
Pedophilic Disorder

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Pedophilia, or a sexual interest in young children, has long been recognized as unusual and deviant, often linked with sexual behaviors involving youth and prepubescent children. Even early cultures which condoned the marriage of older men to adolescent females, or sexual relationships between older males and adolescent males (i.e., pederasty), largely condemned and questioned individuals who engaged in preferential sexual practices with very young children who had not yet reached the age of puberty (e.g., Suetonius, 121/1989; see also Quinsey, 1986; Seto, 2008a). Early works dedicated to the discussion of aberrant sexual behaviors as a form of mental illness (e.g., Krafft-Ebing, 1886/1997) also noted the peculiarity of individuals who chose to engage in sexual behavior with infants and young children. It seems that despite cultural variations in marriageable age and perceptions of sexual development, sexual interest, and arousal associated with infants and very young children are almost universally perceived as unconventional and at the same time, inappropriate.

Diagnosis and Diagnostic Considerations

Pedophilia first appeared in the context of mental disorder in the late nineteenth century, when it was labeled *paedophilia erotica* by Krafft-Ebing (1886/1997). It was later included in the diagnostic nomenclature for mental health professionals with the publication of the *Diagnostic and Statistical Manual for Mental Disorders, 2nd edition* (American Psychiatric Association, 1968) and has continued to be defined as a

mental illness in subsequent revisions of diagnostic criteria related to problematic sexual interest and behavior.

Our most current diagnostic definition of pedophilia comes from the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM 5, American Psychiatric Association, 2013). Termed pedophilic disorder, this diagnosis connotes not simply sexual interest in prepubescent children but also the presence of significant distress, interpersonal impairment, or other difficulty as a result of these sexual interests. The DSM 5 contains a number of key diagnostic elements that were similarly present in the previous 4th edition and text revision of the *Diagnostic and Statistical Manual* (DSM-IV-TR, American Psychiatric Association, 2000). Within this definition are several crucial features: (1) recurrent and intense sexually arousing fantasies, urges, or behaviors involving prepubescent children, (2) acting on the urges or experiencing clinically significant distress or interpersonal impairment, and (3) time-related criteria, including a duration of at least 6 months for fantasies, urges, or behaviors and an age of 16 for the individual in question, with at least 5 years' difference in age between the individual and the children of interest. Additional specifiers include child gender preference, incestuous sexual interest, and whether or not the individual is also attracted to adults as well as children. While it is noted that the sexual interest involves a prepubescent child, this is merely defined as "generally 13 or younger," given that signs of pubescence are fluid throughout early pubertal development and vary from child to child. Diagnostic criteria for pedophilia described in the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision, 2007 Version* (ICD-10; World Health Organization, 2007) are relatively brief, stating only that it reflects a sexual preference for children of prepubertal or early pubertal age. This remains the key feature with regard to most definitions of pedophilia—that it connotes a sexual interest in young children.

Oftentimes, the term "pedophile" is used rather loosely within a general context, referring broadly to individuals

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who have committed sexual crimes against children and used interchangeably with “child molester.” However, it is important to note that given current diagnostic labels, not everyone who has engaged in sexual acts involving children would meet criteria for pedophilia, nor have all individuals diagnosed with pedophilia necessarily engaged in acts of child molestation or child sexual abuse. This is an important distinction, as much of the literature on pedophilia may be clouded by the inclusion of individuals who have not met specific criteria categorizing their sexual interest and behavior as a mental illness (Seto, 2008a). It is noted that individuals may engage in sexual behavior involving children without clear pedophilic interests, for reasons such as impulse control problems, dysfunctional relationship models stemming from histories of sexual abuse and trauma, intimacy deficits with adults (e.g., Beech & Fisher, 2002; Bumby & Hansen, 1997; Marshall, 1989, 1993), or self-regulatory deficits (e.g., Stinson, Sales, & Becker, 2008).

Victim research indicates that as many as 20 % of females and 10 % of males have been sexually victimized as children (Finkelhor, 1994), and that approximately 90,000 cases of child sexual abuse were reported to the authorities in the USA in 2000, though there appears to have been a decrease in actual offending, reporting, or both in recent decades (Finkelhor & Jones, 2004). From this, however, it is difficult to determine the exact number of pedophilic offenders, given that many sexual offenders against children may not demonstrate these characteristics or that some of the children represented in these numbers may have been victimized by the same perpetrator.

With regard to the prevalence of pedophilia, we do not currently know how many individuals are afflicted with this disorder. We do know that it is infrequent and that on surveys eliciting responses regarding sexual fantasies involving young children, approximately 3–5 % of individuals surveyed report some sexual interest and arousal associated with prepubescent children [as reported in Seto (2008a, 2008b)]. Even fewer individuals have reported acting on their sexual interest or fantasies in these same surveys. However, it becomes clear that despite the relative rarity of cases of pedophilia, it is more common among some groups than others. Not surprisingly, cases of pedophilia are most often identified among groups of known sexual offenders against children. Research regarding sexual interest and arousal patterns among adult men who have committed known acts of child sexual abuse reveals that between 40 and 50 % of these men would meet DSM-IV-TR (American Psychiatric Association, 2000) criteria for pedophilia (Blanchard, Klassen, Dickey, Kuban, & Blak, 2001; Maletzky & Steinhauser, 2002; Seto, 2008a; Seto & Lalumiere, 2001).

Recent attention to the use of child pornography, particularly given its availability on the internet, highlights the reality that not all individuals with sexual interests in young

children are known offenders, and that little is in fact known about pedophilic individuals who have not acted on their sexual interests. In a study by Wolak, Finkelhor, and Mitchell (2005) describing the content of pornographic materials associated with a sample of child pornography offenders, 85 % possessed pornography involving children under the age of 12, in addition to pornography depicting post-pubertal adolescents. In this same sample, 17 % possessed depictions of prepubertal children exclusively. Thus, while approximately half of child sexual abusers may meet criteria for pedophilia, perhaps more than half of individuals who collect images of underage youth may demonstrate significant sexual interest in prepubertal children.

Sexual development and age of onset of pedophilic sexual interests do not appear to be substantially different from the sexual development or age of first sexual interests and experiences in non-pedophilic males (Seto, 2008a), though these individuals do differ in terms of the nature of their sexual interests. It is therefore likely that pedophilic sexual interests first manifested themselves in adolescence, along with the advent of puberty, for these individuals. Additional research does suggest higher rates of sexual abuse or trauma in the histories of adolescent and adult sexual offenders against children than those against adults, perhaps implying some early disturbances in normative sexual experiences and development (see Seto, 2008a).

With regard to comorbidity with other sexual disorders, pedophilia is often associated with comorbid diagnoses of exhibitionism, voyeurism, and frottagage, as well as acts of rape (Abel, Becker, Cunningham-Rathner, Mittelman, & Rouleau, 1988; Raymond, Coleman, Ohlerking, Christenson, & Miner, 1999). Although criteria used to define pedophilia were predominantly behavior-based, findings from Abel et al. (1988) additionally reveal that 80–95 % of individuals with pedophilic interest in male children met criteria for one or more additional paraphilias, with the same being true for 60–85 % of individuals with pedophilic interest in female children. Similar results were obtained by Raymond et al. (1999), in that 53 % of the individuals in a sample of pedophiles met diagnostic criteria for at least one other paraphilia.

In terms of comorbidity with other psychiatric symptoms and diagnoses, individuals with pedophilia are often diagnosed with other Axis I and II conditions at a significant rate. In one study of individuals diagnosed with pedophilia (Raymond et al., 1999), current and lifetime rates of other Axis I disorders were 75 % and 93 %, respectively. The most common of these were mood disorder (31 % current; 67 % lifetime), anxiety disorder (53 % current; 64 % lifetime), and substance use disorder (4 % current; 60 % lifetime). Rates of Axis II personality pathology were reported at 60 % in this same sample. Few other studies have examined rates of psychopathology specifically among pedophiles, but other

empirical research denoting comorbid psychiatric disorder among individuals who meet criteria for one or more paraphilias reveal similar levels of psychopathology (e.g., Kafka & Hennen, 2003), particularly with regard to mood-disordered and personality-disordered symptoms.

Etiology of Sexual Interest in Children

Initial efforts to describe the causal mechanisms of pedophilia categorized pedophiles into two typologies—fixated and regressed (e.g., Groth & Birnbaum, 1978). These terms originate from a psychodynamic conceptualization of pedophilia and refer to an assumption that individuals who show some sexual interest in or behavior related to children are relying on sexual impulses from an earlier developmental stage. The fixated pedophile is an individual who is “fixated” in an earlier developmental stage and who identifies him- or herself with children. The fixated pedophile demonstrates poor or limited social interactions with adults and a lack of intimate relationships with adult partners. He or she will presumably engage in immature behaviors and associate more frequently with children. It is also hypothesized that the primary targets of a fixated pedophile are male children, and that this represents intrapsychic resolution of difficulties with achieving later stages of adult maturity. The regressed pedophile, on the other hand, is primarily sexually interested in same-aged adult partners and has likely engaged in such relationships during adulthood. However, under conditions of extreme stress, or when adult sexual partners are unavailable, the regressed pedophile may “regress” to an earlier developmental stage and select a child sexual partner to fulfill intimacy needs. This substitution of sexual partners may be situational or dependent on the moment and often does not reflect the degree of planning which is assumed in the sexual offenses characteristic of the fixated pedophile. Further, the regressed pedophile is presumably more likely to select female child victims, as this does not reflect conflicts in prior developmental stages of the offender himself. These views of pedophilia eventually fell out of favor as many researchers and clinicians moved away from psychodynamic personality explanations of sexual deviance and other maladaptive behaviors and adopted theoretical perspectives incorporating cognitive-behavioral, learning, and biological approaches.

A later conceptualization of pedophilia focused on the role of childhood experience, proposing that many sexual abusers of children are themselves former victims of childhood sexual abuse. This idea, labeled the abused–abuser hypothesis (Burgess, Hartman, & McCormack, 1987; Burton, Miller, & Shill, 2002; Freeman-Longo, 1986; Freund & Kuban, 1994; Garland & Dougher, 1990), adopts a social learning theory framework and assumes that modeling and

internalization of sexual roles for adult and child following experiences of sexual abuse may lead to subsequent sexual interests in children or in adult–child sexual relationships. Three key components to this process are the child victim’s initial interpretation of the abuse (e.g., beliefs in the normality of the behavior, belief that it is not harmful) which may serve to normalize the experience, factors specific to the relationship between victim and perpetrator, such as the age of the victim, the identity of or relationship with the perpetrator, or the frequency, severity, and type of abuse, and the initial response of the victim or the reactions of others who may become aware of the abuse. It was believed that through a specific confluence of these factors, some individuals who were victims of childhood sexual abuse would develop sexual preferences of their own which reflected sexual interest in adult–child sexual relationships, thus leading to more lasting pedophilic interest and arousal. Several problems with this hypothesis have limited its usefulness in describing the process through which pedophilic interests form, however. This includes discrepancies between the number of individuals who are victims of child sexual abuse and those who develop pedophilic interests, the rate of pedophiles with no known instances of sexual abuse during childhood, and the lack of empirical research to support many of the hypothesized factors which are believed critical to this process (e.g., Benoit & Kennedy, 1992; Haapasalo & Kankkonen, 1997; Jonson-Reid & Way, 2001).

Some research has considered the role of biological processes in the development of pedophilic sexual interests. Early efforts explored intellectual differences between pedophiles and other sexual offender groups, suggesting that perhaps intellectual or cognitive impairments might characterize the majority of adult individuals who manifest sexual interests in children. Studies comparing intellectual assessment results of sexual offenders with child victims and other offenders have noted some important differences (e.g., Hucker et al., 1986; Langevin, Wortzman, Wright, & Handy, 1989), while others have noted low rates of intellectual impairments among pedophilic or general sex offender samples (e.g., Lambrick & Glaser, 2004; Lindsay, 2002). Other neurological research has considered the possibility of structural brain impairments among pedophilic sexual offenders. Initial research utilizing brain scanning techniques identified abnormalities in the left temporal lobe differentiating pedophilic sexual offenders from other sex offender groups (Galski, Thornton, & Shumsky, 1990; Lang, 1993; Langevin et al., 1988; Langevin, Wortzman, Dickey, Wright, & Handy, 1988; Wright, Nobrega, Langevin, & Wortzman, 1990). Similar research has also identified significantly lower levels of cerebral blood flow, particularly within the frontal and left temporal lobes, of individuals with sexual interest in children as opposed to other sexual offenders or non-offenders (Hendricks et al., 1988; Raine & Buchsbaum, 1996).

Unfortunately, these biologically based theories have failed to provide a specific causal mechanism through which these neurological impairments or differences lead to pedophilic sexual interests, and still only a portion of individuals with sexual interests in children demonstrate these differences. Further, the biological explanations of pedophilia fail to account for important social, cognitive, and behavioral factors which can influence the development of sexual behaviors involving children.

Other etiological conceptualizations have relied on a cognitive-behavioral framework, emphasizing the role of offense-supportive beliefs, cognitive schemas and information processing, behavioral reinforcement contingencies which may strengthen pedophilic arousal, and patterns of sexually deviant interest and arousal. These principles have been utilized to shape a variety of integrated cognitive-behavioral theories, including Finkelhor's Precondition Model (Finkelhor, 1984), Marshall and Barbaree's integrated theory of sexual offending (Marshall & Barbaree, 1990), and other models which use cognitive-behavioral theory to not only explain pedophilic offenses but other sexual offenses as well [e.g., Hall and Hirschman's Quadripartite Model, Hall and Hirschman (1991); the Pathways Model, Ward and Siegert (2002)]. Important components of these theories include sexual beliefs about children (e.g., "Sexual activity between adults and children isn't harmful" or "Children know about sex and benefit from sexual experiences") which may facilitate sexual offending against them, ways of processing interpersonal information which overemphasize sexual interaction or sexual interest (e.g., perceiving that a child asking for a hug from an adult is in fact sexually interested in that adult, interpreting questions about sex or sexual activity as sexual interest or a desire for sexual activity), or beliefs about the world which may suggest sexual entitlement or sexual expectations of others. Other factors which are relevant from a cognitive-behavioral perspective include intimacy deficits, limited social skills or social competence, loneliness, empathy deficits, or antisociality. Theories emphasizing these principles suggest that sexual interests in children thus develop through a combination of experience, cognitive beliefs about sexuality and children, and the gradual reinforcement of sexual arousal in response to children over time. These theories inform perhaps the majority of current treatment approaches, though few of them have been rigorously empirically tested from a causal perspective (Seto, 2008a; Stinson, Sales & Becker, 2008).

More recent etiological considerations have examined the role of self-regulatory processes in the development of pedophilia and other sexual pathology and problematic sexual behaviors [Multi-Modal Self-Regulation Theory, Stinson, Sales, and Becker (2008); Self-Regulation Model, Ward and Hudson (2000)]. While these do not specifically focus on only the development of pedophilia or sexual

interest in children, they do propose relationships between deficits in self-regulatory functioning and the use of sexual goals as a regulatory strategy. Important components of these conceptualizations as related to pedophilic interests include difficulties with regulating mood or thoughts, deficits in adaptive functioning with regard to relationships, reinforcement of specific sexual behaviors or interests, and goals consistent with sexual offending. As noted, these ideas are relatively recent and have thus been subjected to only limited empirical evaluation (e.g., Stinson, Becker, & Sales, 2008; Stinson, Robbins, & Crow, unpublished manuscript).

Assessment Strategies

Mental health professionals are often called upon to do various forms of assessment with individuals who have committed sexual offenses, many of whom have engaged in sexual activity with children and who might meet criteria for pedophilia. Some of these evaluations are for legal purposes. Some are for treatment. Others involve mitigation of legal culpability or even determinations of treatment progress. This section of the chapter will focus on those assessments which occur prior to beginning treatment. These assessments focus on a variety of issues, including diagnosis and history, description of the offense process, and identification of treatment needs.

Pretreatment assessments for individuals who have engaged in sexual offenses against children or who have demonstrated pedophilic interests should be comprehensive and include many of the following elements. A first step includes review of collateral materials, including victim statements, criminal and/or juvenile justice records, and any other legal documents related to prior offenses that the individual might have committed. A thorough clinical assessment also involves describing developmental and family history, education, medical history, school history, substance abuse history, any history of abuse, or neglect. One should also obtain information regarding the individual's living situation, hobbies or interests, and available supports. It is critical to ascertain whether or not the individual has ever received prior psychological or psychiatric counseling and if that was helpful. It might also be beneficial to obtain prior therapy records, if potentially related to the assessment question at hand.

Personality characteristics or traits may additionally be useful in determining important factors related to the client's offending, responses to treatment, and possible risks for future sexual offenses. There are numerous personality inventories which could be used as part of a comprehensive assessment. Such measures might include the Personality Assessment Inventory (PAI; Morey, 1991), the Minnesota

Multiphasic Personality Inventory, 2nd Edition (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), or the Millon Clinical Multiaxial Inventory, 3rd Edition (MCMI-III; Millon, Davis, & Millon, 1997). Since psychopathy has been found to be predictive of recidivism (e.g., Hanson & Harris, 1998; Hanson & Morton-Bourgon, 2005; Hemphill, Hare, & Wong, 1998) as well as success in treatment (Seto & Barbaree, 1999), it is recommended that adults also be assessed using the Psychopathy Checklist, Revised (PCL-R; Hare, 1991).

Regarding sexual interests, a comprehensive and thorough sexual history is essential. This includes a history of “normative” (age appropriate consensual sexual behaviors) as well as paraphilic fantasies and behaviors. A number of specialized instruments are available to assist the clinician in assessing the nature of the individual’s sexual interests. Physiological assessments of sexual arousal, particularly related to children, include penile plethysmography and the Abel Assessment of Sexual Interest (AASI; Abel, Huffman, Warberg, & Holland, 1998), which assesses sexual interest via viewing time technology. Research has indicated that viewing time measures are able to distinguish pedophiles from non-pedophiles (Abel et al., 1998, 2004; Abel, Jordan, Hand, Holland, & Phipps, 2001), who have targeted male child victims from those who have targeted female child victims (Abel et al., 2004; Worling, 2006), and different types of paraphilic sexual interests (e.g., Gray & Plaud, 2005; Stinson & Becker, 2008). However, despite these successes, others have questioned the use of these instruments, as they are often expensive, invasive, and do not always lead to definitive findings of sexual interest (e.g., Freund, Watson, & Rienzo, 1988; Gray & Plaud, 2005; Howes, 1995, 2003; Looman, Abracen, Maillet, & DiFazio, 1998; Stinson & Becker, 2008).

Some have also used the polygraph as a physiological measure of sexual activity involving children. While this cannot be used to diagnose pedophilia or corroborate sexual fantasies involving children, it may be used to validate historical instances of sexual behavior involving children (e.g., Abrams, 1991; Ahlmeyer, Heil, McKee, & English, 2000). However, there are few articles in the literature attesting to the validity of polygraphy with a pedophilic population or other sex offender populations.

Other measures of sexual interest and related cognitions and behaviors may include combination of self-report and historical variables, such as the Multiphasic Sex Inventory, 2nd edition (MSI-II; Nichols & Molinder, 2000), Clarke Sexual History Questionnaire (Langevin & Paitich, 2002; Paitich, Langevin, Freeman, Mann, & Handy, 1977), the Abel and Becker Cognition Scale (Abel et al., 1989), and the Abel and Becker Sexual Interest Cardsort (Abel & Becker, 1985). Interestingly, recent research has indicated that some self-report instruments, such as the MSI-II (Nichols &

Molinder, 2000) or self-report sexual fantasy content, may be more accurate predictors of sexual interests in children or other targets than the traditional physiological measures in some populations of sexual offenders (Stinson & Becker, 2008). Thus, these instruments, which are perhaps more cost-effective, easy to administer, and less invasive, might provide much valuable information for those interested in examining sexual interest in children [For a more detailed list of assessment inventories that have been used in assessing sexual offenders, readers are referred to Prentky and Edmunds (1997)].

Treatment Models

Historically, a variety of treatment theories have governed the development of treatment models or treatment strategies for working with pedophiles. Individuals have used psychodynamic therapy, eclectic approaches, and generic group therapy. More recently, cognitive-behavioral interventions, the relapse prevention model, and in some cases, psychopharmacologic interventions have been the predominant methods of providing sex offender treatment. Cognitive behavior therapy utilizes a multicomponent approach and targets both cognitive treatment needs, such as deviant sexual arousal, distorted cognitions, pro-offending attitudes, impulse control deficits, social skills deficits, poor emotional regulation, environmental triggers, and behavioral components like masturbatory reconditioning, covert sensitization, or olfactory aversion therapy (e.g., Marshall & Eccles, 1996; Marshall & Fernandez, 1998; McGrath, Hoke, & Vojtisek, 1998). An important part of these therapies also involve assisting the client in overcoming the denial and minimization and developing empathy. With regard to pedophilia and offenders with sexual interest in children, the goal of cognitive-behavioral sex offender treatment would be to reduce offense-supportive beliefs (e.g., “Ancient societies encouraged sex between adults and children,” or “Children need to have sex to learn about it.”), develop empathy for children, improve relationships with adult consenting sexual partners, and reduce deviant arousal to child stimuli. Although the majority of treatment programs in North America utilize cognitive-behavioral techniques, the effectiveness of such programs has been questioned (e.g., Kirsch & Becker, 2006; McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010; Rice & Harris, 2003). Empirical research evaluating the effectiveness of cognitive-behavioral treatment in reducing violent sexual recidivism among general sexual offenders has produced minimal, mixed, or even negative effects (Hanson, Steffy, & Gauthier, 1993; Marshall, Jones, Ward, Johnston, & Barbaree, 1991; McGrath et al., 1998; Quinsey, Harris, Rice, & Lalumiere, 1993; Quinsey, Khanna, & Malcolm, 1998; Rice, Quinsey, & Harris, 1991).

Relapse prevention is a type of cognitive-behavioral intervention which has been continually dominant in North American sex offender treatment programs (McGrath et al., 2010). Relapse prevention relies on the identification of high-risk situations, triggers which may initiate the sex offense process, and the development of a relapse prevention plan. These high-risk situations or triggers may include environmental factors, “seemingly unimportant decisions” which can lead to offending or beliefs or thoughts which are supportive of the offense process. The ultimate goal of relapse prevention is to develop a comprehensive plan to assist the client with accurately identifying these precursors and minimizing risk. Though many programs have used a relapse prevention approach, recent research regarding its outcome has been less than encouraging and suggests that there are few differences between treated and untreated offenders (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005).

Psychopharmacologic interventions are frequently used in some treatment programs as an adjunct to treatment. Hormonal treatments such as medroxyprogesterone acetate, cyproterone acetate, and leuprolide acetate have been used in the treatment of individuals with pedophilia. These medications are used to lower the individual’s testosterone levels and consequently reduce sexual drive, though they do not redirect the individual’s patterns of sexual interest (i.e., sexual interest in children or minimal erectile capacity may remain despite treatment). However, these forms of medication can cause unwanted side effects, including weight gain, increased blood pressure, impaired glucose tolerance, and gallbladder disease (Meyer, Walker, Emory, & Smith, 1985) and may be subject to continuing compliance problems, as is the case with other pharmacological interventions. Others have questioned the use of these medications on ethical grounds (e.g., Meyer & Cole, 1997; Stinneford, 2006), while others have noted their failure to reduce sexual recidivism (Rice & Harris, 2003). Other pharmacological treatments have involved the use of Selective Serotonin Reuptake Inhibitors (SSRIs) for the treatment of paraphilic and non-paraphilic sexual disorders (e.g., Greenberg & Bradford, 1997; Greenberg, Bradford, Curry, & O’Rourke, 1996). As noted by Becker and Johnson (2008), it is possible that these medications may decrease sexual obsessions, improve disordered mood symptoms, and perhaps decrease impulsivity.

While it does not endorse a specific treatment approach, the risk-needs-responsivity model (Andrews, Bonta, & Hoge, 1990; Bonta & Andrews, 2007) has been applied to the treatment of pedophilic sex offenders as well as other offender groups. This model emphasizes discriminating high from low risk offenders and offering treatment to those most at risk, targeting criminogenic needs related to the individual’s sex offending behavior, and considering responsivity factors such as motivation, special needs, or barriers to treatment [see further Hanson, Bourgon, Helmus, and Hodgson

(2009a, 2009b), Becker and Stinson (2011)]. This approach calls for continued research in identifying those at highest risk and thus in most need of treatment, targeting treatment needs which may be most relevant for reducing risk and producing a better outcome for offenders, and tailoring treatments so as to have the greatest preventative impact on future sexual offending.

As can be seen from the previous discussion, many problems remain with current approaches to sex offender treatment. This may be due to a number of factors, including a rather atheoretical approach to sex offender treatment (i.e., that our theories of what causes sex offending behaviors and pedophilic interests do not match our strategies for treating these behaviors and interests; Kirsch & Becker, 2006), problems with treatment duration or delivery, a lack of comprehensive and integrative treatment targets, or poor aftercare and follow-up once treatment has been completed. With regard to pedophilic sexual offenders, given the high rates of comorbidity with other paraphilias and other psychiatric disorders, it is possible that traditional treatments are less successful for this population given the psychiatric complexity of individuals with this disorder, and the corresponding adaptive and functional deficits which may be seen accompanying this diagnosis.

Recidivism and Risk Assessment

With regard to known recidivism among pedophilic sexual offenders, research indicates that anywhere from 5 to 42 % of individuals studied have engaged in further acts of sexual violence after release (Hanson et al., 1993; Hanson & Bussiere, 1998; Langan, Schmitt, & Durose, 2003; Moulden, Firestone, Kingston, & Bradford, 2009; Prentky, Knight, & Lee, 1997). Interestingly, one recent study of recidivism among offenders against children under the age of 16 utilized phallometric testing and the Screening Scale for Pedophilic Interest (Seto & Lalumiere, 2001) to differentiate pedophilic from non-pedophilic offenders and found no significant differences between the recidivism rates of these two groups (Moulden et al., 2009). This suggests that much about the nature of sexual recidivism among pedophiles, and whether or not it differs from other sex offender groups, remains unknown. There is also some research to indicate that a small subgroup of sexual offenders against children continue offending until later in life (e.g., Hanson et al., 1993), though this may not be the case with the larger population of pedophiles and sexual offenders against children (Barbaree, Blanchard, & Langton, 2003).

The assessment of risk for individuals who have committed sexual offenses focuses primarily on determining the risk of future sexually violent recidivism upon release into the community. This may include determining risk in order to

assign an offender to treatment and emphasize treatment needs in accordance with the risk-needs-responsivity model (Andrews et al., 1990; Bonta & Andrews, 2007), to assess dangerousness according to specific legal standards or criteria, or to make placement or risk management decisions. Few studies of risk have differentially focused on individuals who are at greater risk of sexually offending against children as opposed to other victim groups, though some risk factors specific to pedophilic sexual interests have been implicated as crucial determinants of risk. For example, general risk factors for the detection of known sexual recidivism include offender age, history of arrest for sexual and nonsexual offenses, patterns of violence associated with sex offending behavior, anti-social lifestyle characteristics, poor mood or affect regulation, anger control, and cooperation with supervision requirements (Hanson & Bussiere, 1996; Hanson & Harris, 1998, 2000; Hanson, Harris, Scott, & Helmus, 2007; Hanson & Morton-Bourgon, 2005). Risk factors more specific perhaps to individuals with pedophilia or sexual offenses against children may include certain victim characteristics (e.g., age), deviant sexual interests, problems with sexual self-regulation, and attitudes or beliefs which are supportive of sexual offending (Hanson et al., 2007; Hanson & Harris, 1998, 2000; Hanson & Morton-Bourgon, 2005). Individuals with pedophilic sexual interests may thus be at greater levels or risk with regard to these factors due to the age of their victims, sexual interests in children, and attitudes or beliefs which are related to their sexual behaviors involving children.

The way in which this risk is determined typically involves the use of actuarial instruments designed to predict risk among a diverse population of sexual offenders. These instruments, developed by determining the known recidivism rates of large groups of sexual offenders post-release and statistically calculating characteristics of these individuals most predictive of their recidivism, have demonstrated predictive superiority over clinical judgment alone (e.g., Meehl, 1954). Because these measures rely on statistical relationships, they do not inform us as to causal mechanisms behind an individual's risk; in other words, they do not tell us why a certain factor is predictive of risk nor will they give us a true estimate of risk on an individual basis. Instead, they predict risk based on a set of characteristics which were significant for a group of individuals who had engaged in additional acts of sexual violence. A combination of static and dynamic risk variables have been incorporated into these instruments, including the Static-99 and Static-99R (Hanson & Thornton, 2000; Helmus, 2009), the Static-2002 (Hanson & Thornton, 2003), the Rapid Risk Assessment for Sex Offense Recidivism (RRASOR; Hanson, 1997), the MnSOST-R (Epperson, Kaul, & Hesselton, 2005), the Sex Offender Risk Appraisal Guide (SORAG; Quinsey, Harris, Rice, & Cormier, 1998), the Sexual Violence Risk-20 (SVR-20; Boer, Hart, Kropp, & Webster, 1997), and the Stable-2000/

Acute-2000 and Stable 2007/Acute 2007 (Hanson et al., 2007). As noted above, many of these instruments contain items which may rely on a history of pedophilic sexual behaviors and interests, including sexually deviant interests, youthful victim age, and offense-supportive beliefs.

Though actuarial instruments are typically considered the most precise and objective means of measuring risk of future sexual offending, some research has evaluated the utility of using clinical adjustments to static actuarial measures. Unfortunately, some research suggests that the addition of clinical or discretionary material makes no impact on actuarial prediction (e.g., Krauss, 2004) or may actually worsen it [Barbaree, Seto, Langton, and Peacock (2001), for further discussion, please see Seto (2008a)]. Other recent work regarding the use of clinical data to supplement actuarial decision making involves the development of structured clinical and actuarial assessment tools, including the Historical Clinical Risk—20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997) and the Structured Anchored Clinical Judgment—Minnesota (SACJ-Min; Grubin, 1998). Again, though these instruments do not exclusively address risk concerns related to pedophilia, a number of the risk items do relate to specific sexual interests or behaviors which may be relevant for individuals with pedophilia.

With regard to individuals who have demonstrated pedophilic sexual interests but who have not yet been known to act on them (e.g., individuals who utilize child pornography but who have not been arrested for sexual acts involving children), few available resources exist to describe their future risk of engaging in sexual behaviors with child victims. Many of the above-described risk assessment actuarial instruments rely heavily on history of arrest or known offense behaviors in order to make determinations of an individual's potential risk. Seto (2008a) and Seto and Eke (2005) have noted that men who utilize child pornography but who have not committed contact sexual offenses against children are perhaps less likely to commit future sexual offenses involving children than men who utilize child pornography but who have already engaged in child sexual offenses, again suggesting that history of behavior is a highly predictive factor. Whether or not the presence of pedophilia alone may be predictive of future offending when compared with non-pedophilic individuals who have been found with child pornography has yet to be determined.

Policy Issues

In an effort to make for safer communities, legislators have enacted numerous laws that impact or regulate the behavior of sexual offenders, particularly offenders who have targeted child victims. Such laws have included longer sentences, sex offender registration, community notification and residency restrictions, and long-term post-incarceration civil commitment.

These laws apply to both juvenile as well as adult sexual offenders. In many cases, the impetus for the development of these laws was a particularly heinous and public case where a child was sexually assaulted and/or murdered by an individual with a history of sex offending behavior. In fact, many of these laws have been named after the very victims in these cases (e.g., Megan's Law, the Jacob Wetterling Act). While some policies have been criticized as being unconstitutional (e.g., Sexually Violent Predator civil commitment), the U.S. Supreme Court and other courts have often upheld them (e.g., *Kansas v. Hendricks*, 1997). However, several states' efforts to enact the death penalty for cases of child molestation did result in a reversal by U.S. Supreme Court decision (*Kennedy v. Louisiana*, 2008).

Many of these policies, particularly those involving community registration and notification, are predicated on the assumption that knowing who the offenders are will prevent future sexual violence. This also presumes that these individuals are unknown to the victims and their families, whereas much of the research has indicated that perpetrators of sexual violence against children are often known or even related to the victims (e.g., Snyder, 2000), thus perhaps negating the effectiveness of prior registration and notification. Policies instead should perhaps focus on education regarding child sexual abuse or decreasing stigma for victims of child sexual abuse which may in turn increase willingness to report such offenses.

Though few research efforts have been conducted to evaluate the efficacy of many legislative policies directed toward sexual offenders against children, some recent data have examined recidivism rates of both adults and juveniles who are impacted by registration and notification policies. Evaluation of several states' registration and notification policies as well as related residency restrictions reveal somewhat mixed results, in that there were no significant effects on juvenile sexual recidivism (Letourneau & Armstrong, 2008; Letourneau, Bandyopadhyay, Armstrong, & Sinha, 2010), but some initial deterrent impact on adult sexual offending (Letourneau, Levenson, Bandyopadhyay, Armstrong, & Sinha, 2010). However, examination of a change in trajectory of adult offending (i.e., differentiating different offender risk groups) following the implementation of registration and notification laws (Tewksbury & Jennings, 2010) and of recidivism and child offenders' proximity to schools and daycare centers (Zandbergen, Levenson, & Hart, 2010) failed to find significant effects.

Other research has assessed the impact of sex offender registration and notification policies on offenders, their families, and the reduction of recidivism. Levenson, D'Amora, and Hern (2007) examined the impact of community notification on 239 registered sex offenders from one state and 148 from another state. The offenders were surveyed as to outcomes including job loss, housing disruption, assault

victimization, property damage, harassment, and suffering on the part of their family members. They were also queried as to psychosocial effects such as stress, isolation, fear for their safety, shame, and embarrassment and as to whether or not having community notification helped them manage risk and prevented reoffense. The majority of the sex offenders reported negative consequences; for example, 21 % reported they lost a job because their boss or coworker discovered their registration status. Ten percent were forced to move from their homes, and 21 % had been threatened or harassed by neighbors. Eighteen percent experienced property damage. The majority of offenders experienced psychosocial distress in relation to the public disclosure, and nearly half were afraid for their safety because their sex offender status was known. Specifically, 62 % reported that the community notification made recovery more difficult by causing stress, 58 % reported shame and embarrassment, 54 % reported feeling alone and isolated, and 55 % reported less hope for the future now that they would be a registered sex offender. Given the role of negative affect and lifestyle instability in the determination of an offender's risk to reoffend, these effects are concerning.

Levenson and Tewksbury (2009) examined the stress experienced by family members of adults who were registered sex offenders. Sixty-eight percent of survey respondents reported frequent stress due to their family member's registration as a sex offender. Almost half of the respondents reported fearing for their safety due to their loved ones being registered as a sex offender, and 31 % of the respondents reported they were forced to move due to residential restriction laws or community pressure. Stress levels were high among the family members of registered sex offenders, as were isolation, loss of friends, and relationships and fear for their safety.

Thus, it would appear that there are a number of unintended consequences either to sex offenders who are made to register or to their family members. Since family members are a potential source of support for individuals who have committed sexual offenses, it is important to identify strategies which might be helpful in aiding relatives who are in relationships with individuals who must register or who are involved in community notification. Finally, though some initial research has demonstrated perhaps small, though inconsistent, effects of registration and community notification on recidivism, more research is clearly needed to determine if other policies are achieving their goals relative to reducing recidivism and enhancing community safety.

Future Directions

As has been highlighted throughout this chapter, a number of areas still remain relatively unexplored with regard to understanding individuals with pedophilic sexual interests. In order

to provide the most effective assessment, treatment, risk management, and prevention, we should continue to focus on these unknowns in our research and clinical practice with pedophilic sexual offenders.

First, we must gain a more complete understanding of the causal mechanisms underlying etiology and risk. For example, recent theoretical and empirical findings have implicated self-regulation and self-regulatory deficits as not only important etiological considerations (Stinson, Becker & Sales, 2008; Stinson, Sales & Becker, 2008; Ward, Polaschek, & Beech, 2006) but also as significant predictors of risk (Hanson et al., 2007; Hanson & Harris, 1998). However, this work is still relatively new and lacks comprehensive empirical study. And while research has determined many significant factors which may precede sexual offending or predict risk, the causal mechanisms explaining these statistically significant relationships remain elusive. In other words, in order for us to truly understand not only how pedophilic sexual interests develop but also how they impact continued sexual behavior, we must know more about why certain constructs or factors are significant and how they impact and interact with one another.

A related concern involves the need for more effective integration between theory and practice. Many current treatment interventions for pedophilia, including those which involve chemical or biological solutions, are predicated on the belief that treating outward symptoms of the disorder (e.g., sexual arousal, sexual beliefs about children) will ultimately reduce sexual interest in children and related behaviors. However, the etiological link between these concepts and offending behavior remains unclear (e.g., Stinson, Sales & Becker, 2008). In order to remain effective, our practices of assessing and treating pedophilia must match what is known from empirical evaluation of causal theory. In this way, we can ensure that we are truly addressing those causal or maintenance factors most related to risk and prevention of sexual violence.

Similarly, we must focus efforts on developing and researching the most effective treatment interventions for individuals with pedophilia and pedophilic sexual interests. Emerging criminal justice trends in the detection of users of child pornography suggest that a number of individuals with pedophilia who were previously unidentified will now be in need of treatment intervention. Most treatments for sexual offending thus far, including those aimed at reducing sexual interests and behaviors involving children, have focused primarily on contact pedophilic offenders. And while much remains to be improved with regard to these treatments [e.g., limited treatment effectiveness noted by Marques et al. (2005)], even greater need lies in the treatment of these increasingly salient pornography offenders with clear sexual interests in children, but whose behaviors and clinical

presentation may be different from that of the traditional contact child sexual offender seen in correctional samples.

With regard to improvements in our understanding of risk, we should perhaps place greater emphasis on the changing or dynamic nature of risk, particularly within the community following treatment. While several risk assessment instruments have incorporated dynamic factors, such as treatment progress, understanding of risk, or compliance with supervision requirements, the ability to capture the rapid and situational factors impacting risk on a daily basis in other settings is still largely absent from our risk prediction tools. Some in this area have made distinctions between risk status and risk state, noting that while status may remain relatively constant, the state of risk is constantly changing and building over time (Douglas & Skeem, 2005). Others have likened risk prediction to weather prediction (Monahan & Steadman, 1996), comparing the prediction of dangerousness to the prediction of the weather, where conditions are variable and can only be known for short periods of time. Future research with regard to pedophilia and risk of sexual offending should incorporate many of these principles.

Finally, we have voiced concerns that many legislative efforts in the area of prevention and treatment for sexual offenders against children have resulted from reactive public outcry rather than sound empirical research. Thus, an obvious area for future research includes education and empirically informed legislative policies. This may involve a change in emphasis from reactive deterrence measures to those aimed at prevention, treatment, and reintegration into the community. It also may include more rigorous evaluation of the effectiveness of current legislative practices, including community registration and notification, civil commitment for dangerous sexual offenders, and sentencing practices for sexual crimes, as well as identifying proactive research contributions to proposed legislation.

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