Pedophilia

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This article addresses the risk factors associated with the psychiatric disorder pedophilia, its treatment, and treatment outcomes. It addresses physician responsibilities associated with case identification of victims and possible roles in the medical management of pedophilia. The essential feature of pedophilia is that an individual is sexually attracted exclusively or in part to prepubescent children. While pedophilia may be limited to fantasies and impulses, pedophilic behaviors are the primary concern of both the mental health and criminal justice systems. Remote risk factors for development of pedophilia often include the individual having been sexually abused as a child. Proximate risk factors for its behavioral expression are prevalence of comorbid psychiatric disorders and substance abuse disorders. Current treatment goals focus on stopping the behavior and achieving long-term behavioral control in the community. Common treatment methods are cognitive-behavioral, group therapy, and, when appropriate, medications such as androgen-lowering agents that can act as sexual appetite suppressants. Meta-analyses have established that treatment is more effective than nontreatment in preventing recidivism of sexual offenders in general, a finding that has a high probability of application to individuals with pedophilia. Pedophilia is a chronic psychiatric disorder, but it is treatable in terms of developing strategies for preventing behavioral expression. Ultimately, reducing the prevalence of pedophilic behavior requires further collaboration between the criminal justice system and the health care communities.

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THE PURPOSE OF THIS ARTICLE IS to increase health care professionals' understanding of pedophilia, a psychiatric disorder affecting a portion of the individuals who sexually abuse children. It addresses risk factors associated with the disorder, treatment, treatment outcomes, physician responsibilities associated with case identification, and recommendations for criminal and medical systems collaboration.

Pedophilia is a diagnosis applicable to only a portion of individuals who sexually abuse children. Information has been drawn from published research about pedophilia and child sexual abuse in general to present the current state of knowledge. Despite a sizeable body of published, peer-reviewed articles about topics such as child sexual abuse, child molestation, and sexual offenders, data and our knowledge base about pedophilia have significant limitations.

METHODS

A MEDLINE search conducted in June 2002 using the Medical Subject Heading (MeSH) *pedophilia* identified a total of 447 articles from 1965 to the present. A second search using the MeSH term *child molestation* yielded 137 citations. These articles were examined for relevance to the prevalence, expression, and treatment of pedophilia. Special attention was given to those articles that were reviews of the literature, contained meta-analyses, or written by recognized experts on the topic of pedophilia. Several of the latter have written books or chapters in texts that allowed the search to be extended with the assistance of further bibliographic resources. Staff members at the National Clearinghouse on Child Abuse and Neglect Information (www.calib.com/nccanch) provided helpful assistance in obtaining data.

SCOPE OF THE PROBLEM

Since the initial research on the epidemiology of child sexual abuse by Finkelhor,[1] it has been generally accepted that child sexual abuse is a major public health problem. In a general population study of sexual behaviors in the United States, 12% of men and 17% of women in the study reported being sexually touched by an older person when they were children.[2] Governmental agencies working largely from criminal records and child protective services agencies data have provided further es-

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timation of the magnitude of the problem. The Third National Incidence Study of Child Abuse and Neglect (NIS-3), which addressed only those cases involving parents, parent substitutes, adults, or nonparental teenagers in a caretaking relationship with the child, estimated that the number of sexually abused children rose 125% from 133 600 reported cases in 1986 to 300 200 in 1993.[3] The report concluded that children are consistently vulnerable to sexual abuse from the age of 3 years on, girls were sexually abused 3 times more often than boys, children from the lowest-income families were 18 times more likely to be sexually abused, and there were no racial differences in maltreatment incidence.[3]

The NIS-3 reported that natural parents accounted for 29%, other parents for 25%, and others in a caretaking role for 46% of the offenders. In addition, a sexually abused child was most likely to sustain a serious injury or impairment when a birth parent was the perpetrator. Approximately 89% of the children were abused by a male, compared to 12% abused by a female.[3]

Additional incidence data about both custodial and noncustodial sexual abuse have been provided from findings from the Federal Bureau of Investigation's National Incident-Based Reporting System.[4] Based on reports from 12 states from 1991 to 1996, 67% of sexual assaults handled by law enforcement agencies involved juvenile victims, of whom 1 of every 7 was younger than 6 years and a third of whom were younger than 12 years. Eighty-three percent of the younger than 12 years cohort was female. Adults were the offenders in 60% of the sexual assaults on children younger than 12 years, and 5 of every 6 assaults occurred in a residence. Nearly all the offenders were male (96%), although female offenders were most common in assaults on victims younger than 6 years. Strangers accounted for less than 5% of the offenders, while except for the younger than 6 years group, acquaintances were 53% and family members were 42% of the offenders.[4]

Box. Diagnostic Criteria for Pedophilia

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).
B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
C. The person is at least age 16 years and at least 5 years older than the child or children in Criterion A.

Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old.

Specify if:
Sexually attracted to males
Sexually attracted to females
Sexually attracted to both

Specify if:
Limited to incest

Specify type:
Exclusive type (attracted only to children)
Nonexclusive type

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Such data can provide only some approximation of the prevalence of pedophilia in a population for 2 reasons. First, a pedophilic disorder may be present in a person who does not act on the fantasies and impulses. Second, not all child sexual crime is the product of a pedophilic disorder. This caveat notwithstanding, these data and the general conclusions of similar reports leave little doubt that sexual crimes against children, and by inference pedophilia, are both a major public health problem as well as a criminal justice problem.[5]

PEDOPHILIA: A PSYCHIATRIC DISORDER

Pedophilia should be distinguished from other terms that may be applied to behavior involving sex with minors but are not equivalent constructs. The essential feature of pedophilia is that an individual is sexually attracted either exclusively, or in part, toward prepubescent children. It is operationally categorized in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* of the American Psychiatric Association (BOX).[6]

The word *pedophilia* comes from a term coined by Krafft-Ebing—pedophilia erotica—which literally means the erotic love of children.[7] The ruminations of Humbert Humbert in Vladimir Nabokov's *Lolita* give a graphic picture of the erotic mental life of a man attracted to a 12-year-old girl.[8] The term "ephebophilia" (or "hebophilia") has occasionally been used to denote an inordinately high sexual attraction to postpubescent adolescents. What persons with pedophilia or ephebophilia share in common is an attraction to children who are legal minors. This rational distinction is often not mirrored in the erotic mental life of the pedophilic individual, again using as an example Humbert Humbert, who was attracted to "girl children" aged 9 to 14 years.

Terms such as "child sexual abuse," "incest," "child molestation," and "pederasty" are not equivalent to pedophilia. Terms that denote sex with minors are criminal actions; pedophilia is the sexual attraction to children and is a psychiatric disorder. Not all who sexually abuse minors are pedophilic. For example, some who sexually abuse children may opportunistically select minors simply because they are available. Sex with a minor is not, ipso facto,

a determination of pedophilia. Also, not all individuals who fulfill the diagnostic criteria for pedophilia actually abuse children. Possessing such fantasies and being distressed by them is sufficient to meet diagnostic criteria. An individual with pedophilia is not a sexual offender unless he or she commits a legally proscribed act.

We were unable to find any published reports indicating the prevalence of pedophilia among those who were either arrested for or convicted of child sexual abuse or the prevalence of pedophilia in the general population. Research inventories on psychiatric disorders or sexual behaviors in the general population have not inquired about pedophilic fantasies or behaviors.[2,9] We suspect that researchers had concerns about the validity of the data they would obtain, the participant reactions leading to dropping from the interview, and the need to report the pedophilic participants to civil authorities if behaviors were admitted.

Behaviors Associated With Pedophilia

While the psychiatric disorder may be limited to fantasies and impulses, the pedophilic behaviors are the primary concern of mental health and criminal justice systems. Based on the assumption that pedophilic behaviors are similar to those reported for child molestation, we can expect that the offending individual usually begins pedophilic behaviors in the middle to late teen years, while others may act on the attraction in middle adulthood.[10] Typically, fondling and genital exposure are performed, while oral, anal, or vaginal intercourse are less frequent progressions of pedophilic behavior.[11] It is less common to assault (rape) or abduct the child, although such cases have been given notoriety in the media.[12] While some persons with pedophilia view children as objects solely for sexual gratification, many pedophilic individuals report they feel affection toward children.[13] This has been described further by Freund et al[14] and Money,[15] who view pedophilia as a "courtship disorder," or as the manifestation of a distorted "love map." These feelings may further obscure perception of the children's reaction of fear, anxiety, and, in some cases, pain to the sexual abuse. Thus, when confronted by the legal system, many pedophilic offenders initially respond with excuses rife with cognitive distortions such as, "The child wanted it. She was the initiator. She was not harmed." Others will be relieved that they have finally been apprehended and harbor the hope that with treatment and control by the legal system, the behaviors will cease.

Researchers in a child sex offender program based in Seattle, Wash, have provided a qualitative study of the attitudes and modus operandi of men who have sexually abused children.[13] The men reported being attracted to a friendly, open, vulnerable child who would be easily persuaded and would remain silent after the sexual abuse. The initial social contact with the child involved some nonsexual enticements such as purchases or flattery. Sexual conversation generally followed. A gradual progression from nonsexual touch to sexual touch happened with the purposeful desensitization of the child to the purpose of the touch. A sleeping child was often the victim of the touching. Following the sexual contact, the offender would use his adult authority to isolate the child and the "shared" behavior from family or peers. Physical threats were rare, but threats to the child's sense of psychological security were common.[13]

Sexual abuse is a risk factor for subsequent psychological morbidity. Higher morbidity occurs in adolescence and adulthood. In adolescence, behavioral problems, substance abuse, and suicidal ideation are associated with reported sexual abuse.[16-18] Further, men and women who were abused during childhood are at higher risk for mood, anxiety, and substance abuse disorders as well as suicide attempts.[19,20]

Even when there are no subsequent physical or emotional sequelae, however, pedophilic behavior is an infringement on the child's right to physical and psychological integrity.[12,21] Children do not have the ability to give consent to the sexual relationship. The sexual behavior is a violation of the child's sense of security and control of personal boundaries in a (usually) trusted relationship. The consequent secrecy about the behaviors further erodes trust with the adult world that should be serving as a protective and nurturing environment.

Typologies of Pedophilia

It is not known why some adults and older adolescents are sexually attracted to prepubescent children. Lacking this knowledge, clinicians and researchers have used typologies to gain a greater understanding of the causal or correlational phenomena involved in pedophilia. Thus, dichotomous types such as familial vs nonfamilial offenders, touching vs nontouching, seductive vs aggressive are appealing at first glance. But the dichotomies should not obscure the variety and complexity of the expression of pedophilic behaviors.[12] At this point, the typologies and categories should be considered conjunctive and suggestive of group differences, not mutually exclusive categories. Individuals who have been apprehended for incest may also have sexually abused children outside their families. The current standard typologies are the specifications suggested by the *DSM-IV-TR*, which in an effort to be descriptive without implying etiology, has 3 specifications for pedophilia: (1) sex of the children toward whom they are sexually attracted (male, female, both); (2) range of attraction (incest only); and (3) age of the individuals toward whom they are sexually attracted (exclusively to children or to children and adults) (Box). Even these specifications should be seen as descriptors rather than mutually exclusive categories.

Etiological and Precipitant Risk Factors

Another strategy to better understand etiologic issues in pedophilia is to identify risk factors—both remote and precipitant.[22] Risk factors in the early life his-

tory that may have been pathogenic for pedophilia can differ from those risk factors that maintain continuance in the present. One of the most frequently cited remote risk factors for pedophilic behaviors is the individual's own personal experience of being a victim of sexual abuse.[23,24] Other researchers have cited an inadequate attachment style that is rooted in a dysfunctional family as a remote risk factor.[25]

Elevated plasma epinephrine and norepinephrine levels, and reduced cortisol responses to meta-chlorophenylpiperazine challenges have been identified [illegible] vestigators hypothesized that [illegible] increased sympathetic activity and reduced serotonergic activity present in the pedophilic samples. However, the investigators could not rule out the possibility that their pedophilic sample had a high comorbidity of anxiety disorder, and as a consequence could not be certain whether the documented results were specific to pedophilia or an artifact attributable to the presence of anxiety disorder. Other developmental[28,29] and organic[30] phenomena have been described in pedophilic individuals. Gaffney and Berlin[31] documented a marked elevation in the release of luteinizing hormone to the intravenous infusion of luteinizing hormone-releasing hormone within a group of pedophilic patients when compared with nonpedophilic patients. A report of 2 older men with temporal lobe disease and the emergence of late life pedophilia led the authors to suggest that a dementing illness may lead to sexual disinhibition of previously behaviorally controlled pedophilic vulnerabilities.[32]

Precipitating factors that may lead to the expression of the behavior are affective illness, psychosocial stress involving loss of relationship, or status and alcohol abuse. When any of these factors concur with a situation in which the individual with pedophilia has access to children, the tragic stage is set for pedophilic behaviors. High rates of psychiatric comorbidity have been found among pedophilic sex offenders. Raymond et al[33] reported the presence of a 93.3% lifetime and 75.5% current psychiatric comorbid disorder, most of these being depression and anxiety disorders. Sixty percent had a lifetime substance abuse history, 51% of the total group having alcohol as their drug of choice. Sixty percent of the men met the criteria for a personality disorder, the chief among them being obsessive-compulsive (25%), antisocial (22.5%), narcissistic (20%), and avoidant (20%). These data indicate a high prevalence of personality disorder relative to the population and counter the belief that pedophilic behaviors are simply an expression of antisocial or narcissistic personality disorders. As noted by Raymond et al,[33] 77.5% of the men did not meet criteria for antisocial personality disorder, and 80% did not meet the narcissistic personality criteria.

RESPONSIBILITIES OF PHYSICIANS

Victims of Sexual Abuse. Early identification of the victims of sexual abuse is essential. The physician in office practice may encounter child sexual abuse in the course of a routine physical examination or parents may request an evaluation for confirmed or suspected sexual abuse of their child. Children who have been sexually abused may display depression and aggressive behaviors, have an increased frequency of anxiety disorders, and have problems with age-appropriate sex roles and sexual functioning.[34,35] However, such behaviors, as well as persistent and unexplained somatic complaints, are not specific to a sexual abuse etiology. The optimal strategy is to provide a trusting environment for the child and, if there is reason to suspect abuse, evaluate the child accordingly.

Symptoms such as genital or rectal pain, injury to genitals or rectum, sexually transmitted disease, and pathological anatomy of the hymen are more definitive signs of possible sexual abuse.[36] These warrant further evaluation regarding their causes. When there is little doubt that sexual abuse did occur, the clinician should screen for medical and emotional problems requiring immediate attention and refer the child to an agency or group that specializes in the treatment of children who have been sexually abused.[37]

All physicians who have children as patients should be familiar with "Guidelines for the evaluation of sexual abuse of children."[38] Those who are involved more intensively in the forensic aspect of the evaluation should be aware that the general guidelines for evidence collection in cases of acute sexual assault are not well suited for prepubertal victims.[39] Further guidance regarding the evaluation of children for sexual abuse is beyond the scope of this article and is available elsewhere.[40]

Mandated Reporting. Statutes that mandate clinicians to report suspected child sexual abuse to criminal justice authorities can sometimes deter individuals with pedophilia from seeking treatment even though they have not been identified or apprehended and may want help.[41] However, physicians have an administrative responsibility when faced with actual or suspected child abuse. In most jurisdictions, all health care professionals must report suspected child sexual abuse to civil authorities. Mandatory reporting laws vary from jurisdiction to jurisdiction in scope and application. The standard of care is that physicians understand and conform to the reporting laws of the jurisdictions in which they practice. In cases where the physicians are uncertain about reporting a case, they should consult with colleagues in local child abuse agencies or the jurisdiction's child protection agency.

THE SPECTRUM OF PEDOPHILIC DESIRES AND ACTS: IMPLICATIONS FOR TREATMENT

Pedophilic individuals are heterogeneous with regard to character, temperament, and manner of expressing their sexuality.[21,42,43] Clinicians might see patients with pedophilia who have interacted sexually with children, who have only looked at sexualized pictures of children, or who have not in

any way acted on their urges but seek treatment because of distress and shame about having such feelings. For these reasons, clinicians must develop individualized formulations and treatment plans for each patient, even though certain generalized principles are applied to treating the disorder.

Some men become aroused by looking at sexual images of children but never seek out such relationships.[44] Even that sort of voyeuristic pedophilic behavior can pose a threat to the individual and warrant treatment, because it is a criminal felony to possess and view images of real children. A recent United States Supreme Court decision removed criminal sanctions for viewing sexualized images of children, if such images have been computer generated (so-called virtual reality).[45]

Rationale for Treatment

During psychosexual development, no one decides whether to be attracted to women, men, girls, or boys. Rather, individuals discover the types of persons they are sexually attracted to, ie, their sexual orientation. When the powerful biological force that constitutes sexual drive becomes misdirected toward children, it recurrently craves satiation.[12] Thus, by fantasy or by behaviors, individuals with pedophilia discover their sexual attraction toward children. Although the person with pedophilia is not at fault for having this psychiatric disorder, he or she has the responsibility for controlling its expression.

The moral argument that an individual should be capable of exercising consistent self-control does not mean that he can actually do so. Recently, the United States Supreme Court, in reaffirming the involuntary civil commitment of some persons with pedophilia, suggested that it is just such an impairment in volitional capabilities that, in part, constitutes justification for forced confinement and treatment of some pedophilic individuals.[46]

Earlier Treatment Methods

Historically, several types of treatment had been proposed. Psychodynamic theories suggest pedophilia is the manifestation of underlying conflicts that developed during a maladaptive childhood.[47] According to this view, the condition could be "cured" through the development of insights about those conflicts. It was this theory that led many to believe that a person with pedophilia who had been "cured" could be returned to an environment with minimal or no risk of further pedophilic behaviors. Behavior therapists have attempted to recondition the sexual orientations of persons with pedophilia.[48-50] The goal is to decondition sexual arousal toward children, while reconditioning erotic feelings toward adults. In considering such an approach, it is important to appreciate that even if pedophilic desires had been learned, the learning involved may have been imprinting, a type of "stamping in," rather than classic conditioning.[51] In the case of imprinting, that which has been learned cannot ordinarily be deconditioned or unlearned. If one heeds the American Psychiatric Association's advisory against attempts to recondition sexual orientation, then treatment efforts, especially with the individual attracted exclusively to children, will be aimed more at controlling the behaviors rather than reconditioning the drive toward adults.[52]

Since the late 1980s, pedophilia has generally not been considered curable in the sense that the individual would no longer be sexually attracted to children. As Fuller wrote, "The aim of treatment [for pedophilia] is to stop abuse of children, to prevent its recurrence, and to help the patient control his deviant behavior, impulses and preoccupations."[53] Currently, pedophilia is considered a chronic disorder. Therefore, treatment should focus on stopping the behavior and achieving long-term behavioral change in the community.

The Cognitive and Social Components of Treatment

One method commonly used for treating pedophilia is outpatient group therapy, which is sometimes combined with the administration of antiandrogenic (sex drive–lowering) medications. The group process allows for therapeutic confrontation of denial and self-deception. Through therapeutic confrontation, an individual can be helped to appreciate the true ramifications of his actions. The sequence of events that has led to any past sexual misconduct is identified, and the patient is taught about the changes in lifestyle needed to achieve control of the behaviors. The therapy also provides emotional support, while encouraging the development of a social support network. Brief periods of inpatient hospitalization may be required as a precaution during periods of heightened stress or risk. Any comorbid conditions, such as alcoholism and affective illness, also must be treated.

For those with pedophilia who are either on parole or probation, clinicians must work collaboratively with the criminal justice system. Electronic surveillance and polygraph testing can be used when indicated, and noncompliance with treatment should not be tolerated. At the same time, every effort should be made to maintain a good patient-physician relationship.

Treating Volitional Impairment in Pedophilia

Medications that can act as sexual appetite suppressants have proven to be helpful in augmenting volitional control of pedophilic attractions.[54-61] In most species that have been studied, including humans, a significant decline in testosterone level is ordinarily associated with a marked decrease in sexual drive and in the frequency of sexually motivated behaviors.[62] In the past, testosterone could only be reduced via surgical castration. Though less vigorous than today's standards, early studies that investigated reducing testosterone in sex offenders, including those with pedophilia, generally confirmed that doing so could result in long-term low rates of criminal recidivism.[62-65]

The testosterone-lowering medications currently used in the United States are Depo-Provera (medroxyprogesterone acetate) or Depo-Lupron (leupro-

lide acetate).[66] A recent study reported that triptorelin is also effective.[67] Although these drugs suppress the intensity of libidinal drive, they generally allow erectile function, thereby making intercourse with an age-appropriate partner possible. Persons receiving testosterone-lowering medications should be maintained on a treatment protocol that includes a complete physical examination with appropriate laboratory testing yearly.

In addition to the testosterone-lowering medications, some clinical researchers have prescribed selective serotonin reuptake inhibitors in an effort to treat pedophilia. The mechanism of action hypothesized is that these drugs increase levels of serotonin, thereby lowering sexual drive.[68]

The primary goal of sex drive-lowering medications in pedophilia is to enhance the capacity to exercise appropriate self-control. These medications should not be denied to persons who fear losing control or who appear to be at risk of failing a more conservative treatment approach.[69] Incarcerated persons with the disorder may also benefit from such care to the extent that they can be relieved of intrusive pedophilic sexual preoccupations and urges.

Results of Treatment

Media presentations that ignore treatment successes have often left the public with a false impression regarding treatment efficacy.[70] At the same time, there are also legitimate challenges in assessing the treatment efficacy for pedophilia. The vast majority of recidivism and treatment effectiveness studies do not limit their participants to those with pedophilia, but rather describe participants according to the behavior (eg, child abuse) or by relationship to the victims (eg, incest vs extrafamilial). Many studies have used diverse terms such as "sexual offenders," "sexual predators," or "child molesters," none of which have any diagnostic specificity. This blurring of inclusion criteria in studies further compromises any attempt to look specifically at the treatment outcome for pedophilia.[71] Finally, double-blind studies involving placebo treatments are difficult for ethical reasons.

On average, 10% to 17% of offenders commit another offense after 4 to 5 years when untreated.[72,73] This relatively low recidivism baseline makes establishing treatment effectiveness a statistical and clinical challenge. Measurements of treatment efficacy vary from decrease of sexual arousal to erotic stimuli as measured by penile plethysmography to no subsequent arrest.[74] Much controversy exists about the reliability and validity of penile plethysmography assessment, and arrest data are likely to underreport actual incidence of pedophilic behaviors.[75,76] Finally, great variability exists between the protocols of treatment programs and the length of follow-up time for possible recidivism.

Clearly, early treatment efforts often have been unsuccessful. A large meta-analysis on treatment efficacy of regimens for sexual offenders in general documented some successes, but a number of failures as well.[77] Many of the programs reported were in the 1960s and 1970s and would not meet practice standards today.[71]

Four recent reviews and meta-analyses of recidivism of sexual offenders in general, not pedophiles specifically, suggest a positive effect of treatment. Alexander[78] found lower recidivism rates, defined as rearrest, among treated (14.4%) as contrasted with nontreated (25.8%) child molesters. Two other reviews[79,80] reported a significant treatment effect for cognitive behavioral treatments, and one[79] found a similar effect for medical treatments for sexual offenders in general.[80] A meta-analysis published in 2002 included 43 studies of the psychological (largely cognitive-behavioral) treatment for sex offenders.[71] The findings were that sexual offense recidivism was significantly lower for the treatment groups (12.3%) than the untreated comparison groups (16.8%) over an average 46-month follow-up period. This meta-analysis was conducted on sexual offenders in general, not on pedophiles in particular. It also did not review medical and drug treatment programs. From a practical standpoint, what seems clear in recent years is that the majority of persons who have undergone therapy for sexual offenses have not reoffended. A hopeful indicator that this conclusion applies to persons with pedophilia is suggested by a study in which the sexual recidivism rate (based on criminal charge) was 7.4% over an average 5.12 years.[81] Those who had been fully cooperative with treatment, as opposed to those discharged for treatment noncompliance, had an even lower recidivism rate of 2.9%.

Recent Legislation and Its Relationship to Treatment

Four types of legislation have been introduced in recent years pertaining to individuals with pedophilia who have been criminally convicted.[82] Such statutes have mandated registration, community notification, civil commitment, or the involuntary imposition of either "surgical or chemical castration." Recently, legislators in Alabama have introduced a bill calling for the execution of certain repeat child molesters (House Bill 209).[83]

Registration statutes require individuals with pedophilia who have been convicted of a sexual offense to provide certain information to local criminal justice authorities. Doing so would seem to have few, if any, mental health implications. Community notification statutes require public disclosure of the fact that a given individual is a registered sex offender. To the extent that doing so may make it difficult to find housing, employment, and public acceptance, such statutes may make treatment success more problematic.[84] Though potentially helpful in its intended purpose of warning communities, there have also been instances in which this has inadvertently caused distress to an innocent child whose parent was a sex offender.[84]

Civil commitment statutes, which are now in force in 14 states, involve the continued involuntary detention of cer-

tain persons with pedophilia following the completion of a prison sentence. The existence of such statutes in states where no treatment is available in prison suggests a possible failure of collaboration between the medical and criminal justice sectors in dealing with pedophilia.[85] Upon entering prison, a person with pedophilia is considered to have been of sound mind, but to have acted in a way that is unlawful and deserves punishment. However, only when further deprived of his liberty, after having served his time, is he then considered to be mentally disordered and in need of care.

In some states, persons with pedophilia who desire and need access to sex drive–lowering medications are unable to access them. At the same time, 9 states have mandated the forced administration of such medications, in some instances to persons who do not want them and who medically may not require them.[86] Once again, this suggests a need for a coherent approach that incorporates both criminal justice and medical requirements into an effective public policy for dealing with pedophilia.

CONCLUSION

Clinicians should never forget that an individual who acts on pedophilic urges with a child has committed a crime but also has a psychiatric disorder. The duality of this phenomenology makes management complex. Historically, dealing with this complexity and the accompanying societal ostracism have resulted in relatively few mental health resources available to persons with pedophilia, and relatively few psychiatrists or psychologists trained to conduct research or to treat the patients. Both research and treatment programs should continue, and where necessary, be supported by public and private funds. Meta-analyses have established that treatment is more effective than nontreatment in preventing recidivism of sexual offenders in general. This finding has a high probability of applying to individuals with pedophilia also. As with treatments for many chronic illnesses and motivated behaviors, both medical regimens and cognitive-behavioral strategies must be used to prevent the expression of the disorder of pedophilia.

Pedophilia is a chronic psychiatric disorder that is treatable in terms of developing strategies for relapse prevention. Treatment will be effective to the extent that it is comprehensive, specific, and integrated with the criminal justice system whenever possible.[87] It must be comprehensive in that if other psychiatric or substance comorbidities are present, they need to be treated for any successful outcome of the pedophilia treatment to occur. The treatment must be specific in that the clinicians should identify and address the precise problematic sexual behaviors. The emphasis should remain focused on stopping the pedophilic behaviors. For those on parole or probation, there must be effective communication and collaboration between criminal justice and mental health professionals. Ultimately, the appropriate treatment and management of pedophilia requires an informed, ongoing collaboration between the criminal justice sector and the scientific medical communities so that the prevalence of pedophilic behavior can be significantly reduced.

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