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Is There Familial Transmission of Pedophilia?

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A naturalistic, double-blind, family history comparison of sexual deviancy in the first degree relatives of inpatients with pedophilia and nonpedophilic paraphilia was done. Both proband groups were similar in demographic characteristics, except that pedophiles had a later onset of illness and were older during hospitalization. All patients were men. Sexual deviancy was found in 18.5 per cent of the families of paraphiliacs; only 3 per cent of a psychiatric control group had a family member with sexual deviancy. The preponderance of affected relatives were men. The types of sexual deviancy found in the families of the groups differed. Sexual deviancy among the pedophiles' families consisted of pedophilia. In families of nonpedophilic paraphiliacs, sexual deviancy was predominantly a paraphilia not involving children. These data suggest that pedophilia is familial; however, further studies are needed to delineate the manner of transmission. Nonetheless, pedophilia is found more frequently in families of pedophiles than in families of nonpedophilic paraphiliacs. This indicates specificity in the familial transmission. Thus pedophilia may be independent of the other paraphilias.

Family studies, and family history studies of psychiatric disorders have been used successfully in delineating the major psychoses and the anxiety disorders. Family history was included in the landmark Feighner criteria (6), as one step in the process of validating a syndrome. Data from family history studies have been incorporated into DSM-III (2). However, there are syndromes in DSM-III with a paucity of information concerning familial pattern. The paraphilias are such syndromes.

Prior literature review revealed no systematic studies of the familial pattern of any paraphilia. There were case reports of multigenerational transvestism (3, 10, 11), and exhibitionism (4). There were no reports, to our knowledge, of familial pedophilia.

Pedophilia is clinically different from all other paraphilias, in that the erotic stimulus is children. This suggests that pedophilia may be separate. A family history comparison would be useful in qualitatively separating pedophilia from other sexual deviancies, despite limitations in delineating the manner of familial transmission.

Thus we sought to investigate the familial pattern of pedophilia, by means of a blind family history comparison of pedophilia and nonpedophilic paraphilia, in relatives of pedophilic and nonpedophilic probands.

Methods

All records of inpatients at the Johns Hopkins Biosexual Psychohormonal Clinic (a unit specializing in the treatment of sexual deviancy) from January 1980 to April 1983 were reviewed. All patients were men. Admission dictations by resident and attending physicians were used for evaluation. Those dictations were generated from a semistructured interview that has been used at the Phipps Clinic, Johns Hopkins Hospital (14), since Adolf Meyer. Family history data were separated from other clinical data. The records were reviewed for demographic data, then for the history of the present illness. Diagnoses were made by applying DSM-III criteria for the paraphilias to all history data; this was done blind to family history. All charts not meeting strict DSM-III criteria for a paraphilia were discarded. First degree family members were diagnosed from the chart material, according to the Family History Research Diagnostic Criteria (FHRDC) of Endicott *et al.* (5). Sexual deviancy in a family member was diagnosed by the criteria of "other psychiatric disorder" in the FHRDC, plus a sufficient description of the deviant sexual behavior. Proband charts were divided into pedophilia or nonpedophilic paraphilia groups; records with both pedophilia and nonpedophilic paraphilia in the same patient were discarded.

Thirty-three charts of male inpatients meeting DSM-III criteria for depression, from the same age range (depressive mean = 35.5) as the pedophilia charts, were used as a comparison of the rate of familial sexual deviancy in a hospitalized psychiatric population. These charts were handled in the same manner as the paraphilic charts.

Family history data were organized by a) tabulating data by families, and b) tabulating individual data, then calculating morbidity risks. Morbidity risks were calculated using the Weinberg shorter method (16).

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The age of risk for paraphilia was 15 to 40 years. These years of risk would have included the onset of illness in 94 per cent of the pedophiles and 86 per cent of the nonpedophilic paraphiliacs in the study.

Data were statistically evaluated by a group t or χ^2 test, in appropriate applications.

Results

Four patient records were discarded because criteria of both pedophilia and exhibitionism were met; these patients were exposing themselves to children, thus they probably did not have a true mixed paraphilia. No relatives of these patients had a sexual deviancy.

Thirty-three patients met criteria for pedophilia; of these 16 had homosexual, 13 had heterosexual, and 4 had bisexual pedophilia. Twenty-one patients met criteria for nonpedophilic paraphilia; of these, nine had exhibitionism, three had sadism, one had voyeurism, two had fetishism, one had zoophilia, and five had a mixed paraphilia. The pedophiles had 148 first degree relatives; nonpedophilic paraphiliacs had 83 first degree relatives. These were age corrected to 121 and 65, respectively. The depressives had 170 relatives, age corrected to 135.

Demographic data are found in Table 1. There were statistically significant differences among pedophiles and nonpedophilic paraphiliacs in age at present hospitalization and in age at onset; the pedophiles were older at the age of onset as well as older at the index hospitalization. The two groups were similar in all other aspects recorded. It is of note that almost twice as many pedophiles were molested in childhood as nonpedophiles; however, this difference did not reach statistical significance.

Morbidity risk and family history data are reported in Table 2. The families of pedophiles and nonpedophilic paraphiliacs differed in the sexual deviancy exhibited in their families. Pedophilia was found in five of 33 families of pedophiles. Pedophilia was found in one of 21 families of nonpedophilic paraphiliacs. There was no other paraphilia in the pedophiles' families. However, four of 21 nonpedophilic paraphiliac families had a sexual deviancy not involving pedophilia. These results were statistically significant. The morbidity risks were also different. The highest morbidity risk in pedophile families was for pedophilia; the highest morbidity risk in the nonpedophilic families was for a nonpedophilic paraphilia. These results were also statistically significant. Table 3 reveals morbidity rate broken down according to sex. The morbidity risk for men was much higher than for women. Thus most relatives with paraphilia were men. The depressive families had, as expected, a low familial rate of paraphilia (3 per cent *vs.* 18.5 per cent in paraphilic families) and a very low morbidity risk.

TABLE 1
Comparison of Inpatients with Pedophilia and Inpatients with Nonpedophilic Paraphilia

	Pedophilia ($N = 33$)	Nonpedophilic Paraphilia ($N = 21$)	
Age at onset	27 ± 3	16 ± 1	—[a]
Age at hospitalization	39 ± 3	28 ± 2	—[a]
Per cent ever married	51	29	NS
Per cent white	94	95	NS
Per cent employed	79	76	NS
Per cent molested in childhood	27	14	NS

[a] $p < .01$ group t-test; ± SE. NS, not significant, χ^2.

TABLE 2
Pedophilia and Nonpedophilic Paraphilia in First Degree Relatives

Morbidity Risk[a] (No. Affected/No. at Risk)

Probands	No. relatives at risk	Relatives' morbidity risk: Pedophilia	Nonpedophilic paraphilia
Pedophiles (33)	121	5.0	0
Nonpedophilic paraphiliacs (21)	65	1.5	6.1
Controls (33)	135	0	.7

Number of Families[b] (with at Least One Member Affected, FH+)

Probands	No. families at risk	No. families affected: Pedophilia	Nonpedophilic paraphilia
Pedophiles	33	5	0
Nonpedophilic paraphiliacs	21	1	4
Controls	33	0	1

[a] Morbidity risks: pedophiles *vs.* nonpedophilic paraphiliacs *vs.* controls, 3 × 3, $\chi^2 = 16.16$, $df = 4$, $p < .005$; pedophiles *vs.* nonpedophilic paraphiliacs, 2 × 3, $\chi^2 = 8.02$, $df = 2$, $p < .025$.
[b] Families (FH+): pedophiles *vs.* nonpedophilic paraphiliacs *vs.* controls, 3 × 3, $\chi^2 = 15.13$, $df = 4$, $p < .005$; pedophiles *vs.* nonpedophilic paraphiliacs, 2 × 3, $\chi^2 = 7.65$, $df = 2$, $p < .025$.

TABLE 3
Morbidity Risks (MR) in First Degree Relatives by Sex

	MR (%)
Families of pedophiles[a]	
Men	
Pedophilia	10.3
Nonpedophilic paraphilia	0
Women	
Pedophilia	0
Nonpedophilic paraphilia	0
Families of nonpedophilic paraphiliacs[b]	
Men	
Pedophilia	3.7
Nonpedophilic paraphilia	14.8
Women	
Pedophilia	0
Nonpedophilic paraphilia	3.2

[a] χ^2 (3 × 2) = 12.49, $df = 2$, $p < .01$.
[b] χ^2 (3 × 2) = 10.86, $df = 2$, $p < .01$.

Discussion

Despite paucity of prior literature on the familial pattern of paraphilia, we found that 18.5 per cent of those with paraphilia had other family members, mostly male, with sexual deviancy. The control rate in depressive families was 3 per cent. This indicates that family studies are needed to delineate further the familial incidence of paraphilia.

Furthermore, we found a clear separation of pedophilia from the nonpedophilic paraphilias. Families of pedophiles exhibited pedophilia; families of nonpedophilic paraphiliacs, a nonpedophilic paraphilia. These data have several implications. They suggest that sexual deviancy in the broad sense is not familial, rather that a specific syndrome, in this case pedophilia, is familial. If verified in a family study, this would be evidence of an important distinction between pedophilia and the other paraphilias. Apparently, sexual deviancy is not a continuum. Indeed there are other differences between the syndromes. Abel *et al.* report that there are important differences between pedophiles and other paraphiliacs in objects of sexual arousal and erectile response (1). Endocrinological differences between the two groups have also been reported (9).

That the syndrome is familial suggests, but does not prove, that genetic factors are responsible. As Winokur writes, "Only specific modes of transmission, positive linkage studies, or positive association studies could prove genetic factors" (16, p. 464). Furthermore, psychosocial factors could influence familial transmission: however, a different methodology needs to be employed to elucidate these factors (16).

Age of onset data provide more evidence that there are major differences between pedophilia and the nonpedophilic paraphilias. We found a significant difference between the two groups, the pedophiles having a later age of onset. This agrees with several other studies (7, 8, 12, 13, 15). However, unlike most studies, ours does not find pedophiles to be middle aged; the mean age of hospitalization was 39, the mean age of onset was 27. Perhaps the disagreement between this study and past studies was the method of ascertainment. All past studies ascertained pedophiles through prison populations; our population was a hospital inpatient group. Furthermore, no past paper reported the age of onset, which may be quite different from the age at imprisonment.

Conclusions

In conclusion, we found that pedophilic and nonpedophilic patients differed in age of onset and age of hospitalization; however, pedophiles were not the middle-aged offenders of previous reports, their average age of onset being 27. We also found that 18.5 per cent of the families of all patients with sexual deviancy had family members, mostly men, with a sexual deviancy. Families of those with pedophilia had members also having pedophilia. Families of those with nonpedophilic paraphilia had members with a sexual deviancy not involving pedophilia. These data indicate that pedophilia is a familial disease, not associated with an increased familial risk of the other paraphilias. Further studies are needed to elucidate the manner of transmission.

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