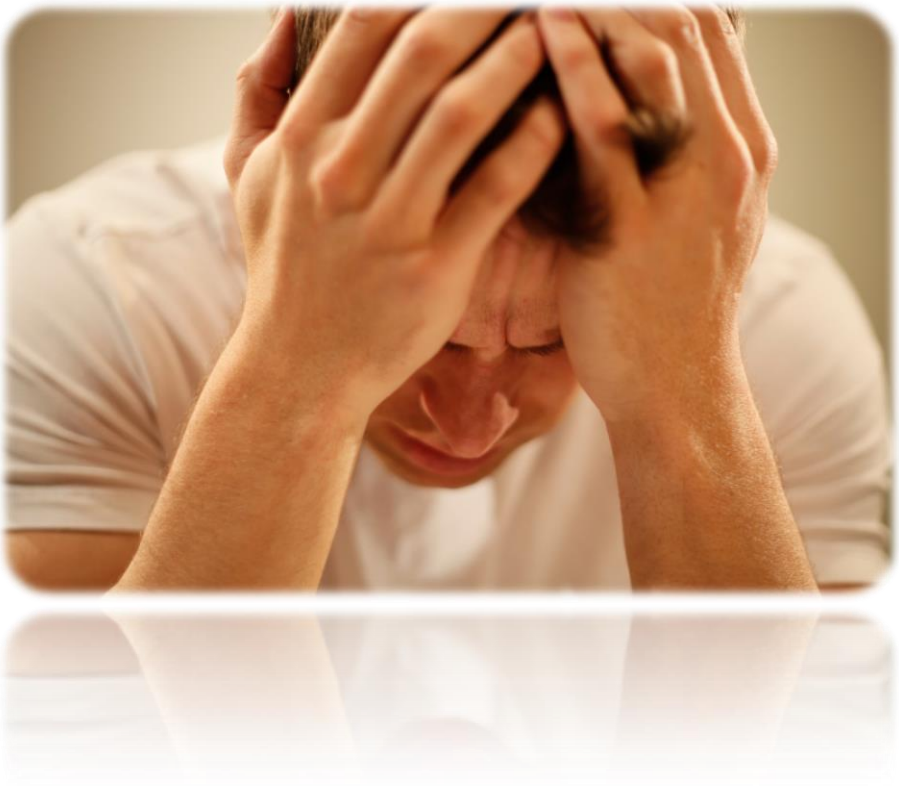
# Examining Pedophilia: Causes, Treatments, and the Effects of Stigmatization



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International Centre
FOR MISSING & EXPLOITED CHILDREN

**Examining Pedophilia:**

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# About Us

The International Centre for Missing & Exploited Children (ICMEC) is leading a global movement to protect children from sexual abuse, exploitation and abduction. ICMEC's work brings promise to children and families by: establishing global resources to find missing children and prevent child sexual exploitation; promoting the creation of national operational centers based on a public-private partnership model; building an international network to disseminate images of and information about missing children; providing training to law enforcement, prosecutors, judges, legal professionals, non-governmental organizations, and government officials; advocating and proposing changes in laws, treaties, and systems to protect children worldwide; conducting international expert conferences to build awareness, encourage and increase cooperation and collaboration between and among countries; and leading a global financial coalition to eradicate commercial child pornography from the Internet.

The Koons Family Institute on International Law & Policy (The Koons Family Institute) is the in-house research arm of ICMEC. The Koons Family Institute conducts and commissions original research into the status of child sexual exploitation and child protection legislation around the world and collaborates with other partners in the field to identify and measure threats to children and ways ICMEC can advocate change to help make children safer. The Koons Family Institute works to combat child abduction and child sexual exploitation on multiple fronts: by creating replicable legal tools, building international coalitions, bringing together great thinkers and opinion leaders, and creating best practices on training and the use of technology.

# TABLE OF CONTENTS

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*Points of view and opinions presented in this publication are those of the author and do not necessarily represent the views of the International Centre for Missing & Exploited Children.*

## Acronyms

CBT – Cognitive Behavioral Therapy

CDC – U.S. Centers for Disease Control and Prevention

CoSA – Circles of Support & Accountability

CPA – Cyproterone Acetate

CSA – Child Sexual Abuse

CSE – Child Sexual Exploitation

DSM-V – Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

E.U. – European Union

fMRI – Functional Magnetic Resonance Imaging

GnRH-A – Gonadotroptin-Releasing Hormone Agonist

ICD – International Classification of Diseases

ICMEC – International Centre for Missing & Exploited Children

LA – Leuprolide Acetate

LHRH – Luteinizing Hormone-Releasing Hormone

MPA – Medroxyprogesterone Acetate

NT – Neurotransmitter

OCD – Obsessive Compulsive Disorder

PPD – The Berlin Prevention Project Dunkelfeld

SSRI – Selective Serotonin Reuptake Inhibitor

U.K. – United Kingdom

U.S. – United States of America

# INTRODUCTION

Pedophilia, defined by the International Classification of Diseases (ICD) as the "sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal age," [1] is gaining recognition as a global public health issue, yet treatment of the problem is hindered by many factors, including the lack of concrete prevalence rates.[2] Much of the research that exists regarding prevalence rates and treatment methods analyzes convicted or otherwise identified sex offenders. However, some estimates suggest that up to 80-90% of sexual offences are never reported.[3] For the purpose of this report, pedophiles and sex offenders are not synonymous. According to the U.S. Sex Offender Registration and Notification Act (SORNA), Title I of the Adam Walsh Child Protection and Safety Act of 2006[4], "The term 'sex offender' means an individual who was convicted of a sex offense."[5] The definition of the term "sex offense", as defined in §111(5) of the same Act, "means (i) a criminal offense that has an element involving a sexual act or sexual contact with another; (ii) a criminal offense that is a specified offense against a minor, …."[6] Sex offences, are further defined by the Institute of Health Economics (IHE), as "any violation against established legal or moral codes with respect to sexual behaviours. They can vary from non-contact offences such as exhibitionism, voyeurism, and Internet-related (online) sex offences to contact offences such as rape and child molestation."[7] In this report, offences are considered to be against children, although it is important to consider that the ages of sexual consent and the severity of offender punishment based upon victim age vary between countries. The main distinction between pedophiles and sex offenders is that pedophiles do not necessarily act upon their sexual attractions, whereas sex offenders do act upon their desires. Therefore, not all pedophiles are sex offenders, just as not all sex offenders are pedophiles. Sex offending can, and often does, exist on a spectrum. The most threatening type of sex offender to society is the predator offender, who seeks out victims and actively seeks to engage in sex offending. Opportunistic offenders, on the other hand, offend when the occasion arises, but do not actively seek to engage in sex offending.

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1 *International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) Version for 2010, F65.4 Pedophilia.* WORLD HEALTH ORGANIZATION, (2010), http://apps.who.int/classifications/icd10/browse/2010/en (last visited April 28, 2014).

2 Ryan C. W. Hall & Richard C. W. Hall, *A Profile of Pedophilia: Definition, Characteristics of Offenders, Recidivism, Treatment Outcomes, and Forensic Issues*, 82 MAYO CLINIC PROCEEDINGS 457, 460 (2007).

3 Paula Corabian et al., INSTITUTE OF HEALTH ECONOMICS, Treatment for Convicted Adult Male Sex Offenders 1, 3 (2010).

4 42 U.S.C. § 16901 (2006).

5 Id.

6 Id. at § 111(5).

7 CORABIAN et al., *supra* note 3, at 2.

Media attention and legislation modifications have increased societal awareness of the prevalence of pedophilia, but have simultaneously caused the incorrect social preconception that pedophilia is synonymous with sex offending. Furthermore, analysis of pedophilia and sex offences as a global health issue often focuses on the effects on victims or on treatments to reduce recidivism, rather than on preventative treatment methods to stop the progression from pedophile to sex offender. Social stigma, legal implications, and other deterrents likely have a negative influence on the rate of treatment sought to minimize the manifestation of pedophilic fantasies and attractions in sexual offences.

Addressing pedophilia preventatively before it progresses to sex offending is important not only from a social and public health perspective, but also with regard to monetary expenditure on victim and offender treatment. Most data regarding economic impact of pedophilia is restricted to the analysis of convicted sex offenders and/or recidivism of such populations. However, due to the conservative estimates of the frequency of child molestation,[8] the reported expenditures are in all probability not all-encompassing. Furthermore, costs can be difficult to calculate accurately due to variations in the inclusion/exclusion of different tangible/intangible costs such as incarceration and court costs, medical costs, police and social welfare services, loss of income, and compensation for being victimized.[9] The costs of mental health treatment for child sexual abuse (CSA)[10] and child sexual exploitation (CSE)[11] are long-term, can be incurred immediately or years after the abuse, and account for a large portion of the monetary expenditures of counseling/treatment received by victims of crime.[12] One study suggests that every victim of nonfatal child maltreatment (i.e. physical, sexual, and psychological abuse and neglect) faces lifetime costs of $210,012 and that every fatality results in lifetime costs of $1,272,900, resulting in a total economic burden of approximately $124 billion in the United

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8 Caroline Wong. *Comment: Chemical Castration: Oregon's Innovative Approach to Sex Offender Rehabilitation or Unconstitutional Punishment?*, 80 OR. L. REV. 267, 2(2001).

9 Ron Donato & Martin Shanahan, *The Economics of Implementing Intensive In-prison Sex-offender Treatment Programs*, Trends & Issues in Crime and Criminal Justice, AUSTRALIAN INSTITUTE OF CRIMINOLOGY (1999) available at http://www.aic.gov.au/publications/current%20series/tandi/121-140/tandi134.html (last visited April 28, 2014).

10 Shelia Savell, *Child Sexual Abuse: Are Health Care Providers Looking the Other Way?*, 1 J. OF FORENSIC NURSING 78, 78 (2005), (stating that "any sexual activity with a child when consent is not or cannot be given; it includes sexual penetration, sexual touching, exposure, and voyeurism").

11 DEP'T FOR EDUC., U.K. GOV'T, *Safeguarding Children and Young People from Sexual Exploitation* (2009)
CSE is "Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability."

12 Mark A. Cohen & Ted R. Miller, *The Cost of Mental Health Care for Victims of Crime*, 13 J. OF INTERPERSONAL VIOLENCE 93 (1998).

States in 2008.[13] Due to the large annual expenditures incurred as a result of both tangible and intangible costs resulting from sex offending, addressing pedophilia to minimize its progression to an offense could lead to considerable economic benefits.[14]

Recent initiatives have been established in countries throughout the world that share the general goal of helping pedophiles refrain from engaging in sexual contact with children. Although these programs have demonstrated successful outcomes and show potential for aiding pedophiles to cope with their feelings and emotions, legal and ethical discrepancies between countries act as one of the largest barriers to implementing such programs on an international level. As a result, countries that offer preventative treatment programs often vary in treatment modalities and in the involvement of professionals in the therapeutic process. For instance, some countries have established programs that largely focus on therapy guided by professionals, while other countries only have anonymous Internet-based support networks.

Variations in reported recidivism rates of sex offenders, and little consensus around defining "recidivism", present yet another hindrance to the universal implementation of pedophile-directed sex offender prevention programs. Reported pedophile recidivism rates range widely, which might be partially due to differences in the definition of the term "recidivism" itself, and creates confusion as to who would benefit from such programs. Some recidivism statistics include repeated arrests for any crime committed by a sex offender, whereas others assess repeated arrests specifically for sexual crimes, convictions, while still others rely upon self-report data.[15] Another factor that should be considered is that longer periods of analysis following initial assessment and treatment can result in higher recidivism rates, so more accurate rates might be obtained following a longer follow-up period.[16] Finally, the majority of recidivism rate data is obtained through the analysis of convicted sex offenders, which leads to some ambiguity regarding the accurate regression rates among non-convicted pedophiles.

This report seeks to better understand the differences between pedophilia and sex offending, to identify treatments used historically and presently to treat pedophiles, and to identify the success of several programs implemented throughout the world to promote abstinence from offending. The goal of this report is to accumulate information that can be used to better understand the complications of and potential for initiating preventative treatments on a global scale to help reduce the progression of pedophilia to sex offending.

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13 Xiangming Fang, et al., *The Economic Burden of Child Maltreatment in the United States And Implications for Prevention*, 36 CHILD ABUSE NEGL. 156 (2012).

14 Donato & Shanahan, *supra* note 8.

15 Hall & Hall, *supra* note 2, at 467.

16 Barry Maletzky & Cynthia Steinhauser, A *25-Year Follow-Up of Cognitive/Behavioral Therapy with 7,275 Sexual Offenders*, 26 BEHAVIOR MODIFICATION, 123, 131 (2002).

# METHODOLOGY

Information was gathered over a four-month period in the spring of 2014 from online databases, reference lists, and specialized journals. Electronic databases such as ArticlesPlus, JSTOR, PsycINFO, and Sage Journals Online were initially searched using key terms.[17] Specialized medical, psychological, economic, sociological, and criminology journals including *Child Abuse & Neglect, Journal of Psychiatric Research, The Journal of Forensic Psychiatry & Psychology, and the Journal of Interpersonal Violence* among others were also searched using key terms. Open sources and a manual search of reference lists from relevant articles were searched to supplement the materials selected to contribute to this report.

Studies were considered if they met any or a combination of the following criteria:

- Any study that defined anatomical, biological, psychological, sociological, or other risk factors/indicators of pedophilia or sex offending;
- Any study that provided legal requirements regarding pedophilia or sex offending;
- Any study that discussed medical, psychiatric, psychological, or sociological treatments of pedophiles and/or sex offenders;
- Any relevant study published in the last 25 years;
- Meta-analyses of original research results;
- Information distributed directly by support networks, intervention programs, or treatment facilities/programs for pedophiles or sex offenders.

There were several limitations to this study. Due to time constraints, a more extensive search of databases and journals was not possible, and not all available literature on this topic could be analyzed and processed. Terminology used across research studies and publications in the field of CSA and CSE is not always consistent, which may have resulted in some research not being identified. In addition, time constraints restricted this study to legal requirements and treatment programs in Germany, Canada, and the U.S. This study primarily focuses on male pedophiles and sex offenders, as there is less research available on the prevalence and consequences of female pedophiles and sex offenders. As there is no current consensus on the exact causes of pedophilia, this study begins by summarizing leading risks and/or contributing factors prevalent in the field in order to better understand the utility and possible success of a variety of preventative treatment approaches.

[17] Key search words include, but are not limited to: sex offender treatment, Cognitive Behavioral Therapy, chemical castration, disclosure laws, and preventative treatment in conjunction with pedophile, pedophilia, minor-attracted, minor, or child.

## CAUSES OF PEDOPHILIA

The causes underlying pedophilia are still largely unknown and disputed, yet several different factors have been identified as potential contributors and/or indicators of pedophilic tendencies. Biological, psychological, and social factors have been indicated in the foundation and development of pedophilia. The use of medical imaging technology, such as functional magnetic resonance imaging (fMRI), a neuroimaging procedure, suggests that the anatomy of the brain might play a role in the sexual preference for different age groups. Specific structural differences indicate decreased grey matter in regions including the bilateral ventral striatum orbitofrontal cortex[18] and decreased volumes of white matter in two neural fiber bundles (the superior fronto-occipital and arcuate fascicule) responsible for sexual cue recognition[19] as two factors increasing the risk for pedophilic attraction. Another brain region that has attracted research attention is the amygdala, shown to exhibit an abnormal activation profile in pedophiles, suggesting that brain activation upon visual stimulation might be significantly different in pedophiles.[20]

Pedophilia has also been linked to unusual hormonal and neurotransmitter levels and pathways. Elevated activity of the catecholaminergic system and heightened testosterone levels, involved in enhancing arousal and orientation in response to threatening stimuli, have been indicated as a potential underlying cause of pedophilia.[21] Heightened testosterone levels have led to the use of antiandrogen treatments for pedophiles.[22] The serotonin system has gained even more focus in research since it plays a significant role in impulse control disorders, such as Obsessive Compulsive Disorder (OCD), that have commonly been indicated as being involved in pedophilia and other paraphilia. One theory is that decreased activity in the presynaptic neuron coupled with hypersensitivity of the serotonin 2 postsynaptic receptor is responsible for these serotenergic abnormalities.[23] The relationship between impulse control disorders and pedophilia has resulted in the formulation of the theory that pedophilia may be caused by neurodevelopmental problems.

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18 Boris Schiffer et al., *Structural brain abnormalities in the frontostriatal system and cerebellum in pedophilia*, 41 J. OF PSYCHIATRIC RESEARCH 753, 757 (2007).

19 James M. Cantor et al., *Cerebral white matter deficiencies in pedophilic men*, 42 J. OF PSYCHIATRIC RESEARCH 167, 167 (2008).

20 Alexander Sartorius et al., *Abnormal amydgala activation profile in pedophilia*, 258 EUR ARCH PSYCHIATRY CLIN NEUROSCI 271, 273 (2008).

21 Michael Maes, *Pedophilia: a biological disorder?*, 14 CURRENT OPINION IN PSYCHIATRY 571, 571 (2001).

22 Lisa Cohen & Igor I. Galynker, Clinical *Features of Pedophilia and Implications for Treatment*, 8 J. OF PSYCHIATRIC PRACTICE 276, 285 (2002).

23 Hall & Hall, *supra* note 2, at 463.

The serotenergic system is involved in many cognitive disorders that have been identified as psychiatric comorbidity diagnoses such as depression and anxiety disorders. Other comorbid disorders include substance abuse disorders, bipolar disorder, antisocial personality disorder, and other paraphilic disorders.[24] These findings support research that suggests that up to 93% of pedophiles meet the diagnostic criteria for other axis I disorders, mood and anxiety disorder comorbidity being most prevalent.[25] Consistent comorbidity with axis II Personality Disorders has also been identified.[26] There is a correlation between pedophilia and low self-esteem, emotional immaturity, internal dysphoria, and sentiments of isolation or loneliness, which can also contribute to or be indicative of other psychological disorders.[27] The similarities between pedophilia and other cognitive disorders have played a significant role in the psychological aspects of pedophile treatment, but have simultaneously acted as a barrier to the acknowledgement of pedophilia as its own condition in need of unique corresponding treatment methods.

Social factors such as childhood abuse, as well as easy access to social platforms, including Internet-proliferated pornography, have also been identified as potential contributing and/or identifying factors for pedophilia and sex offending.[28] Research has indicated a correlation between child pornography viewing and engaging in CSA, although it is important to acknowledge that not all individuals who view child pornography engage in CSA. The Internet has helped in the proliferation of child pornography by making it easily accessible and allowing viewers a way to maintain a certain degree of anonymity. The Internet also allows for adults to engage in activities that are legal but inappropriate and might contribute to the etiology and progression of pedophilia.[29] However, research has suggested that significant differences exist between pedophiles who solely engage in the viewing of child pornography and individuals who sexually abuse children; the prior tend to be younger, more educated, and more commonly employed than the latter.[30] Therefore, although the Internet might facilitate pedophilia, viewers of child pornography do not necessarily exhibit the same characteristics as child sex abusers.

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24 AMERICAN PSYCHIATRIC ASS'N, Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 5th ed. 2013); Cohen & Galynker, *supra* note 20, at 281.

25 Nancy C. Raymond et al., *Psychiatric Comorbidity in Pedophilic Sex Offenders,* 156 AM. J. PSYCHIATRY 786, 787 (1999).

26 Cohen & Galynker, *supra* note 21, at 282.

27 Hall & Hall, *supra* note 2, at 462.

28 Anthony R. Beech et al., *The Internet and child sexual offending: A criminological review,* 13 AGGRESSION AND VIOLENT BEHAVIOR 216, 222-225 (2008).

29 *Id.* at 220; Ethel Quayle & Max Taylor, *Model of Problematic Internet Use in People with a Sexual Interest in Children*, 6 CYBER PSYCHOLOGY & BEHAVIOR 93, 103-104 (2003).

30 Janina Neutze et al., *Predictors of Child Pornography Offenses and Child Sexual Abuse in a Community Sample of Pedophiles and Hebephiles*, 23 SEX ABUSE 212, 230-231 (2011).

Predicting sex offending, like pedophilia, is not a concrete science and as indicated earlier, much of the available data is confined to analyses of convicted sex offenders. As such, indicators of either identified pedophiles or sex offenders may not be successfully extended to unidentified offenders. Analysis of convicted sex offenders, typically conducted in an effort to reduce recidivism, identifies sexual deviancy and antisocial orientation as strong predictors of sexual recidivism. Sex offending has been identified as a potential coping mechanism for stress and low self-control, two factors that also contribute significantly to cognitive disorders that are often comorbid with pedophilia.[31]

## TREATMENTS FOR SEX OFFENDERS

Treatment methods to limit sexual offences against children often involve the treatment of diagnosed (usually convicted) sex offenders to reduce recidivism of sexual offences. As a result, more information and research is available regarding such populations as opposed to unknown pedophiles who may ultimately become offenders. This is problematic because it limits the availability of preventative treatment modalities that can be utilized comprehensively. Additionally, the treatments for identified sex offenders are not universally used and have varied throughout history due to ethical and economic considerations, among other obstacles. Finally, administering the same treatments for child sex abusers and pedophiles may not be effective for several reasons. For instance, pedophiles do not necessarily want to or intend to hurt children as they seek an emotional bond with the child, while sex offenders make the conscious decision to engage in activities against children without the consideration of what the implications are for the child. Pedophiles understandably try to separate themselves from being labeled sex offenders.

Physical treatment is one method that has been shown to be effective in the reduction of subsequent sex offences and also provides a potential method to reduce the progression of pedophilia to engagement in pedophilic activity. For example, surgical castration, the physical removal of male testes, lowers testosterone levels which in turn reduces sexual arousal and activity. In contrast, chemical castration involves the use of hormonotherapy, and reduces sexual recidivism by lowering testosterone through drug use. Within the U.S., surgical and chemical castration is authorized for certain sex offences in only select states, and those states vary significantly in the financial obligations, the castration method, and whether or not the

[31] R. Karl Hanson & Kelly E. Morton-Bourgon, *The Characteristics of Persistent Sexual Offenders: A Meta-Analysis of Recidivism Studies*, 73 J. OF CONSULTING AND CLINICAL PSYCHOLOGY 1154, 1158 (2005).

castration is discretionary, mandatory, or voluntary.[32] In the U.S., surgical castration is viewed by most courts as being a cruel and unusual method of punishment, whereas chemical castration has become more widely accepted due to medical advances and because it is less invasive. [33] Associated medical and psychological considerations, in contrast to legal considerations, limit the acceptance of this drastic and sometimes permanent treatment method. A further limitation of surgical and/or chemical castration in reducing recidivism long-term is that the effects can be minimized or reversed by increasing testosterone levels, which can be achieved simply by increasing testosterone intake.[34]

Research investigating the success of chemical castration used as a form of rehabilitation in Europe (specifically Denmark, Germany, Norway, Sweden, and Switzerland) has shown a drop in recidivism rates from 65% to 15%.[35] Several chemical treatment methods have been indicated as effective for convicted sex offenders. For example, testosterone suppression through the use of antiandrogen treatments such as Cyproterone acetate (CPA) and Medroxyprogesterone acetate (MPA) are widely acknowledged in paraphilia treatment due to their significant role in neurotransmitter (NT) regulation.[36] However, these two antiandrogens are not approved for treatment of sexual disorders universally. For example, while MPA is approved in the U.S. as a sexual disorder treatment, Germany only allows the use of CPA.[37] Although approved in some countries for utilization as treatment components, neither CPA nor MPA reduce testosterone to castrate levels.[38] Other pharmacological options aimed at reducing sexual arousal and activity include luteinizing hormone-releasing hormone (LHRH) agonists and Gonadotropin-Releasing Hormone Agonist (GnRH-A) Therapy. [39] Because of the suspected role that the serotonin system plays in pedophilia, selective serotonin reuptake inhibitors (SSRIs) have also gained a great deal of respect in treatment regimens. The efficacy of SSRIs in paraphilias to reduce recidivism has been demonstrated in several clinical studies. [40] Some researchers suggest that SSRIs are effective due to the reduction or inhibition of sexual activity, impulsivity, obsessive-compulsive

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32 Charles L. Scott & Trent Holmberg, *Castration of Sex Offenders: Prisoners' Rights Versus Public Safety*, 31 J. AM. ACAD. PSYCHIATRY LAW 502 (2003).

33 Wong, *supra* note 7, at 3.

34 T. Howard Stone et al., *Sex Offenders, Sentencing Laws and Pharmaceutical Treatment: A Prescription for Failure*, 18 BEHAVIORAL SCIENCES AND THE LAW 83, 92-93 (2000).

35 Wong, *supra* note 7, at 2-3.

36 Andreas Hill et al., *Differential Pharmacological Treatment of Paraphilias and Sex Offenders,* 47 INT'L J. OF OFFENDER THERAPY AND COMPARATIVE CRIMINOLOGY 407, 412 (2003).

37 Till Amelung et al., *Androgen deprivation therapy of self-identifying, help-seeking pedophiles in the Dunkelfeld*, 35 INT'L J. OF LAW AND PSYCHIATRY 176, 176 (2012).

38 Justine M. Schober et al. *Leuprolide Acetate Suppresses Pedophilic Urges and Arousability.* 34 ARCHIVES OF SEXUAL BEHAVIOR 691, 692 (2005).

39 Virginie Moulier et al., *A Pilot Study of the Effects of Gonadotropin-Releasing Hormone Agonist Therapy on Brain Activation Pattern in a Man With Pedophilia,* 56 INT'L J. OF OFFENDER THERAPY AND COMPARATIVE CRIMINOLOGY 50, 58 (2012); *see also* Hill et al., *supra* note 35, 412-414.

40 Federico Duarte Garcia et al., *Pharmacologic Treatment of Sex Offenders With Paraphilic Disorder*, 15 CURRENT PSYCHIATRY REP. 356 April 2013, at 2.

characteristics, depression, and testosterone reduction.[41] Although it is important to note that the studies concerning SSRI efficacy often contain small research samples and fail to utilize blinded placebo-controlled trials.[42] Because SSRIs have been shown to address psychological and neurohormonal aspects associated with pedophilia, this treatment method is quite promising in treatment considerations. While the use of chemicals has demonstrated significant reductions in reoffending rates, consideration of significant health implications and economic impact act as barriers to the implementation of such treatment programs in many countries.[43]

Finally, psychological treatments have also been indicated as effective components of treatment programs. Within this field, the method that has gained perhaps the most recognition is Cognitive Behavioral Therapy (CBT). This method is designed to address distortions and denial, and is often combined with other psychological treatment methods, such as empathy and impulse control training, biofeedback, and relapse prevention.[44] CBT has repeatedly shown successful results in lowering pedophile recidivism rates and, subsequently, community risk after treatment.[45] However, it has also been found that the effectiveness of this treatment method decreases as time progresses.[46] Furthermore, comorbidity of pedophilia with mood, anxiety, and personality disorders may limit the effectiveness of CBT approaches for convicted sex offenders,[47] leading many researchers to suggest the dual implementation of psychological treatments and pharmacotherapy in sex offender treatment and preventative initiatives. An example of this method is the coupling of CBT and leuprolide acetate (LA), a GnRH-A, which reduces pedophilic fantasies and masturbation, but does not change pedophilic sexual preference.[48]

## LEGAL CONSIDERATIONS AFFECTING PREVENTATIVE TREATMENT INITIATIVES

During the period between 1945 and 2005, 90 countries revised legal provisions regarding CSA (see Appendix 1), which highlights the impact of individualization and shifting international human rights standards.[49] These changes, while effective in increasing child protection, are not

41 Hill, et al., *supra* note 35, 416.
42 Hall & Hall, *supra* note 2, at 466.
43 Garcia, et al., *supra* note 39, 2-3; Donato & Shanahan, *supra* note 7; Schober, et al., *supra* note 36, at 692 and 702.
44 Hall & Hall, *supra* note 2, at 466.
45 Harvard Medical School, *Pedophilia: Who are the men who "love" children in intolerable ways? And how can they be helped to change?* 20 THE HARVARD MENTAL HEALTH LETTER 1 (2004).
46 Maletzky & Steinhauser, *supra* note 15, at 139.
47 Raymond, *supra* note 24, at 787.
48 Schober et al., *supra* note 37, at 704.
49 David John Frank, et al. *Worldwide Trends in the Criminal Regulation of Sex, 1945-2005*, 75 AM. SOCIOLOGICAL REV. 867, 879-880 (2010).

universal and vary significantly in their interpretation of CSA, as well as methods to ensure child safety and access to resources. As modernization and globalization expand, countries are also being forced to address the presence of Internet-facilitated CSE, trafficking, and sex tourism.

Legal discrepancies regarding the treatment of pedophilia serve as perhaps the largest barrier to addressing pedophilia as a public health concern before it progresses to sex offending. One of the biggest legal inconsistencies is in the age of consent. For instance, in the European Union (E.U.) alone, the age of consent spans a range of five years. The age of consent is 18 in Malta; 17 in Ireland and Northern Ireland; 16 in Belgium, Cyprus, Finland, and the Netherlands; 15 in Czech Republic, Denmark, France, Greece, Slovenia, and Sweden; 14 in Austria, Estonia, Germany, Hungary, Italy, Luxemburg, Portugal; and 13 in Spain.[50] Lower ages of consent mean that a greater number of adolescents are not protected under child protection laws, and that sexual offences committed against children beyond the age of consent are not necessarily considered cases of CSA. This is one factor that limits the identification of international pedophile prevalence rates and complicates international implementation of child protection laws.

Another legal consideration that hinders the preventative treatment of pedophilia is the variation between confidentiality and reporting laws for healthcare workers in different countries. In the U.S., healthcare professionals are required to report possible CSA offences to social services or law enforcement. These potential abusers are subsequently required to be identified to law enforcement on the sex offender register once convicted of an offense.[51] The implications of such requirements act as a considerable deterrent for pedophiles hoping to seek counseling for their sexual interests and help them refrain from engaging in pedophilic activity. Another consideration that impacts the likelihood of individuals voluntarily seeking treatment is the discrepancy in reporting requirements regarding CSA that occurred prior to the initiation of treatment. Strict reporting laws within the U.S. have been found to reduce the identification of undetected adult abusers and abused children, lower the disclosure rate of CSA during treatment, and decrease voluntary treatment enrollment.[52]

In contrast, German legislation requires strict confidentiality by healthcare professionals regarding previous CSA offences, as well as confidentiality regarding previous and planned CSA offences, unless coupled with intentions to commit murder.[53] In other words, upon

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50 Gert Vermeulen, *Missing and sexually exploited children in the enlarged EU: Epidemiological data in the new member states* (2005).

51 Hall & Hall, *supra* note 2, at 467.

52 Fred S. Berlin et al., *Effects of Statutes Requiring Psychiatrists to Report Suspected Sexual Abuse of Children*, 148 AM. J. PSYCHIATRY 449, 452-453 (1991).

53 Klaus M. Beier et al., *Can pedophiles be reached for primary prevention of child sexual abuse? First results of the Berlin Prevention Project Dunkelfeld (PPD),* 20 The J. OF FORENSIC PSYCHIATRY & PSYCHOLOGY 851, 855 (2009).

disclosure of offences or planned offences, medical or counseling professionals are not legally permitted to report the offences. In countries that do not require disclosure of pedophilic preferences by healthcare professionals, preventative treatment programs to reduce sex offending and offer support to pedophiles appear to be more prevalent. The confidentiality laws allow for pedophiles to seek treatment without fearing criminal prosecution or negative social outcomes (e.g. being placed on a sex offender registry), increasing the likelihood of voluntary treatment enrollment and identification of sex offences by the offender.

Because of the legal considerations, the implementation of preventative programs to stop pedophilia from resulting in sex offending has only been attempted and successful in select countries, likely due to variations in therapeutic confidentiality and mandatory reporting requirements.[54] Although legal factors play an influential role in the potential of preventative treatment programs being established and implemented in different countries, it is vital to understand that this is a complex and multifaceted issue that is not only limited to legal issues, but also depends on social, economic, medical, and psychological perspectives and potentials in different countries.

## PREVENTATIVE TREATMENT PROGRAMS FOR PEDOPHILES

Due to legal considerations and social factors, the implementation of preventative treatment programs to help pedophiles avoid engaging in sex offending behaviors has not been widely studied. However, several countries have been successful in implementing programs in this endeavor.

### *Germany*

It is estimated that within Germany there are approximately 15,000 reported cases of CSA and around 3,000 convicted offenders each year, although population-based studies estimate roughly 60,000 cases annually.[55] Confidentiality requirements for health professionals in Germany have allowed for the 2005 establishment of The Berlin Prevention Project Dunkelfeld (PPD)[56], a preventative treatment program implemented in Germany to target pedophilic men voluntarily seeking help to avoid engaging in CSA. The program began in the Institute for

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54 *Id.*at 854.

55 Klaus M. Beier, MD PhD, Institute of Sexology and Sexual Medicine, Charité Berlin. The German Dunkelfeld Project: Proactive Strategies to Prevent Child Sexual Abuse and the Use of Child Abusive Images at the ATSA 31st Annual Research and Treatment Conference (Oct. 17-20, 2012).

56 *Project*, DON'T OFFEND, https://www.dont-offend.org/story/78/3878.html (last accessed May 16, 2014).

Sexology and Sexual Medicine within the University Hospital Charité in Berlin, and has expanded to six other cities across Germany.

PPD was launched with a media campaign, which provided the general public with information about the program. The media campaign was designed to communicate 1) empathy for the situation of the individuals, 2) no discrimination regarding the individual or sexual preference, 3) reassurance of no criminal repercussions, 4) assurance of confidentiality, and 5) reduction of guilt and shame.[57] A website was also created to provide individuals with more information about the program and guidance on how to enroll in the project. In June 2009, a second media campaign was released to target individuals who engage in online offending specifically (viewing and possessing child pornography).

PPD is a somewhat selective program, requiring that participants either 1) have not committed criminal offences, but fear that they might in the future (potential offenders), 2) have committed criminal offences, but have not been identified by the judicial system (Dunkelfeld offenders), or 3) have committed criminal offences that have been reported for which they have been legally convicted, given that the sentence has been served, all legal issues have been settled, and they are no longer under judiciary supervision (ex-Hellfeld offenders).[58] The individual must be aware of the problems associated with child-directed sexual preference and be self-motivated to seek and utilize therapy to avoid engaging in CSA. The applicant cannot be an alcoholic nor have a psychotic condition, and must undergo clinical diagnosis before being accepted into the program. The design of the program includes the following components: telephone hotline/screening, clinical interview, psychometric assessment, examination for intake/exclusion criteria, treatment, and post treatment and one-year follow-up(s).[59]

Treatment within PPD is structured and utilizes CBT, pharmacotherapy, and sexological tools.[60] The purpose of therapy is to encourage the participant to accept his sexual preference and to take the initiative to refrain from engaging in CSA and/or using child pornography images. Treatment can either be conducted in groups or individually, with participants not receiving more than 50 of these out-patient treatment sessions. The pharmacotherapy methods employed in this program include SSRI and antiandrogen treatments.[61] Sexological tools can include adult sexual partners, where applicable.

Within 38 months of the project's initiation, 808 individuals contacted and demonstrated an interest in participating in the program. 358 of those respondents (~45%) proceeded from the

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57 Beier, *supra* note 52, at 856.

58 *Id.* at 858.

59 Beier, *supra* note 54.

60 Beier, *supra* note 52, at 854.

61 *Id.*

anonymous telephone stage to the full assessment at the outpatient clinic. The program not only drew significant attention from German citizens shortly following its initiation, but also from individuals within other European countries such as Austria, Switzerland, and England.[62]

While many recognize the potential of a program such as PPD, it is also important to understand the limitations of the program. For instance, because the participants in the program must volunteer, it is likely that this population is not only different from convicted sex offenders, but also other non-identified sex offenders who do not seek treatment. Therefore, the extrapolation of results from PPD to encompass all non-identified offenders might not be possible. The success of PPD is due in large part to the country's legal confidentiality requirements. The potential for international expansion is greatly limited by disclosure requirements and varying levels of social acceptance of pedophilia. For instance, the media campaign used to advertise PPD demonstrates that Germany is, in a sense, socially accepting as it acknowledges that pedophilia is prevalent within society. In contrast, countries that deny the existence of pedophilia in its entirety fail to acknowledge and/or accept the segment of their population that is sexually attracted to children.

### *Canada*

61% of all sexual assault victims reported to the police in Canada in 2003 were children and youth, and 80% of those identified victims were female. Females in the 14-17 year age category accounted for 31% of the child and youth sexual assault victims, while females aged 11-13 represented 23%. Of the ~21,000 cases involving pedophilic sex offences brought before Canadian courts between 1994 and 2004, 58% of the offenders received prison sentences.[63]

The Phoenix Program[64] is one program that has been established to target identified sex offenders. The program is a multidimensional, comprehensive treatment program run by the Alberta Mental Health Board for convicted sex offenders in Edmonton. The participants in this program are predominantly volunteers from the correctional system. The Phoenix Program is a 19-bed, minimum-to-maximum security in-hospital treatment program. Participation typically spans ten months, with a minimum stay of six months required to complete treatment. Participants engage in 32-35 hours of therapy weekly, administered in the form of psychotherapy, victim empathy, cognitive restructuring, anger management, human sexuality, relapse prevention, life planning, and other forms. The use of psychotrophic medication and antiandrogens is uncommon in this program. Recidivism rates among sex offenders following

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62 *Id.* at 859.

63 Kathy AuCoin, *Children and Youth as Victims of Violent Crime.* 25 STATISTICS CANADA – CATALOGUE no. 85-002-XIE (2005).

64 JOHN HOWARD SOCIETY OF ALBERTA, *Sex Offender Treatment Programs*, (2002), at 9, http://www.johnhoward.ab.ca/pub/respaper/treatm02.pdf.; *see also* Lea H. Studer et al., *Phoenix: An Inhospital Treatment Program for Sex Offenders*, 23 J. OF OFFENDER REHABILITATION 91 (1996).

treatment at The Phoenix House is reported to be as low as 3.3%, making it a highly regarded example in sex offender treatment initiatives. A similar program called Counterpoint House[65], also run by The Alberta Mental Health Board, but independent from The Phoenix Program, employs a similar multidimensional approach to the treatment of adolescent sex offenders. Counterpoint House uses CBT, psychotherapy, and skills therapy as treatment modalities and has reported an overall reduction in deviant masturbation and deviant fantasizing over long-term analysis. However, deviant fantasies were still more commonly reported than non-deviant fantasies.[66]

Circles of Support & Accountability (CoSA) is a community-based support program designed to offer social support to sex offenders upon their reintegration into society following their release. The program was founded in 1994 and there are now 16 CoSA sites throughout Canada.[67] The program pairs a released sex offender with four to six community volunteers who assist, support, and help to hold the core member (the ex-offender) accountable for their behavior.[68] Research has shown that CoSA is very effective, reducing recidivism of sex offenders by 70% or more, and contributing to the implementation of similar programs in the United Kingdom (U.K.) and in the U.S.[69]

Although these three programs are regarded as successful, they only serve populations that are identified as offenders. Thus, the programs do not adequately address non-identified individuals with pedophilic sexual attractions.

### *The United States*

Because of strict disclosure laws, the implementation of prevention programs such as PPD within the U.S. is not currently realistic. Instead, a variety of other community-based and education-based programs have been introduced in an effort to help communities and children identify sex abuse and/or sex offending behavior. Additionally, web-based support groups have been established to provide pedophiles with support from other anonymous users.

Stop It Now! was founded in the U.S. in 1992 with the goal of reducing CSA by "mobilizing adults, families, and communities to take actions that protect children before they are harmed."[70] The program employs a multidimensional approach to prevent CSA including help

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65 JOHN HOWARD SOCIETY OF ALBERTA, *Sex Offender Treatment Programs*, (2002), at 8, http://www.johnhoward.ab.ca/pub/respaper/treatm02.pdf.

66 Sex Offender Treatment Programs. *John Howard Society of Alberta,* (2002), http://www.johnhoward.ab.ca/pub/respaper/treatm02.htm.

67 *Church Council On Justice And Corrections,* COSA, http://ccjc.ca/practice/cosa/ (last accessed April 14, 2014).

68 Robin J. Wilson et al., *Circles of Support & Accountability: A Canadian National Replication of Outcome Findings*, 21 SEX ABUSE: A JOURNAL OF RESEARCH AND TREATMENT 412, 425 (2009).

69 *Id.*at 416.

services, prevention advocacy, prevention education, and training.[71] At the initiation of the Stop It Now! Vermont program, 52% of the callers to the helpline were self-identified abusers. This percentage dropped to 15% following the initial period and remained constant until 1996, when legislation changes and media attention on Megan's Law reduced the number of self-identified abusers to 0%.[72] Although there are Stop It Now! programs in several states within the U.S., the drastic drop in self-identified reporting rates exhibited in the Vermont program is reflective of the significant impact that legislative changes have had in the ability of such programs to target unidentified pedophiles. In addition to domestic expansion within the U.S., the Stop It Now! program has expanded internationally to countries such as the U.K. and the Netherlands.

Another organization designed to help address pedophilia is B4U-ACT, established in 2003 to facilitate understanding between mental health professionals and individuals who are sexually attracted to minors. Annual workshops are held in Maryland to promote communication, understanding, and awareness of issues regarding attraction to children and adolescents.[73] This program has faced strong criticism from the public, and has been accused of being a "slippery slope"to creating societal acceptance of pedophilia. The criticism that the organization has faced is reflective of the stigmatization that pedophiles face within the United States in particular.

There are other networks within the U.S. that seek to reduce the social stigma against pedophiles through peer-to-peer support. An example of these networks is Virtuous Pedophiles, a web-based support network that seeks to "reduce the stigma attached to pedophilia by letting people know that a substantial number of pedophiles do not molest children, and to provide peer support and information about available resources to help pedophiles lead happy, productive lives," and stating that the program's "…highest priority is to help pedophiles never abuse children."[74] Although this network allows pedophiles anonymity and peer support, Virtuous Pedophiles does not allow for the treatment of pedophilia through interpersonal interactions and medical interventions that have been found to be effective in other programs.

The implementation of preventative programs that have been shown to be effective, such as PPD, is unlikely within the U.S. due not only to legislative factors, but also contributing societal factors.

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70 *About Us,* STOP IT NOW! www.stopitnow.org/about , (last accessed April 14, 2014).

71 *Can Australia 'Stop It Now!'?,* WHITE RIBBON (2013). http://www.whiteribbon.org.au/uploads/media/Conference_2013/Will_Australia_Stop_it_Now_Phoenix_House.pdf.

72 Joan Tabachnick & Elizabeth Dawson, *Stop It Now! Vermont Four Year Program Evaluation 1995-1999,* 1 OFFENDERS PROGRAMS REPORT 49, at 24 (2000).

73 *Workshops,* B4U-ACT (2012), http://b4uact.org/workshops.htm (last visited April 14, 2014).

74 *Home,* VIRTUOUS PEDOPHILES (2014), http://virped.org/ (last visited April 14, 2014).

# RESULTS

As noted previously, pedophilia can be partially attributed to a variety of anatomical, biological, psychological, and sociological factors. The diversity of identified causal factors shows how multifaceted pedophilic attraction can be. Analysis of treatment methods for people who are attracted to minors has shown that a combination of medical and psychological treatment methods presents the most promising treatment approach for pedophilia, a finding similar to the approach currently being employed in various countries to reduce recidivism among convicted sex offenders. Because of the enormity of the effects that sex offending has on society with regard to economics, health outcomes, and mental health outcomes, many countries have begun programs designed to reduce recidivism rates among convicted sex offenders. However, the treatment of pedophiles (unidentified and identified) is not only less researched, but also less common and less accepted.

In conclusion, although pedophiles have the potential to sexually offend against minors, they do not necessarily wish to engage in CSA. As a paraphilia, pedophilia should be viewed as a threat to public health. Every effort should be made to better understand the foundations of pedophilic attraction and to identify and establish preventative treatment methods internationally. To achieve this, both legislation and social acceptance, which are highly related to one another, must be modified. Until such changes are achieved, the international implementation of programs such as the PPD will be limited and pedophiles will continue to be stigmatized in society. That is not to say that pedophilia should be condoned, but rather to suggest that the negative impacts of pedophilia possibly can be mitigated with support and treatment to help them cope with their sexual preferences and/or refrain from acting upon their sexual desires toward children.

## Appendix 1. Expansions and Contractions in the Scope of Child-Sexual-Abuse Laws (Nonviolent Heterosexual Intercourse between Adult and Minor Child), 1945-2005 (Frank et al., 2010)

| | expand | contract | expand | contract | expand | contract | expand | contract |
|---|---|---|---|---|---|---|---|---|
| France | 1946 age | | Portugal 1982 | | vaginal Norway 1994 vaginal | | Costa Rica 1999 gender | |
| India | 1949 age | | Portugal 1982 | | age Sudan 1994 age | | Costa Rica 1999 vaginal | |
| Greece | 1952 age | | Portugal 1982 chastity | | Albania 1995 | age | Senegal 1999 age | |
| South Korea | 1953 | gender | Lebanon 1983 age | | Antigua 1995 age, gender | | Slovenia 1999 age | |
| Tunisia | 1958 age | | Mexico 1983 vaginal | | Panama 1995 vaginal | | Spain 1999 age | |
| Ecuador | 1959 | age | Mexico 1983 gender, chastity | | Panama 1995 age, chastity | | Azerbaijan 2000 vaginal | |
| Congo DR | 1960 age | | Canada 1985 gender | | Portugal 1995 vaginal | | Colombia 2000 vaginal | |
| Mongolia | 1961 age | | Canada 1985 vaginal | | Portugal 1995 gender | | Dominica 2000 age | |
| Central Af Rep | 1964 age | | Canada 1985 | | Spain 1995 vaginal | | Malawi 2000 age | |
| Somalia | 1964 | age | Honduras 1985 vaginal | | Sri Lanka 1995 vaginal | | Namibia 2000 vaginal | |
| Laos | 1965 gender | | Trinidad 1986 age | | Sri Lanka 1995 age, gender | | Namibia 2000 gender | |
| East Germany | 1968 chastity | | Greece 1987 | age | Italy 1996 vaginal | | Vietnam 2000 age | |
| East Germany | 1968 vaginal | | Thailand 1987 age | | Seychelles 1996 gender | | Albania 2001 age, gender | |
| Iraq | 1969 age | | Israel 1988 | age | Seychelles 1996 vaginal | | Estonia 2001 gender | |
| Finland | 1971 chastity | | Mexico 1988 | vaginal | Burkina Faso 1997 age | | Rwanda 2001 age | |
| Finland | 1971 | age | South Africa 1988 gender | | El Salvador 1997 gender | | Zimbabwe 2001 gender, chastity | |
| Cameroon | 1972 age | | Belgium 1989 vaginal | | El Salvador 1997 vaginal | | Romania 2002 vaginal, extension | |
| Cuba | 1973 chastity | | Malaysia 1989 age | | Honduras 1997 gender | | Romania 2002 gender | |
| Cuba | 1973 vaginal | | Spain 1989 gender | | Paraguay 1997 age, gender | | Armenia 2003 vaginal | |
| West Germany | 1973 chastity | | Spain 1989 vaginal | | Philippines 1997 vaginal | | Bosnia 2003 vaginal | |
| Mali | 1973 age | | Mexico 1990 chastity | | Thailand 1997 | age | Kenya 2003 age | |
| Tanzania | 1973 age | | Paraguay 1990 chastity | | Botswana 1998 gender | | Lithuania 2003 gender | |
| Peru | 1974 | age | Uganda 1990 age | | Chile 1998 vaginal | | Mauritius 2003 gender | |
| Algeria | 1975 age | | Bahamas 1991 gender | | Chile 1998 gender | | Spain 2003 vaginal | |
| San Marino | 1975 age, extension | | Mauritius 1991 age | | Croatia 1998 vaginal | | Sudan 2003 age | |
| Congo DR | 1978 | age | Netherlands 1991 gender | | Ecuador 1998 vaginal | | UK 2003 vaginal | |
| Cuba | 1978 extension | | Netherlands 1991 vaginal | | Portugal 1998 vaginal | | UK 2003 gender | |
| Spain | 1978 gender | | Peru 1991 chastity | | Russia 1998 | age | Vanuatu 2003 gender | |
| Spain | 1978 | age | Barbados 1992 gender | | Sweden 1998 vaginal | | Brazil 2005 | age |
| Pakistan | 1979 age, gender | | Cambodia 1992 age | | Tanzania 1998 age | | Liberia 2005 vaginal | |
| Colombia | 1980 | age | Nicaragua 1992 vaginal | | Argentina 1999 vaginal | | Liberia 2005 age | |
| Australia | 1981 gender | | Nicaragua 1992 age, gender | | Argentina 1999 age, chastity | | New Zealand 2005 vaginal | |
| Burundi | 1981 age | | USA 1993 gender | | Austria 1999 vaginal | | New Zealand 2005 gender | |
| Denmark | 1981 vaginal | | Germany 1994 gender | | Bolivia 1999 vaginal | | Romania 2005 | age |
| Panama | 1982 | age | Germany 1994 vaginal | | Bolivia 1999 chastity | | Turkey 2005 | age |

*Note:* Gender = reforms remove or impose distinctions based on gender (e.g., granting boys equal protection to girls).
Age = reforms lower or raise distinctions based on age (e.g., reducing the age of consent).
Chastity = reforms remove or impose distinctions based on chastity (e.g., eliminating provisions differentiating prostitutes from maidens).
Vaginal = reforms remove or impose distinctions around penile–vaginal sex (e.g., redefining sex to include anal and oral intercourse).
Extension = reforms remove conditions limiting the scope of the law, other than as specified above.


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