview; (b) the second text reading to identify the core categories which characterize the interview; (c) the third text reading to identify and estrapolate the main representative sentences and words associated with the core categories.

The interview focused on the relationship with parents, childhood, sexual and affective education, self-image, criminal onset and the perception of the offence. From the analysis of the text, the following core categories were identified: relationship with parents, repressive sexual education, negative self-perception, cognitive distortion in the sexual offence and in the perception of children. These categories were analized in order to investigate the affective and sexual development of the participant and to evaluate the connection with his cognition, his behavior and his offence, associating these factors to the theoretical framework.

CASE STUDY

A. is a man of 50 years old, who was released from the Correctional Facility, where he had spent nine years for child sexual violence conviction. He was born and grew up in Italy from a middle-class family. The father spent his life travelling as a dealer for a company and the mother was a homemaker taking care of the family. In telling his story, A. immediately spoke about his mother, showing the impact that this bond had in his life. He had a difficult relationship with his mother, who never showed her affection and love for him. During his early years A. was afraid of his mother because she punished and humiliated him. At the same time, he needed her, and this perception and cognition caused him to develop a conflict which divided him in two parts. One part he wanted to have a loving mother and so he tried to be the best son as possible for her; the other part he resented his mother and wanted to punish her. This conflict worsened when his sister was born. This event affected his relationship even more with his mother because of her particular affection for the baby. The mother loved her and began treating her son worse. As a consequence, A. felt angry about his sister until he physically attacked her, while she was sleeping, causing scratches on her face. For this aggression A. was severely punished by his mother who locked him in a closet for one night. Following this episode A. no longer tried to attack his sister, but it increased the feeling of rage and jealousy towards her. He also stopped speaking to both his mother and his father, whom he rarely

saw. At age of ten A. was an introverted and angry child. He had no friends and suffered bullying at school and these feelings continued until A. was fourteen years old and went to the high school. He felt insecure and unable to have relationships with his peers, especially with girls. A. was still jealous of his sister, who had boyfriends and who was popular among her classmates. During this time of his adolescent life A. Described a change in the relationship between his mother and his sister. The relationship became conflictive and competitive because they were both *"perfect social models, obsessed by the idealization of beauty and perfection."* According to the A.'s perspective, he was excluded and was considered imperfect and not good enough from them.

During the interview, A. reported some powerful memories which portrayed his mother as possessive and sadistic. A. remembered that she forbade him from locking his room. However, she would enter without knocking especially when she suspected he was masturbating, then she would shout at him and forbade him to do it. A. perceived a form of hostility towards male gender by his mother, as reported during the interview:

> "She feels a form of anger towards men, so when she has a male she tries to manage his life, she likes to tease the child's sexuality and then have power and control against him."

A. considered himself as part of the same category hated by his mother, the category of men. This perceived rejection from his mother led to a progressive psychological denigration in terms of self-esteem and self-image and a strong hostility and fear towards women. Thus, A. spent all his adolescence avoiding physical contact with girls and being afraid of them. During this period, he started to think that girls and women were *"bad," "oppressive"* and *"coercitive"* perceiving himself as he was living inside an *"emotional cage without an identity."*

When A. was sixteen years old, he became overweight and insecure. He began to display high frustration and anger. His mother forced him to buy new clothes and she ridiculed him about his psysical appearance. She continuously shouted at him saying she was ashamed of how he looked:

> "she was obsessed ... there was more to it than her fixation of having a beautiful, clean and tidy son… maybe she felt a perverse satisfaction in pretending that she cared about her son. My mom comes from a fairly low-level culture. …"

A. never disclosed to anyone the psychological violence that he was suffering in his family and he became more and more introverted and anxious in his relationships with others. The only person of whom A. had a positive memory is the governess who lived in their house during his childhood and adolescence. She was like a mother to him and she gave him psysical and emotional solace, but she never protected A. from his mother.

A. did not speak a lot of his father during the interview, saying that he often was absent for work and that he met his father only during the evening. Despite his absence, during his infancy A. perceived his father as the savior in the family, the mother as the persecutor and he as the victim. But his father was totally submissive to his wife and he never protected A. from the humiliations and the pressures of the mother. A. compared his father to a parasite who did not have the courage to face his wife and allowed himself to be trampled and humiliated by her. He interiorized two family models: the mother - sadistic and abusive; the father - submissive and indifferent. In this situation A. never asked advice from his parents and never shared his problems or needs with them. A. did not report a lot of events of his adolescence, affirming that he felt as if someone else lived his life for him:

> "I don't know what I should tell, and at one point, I remember that everything went dark and I ended up in prison. When I was a child, my parents ignored me and humiliated me and after a while I began to think that I deserved it and that no one will love me."

In late adolescence something changed, A. fell in love with a girl, one of his classmates and felt the need to share this new feeling with someone. However, he had no one. Thus, he decided to ask his father for advice, but his father refused to have an open discussion with him and forbade him to talk about the subject again. After this episode and due to the fear of being mocked by others, A. gave up building affective relathionships:

> "I thought that in courting a girl, there was something wrong because sexuality is something to blame and… the idea that girls could react showing anger to me was one of those things that made my legs shake and become afraid to get closer to girls… and this was one of the reasons why, from adolescence, I started giving up on girls. Giving up before beginning."

According to A. it was at this point of his story that he became "*sick,"* feeling attraction for children

> "I said to myself... I realize that I have no chance with girls, I can't ... I like them a lot and so I must make another choice, also because at that age (you) cannot choose to not live completely (your) sexuality and I started to explore my body and my sexuality with my three-year-old cousin and I succeeded perfectly."

A. shifted his attention to children, feeling a sense of control and satisfaction as he never did with his peers, with whom he felt awkward and insecure. At the age of 20, he continued to explore his body as he did when he was a child, getting stuck in his childhood and seeking contact with children. In his relationship with children he felt free from the humiliation and the abuses he suffered from his mother.

A. became manipulative and would go every afternoon to the park to seek out children. A. was attracted to children aged 4-5 years old, both genders, having a greater attraction to those who seemed to be repressed and ignored by adults. Before choosing his victim, A. stalked children in the park, studying them and their social interactions with peers and adults for a long period of time. Finally, when he found a child alone or upset, he would obtain his trust, then he would take him to an isolated place to molest him. A. felt sexual arousal in touching and masturbating children for it was his only way to reach a climax.

In the meanwhile, he worked in his father's agency, but the relationship with his parents remained the same. His father was psychologically absent, and neglectful and his mother was sadistic and humiliating. During the following three years, A. sought new ways to explore his sexuality and at 23 years old his behavior underwent an escalation which culminated in a sexual intercourse with a child. A. described what he did comparing his sexual

violence to a romantic sexual intercourse of a couple, using words such as *"we fall in love each other"* or "*that kid loves me, and he wants to have sex with me."* He totally ignored the perspective of the child, showing an inability to be empathetic with him:

> "I was with my father in a restaurant having lunch and I noticed a family, a father and mother and their son. They were constantly reproached their son, a child of about ten years old, an angel… I looked at him and he looked at me. I understood that he wanted me to save him from his family."

While the parents were distracted, A. followed the child to the bathroom. He said he seduced him and touched him for fun, as he always did, but then he couldn't hold back, so he had sexual intercourse with the child, who told his parents immediately what happened to him.

A. was convicted and reclused in a Correctional Facility where he thought about his behavior and his feelings. He did not recognize his action as an offence until his parents refused to visit him in the Facility. During this period of his life he understood that he interiorized all the negative emotions against his parents, becoming insecure and scared of interpersonal relationships. This fear resulted in him feeling more comfortable with children, especially with those who were oppressed as he was during his childhood. He claimed to want to release himself using a "retroactive projection," based on which in involving children in sex he authorizes himself to feel pleasure.

A. spent nine years in the Corretional Facility. There he suffered a long period of depression due to the difficult relationships with other inmates, who considered him as a monster. He did not speak with his parents anymore, while he was incarcerated and also after his release.

Despite the negative feelings connected to the Facility A. believes that the experience of detention had the capacity to absorb most of the anxieties related to his sexual offence. On one hand, he describes himself as afraid of the "dark side" of his mind and believes that he would commit another sexual offence; while on the other hand, he knows that his actions are associated and are a part of his past. In thinking about it, he remembers how

much he suffered during his childhood and adolescence. The participant reported to have had suffered psychological and emotional abuses from his sadistic mother, who often humiliated and devaluated him. The role of the father was that of an absentee parent and being submissive to the mother. Today, A. lives alone, and he is trying to build new relationships and to find a job.

In conclusion, from the analysis of the case, some core categories emerged, which represent common characteristics in child molester profile:

- passive and scared of women
- experiencing his sexuality in a context of suppression and shame
- forbidden to explore his body as is norm during development
- having relational difficulties with his peers, especially with girls
- seeing the world as a dangerous place
- seeing adults as scary, especially women
- having feelings of trust only in children

Child sexual violence might express different meanings according to the perpetrator's profile. In this specific case, child sexual violence represents a projection of the abuses experienced during childhood. The forbidden act of masturbation and sexuality influence social and relational skills, preventing the person from adjusting to the normal stages of his development. The person feels unable to establish relationships with peers and feels more confortable with children, who become a sexual object and consolation from the delusions of childhood and the fears of adulthood.

THEORETICAL FRAMEWORK

The Need for a Theoretical Approach for Child Abuse

Since the dawn of criminology before, and forensic psychology later, researchers and therapists have tried to identify the significant clinical,

biological and/or social phenomena evident in the sexual offending background. Theory construction allows to consider the causal mechanisms that can be responsible for the occurrence of sexual violent behaviors, with the aims to design effective prevention and intervention programs, in order to reduce the probability of individuals reoffending. For these reasons, researchers, therapist, psychologists and sociologists should operate within a theoretical frame understanding of the likely causes of sexual abuse, otherwise any interventions and treatments may be unsuccessful (Ward and Siegert 2002). Besides that, the need for a comprehensive theory that can explain sexual abuse, especially child sexual offending, has also an important social meaning: a growing number of studies are analyzing the idea of general population about the causes of child molesting and child sexual offending, which can have an influence on policy makers decisions, trials' outcomes (a.e. exemplary punishment) and the general approach or concern about the phenomenon. Moreover, the theoretical model chosen to address pedophilia and children sexual abuse plays a significant role in the construction of diagnosis both in the clinical and jurisdictional settings.

In the last 40 years, a significant number of scholars have proposed theoretical models in order to contribute to the understanding of child abusers' behavior, some focusing more on medical and neurobiological factors, others on relations and past experiences, or again on perception and cognitive factors. Nevertheless, all these aspects appear to be relevant in the explanation of child sexual abuse committed by adults and should be taken into account especially in clinical and rehabilitation assessments, to determine positive and negative aspects of the individual sexual function and in terms of differential diagnosis.

Classifying Child Abusers

One of the main problems in exploring the causes beyond violent sexual behaviors against children, is to understand the characteristics of the offender. Pedophilia and sexual abuse on children have several aspects in common, but the two concepts cannot be interchangeable, there are child

molesters who do not have a solid, ongoing sexual interest in children (i.e., are not pedophilic) and there are pedophiles who never abuse (i.e., are not child molesters) (Feelgood and Hoyer 2008). In fact, pedophilia, according to the DSM-5 (American Psychiatric Association 2013), is a paraphilic disorder regarding a person of at least 16 years old who "has had arousing fantasies about, urges for, or behaviors with a prepubescent child or children, for at least 6 months." The diagnosis must include if the individual is attracted only to children (boys/girls/both) or also to adults: this fact may open a large number of different scenarios with different outcomes and different profiles, suggesting the heterogeneity of sexual offenders and the heterogeneity of causes that influence such behaviors (Bickley and Beech 2001). For instance, when the onset of the disorder is at an early age, as early adolescence, there is a consistency in the sexual preference and the desire for a romantic relationship along with the persistency of the sexual fantasies is stable during the time. Seto suggested that pedophilia could be a sexual orientation rather than a mental disorder (Seto 2012). This definition cannot be applied to individuals who have or have had sexual relationship with consentual adults or to those who have "acquired pedophilia" (Mohnke et al. 2014; Camperio Ciani et al. 2019). This controversy, whether considering pedophilia from a psychopathological perspective (in accordance with the DSM criteria) or according to a more offence-oriented criteria, the sociolegal perspective, where a child molester is considered any adult who had sexual contact with children (or even a minor), contributes to the idea that a generalization of the findings in the fields is not methodologically appropriate (Imhoff 2015; Bickley and Beech 2001). Keeping that in mind, it is possible to approach all the different models proposed by the literature on the etiology of pedophilia and sex offenders, considering that there are inter and intra-individual differences that must be considered in therapeutic settings.

From Finkelhor's Four Factor Model to Contemporary Evidences

In 1986, Finkelhor proposed a comprehensive theory that, for the first time, systematized all the different causes proposed by the literature, in a multifactor model composed by four main aspects (Finkelhor and Araji 1986). The model proposes four specific factors that gather together all the evidences from the clinical and empirical studies on pedophiles back then. These factors are Emotional Congruence, Sexual Arousal to Children, Blockage and Disinhibition. This model has not been exempt from critiques (Ward and Siegert 2002), but the four cornerstones of the theory have set the foundations for the contemporary etiological explanation for child abusing and pedophilia. Later, in 1992, Hall on the line of Finkelhor's studies, suggested a quadripartite model composed by four factors that are involved in the onset of pedophilic behaviors: physiological sexual arousal, cognitions justifying sexual aggression, affective dyscontrol, and personality problems (Hall and Hirschman 1992). The two models have many aspects in common, and these factors have been studied and deepened by the literature in the last 30 years, but the results are still controversial. What is established is that all the factors proposed and described in the next paragraphs work together to influence sexually abusive conducts on children, and that offenders can sexually abuse children for very different reasons, and all the theories should be "knitted" together as suggested by Ward and Siegert (2002).

Emotional Attachment to Children and Affective Dyscontrol

The first factor in Finkelhor model is called *Emotional Congruence,* suggesting that pedophiles due to an arrest in developing an adequate emotional system, experience themselves as children and fit their needs to children' characteristics. This idea that offenders are trying to develop an emotional attachment to their children victims has been confirmed by the recent literature and represents one of the most common characteristics of

sexual offenders (Konrad et al. 2018; McPhail, Hermann and Fernandez 2014). This emotional pattern can also explain the urge of some offenders to pursue romantically a young boy or girl, to gain their trust and share intimacy without the specific goal to have a sexual interaction with him or her. These pedophiles are not sexually motivated but emotionally, in order to fulfill a specific emotional need of closure and intimacy (Konrad et al. 2018). This aspect is described by Hall's model as "affective dyscontrol" or emotional instability and there are evidences supporting the idea of an emotional immaturity underlining child molesters' behaviors (Hall and Hall 2007).

The Abused Abuser Theory

The second factor of Finkelhor's theory the *Sexual Arousal to Children* explains how a grown adult can have a physiological response to the presence of children or erotic fantasies about them (Finkelhor and Araji 1986). One of the focus of the scientific literature on the topic is to understand why an adult can find a child sexually attractive and the results are still controversial. In fact, one of the prevalent aspects in the life history of pedophiles is previous abuse during childhood (Whitaker et al. 2008; Salter et al. 2003), called "the abused abuser theory" (Freund and Kuban 1994). Nonetheless this traumatic event (or ACE- Adverse childhood effect) (Grady, Levenson and Bolder 2017) is quite common in all sex offender, not only in pedophiles and is not sufficient to explain the sexual arousal toward children (Jespersen, Lalumière and Seto 2009). What instead appears to have a significative influence are early sexual experiences, producing a conditioning or imprinting causing the individual, later, on becoming an adult, find children to be attractive (Cohen et al. 2002). This process of fixation could be sustained by masturbatory compulsion and fantasizing or thinking about the event to relieve the sense of frustration when the event is perceived as traumatic or something of which to feel ashamed (Grundmann et al. 2016; Sawle and Kear-Colwell 2001). These theories suggest that there may be a sort of modeling on a specific sexual interest when the onset of

sexual activity is at an early age, before puberty (Houtepen, Sijtsema and Bogaerts 2016).

Personal Characteristics and Personality Problems

The third aspects of Finkelhor theory is *blockage,* suggesting that due to negative experiences with adult romantic relationship or family trauma, individuals are blocked in their ability to get their sexual and emotional needs met in adult relationships (Finkelhor and Araji 1986). These situations have been seen to have an influence on developing some specific characteristics such as unassertiveness, shyness and awkwardness (Finkelhor and Araji 1986). Further research, starting from Hall's model (Hall and Hirschman 1992), have suggested in fact, that there are specific personal characteristics and personality aspects connected to child abusing: children abusers appear to be introvert and prone to obsessive planning (Jahnke et al. 2019), showing low-self esteem and feelings of isolation and inferiority (Carvalho 2018).

Neuropsychological Aspects

The last factor in the Finkelhor model, *Disinhibition* accounts of why inhibitions against having sex with children are overcome or are not present in children abusers and pedophiles (Finkelhor and Araji 1986). That idea has been developed by neuropsychologist during the last 20 years and many studies have found several evidences about the association between frontostriatal morphometric abnormalities and pedophilia (Schiffer et al. 2007; Mohnke et al. 2014; Becerra-García 2009) suggesting that there is a strong impulse dyscontrol that may be responsible for the sexual deviant behavior in pedophiles and child molesters. Studies on structural brain alterations indicate that sexual compulsive disorders such as pedophilia may be associated to the obsessive–compulsive spectrum disorders (OCD spectrum), due to the fact that they share some substantial phenomenological

and genetical features as repetitive and poorly inhibited behaviors, high level of anxiety and dopamine receptor alleles (Schiffer et al. 2007). Neurobiological and neuropsychological aspects can be perceived as risk factors that, when other situational and developmental factors are present, can influence the onset of sexual deviant behaviors.

Cognitive Distorsions and Moral Disengagment

Hall'stheory on "cognitions justifying sexual aggression" has been studied by Ward and colleagues, demonstrating that behind sexual deviant behaviors there are five implicit hypotheses that account for the majority of their cognitive distortions and thinking errors (Ward and Siegert 2002; Marziano et al. 2006). Cognitive distorsions are maladaptive beliefs and cognitive defective activities that justify and sustain offenders' violent conducts. These are connected to the factors described above and are: *Child as a sexual being* where children are perceived as individuals willing to participate in sexual and romantic activities with adults; *Nature of harm* suggests that children cannot be harmed by sexual activities but maybe can benefit by the contact; *Entitlement*, where the sexual abuser perceived himself as more important or special than other people; the *Dangerous world* distortion where the offender thinks of himself as good, and needs to gain back the power over a "wrong" and "bad" world; and the *Uncontrollable* where the abuser believes that circumstances are outside his control (Marziano et al. 2006). These cognitive distortions guide and sustain pedophiles' behaviors and are connected to another psychological construct, the *moral disengagement*: a strategy to escape from ethical codes imposed by society by reframing harmful and negative behaviors as being morally acceptable without actually changing the conduct or the personal moral standards (D'Urso et al. 2019; Bandura 1999). These factors reinforce sexual deviant behavior and violence against children, relieving the offender from his responsibility and sense of guilty, while blaming and de-humanizing the victim (Bandura 1999).

TREATMENT OPTIONS

Sexual offending has long been recognized as a serious problem with significant impacts on victims, their families, and society at large. Coinciding with this recognition has been the development and implementation of treatment interventions designed to reduce the risk of recidivism, empirical research into treatment effectiveness, and an increase in the availability of treatment programs for sexual offenders (McGrath et al. 2010). Treatment options could be mainly divided into two types: Treatment-as-Management and Treatment-as-Rehabilitation.

Treatment-as-Management has as its basic vision the protection of the community, consequently, contemplates a treatment that provides for disability (registration in the database and notification of the community) and rehabilitation (through cognitive-behavioural interventions that address the underlying factors of offensive sexual behavior).

Treatment-as-Rehabilitation is based on a humanistic and holistic view aimed at reducing the risk of recidivism through targeted and personalized interventions.

Within this last construct, two approaches are underlined: a) the Therapeutic Jurisprudence (Wexler 2016; Parry 2009) and b) the Good Lives Model (Ward and Stewart 2003).

a) The Therapeutic Jurisprudence was established to counter the antitherapeutic consequences of the enactment and application of laws that do not aim at the rehabilitation of the sentenced person and do not respect the dictates of civil and humanitarian rights conventions.
   The key point of this construct is the "fair trial" (Ward and Birgden 2007) which consists of the participation of the defendant in the decision-making process, dignity and trust (Tyler 1996) in order to obtain a sentence that maximizes the therapeutic effects of law enforcement (Tyler 2010).
b) The Good Lives Model is a model of theoretical-practical intervention whose objective is the re-education of sex offenders

through simulations that allow the remodeling of maladaptive behaviors aimed at achieving the satisfaction of basic needs. It is often integrated with the Self-Regulation Model (SRM), an approach in which the objective is the self-regulation of actions through a step-by-step approach that takes up static and dynamic risk factors.

It focuses on dynamic risk factors and the motivation that drives abuse. The high validity is given by the individualization of the path before and during the treatment (Ward and Stewart 2003).

Treatment of sexual offenders has evolved substantially over the years; various theoretical and practice models of treatment have been developed, modified, refined, and proposed over time. The predominant current recommended approach, supported by research, adheres to specific principles of effective correctional intervention, follows a cognitive-behavioral, skills-based orientation, and explicitly targets risk factors empirically associated with sexual offending and with recidivism, so that risk of re-offending may be reduced. Current best practice involves the application of cognitive-behavioral interventions that target risk and that adhere to the principles of effective correctional intervention (Andrews and Bonta 2010; Hanson et al. 2009). Cognitive-behavioral treatment focuses on changing behavior, cognition, and affect, using a skills-based approach, with the aim of reducing risk of recidivism, and includes specific characteristics and methods on the part of treatment providers. Treatment is also guided by specific principles of intervention to maximize effectiveness. In addition, meta-analytic research has found that cognitive-behavioral treatment is most effective in reducing recidivism in comparison to both other types of treatment and to criminal sanctions (Hanson et al. 2002; Lösel and Schmucker 2005). New models of treatment have been proposed with the aim of replacing and/or augmenting existing models (Yates 2013).

When discussing therapeutic interventions for sex offenders, it is not easy to avoid the reflective and ethical questions pertaining to more actors in the field, such as the following: the protection of the victims, the protection of the community, but also the protection of the human rights of

the same sex offenders. Protection of the community is a pressing construct that has led legislation, especially in some countries, to extreme solutions, based more on the punitive aspect, than taking due account of studies and research that in the last 20 years have shown divergent results (Brigden and Cucolo 2011; Ward, Gannon and Birgden 2007). There is a heated scientific debate on the effectiveness of these measures restricting civil rights.

More and more research has shown that the restriction of civil rights does not lead to any statistically significant reduction in the recidivism of criminal behavior (Vasquez, Maddan and Walker 2007). Offenders, moreover, should be perceived as both rights violators and rights holders (Ward and Birgden 2007).

Treatment must integrate with environmental contexts and social supports. Treatment-as-Management emphasizes risk management on a continuum from treatment (cognitive behavioral treatment to manage risk) to incapacitation (sex offender registers, community notification, residence restrictions, and civil commitment) (Brigden and Cucolo 2011). Treatment-as-Management approaches include cognitive behavioral treatment to recondition thoughts, feelings, and behaviors, relapse prevention to support and monitor self-management skills in avoiding high risk situations and places, and the RNR model that targets high-risk offenders with more intensive treatment of problem areas empirically related to the risk of reoffending (Andrews and Bonta 2003). Treatment-as-Management does not detect particular effectiveness in reducing recidivism (Sandler, Freeman and Socia 2008; Walker et al. 2005; Duwe and Donnay 2008; Zandbergen, Levenson and Hart 2010). Treatment-as-Management has antitherapeutic consequences that increase the risk to reoffend. These consequences include unemployment, homelessness, shame, depression and anxiety, disconnection from social supports, and inadequate treatment (Appelbaum 2008; Bonnar-Kidd 2010; Hall and Hall 2007; Levenson, D'Amora and Hern 2007; Scott 2008). Some juvenile offender treatment programs include a healthy sexuality component, in addition to components related to personal accountability.

For example, an article about Child and Youth Services of Saskatoon District Health describes a treatment program for adolescent sexual

offenders that incorporates healthy sexuality content. Clients participate in a 15-session psychoeducational group with two sessions devoted to healthy sexuality. The program presents sexuality as a natural and accettable aspect of the human experience that should be expressed in non-harmful, non-coercive ways (Perry and Ohm 1999).

Table 1. Different treatment options

Treatment	Target	Duration	Efficacy
Psychological treatment + hormonal treatment testosterone antagonists and GnRH agonists and/or psychotropic drugs (SSRI, antipsychotics)	Sex offenders with psychological problems	In place of the sentence or after expiation, often partial (Kraus et al. 2006)	No specific efficacy data
Psychotherapy Cognitive-behavioural approach	Sex offenders with high recurrence risk	There is no specific duration	Effectiveness on reducing recurrences; (Moster, Wnuk and Jeglic 2008); 6-year follow-up, lower recurrences (McGrath et al. 2003)
Psychotherapy Cognitive-behavioural systemic approach	Sex offenders with high recurrence risk	Duration changes depending on the Country (McGrath et al. 2010) Usually 80-120h;	Effectiveness on reducing recurrences (Hanson et al. 2002)
		165-195 h until 300 h for sex offenders at high recurrence risk (Beech and Mann 2002; Marshall 2006; Bourgon and Armstong 2005)	
Pharmacological treatment SSRI, antidepressants, antipsychotics	Sex offenders with compulsive symptoms (Kraus et al. 2006)	The duration could change if associated with cognitive-behavioural treatment	Greater adherence to the programme; more successful control of recidivism (Thibaut et al. 2010)

Treatment	Target	Duration	Efficacy
Chemical castration	Sex offenders with high recurrence risk	Usually for 12 months	Uncertain efficacy; ethical risks and implications (Ward 2010)
Hormone therapy antiandrogenic drugs (especially GnRH agonists)	Paraphilic sex offenders (Czerny, Briken and Berner 2002)	There is no specific duration	Long-term efficacy/needs further research (Garcia and Thibaut 2011)
Pharmacological treatment + psychotheraphy	See cognitive-behavioural treatment	See cognitive behaviourial treatment	More than single therapy (Rice and Harris 2011)
Special control and treatment programmes cognitive-behavioural therapy + relapse prevention	Sexually violent predators, with psychological disease (mental abnormality or personality disorder)	Beyond the duration of the sentence, often during lifetime; (Prentky, Janus, Barbaree, Schwartz and Kafka 2006)	Uncertain effectiveness (Sandler and Freeman 2009)
Prison Oriented Therapeutic programs - Preliminary assessment: Offence; recidivism; - Individual and group meetings: deconstruction of denial and minimization (cognitive-behavioural approach)	Sex offenders who need to work on cognitive distorsions, on denial; with personality, psychopathological disorders, who need to develop communication and to express emotions	There is no specific duration	Reduce recidivism (Hsieh, Hamilton and Zgoba 2016) mutual trust between staff and detainees; the importance of context for rehabilitation (Blagden, Winder and Hames 2016)
Prison Oriented Therapeutic programs In addition to the above: - Good Lives Model; EMDR Schema therapy (cognitive-behavioural approach). (Hall and Hirschman 1991) a) Focus on sex fantasies b) Cognitive-distortion therapy c) Comparison with emotions d) Prevention of recidivism	Sex Offender without cognitive distortions or denial strategies	Duration of the sentence	Theoretical-practical intervention considered effective because it involves re-education, promotes motivation and reduces the risk of abandonment of treatment. Significant reduction in recurrence (McGrath et al. 2010)

Table 1. (Continued)

Treatment	Target	Duration	Efficacy
Relapse Prevention Aims to help the sex offenders to recognize the various previous stages of abuse to interrupt thoughts, emotions and actions	See cognitive-behavioural treatment	See cognitive behaviourial treatment	Incomplete model: does not explain dynamics such as: - Active victim search - Abuse planning (Marlatt and Donovan 1985)
Self-Regulation Model Behavioural self-regulation. Aims to modify this behavior through the achievement of micro-objectives	For all sex offeders	Being an individualized approach, it is no possible to establish a specific duration	More comprehensive model, focusing on dynamic risk factors and motivation for abuse. Valid for the individualisation process. (Ward and Hudson 1998; 2000; Ward, Yates and Long 2006)
Treatment as Management Aims: 1) protection of the community -monitoring of offenders; -informing the community of the addresses of offenders; -residence restrictions;2) rehabilitation using cognitive-behavioural interventions that address the factors underlying problematic sexual behavior	For all sex offeders	Duration of legal proceedings and sentence	Being a coercive treatment, literature highlights the ineffectiveness in reducing risk and the number of victims; in addition to other consequences such as: unemployment, depression and anxiety (Appelbaum 2008; Bonnar-kidd 2010; Levenson, D'amora and Hern 2007; Scott 2008)
Treatment-as-Rehabilitation Two approaches: -Good Lives Model -Therapeutic Jurisprudence	See below for more details	See below for more details (Glaser 2003; Tofte and Fellner 2007)	See below for more details

Treatment	Target	Duration	Efficacy
Good Lives Model (GLM) Often integrated with Self Regulation Model	Sex offenders with greater motivation and participation in the programme aimed at identifying the achievement of primary assets and life plans that are incompatible with offending	The intervention plans are personalized or in addition to cognitive behavioral treatment. There is no specific duration. (Yates, Kingston and Ward 2009; Yates and Prescott 2011b; Yates, Prescott and Ward 2010)	Effective techniques and practices. -Less abandonment of the pathway. -Decrease in recurrence (Ward and Stewart 2003; Ward and Brown 2004)
Therapeutic Jurisprudence Treatment monitoring model: participation of defendants; dignity as a citizen; trust	For all sex offenders	For all the duration of the legal proceedings	Minimizes the anti-therapeutic effects of the law and maximizes the therapeutic effects of the ruling (Tyler 2010).

CONCLUSION

Research and studies carried out in the last 20 years have determined that the application of a single model of treatment does not lead to a statistically significant result, but it is the integration of several models and approaches that, taking into account environmental and clinical variables, seems to favor the possibility of reducing recurrence.

At present, the most effective psychotherapeutic paradigm is the cognitive-behavioural one, since it deals with cognitive distortions, attitudes, sexual, affective, relational and cognitive self-regulation.

Determinants are those factors already recognized as fundamental for each treatment: the personal motivation of the individual (which should not arise from the obligation of the sentence to the treatment), the specific training of the therapist, the climate and therapeutic alliance that prevent the risk of "drop-out" from the treatment (Yalom 1970).

The main objective of each treatment is the recognition of the crime in order to develop the empathic capacity towards the victim and reduce the cognitive distortions of the offender.

Finally, the attention given by some studies and research to the need for ethical interventions that safeguard the human rights of sex offender deserves more reflection.

Examples of the above are found in countries such as Germany and Belgium, where the vision of "disease" does not guarantee the achievement of the statistically relevant objective, and also in countries such as the USA and the UK, which tend to re-propose interventions and treatments that favour a climate of hatred and determine a paradoxical effect with the risk of repetition, but favours it in reducing recurrence among sexual offenders. An explicit skills-based approach is recommended in order to enable treatment participants to change cognition, affect, and behavior such that these become entrenched in their behavioral repertoire. Emerging research suggests that the traditional relapse prevention approach, has not demonstrated its effectiveness as of to date. It is overly simplistic in its conceptualization of pathways to offending. The self-regulation approach, with its broader conceptualization of offense process, dynamics, and motivations, is gaining substantial support for its application to the sexual offender treatment. Research also indicates that there are essential characteristics of the intervention itself and of therapists, which are associated with improved outcomes. In a related vein, the Good Lives Model has been found to have some validity and, importantly, is associated with increased motivation and reduced treatment attrition, although additional research into this Model is also required. It is suggested that treatment of sexual offenders will be most effective when it is based on empirically demonstrated models and methods and conducted in a manner that integrates various approaches, and where those approaches show the greatest promise of reducing recidivism, improving offenders’lives, and contributing to community safety and growth (Yates 2013).

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