UNIVERZA NA PRIMORSKEM
FAKULTETA ZA MATEMATIKO, NARAVOSLOVJE IN
INFORMACIJSKE TEHNOLOGIJE

ZAKLJUČNA NALOGA
(FINAL PROJECT PAPER)

PEDOFILIJA V VARSTVU DUŠEVNEGA ZDRAVJA: TRENUTNI DIAGNOSTIČNI KRITERIJI TER POSTOPKI KLINIČNE OBRAVNAVE

(PEDOPHILIA IN MENTAL HEALTH CARE: THE CURRENT DIAGNOSTIC CRITERIA, ASSESSMENT PROCESSES AND TREATMENT PROCEDURES)

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Zaključna naloga
(Final project paper)

Pedofilija v varstvu duševnega zdravja: trenutni diagnostični kriteriji ter postopki klinične obravnave

(Pedophilia in mental health care: the current diagnostic criteria, assessment processes and treatment procedures)

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Izvleček:

Pedofilija je bila konec devetnajstega stoletja prepoznana kot patološka naravnanost posameznika glede spolne preference in je tako v veliki meri sprejeta še danes. Veliko akademikov se je pridružilo debati na temo kaj točno pri pedofiliji je patološko in kako bi lahko na podlagi tega varstvo duševnega zdravja oblikovalo zdravstveno pomoč za posameznike s pedofilijo. Z namenom diskusije trenutnih pristopov k pojavu, zaključna naloga ponuja pregled nad področjem diagnosticiranja ter kliničnega obravnavanja pedofilije v okviru duševnih motenj ter tako opredeljuje splošne smernice v socialni praksi. Pri tem so izpostavljeni različni znanstveni pristopi, ki poudarjajo potrebo po nudenju tovrstne pomoči osebam s pedofilijo in pomen klinične prakse, ki jo le-ta lahko ima tako za posameznike kot za družbo.

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Abstract:

Towards the end of the nineteenth century, pedophilia was recognized as a pathological condition of sexual preference and still today, it is abundantly perceived as such. Many academics of the field joined the debate about what makes pedophilia pathological and, moreover, how to establish mental health care services with the aim of treating the individuals with pedophilia. As a scientific topic, pedophilia has witnessed a profusion of literature from different perspectives, which suggests that the concept of pedophilia has remained uncertain and needs further research. With the purpose of opening a debate about today's clinical practices, this final paper project provides a coherent discussion about the modern diagnostic criteria, assessment processes and treatment procedures. As such, it introduces a valid framework for the scientific concept of pedophilia and identifies a number of clinical approaches at the disposal of mental health care services. These provide knowledge about the condition and the modern treatments, and further emphasize the need for offering guidance and support to the individuals with pedophilia.

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1 INTRODUCTION

Depictions of child-adult romantic and sexual behaviour can be found throughout the history of human civilization, which seems surprising, due to the fact, that a variety of cultures, in which such depictions have been found, have not acknowledged such behaviour (Evans, 1996). There seems to be a considerable diversity regarding the concept of pedophilia and child-adult relationships, since different cultures from different historical times perceived different elements of such relationships and of pedophilic feelings (Gentry, 2009). Consequently, these cultures have responded in various ways when such behaviour has been detected, which brings up to question, how we should be responding to the phenomenon today.

Most modern societies define relationships between an adult and a child as inappropriate (World Health Organization [WHO], 2006). The reasons why are based on a wide spectre of areas and are grounded upon religious, political, ethical, biological, psychological, physiological, and organizational ideologies. Unequal and unjust distribution of power in such relationships is among the most supported arguments against it (Gentry, 2009; Goode, 2010; Primorac, 2002; WHO, 2006). These arguments state that the adult – who is physically and psychologically more developed than the child, will always allocate the strictly dominant position within the child-adult relationship, leaving the child dependent on the adult and with little possibility (if any) to choose or consent to the activities of the interaction. The general conception of power distribution also suggests that the child makes an easy target for exploitation. Therefore, to protect the child's integrity, a number of laws have been established worldwide with the aim of preventing child exploitation. These laws largely depend on the alleged *age of consent*, i.e., minimal age at which one is legally competent to give consent and thought to have the capacity to make his/her own decisions. However, the proposed age varies to a considerable degree across the international law, which leaves the impression that the age is adjusted too arbitrarily. Because of the differences in perceiving the age of consent, the discussion on the concept of consent remains unclear and unstable.

One of the biggest and most controversial subjects of child exploitation, which is also connected to the alleged age of consent, is *child sexual abuse (CSA)* for which the Slovenian Association Against Child Sexual Abuse – Združenje proti spolnemu zlorabljanju (n.d.) – proposes the following definition:

> …sexual participation of the dependent child in sexual activities with an adult or a person older and bigger than them who uses the child as a sexual object for satisfying individual's sexual needs or wishes.

CSA involves a wide spectre of behaviour, which vary in the context of invasiveness toward the child, including: 'any sexual act between an adult and a minor, or between two minors,

when one exerts power over the other; forcing, coercing or persuading a child to engage in any type of sexual act; and any non-contact acts such as exhibitionism, exposure to pornography, voyeurism, and communicating in a sexual manner by phone or internet' (Darkness to Light, n.d., p. 1). It is widely accepted within the modern Western society that these activities involving simultaneously the child and the adult do not consist within the spectre of normal sexual development in childhood and are therefore harmful for any child, regardless of the possible positive aspects in child-adult relationships (such as the adult being attentive, caring, or loving towards the child) (Goode, 2010; Združenje proti spolnemu zlorabljanju, n.d.). Consequently, CSA and child exploitation are in most countries regarded as a criminal offence, which aims to diminish these negative actions towards children (see United Nations Children's Fund, 2014).

The United Nations Children's Fund (2014) reports the following numbers about the prevalence of sexual violence in the following European countries:

- Germany: In a sample of individuals aged sixteen to forty-six per cent of women reported incidents of sexual harassment. Additional seven percent reported sexual violence with physical contact and two percent reported that they were victims of some other type of sexual violence in the time of their childhood. Before the age of sixteen, one per cent of male participants reported of sexual harassment, one per cent of sexual violence with physical contact and one percent of some other type of sexual violence.
- Italy: In a sample of women between the ages sixteen to seventeen seven per cent said they experienced sexual violence by a non-partner before age sixteen.
- Switzerland: In a sample of individuals aged between fifteen and seventeen, around forty percent of girls and twenty percent of boys reported incidents of sexual victimization at some point in their lives. This included indecent exposure, verbal or written harassment (including online) and exposure to pornography. In the same sample, twenty-two per cent of girls reported incidents of sexual touching, attempted or completed intercourse or other sexual acts, such as oral sex. Male participants reported eight per cent.
- United Kingdom: In a sample of youth aged from eleven to seventeen around seventeen percent experienced sexual abuse by an adult or a peer during lifetime. Out of these, seven per cent of girls and three per cent of boys reported physical contact involved in the sexual abuse.

Annual statistical report retrieved form Ministrstvo za notranje zadeve Republike Slovenije, Policija (2016) indicates that in 2015, the police filed four criminal charges for being involved in activities of using children for sexual purposes and sixty-nine charges of showing, making, or being in possession of child pornography. Eighty-one charges were

filed for sexual assault on children bellow the age of consent. Ministrstvo za notranje zadeve Republike Slovenije, Policija (2016) is alerting that it is to be expected that many unfortunately stay unreported. They also report about several international operations involving child exploitation in Slovenia.

The international statistical reports of CSA, the studies investigating the prevalence of the sexual contact between an adult and a child among different societies, and the reports of organized crimes, involving child pornography and child prostitution, signify that sexual exploitation of children is a big issue of modern societies worldwide (see United Nations Children's Fund, 2014). Thus, investigating the motivation behind the offence and prosecution of the abuse deserves greater attention and more efficient systematic solving, which is hindered because of the fear of the true proportions and the complex multidimensional nature of child sexual exploitation. What characterizes pedophilia as an important issue within the debate on child sexual exploitation is the assumption that it represents one of its biggest determinants. Consequently, the concepts are (too) often interchangeably used by both the public and by the academics dealing with either CSA or pedophilia, which, from the practical aspect, prevents the society to acknowledge and recognize the differences between the two. Based on the results from Jahnke, Philipp and Hoyer (2014) these attitudes are thought to be prevalent in the modern Western society. The surveys estimating the extend of stigmatization of the individuals with pedophilia (IWPs), suggest that the negative reactions of the general public to IWPSs (on cognitive, affective, and behavioural levels) are even stronger in comparison to other negatively attributed conditions such as alcohol abuse, sexual sadism and antisocial tendencies. For example, the participants in the studies were in the case of pedophilia even more likely to agree that the individuals with the condition deserve a hard penalty approach such as imprisonment or even death. Stigma, which puts the labelled person in an inferior position in the society, leaves the stigmatized group with only one possibility – accept the label, if you want to receive (the needed) societal help (Drofenik, 2002).

In the societal practice regarding pedophilia and individuals with pedophilia, the medical characterization is today's leading scientific source for the guidelines in identifying and responding to the pedophilia (Kramer, 2011; Evans, 1996; Šramel, 2014). Handling of the condition, therefore, depends greatly on the standards established within the clinical science and the mental health care, which are the main subjects of this theoretical final project paper. More specifically, the goals of the final project work are to achieve the following: (1) to critically assess the modern concept of pedophilia from an interdisciplinary perspective and to explain the importance of the clinical concept; (2) to define the most widely used practices in clinical psychology – regarding diagnosis, assessment and treatment; (3) to consider new strategies for health services by highlighting current limitations in the modern Western understanding of the concept; (4) to indicate the societal factors contributing to the

development of dysfunctional pedophilic patterns; (5) to investigate the current mental health care approaches towards pedophilia in Slovenia; and (6) to identify the current health care institutions dealing with pedophilia in Slovenia.

2 CONCEPT OF PEDOPHILIA

2.1 Definition of pedophilia

The original meaning of pedophilia is 'love of children' (Gieles, 1997). The term was first attested by the poets in Ancient Greece and, etymologically speaking, comes from the Greek paidophilia (παιδοφιλια) – pais (παις; child, infant) or its genitive case paidos, and philia (φιλια; love, friendship) as a substitute for the word paiderastia (παιδεραστία; love of boys) (Gentry, 2009). The word love has a loose concept and can be used for almost any attraction, whether purely physical or wholly sentimental. Its concept is glorified among the past and modern cultures and perceived as one of the mightiest factors in human civilisation. However, it is also highly dependent on the societal norms of the time and place. If we were to make a hierarchic scale of the societal norms in our society regarding love and sexuality, at the top, we would probably find the marital relationship between an adult man and a woman, followed by the relationship between unmarried man and woman. Most deviant fetishisms, such as necrophilia and zoophilia, would be found at the tail of the scale, while pedophilia would probably be ranked at the very end (Primorac, 2002). Thereupon, pedophilia is rarely associated with the praised concept of love and consequently, the original meaning of pedophilia has lost its positive connotation. The modern concepts generally correlate more with the idea of wrongfulness, unnaturalness and harmfulness of pedophilic attraction and, as such, the expression constitutes a negatively valued attribute or, in other words, stigma (Jahnke, Philipp and Hoyer, 2014).

With the roots in the Ancient Jewish, Roman and early Christian societies, which embraced the belief that the role of sexuality is to lead towards procreation, pedophilia and other sexual preferences that are not pursued with the aim of reproduction (i.e., could not result in conceiving offspring) gained on the idea of being abnormal (Evans, 1996). The belief encouraged the systematic condemnation of the sexual acts within the walls of the newfound states and religions. Until the turn of the twentieth century, legal restrictions and sanctioned punishments were the primary societal approach towards child-adult relationships (especially when involving prepubescent child) (Gentry, 2009).

The beginning of the science of psychiatry induced a shift in the Western societies from viewing these sexual activities (just) as immoral or illegal to perceiving them as clinically atypical and started handling the IWPs as clinical patients who need medical health to be redirected into 'functional relationships and sexual behaviour'. The clinical discussion on pedophilia started with the Austro-German sexologist, psychiatrist, neurologist and criminologist Richard von Krafft-Ebing. In his fundamental work (see Psychopatia Sexualis, 1886 in Šramel, 2014) he defined a disease, which he termed *paedophilia erotica*, as an individual's 'internal' pathological predisposition to be drawn to child-adult relationships

and proposed that it essentially differs from being drawn to child-adult relationships due to external conditions such as intoxication or inaccessibility to a suitable partner. Treating pedophilia as an internal condition suggested the idea that the individuals are in need of medical help, which induced a shift in both understanding of pedophilia and in responding towards IWPs – implying that the institution dealing with IWPs should be a mental health care institution and not a prison. (Šramel, 2014)

The concept of 'pedophilia as an internal condition' suggests that there is an involuntary biological factor playing a role in both the development and the manifestation of the condition (see Cantor et al., 2008; Feierman, 1990) and today, there is a wide consensus that one can associate volitional regulation with the pedophilic tendencies only up to a (small) degree (Berlin, 2002; Jahnke and Hoyer, 2013; Seto, 2010). Therefore, it seems reasonable to assume that pedophilic tendencies can create some forms of burdens and impairments, due to the discrepancy with the general ideas of love and sexuality, which do not approve of such child-adult interactions. Thus, pedophilia could be regarded as a disease and its treatment should be aimed towards achieving the state of 'health' – a state of physical, emotional, mental and social well-being. Because of the general overlap between the concepts of pedophilia, pedophilic tendencies and pedophilic sexuality, the state of 'health' is, in the case of the IWPs, often narrowed down to the idea of 'sexual health' for which the WHO (2006) proposes the following definition:

> …a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

In finding ways to provide specific guidelines to help IWPs towards achieving a better state of health and a more functional quality life, medicalization – as the superior lead – highlights the notion that the IWPs may encounter group-specific problems to satisfy their needs. Consequently, medicalization of the concept introduced a number of 'helping methods'. This development also emphasizes the importance of unequivocal guidelines regarding the diagnosis, assessment processes and treatment procedures, which, furthermore, provides standards for the practical work regarding the mental health care. Simultaneously, all the researches and documented procedures of the services add immensely to the scientific literature about pedophilia, which can be beneficial to both the individuals who are overwhelmed by their pedophilic tendencies and to the societies dealing with the problematics of child exploitation, since it provides more scientific information about the nature of both phenomena. However, up until today, theoretical and practical opinions on

medical categorization of pedophilia as a pathological internal condition vary to a considerable degree (see Peer Commentaries on Green (2002) and Schmidt (2002), 2002; B4U-ACT, 2011), which adds to the confusion surrounding the concept of pedophilia and to the ambiguity of guidelines in dealing with the people who are drawn to child-adult romantic and/or sexual relationships.

2.2 Diagnostic criteria

In order to address the common misconceptions of pedophilia, good scientific characterization might be the best choice. Many authors joined the discussion whether pedophilia could be classified as a mental disorder and how it should be defined as such (see Peer Commentaries on Green (2002) and Schmidt (2002), 2002). The main diagnostic manual for diseases - International Classification of Diseases [ICD] and the more specific manual for mental disorders - Diagnostic and Statistical Manual of Mental Disorders [DSM] routinely include the category pedophilia, identifying it as a clinical condition and proposing a syndromic approach in the identification. Both DSM and ICD specify a variety of syndromes (what the patient feels or has noticed) and easily recognized signs (what the clinician finds on examination) thought to be typical for individuals with pedophilia and in the review of the contemporary adaptations of diagnostic manuals – American Psychological Organization [APA] (2000), APA (2013) and WHO (2008) – it appears that there is a number of commonly recognized characteristics of pedophilia.

Based on the knowledge of psychobiological development (mental capacities, sexual maturation, etc.) and the legislative concept of adulthood (i.e., age of consent, see p. 1) an *age criterion* of sixteen years or above is proposed by the medical community for the diagnosis of pedophilia (APA, 2000; APA, 2013; WHO, 2008). The age criterion provides the basic frame that separates the group of children from the group of adults and, as such, sets boundaries for the age appropriate relationships. APA, 2000; APA, 2013; and WHO, 2008 propose that adult individuals involved in a relationship with a minor – bellow the age of consent – should be taken into consideration for the diagnosis, although additional thought must be given upon the age difference between the involved persons. All three manuals imply that for the diagnosis, there should be at least five years difference between the two individuals. To better characterize the paraphilic object of pedophilia – *the pedophilic stimuli*, the manuals suggest that the child in the centre of pedophilic attraction is generally age thirteen or younger and before the full pubertal maturation. Thus, sexual maturity of the child must be taken into account for a valid clinical judgement of pedophilia (APA, 2000; Seto, 2002; 2010).

Among the essential syndromes of the condition, individuals with pedophilia experience feelings of being attracted to children; also in a sexual sense (Gieles, 1997). The *pedophilic feelings* are brought about by physiological and cognitive reactions to the pedophilic stimuli,

which result in the state of *sexual arousal* – i.e., motivational state of excitement and tension directed towards expressing such feelings (Benson, 2003). These biopsychological reactions are thought to express sexual arousal through the patterns of recurrent, intense sexually arousing thoughts or recurrent, intense sexual urges directed towards the pedophilic stimuli and can ultimately lead to a wide spectre of behaviour, which varies in the context of the child involved. It is important to note once again that *pedosexual behaviour* – i.e., actual sexual interaction between an adult and a child – is in most modern countries prohibited by law (see child sexual abuse, p. 1-2).

Fantasy is in psychological terms a term for mental apprehension of an object of perception in a form of a thought or image that provides a pleasurable experience for an individual (Brenner, 2003). Fantasizing is not perceived as harmful, however, it is considered to be a factor in enhancing motivation for sexual behaviour and amplifying the extent of sexual arousal (see Leitenberg and Henning, 1995). The content of the pedophilic fantasies may trigger negative reactions from the public when observed, which can have severe consequences for the individual on an intrapersonal and/or interpersonal level. Since the social norms support the idea that the pedophilic fantasies are atypical, 'the deviant individual' might report distress, shame, guilt, fear or other psychosocial difficulties for having pedophilic fantasies and/or receiving sexual pleasure from them (APA, 2000; APA, 2013). However, judging someone for having pedophilic fantasies seems unjust for two main reasons: first, people have limited control over the biopsychological mechanisms involved in such perception (Berlin, 2002; Jahnke and Hoyer, 2013; Seto, 2012) and second, when one experiences (sexual) attraction towards children, fantasizing about them might be their best alternative for satisfying their needs (Goode, 2010).

The individual who recognizes strong romantic and/or sexual attraction to children might engage in a variety of sexual and non-sexual behaviours with the aim of fulfilling the pedophilic urges (B4U-ACT, 2011). APA (2013) proposes that some IWPs are able to 'efficiently handle' their pedophilic urges within the social boundaries; however, a minority nonetheless either cannot or will not. The individuals who are unable to restrain from child sexual abuse often try to rationalize and minimalize the consequences of their behaviour (APA, 2000; APA, 2013; WHO, 2008) and sometimes even genuinely believe that they are not causing any harm (Goode, 2010). They may limit the sexual activities to undressing a child while looking, exposing themselves, masturbating in their presence, or gentle touching, fondling the child. Others, however, perform fellatio or cunnilingus on the child or penetrate the child's vagina, mouth, or anus with their fingers, foreign objects, or penis and use varying degrees of force to do so (APA, 2000). B4U-ACT (2011) proposes that patterns of child-adult relationships are in many ways similar to age appropriate relations regarding the development of the relationship and the attachment between the two individuals. Additionally, B4U-ACT (2011) highlights the components of non-sexual behaviours in such

relationships and non-sexual expressions of attraction, which are time after time ignored and contribute to the prejudicial impression that IWPs are devoid of feelings of love and, as such, purely egocentric and dangerous.

For the diagnosis of pedophilia, pedophilic feelings have to be persistent and/or predominant, greater or experienced as equally important in comparison to the attraction towards age appropriate individuals, thus, people address to it in terms of sexual preference (APA, 2013; Seto, 2002; 2010; WHO, 2008). Sexual attraction can be connected exclusively to children (i.e., exclusive type) or also toward adults (i.e., nonexclusive type); it can be gender or age specific; and it can be limited to their own children, stepchildren, relatives or children outside family (APA, 2000; APA, 2013; WHO, 2008). The sex preference, the exclusivity of erotic arousal, and the consideration of incest are required to be specified in the diagnosis by both APA's versions of DSM.

APA (2013), Langevin (2002), and Miner (2002) suggest a theory, that there is a difference between pedophilia (as in sexual preference for children) and pedophilic disorder (as in dysfunctional mental disorder caused by pedophilia) in a sense that there are some IWPs who learned how to 'efficiently handle' their pedophilic urges within the social boundaries. Furthermore, Schmidt (2002) argues that pedophilia should be excluded from the diagnostic manuals and not regarded as a disease at all. Similarly, Green (2002) makes a distinction between three kinds of discourses on pedophilia: the legal one, the moral one, and the medical one, and, like Schmidt (2002), proposes that pedophilia should be excluded from the last. This contrasts the idea that pedophilia should be recognized as a medical issue and shifts the focus of the therapy from feelings of attraction, to discernible dysfunctional patterns. Regarding the assessment, it proposes more specialized tools for measuring the 'negative aspects' of pedophilic disorder. APA (2013) proposes that the diagnosis for pedophilic disorder applies to an individual, if:

- the individual complains that the sexual attractions or preferences for children are causing psychosocial difficulties;
- and/or the individual is functionally limited by the pedophilic impulses.

APA (2013), Langevin (2002), and Miner (2002) imply that much like with gambling or with substance use, pedophilia should be regarded as a disorder only when the attraction to children becomes preoccupying, when it escalates, and/or results in harmful, negative consequences and not as a preference *per se*, which is in contrast to the ideas of Dixson (2002), Seto (2002, 2012) or previous diagnostic definitions from diagnostic manuals, which included pedophilia in their classifications. Up until today, researchers are using different societal approaches to study pedophilia and help the IWPs, however the answer to the

question if pedophilia is pathological remains disputed, which suggests that further research about the condition is needed for providing (more) appropriate help.

3 ASSESSMENT PROCESSES

The assessment processes are intended to facilitate an objective evaluation of the diagnostic criteria in a variety of clinical settings – inpatient, outpatient, consultation-liaison, clinical and private practice, and in primary care. In terms of mental health care, a referral from personal, legislative or medical reasons is needed in order for the clinical assessment of pedophilia to occur. The assessment process is the first step towards providing professional help to individuals with the dysfunctional patterns due to pedophilia and must be conducted prior to any treatment plan (Rosenberg, 2002). Comprehensive psychosexual evaluation of identified or suspected pedophilia helps determine the dynamics involved, the individualized interventions needed, and can later on serve as a baseline level for future evaluations of the intervention's success (Bourget and Bradford, 2008). Besides psychological evaluations, indicative physiological evaluations, such as general internistic, neurological and laboratory tests are a routine standard in the assessment of all mental illnesses (to rule out a list of considerable causal factors like intoxication, infection or traumatic injury) along other physiological evaluations, which tend to be more illness-specific (Tomori and Ziherl, 1999).

3.1 Standardized assessment tools

With the aim of identifying the presence (or absence) of pedophilia and/or pedophilic disorder, standardized evaluation of sexual behaviour presents an important source. The *psychiatric interview* represents the beginning of the psychotherapeutic process. Psychiatric interview consists of observation and the use of unobtrusive and unsuggestive open-ended questions, through which the mental health care workers aim to obtain claims regarding: individuals psychiatric history (i.e., information about individual's psychosocial and medical history) – including the description of the current problematics (what is the problem, what is the mood, welfare, possible fears and individual's subjective perception of the illness); personal history (intended to describe events of major significance and to describe functioning over time with regards to the psychosocial, developmental and medical factors); and family history (since many psychiatric disorders seem connected with genetics and psychosocial influences). The systematic evaluation of the mental status consists of general impression and behaviour, thinking and language, mood, perception, memory, attention, awareness and orientation, intelligence, suicidality, and individual's perception of the mental state. (Tomori and Ziherl, 1999)

In the case of pedophilia, *assessment of the pedophilic focus* (i.e., the child) can be conducted in addition to the more general psychiatric interview. Among most widely known and used rating scales for such evaluation is the Screening Scale for Pedophilic Interests (SSPI; Seto and Lalumiere, 2001 in Seto, Harris, Rice and Barbaree, 2004), which assesses four child victim characteristics: number of victims, age, gender, and the relationship to the victim. In

its revised version – SSPI-2 (Seto, Stephens, Lalumiere and Cantor, 2015), a fifth item, use of child pornography, was added. Based on the historical measure of previous sexual offenses (i.e., number of prior offenses, age at release, victim gender, relationship with the victim) structured *risk assessment* scales for sexual offending are regularly used (Goode, 2010; Seto et al., 2004), such as the Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR; Hanson, 1997).

3.1.1 Psychological tests, inventories and questionnaires

Psychological tests, inventories and questionnaires can also take place in the standardized evaluation of individuals with reported atypical sexual behaviour (which includes the individuals reported for CSA). They are used to provide a more structured and detailed sexual history and measure the nature of sexual behaviour, i.e., components of the sexual arousal; the degree of sexual fantasies (e.g., recurrence, intensity); the nature and the degree of cognitive distortions (e.g., minimization, justification) or comorbidity; and the presence and extent of substance abuse (Bourget and Bradford, 2008). Such questionnaires are:

- Clarke Sex History Questionnaire for Males (SHQ; Paitich, Langevin, Freeman, Mann and Handy, 1977) includes characteristics as the frequency, desire for, and disgust for a wide range of sexual behaviours including pedophilia. It's revised version – SHQ-R (Langevin and Paitich, 2002) also helps to evaluate the individual's risk to others and the potential for rehabilitation.

- Sexual Arousal and Desire Inventory (SADI; Toledano and Pfaus, 2006) assesses subjective experiences of sexual arousal and desire in men and women.

- Sexual Arousability Inventory (SAI; Hoon, Joon and Wincze, 1976) and its expanded version – SAI-E (Chambless and Lifshitz, 1984) are capable of discriminating between the 'normal population' and the individuals seeking therapy for sexual dysfunction and can help determine the efficacy of various therapy programs. Also, it assesses the possible comorbidity of sexual arousability with anxiety.

- Coercive Sexual Fantasies Questionnaire for Males (CSFQM; Greendlinger and Byrne, 1987) assesses sexual fantasies, acceptance of rape myths, and aggressive tendencies. It also measures the likelihood of committing rape and the past occurrences of coercive sexual behaviour.

- Sexual Deviance Card Sort (SDCS; Laws, 1986 in Hall, Hirschman and Oliver, 1995; Laws, Hanson, Osborn and Greenbaum, 2000) assesses the perceived attraction to various depictions of different paraphilic sexual interests by asking the subject to sort them on a scale of attractiveness.

- Sexual Interest Card Sort (SICS; see Holland, Zolondek, Abel, Jordan and Becker, 2000) contains 75-items representing 15 discrete categories of sexual interest and assesses cognitive distortions of child molesters using the Abel-Becker Cognition Scale.

- Implicit Association Test (IAT; Greenwald, McGhee and Schwartz, 1998) measures differential association of two target concepts with an attribute. It is based on the assumption that a person who holds a favourable view of a topic (e.g., sex with a child) will associate specific words together, related to the topics of romantic/sexual attraction (e.g., sex, arousal, love) with the concept of childhood.

3.1.2 Physiological measures of sexuality

Physiological measures of sexuality are used to clarify whether a sexual preference is present or not and to validate the information attained through the psychiatric interview (and scales used in the process), psychological tests, inventories, and questionnaires. Among most common procedures of assessing physiological determinants of sexual behaviour are:

(a) Sex Hormone Profiling – or evaluation of sex hormones – most often includes testing of the luteinizing hormone levels, the follicle-stimulation hormone levels, the free and total testosterone levels, estradiol levels, and progesterone levels (Bourget and Bradford, 2008).

- Luteinising hormone (LH) and follicle-stimulation hormone (FSH) are two principal protein hormones (gonadotrophins), central to the complex endocrine system that regulates normal growth, sexual development, and reproductive function. Both are regulated by the 'HPG-axis', which consist out of three endocrinal glands – the hypothalamus, the pituitary, and the gonads. The hypothalamus produces the gonadotrophin hormone-releasing hormone (GnRH), which stimulates the anterior pituitary to produce LH and FSH. Increased LH and FSH levels trigger the gonads (i.e., reproductive glands) by promoting sex steroid production and gametogenesis. In men, LH stimulates the production of testosterone in the interstitial cells of the testes (Leydig cells) and in women, it stimulates estradiol and progesterone production in the theca cells of the ovaries. Similarly to LH, FSH binds to receptors in the spermatogenic tissue of the testes and to the granulosa cells of ovarian follicles and consequently regulates the gonadal function. (Gabbard, 2009)
- Sex steroids (also gonadal steroids) like testosterone (a common type of androgen), estradiol (a common type of estrogen) and progesterone (a common type of progestin) influence the ability and motivation for sexual behaviour. Since LH and FSH stimulate the production of sex steroids in the gonads, low levels of both gonadotrophins correlate with low levels of testosterone, which is associated with decreased sperm production and sexual motivation in males. In particular, it is

> thought to be involved in the mechanisms of sexual desire, fantasies and behaviour, which also control the frequency, duration and magnitude of spontaneous erections in men. The relation between testosterone and female sexual motivation is somewhat ambiguous, therefore, it is rather associated with sex steroids like estradiol and progesterone. In particular, higher levels of estrogens have been associated positively with increase in female sexual motivation and higher levels of progesterone are thought to correlate with motivational decrease. High levels of estrogen in men can cause feminization (i.e., taking on secondary feminine characteristics). Both the hypothalamus and the pituitary – the other two glands involved in the HPG-axis – are able to respond to the circulating levels of sex steroids and correspondingly adjust the production of GnRH, LH, and FSH accordingly with the necessary feedback (to inhibit or to activate the production of the three hormones). A small amount of sex steroids is also produced by the adrenal glands. The effects of the sex steroids are mediated through their action on the intracellular androgen receptors. (Jabbour, 2016)

The evaluation of the sex hormones is used to clarify the possibility of abnormal levels of these hormones, which could contribute to the overwhelming feelings of arousal or desire regarding the frequency of fantasies and the possibility of obsessive/compulsive sexual acts (Bourget and Bradford, 2008). Such acts can result in illegal actions and clinically significant negative consequences for the individuals, which are, in connection with the condition of pedophilia, to be referred as syndromes of a mental disorder (APA, 2013). The relative importance of hormonal versus psychiatric, social and cultural determinants of sexual motivation and sexual identity is yet unsure, however, the practical use of pharmacology suggests that medical interventions can contribute to the decreased sexual arousal in general (Thibaut, Barra, Gordon, Cosyns and Bradford, 2010). If pharmacological interventions are thought to be needed, the evaluation of sex hormones during the initial assessment of the individual also serves as a baseline for any additional assessments of his/her condition and/or of his/her sexual behaviour (Bourget and Bradford, 2008). With the aim of better understanding the motivation for engaging in pedosexual behaviour, it is important to note, that there are also other hormones (e.g., prolactin, oxytocin, vasopressin) that should gain more attention from both clinicians and researchers dealing with the context of pedophilia, to observe other possible biological agents in the phase of both development and manifestation of the pedophilic tendencies and dysfunctions (Jabbour, 2016). Furthermore, in a biosocial overview of pedophilia edited by Feierman (1990), it is suggested that hormonal activity influences sexual preference and sexual orientation already in the pre-natal brain through the process of so called brain masculinization/defeminisation. If true, this points out a strong biological component of pedophilia and new ideas for the assessment and treatment.

(b) Viewing (Reaction) Time Assessment – VT – is based on the premise that sexual arousal interferes with cognitive processing. The measures assess the time spent viewing a series of slides depicting clothed models in sexually suggestive situations. The subject controls the amount of time each slide is on display, which differ regarding the stimuli – including the categories of age, gender, and deviant sexual behaviour. The evaluation of the VT results can be used in the process of assessment by comparing the amount of time spent on each slide or, like in Abel Assessment of Sexual Interest (AASI), by comparing the 'time measured results' to the additional self-reports of sexual interest to each depiction. AASI also includes a comprehensive questionnaire designed to gather information also about the frequency of sexual thoughts, fantasies and behaviour. (Bourget and Bradford, 2008)

Application of the VT is considered to be relatively easy to administer and can be applicable to both male and female subjects (Bourget and Bradford, 2008; Camillieri and Quinsey, 2008). In comparison to some other physiological measures it is less invasive to the subject and is therefore thought to be a good assessment tool for validating the information about pedophilia reported by the IWPs or the authorities.

(c) Phallometric Assessment – is conducted for male individuals and measures the penile changes (e.g., temperature, penile surface blood circumference, volume) in response to various external stimuli based on the hypotheses that increased activity in the penile function reflects and correlates with sexual arousal and imply overall sexual preference and responsiveness. Penile plethysmography – PPG – is the most common procedure and can measure volumetric and/or circumferential changes in the penis, while the subject is presented with a set of auditory and/or visual stimuli that depict sexual interactions, which differ with respect to the age and gender of the participants, and degree of consent, coercion and violence involved. Consequently, it is designed to discriminate between the IWPs and other sex offenders and serves as an indication for gender/age preferences and for incest or possible homicidal offences. (Camillieri and Quinsley, 2008)

(d) Neuroimaging and Neurophysiological Methods – measure neural activity and structure. Various technologies – computerized axial tomography (CT), electroencephalography (EEG), (functional) magnetic resonance imaging (MRI and fMRI) have been used in studies of pedophilia, however, due to the limited access to equipment and the lack of research on treating the anomalies identified by neuroimaging, these technologies are not yet commonly used in the assessment processes. On the other hand, the use of neuroimaging and neurophysiological methods represents a new component in the understanding of pedophilia and pedophilic disorder in general. With the assumption that there is a neurophysiological determinant of pedophilia, groups of researchers like Cantor et al., Blanchard et al., Ponseti et al., Cohen et al., Schiffer et al. investigated the idea that the brain functioning and brain structure of the IWPs differs from the brains of the individuals

attracted to age appropriate partners. Neuroanatomical study from Cantor et al. (2008) revealed significant negative association between pedophilia and the white matter volume of the superior fronto-occipital fasciculus and the right arcuate fasciculus. Because of the hypothesis that the superior fronto-occipital and arcuate fasciculi connect the cortical regions that respond to sexual cues, these results suggest '(1) that those cortical regions operate as a network for recognizing sexually relevant stimuli, and (2) that pedophilia results from a partial disconnection within that network' (Cantor et al., 2008, p. 167). Another important study was conducted by Schiffer et al. (2007), based on the premise that there is a correlation between pedophilia and inability to inhibit behaviour. Frontostriatal morphometric abnormalities found in Shiffer et al.'s research support their assumption of a pathological mechanism similar to the one observed within the spectrum of obsessive-compulsive disorders [OCD]. Consequently, the idea of *treating pedophilic disorder in a similar manner to OCD* emerged - such treatments are focused on changing the patterns and achieving control over thoughts and behaviour (Jerković and Maurović, 2004). Both mentioned neurological investigations imply that pedophilia is a result of neurodevelopmental perturbations, which happened during the course of one's life. Findings from Mendez, Chow, Ringman, Twitchell and Hinkin (2000) and Burns and Swerdlow (2003), who investigated cases of pedophilia acquired due to other brain disease or brain trauma, additionally support this idea. However, when interpreting these results, one must keep in mind that such research is largely dependent on the reports of judicial or medical system, which would in the new characterization of pedophilia proposed by APA (2013), rather be specific for pedophilic disorder and not pedophilia in general. It is also important to know that the application of imaging technologies to pedophilia has lagged behind the investigations of other psychopathologies and many of the possible hypotheses are yet to be confirmed with a bigger sample. With the aim of providing a coherent theory of the neurobiological basis of pedophilia, new studies based on neuroimaging and neurophysiological methods could again importantly add to the current diagnostic criteria, assessment processes and treatment procedures regarding the condition.

(e) Other Physiological Approaches in the evaluation of sexual behaviour and sexual preference include pupillometry, gaze tracking, assessing changes in the skin conductance, and the use of polygraph or similar devices (Rosenberg, 2002).

Although the application of physiological measures is essential for the objective evaluation of the pedophilic syndromes, at present, the basis of vast amount of physiological correlations and pedophilia and/or pedophilic disorder remains unclear or at least uncertain. Another problem with physiological measures is also the unstandardized use of the stimulus, which leads to even less representative results and conclusions. Bourget and Bradford (2008) warn about the voluntary manipulation of results during such assessments, since it seems that the subjects have at least partially control over his/her body even in the clinical settings.

The limitations of the assessment procedures and, simultaneously, of the diagnostic criteria have enabled to converge upon a standardized and validated evaluation procedure. The use of various tools is proposed in the clinical settings, which, however, is not always within the realistic reach of the assessor and/or institution. Therefore, it seems essential for the workers in the clinical practice to be acquainted with the available assessment tools and understand their relative strengths and weaknesses. Ultimately, it depends on the knowledge of the assessor to help make a decision about individual's condition by the process of gathering and interpreting the information acquired through the assessment processes.

4 TREATMENT PROCEDURES

The beginnings of treating pedophilia as a pathological predisposition can be traced back to the nineteenth century, when the emergence of psychiatry proposed that legislative restrictions and/or sanctioned punishment (e.g., beating, imprisonment) do not provide efficient 'cure' for the pedophilic tendencies (Evans, 1996). The early clinical notion implied that every individual with recognized and/or observed syndromes of pedophilia should be treated as an individual in need of mental health care because of his/her pedophilic sexuality. This assumption is present even today, however, there is a variety of theories used to justify it. The treatment services were established on the idea that being attracted romantically or sexually to children as an adult is pathological. Consequently, the goal of the services has been and yet remains to reduce the amount of pedophilic tendencies overall with the aim of diminishing any overt or covert expressions of pedophilia. The ultimate goal of such approach is to diminish the factors related to reoffending (including the preference itself) and by this contributing to the prevention of child exploitation (Camilleri and Quinsey, 2008).

The initial clinical approach towards achieving the reduction of pedophilic tendencies was *surgical castration* (i.e., removal of the gonads), which was, even before the medical concept, sometimes practised as a judicial punishment for child sexual abuse (Thibaut et al., 2010). A review of the literature on castrated sex offenders by Weinberger, Sreenivasan, Garrick and Osran (2005) reveals that surgical castration typically reduces testosterone levels and contributes to a very low incidence of sexual recidivism among the sex offenders. However, surgical castration is not considered the standard treatment any longer, because of the invasiveness of the intervention and the irreversible effects on sexual reproduction of the castrated individuals. For the same reasons, *surgical lesioning of the brain regions* related to sexual activity has become virtually obsolete (Thibaut et al., 2010).

4.1 Modern treatments

The treatment procedures established towards achieving the reduction of pedophilic tendencies include *chemical castration*, which, by prolonged pharmacological treatment, like surgical castration, produces gonadal atrophy and reduces sexual arousal/drive. It is assumed that reducing general sexual arousal by targeting sex steroids eases the management of any pedohilic thoughts and behaviour (Berlin and Meinecke, 1981). In the past, the use of estrogen agents proved to cause many negative side effects for men – including feminization – and was later supplanted by the pharmacological agents influencing testosterone levels through the HPG-axis (see Sex Hormone Profiling, p. 13-15). Bourget and Bradford (2008) suggest that there are three main pharmacological agents used in the clinical practice

affecting the HPG-axis with all aspects of sexual behaviour (arousal, drive, interest, and fantasy):

- medroxyprogesterone acetate (MPA) - reduces testosterone levels by inhibiting the secretion of gonadotropins LH and FSH in the pituitary and by the induction of testosterone reductase in the liver which accelerates testosterone metabolism;

- luteinizing hormone-releasing hormone (LHRH) – overstimulates the hypothalamus, which causes reduced testosterone and dihydrotestosterone release through their significant inhibitory effects on gonadotropin secretion;

- cyproterone acetate (CPA) – influences the HPG-axis indirectly by blocking androgen receptors throughout the body and consequently blocks the effects of testosterone.

Bourget and Bradford (2008) also describe a different type of pharmacological treatment available and used in practice when dealing with dysfunctional sexual arousal patterns, which, instead of targeting sex hormones, affects sexual arousal by influencing the neural activity, or more specifically, by blocking the reuptake of the neurotransmitter serotonin (5-HT). Fluoxetine, fluvoxamine, and sertraline, which are the most common types of selective serotonin re-uptake inhibitors (SSRIs) used in this manner, indicate correlations with erectile functioning, orgasmic/ejaculatory capacity, and sexual interest in general (Hill, Briken, Kraus, Strohm and Brener, 2003).

Pharmacological treatment is, since its beginning, always applied only in addition to *psychotherapy* (Bourget and Bradford, 2008; Rosenberg, 2002). Psychotherapy aims to ease the management of pedophilic tendencies and the possible negative burdens/impairments by increasing individual's mental status. There are as many kinds of therapies as there are therapists, however, each therapist has to follow specific guidelines based on acknowledged scientific principles in order to help individuals regarding pedophilia in an appropriate clinical setting. Treatment approaches differ in the length of treatment with some programs providing booster sessions upon release, in the form of setting (inpatient, outpatient, and private practice), and in the number of patients included in the treatment session (i.e., group or individual sessions) (Thibaut et al., 2010).

Behavioural treatment approach focuses on *conditioning* the sexual arousal patterns – a behavioural process of responding sexually to an object or event (i.e., stimulus) modified by social learning. The basic tenet is that sexual behaviour is learned and that undesirable behaviour can be unlearned. Therefore, application of positive or negative reinforcement can make a specific behaviour more or less likely to occur. The aim of conditioning is to diminish or reduce sexual responsiveness to children and/or to increase sexual responsiveness to

adults. In the classical aversive conditioning, the subject is presented with a verbal or visual depiction of a child, which is accompanied with an unpleasant, aversive stimulus (e.g., electric shocks, unpleasant smell) (Camilleri and Quinsey, 2008). Chemical treatments like apomorphine and electric shocks are today usually substituted with less invasive techniques due to procedural and ethical changes in human experimentation (Akins, 2004). In response to classical aversive conditioning, the individual is more likely to associate the image of the child with unpleasant smell, which could help decrease his sexual responding to children (Camilleri and Quinsey, 2008). In a similar manner, the subject can be presented with a verbal or visual depictions of consenting sex with an age appropriate partner followed by the absence of the aversive stimulus, which would signal to the subject that such acts are appropriate or, even more, desired (Camilleri and Quinsey, 2008). The term used for the combination of positive and negative reinforcement is classical discriminative conditioning, also operant conditioning or instrumental conditioning. In covert sensitization, the individual is asked to envision a situation in which they are in sexual contact with a child but feel highly unpleasant, such as when feeling nauseous or like the image of being caught (Akins, 2004; Camilleri and Quinsey, 2008). The aim is again to generalize the unpleasant feelings on every sexually arousing situation involving a child. The method called masturbatory satiation interferes with the pedophilic fantasy during the masturbation process. The individual is asked to masturbate to ejaculation while thinking about appropriate sexual acts, then continuing to masturbate in the postorgasmic, refractory period, while thinking about sexual acts involving a child (Laws and Marshall, 2003). Masturbatory satiation is just one of the variations in the clinical modification of techniques with the aim of manipulating the sexual arousal and gratification (Akins, 2004). Despite the differences in all of the mentioned conditioning techniques, they all require the repetitive performance of behaviour under the same stimulus condition for it to be effective and ultimately leading to the attenuation or extinction of pedophilic tendencies. The variety of the methods and, nevertheless, of the material used in the treatment procedures complicates comprehensive assessment of the effectiveness of the conditioning and its application for standardized use. It should also be noted that the problems with these studies is the lack of evidence for long-term effectiveness. Therefore, conditioning techniques are more often paired with other psychotherapeutic interventions (Rosenberg, 2002).

A common combination of behavioural and of cognitive treatment approach – also known as *cognitive-behavioural therapy* (CBT), incorporates the techniques of conditioning and the knowledge about cognition. Regarding the cognitive aspect, the focus is on cognitive distortions, attitudes, and thinking/emotional errors related to pedophilic behaviour. Cognitive distortions provide the IWPs with interpretive framework that allows them to justify, rationalize, and essentially excuse their maladaptive behaviour to themselves and others (see Howitt and Sheldon, 2007). The aim of cognitive-behavioural therapy is to change these aberrant cognitions by teaching the offenders how they influence sexual

behaviour; informing them about the harm of pedosexual behaviour; and teaching them how to identify their own cognitive distortions (Camilleri and Quinsey, 2008). There are various pedagogical methods available for the cognitive-behavioural therapists to use in order to help the IWPs to understand and work through their cognitive distortions (e.g., 'journaling'; challenging beliefs; relaxation techniques; teaching mindfulness; social, physical, and thinking exercises to make a person aware of his/her emotional and behavioural patterns).

In general, psychotherapists are bound to adhere to strict definitions of the specific psychotherapeutic approaches for which they have acquired professional training. Among predominant, many are based on psychodynamic, psychoanalytic, or humanistic traditions.

The psychodynamic and psychoanalytic treatment approaches persist on regular individual sessions with the therapist, who is trained in psychoanalytic/psychodynamic technique, which is focused on discovering the unconscious meanings and motivations of behaviours, feelings, and thoughts that are evolving from early childhood (Thibaut et al., 2010). It is founded on the idea that pedophilic behaviour is not a biological disease but rather a consequence of unresolved childhood complex that manifests itself in the hypersexual drive, lowering the value of sexual objects and can result in perceiving children as sexual (Jerković and Maurović, 2004).

On the other hand, the humanistic treatment approach focuses on self-development in the 'here and now', personal growth and acceptance of the responsibilities by helping the individuals to recognize their strengths of their 'ideal self' on one hand, and to improve the capacity of self-awareness and choice. It is based on the premise that the human nature has inherent potential to maintain healthy, meaningful relationships and to make choices that are in the interest of oneself and others (Rassool, 2016). With the aim of increasing individual's mental status, therapeutic approaches may include modules of general counselling ('talking therapy'); sex education (i.e., giving information about sexuality and sexual disorders); anger management (overview of methods for controlling anger); social skills training (with role-playing); assertiveness trainings (teaching the appropriate methods of expressing both positive and negative feelings); family therapy (offering help to the family and trying to improve family atmosphere); treatment of sex or pornographic addiction; and, as mentioned, relapse prevention booster sessions (Jerković and Maurović, 2004). The latter is a separate program module focusing on factors that maintain changes brought by treatment, in particular: self-efficacy (confidence in coping with high-risk situations), coping skills (skills to cope with high-risk situations), and motivation (increasing desire not to relapse) (Camillieri and Quinsley, 2008). Its organization is similar to the twelve-step program approaches provided for the individuals with drug dependency know as substance abuse recovery programs like Alcoholics Anonymous (AA) (Jerković and Maurović, 2004).

When you take into account that there is such a wide spectre of treatments, it seems evident that pedophilia has profound influence in more than one aspect of the client and the individual's total being. Therefore, it seems vital to remember that proper treatment should address a variety of dimensions in the client's life in order to help the individual to shape into a functional, rational, and moral person. In contrast to the common beliefs, APA (2013), Langevin (2002), and Miner (2002) suggest that some individuals with pedophilia do not need mental health care services in order to achieve 'health' – a state of physical, emotional, mental and social well-being (see p. 6). Distinction between pedophilia (as in sexual preference for children) and pedophilic disorder (as in dysfunctional mental disorder caused by pedophilia) may have significant impact on the clinical practice, for it changes the essential view on pedophilia, proposing it is just one of the natural deviations with which one must learn to live in an adaptive way. Based on the fact, that the preference-based (re-orientational) treatment for now seems insufficient regarding long-term effectiveness (Camilleri and Quinsey, 2008), this view could contribute to a more optimistic prognosis of the IWPs.

4.2 Treatment prognosis

The treatment prognosis must be based on the continuous assessment of the involved individuals. Predicting treatment outcomes is a difficult task, but the main criterion is clear: did the IWP commit any offences after the program (Zessen, 1990 in Jerković and Maurovič, 2004). Regarding the prognosis of the modern treatments, many authors note that the results of the studies about the success of the specific treatments described in the middle of this chapter are incoherent and because the modern treatments are often implemented alongside one another, it is difficult to assess them separately (see Camilleri and Quinsey, 2008). As understood from a thorough review, the success of treatment depends on (1) the observed syndromes; (2) the comorbidity of other clinically recognized disorders involved (see Raymond, Coleman, Ohlerking, Christenson and Miner, 1999); (3) the patient's relationship with the therapist and the other workers in the mental health care service; and (4) whether or not the legal system is involved.

During treatment, a number of issues the IWPs have to face can be constructively discussed with the mental health care workers and are available to be address throughout the modern treatments (Jerković and Maurović, 2004). Involvement of the significant others (e.g., family, close friends) and continued supervision of the IWPs are thought to be of particular importance in the treatment of pedophilic disorder. The significant others involved in the therapy of the IWPs can simultaneously receive education about the disorder, medication, treatment procedures, the importance of psychotherapy, relevant legal matters, and what to do in case of emergency (Brannon, 2016). Continued supervision and relapse prevention

programs are especially needed in the case of child-sexual abuse in order to provide safety regarding the future possible child victims (Pust and Štim, 1996).

With a good prognosis O'Halloran et al. (2016) associate cooperative attitudes of all the participants and the mental health care workers, especially in means of emotional and psychological support; desire to change the behaviour (i.e., motivated outlook) and ultimately the results of the treatment (i.e., making changes and progress in therapy - acquiring skills and knowledge); well-structured and individualized treatment procedures and general positive experience of the relationship with the therapist. On the other hand, early onset, legal charges pending, unmotivated and uncooperative attitudes, low engagement to the treatment, failing to complete various tasks (e.g., homework), paraphilia as an only sexual activity or outlet, comorbidity, engaging in inappropriate/disruptive behaviour, and lack of remorse over acts are generally associated with a poor prognosis (O'Halloran et al., 2016).

Noncompletion (i.e., premature cessation of treatment) can occur as expulsion due to inappropriate behaviour, as an administratively based exit due to the offender being transferred or released from their current environment for reasons unrelated to programme attendance/engagement, and as a patient initiated dropout, in which the offender actively chooses to stop attending treatment (Olver, Stockdale and Wormith, 2011). Noncompletion is associated with poor prognosis and more importantly, with the increased risk of recidivism when compared with offenders who complete their treatments and when compared with untreated individuals (Day, Casey, Ward, Howelly, and Vess, 2010; McMurran and Theodosi, 2007). Noncompletion can also negatively affect the morale in the therapeutic alliance between the IWPs, which is, as mentioned, an important factor associated with good prognosis.

5 CONCLUSIONS

In terms of defining the concept of pedophilia within the fields of science, the current guidelines depend abundantly on the medical characterization of the condition (Kramer, 2011; Evans, 1996; Šramel, 2014). With the aim of better understanding the condition and simultaneously be able to provide more efficient 'helping methods' for the IWPs, mental health care services have established multidimensional diagnostic criteria for pedophilia and developed specific assessment and treatment interventions. The phenomenon can broadly be described as physical or sentimental preference for prepubescent children in a sense of romantic or sexual interest. The etiology of such pedophilic tendencies is until today not yet deciphered, however, both social and biological factors are suggested. The overview of the scientific literature suggests that pedophilia is an internal condition with an involuntary biological factors in the development and the manifestation that (can) create burdens and impairments with respect to an individual's ideas (and actions) of love and sexuality, which deviate from a healthy state of physical, emotional, mental and social well-being. Regarding the individual's sexuality, pedophilic preference tends to remain throughout the lifespan (Schmidt, Mokros and Banse, 2013).

For the diagnosis of pedophilia, the individual has to be taken under evaluation of the specific syndromes. Syndromes of pedophilia, characterized in the contemporary adaptations of diagnostic manuals DSM and ICD – American Psychological Organization [APA] (2000), APA (2013) and WHO (2008) are discussed in the chapter about the *diagnostic criteria* (p. 7-10). Most widely used assessment processes, which are used to determine the dynamics involved and the individualized interventions, include a variety of *standardized tools* (p. 11-17): indicative physiological evaluations, psychiatric interview; assessment of the pedophilic focus by using rating scales like SSPI, SSPI-2 (Seto, Harris, Rice and Barbaree, 2004) or RRASOR (Hanson, 1997); psychological tests, inventories and questionnaires (e.g. SICS, see Holland, Zolondek, Abel, Jordan and Becker, 2000 or IAT, Greenwald, McGhee and Schwartz, 1998); and physiological measures of sexuality – Sex Hormone Profiling, Viewing (Reaction) Time Assessment, Phallometric Assessment, Neuroimaging and Neurophysiological Methods and others.

Although the treatment aims to target a variety of syndromes recognized as clinically significant throughout the assessment processes, the *treatment procedures* (p. 18-23) focus on two main issues: (1) the management of the pedophilic tendencies and (2) the mental status of the IWPs. Throughout the fourth chapter, the final paper project describes and discusses surgical interventions, the use of pharmacology and most common psychotherapeutic approaches (including behavioural, cognitive-behavioural, psychodynamic, psychoanalytic, and humanistic treatment approach).

Giving much consideration and a thorough overview of the scientific papers on pedophilia and its related subjects, I believe that a large amount of sculpting the concept of pedophilia in terms of elements and problematics perceived, besides on the medicalization, depends on the society and the position of the IWPs within it. Society has a significant impact on promoting or inhibiting behaviours and values, thus, familiarizing the society about pedophilia and about the professional help available to the IWPs, could be considered as an important strategy for the systematic solving of the issues that occur when encountered with child-adult romantic and/or sexual situations. A statistically important part of the population is thought to be sexually/romantically attracted to children and as explained, it seems reasonable to assume that pedophilic tendencies can create some forms of burdens and impairments, due to the discrepancy with the general ideas of love and sexuality. The modern Western society tends to be sceptic about the idea that pedophilia could be a part of a broad and diverse biological spectre of sexuality, which is in contrast to the newest diagnostic criteria proposed by APA (2013). These bring to question the implicit connotation of pedophilia being 'incorrect' or 'abnormal' and instead suggest that some of the IWPs are able to restrain from child sexual exploitation and CSA. Such understanding of pedophilia challenges the public's belief that pedophilia always results in child sexual abuse and that the IWPs are all criminals, who are incapable of feeling love and are without moral conscience. The clinical distinction proposed in the DSM-V (APA, 2013) between pedophilia (i.e. sexual preference) and pedophilic disorder (i.e. mental disorder) could help acknowledge a perhaps more understandable view on the concept of pedophilia, since it implies that individuals are not responsible for their condition but they are responsible for their actions. This avoids the discriminatory idea mentioned before – that pedophilia always leads to child sexual exploitation – and rather addresses such negative attributes only to a number of the IWPs. It would seem reasonable to assume that diminishing any amount of social distance between the IWPs and the general public could be beneficial for both the society and the IWP since they will be more likely to reach out earlier for help and come out of the grey zone where their condition was kept in secret. Thus, individuals with pedophilia should have access to informed professional help if we wish to provide a humane environment in the society we live in.

Švab, Bernik and Kuhar (2010) argue, that in Slovenia, the research of sexuality in general has lagged behind and finding available services for the IWP in the country can be a hard task, which suggests that in terms of research and optional treatment services, the discussion on pedophilia is pushed aside. Consequently, there is only a small amount of actual studies or reports from the clinical field dealing with atypical attractions and behaviours. There is one primary institution, which is specialized for the clinical services offered to individuals with pedophilia – Clinic for Sexual Health at the Clinical centre of the University of Ljubljana (Ambulanta za spolno zdravje; Univerzitetni klinični center Ljubljana) – but there are not many other public nor non-governmental services that could provide the needed

treatment. From my own evaluations, it seems there is not even a lot of questioning about such services, however, the statistics reporting child sexual abuse in Slovenia show that Slovenian environment is no exception regarding child sexual exploitation (see Ministrstvo za notranje zadeve Republike Slovenije, Policija, 2016). Therefore, more debates have to be opened within the academic fields in Slovenia with the aim of reaching out to the IWPs and helping the individuals who are functionally limited by their sexual urges. Appropriately addressing the issues regarding pedophilia in the society could contribute to the prevention of the harmful actions and can help provide more pleasant environment in which the IWPs would be more motivated to look for help.

6 POVZETEK NALOGE V SLOVENSKEM JEZIKU

Upodobitve otrok in odraslih v smislu romantičnih ali seksualnih razmerij je mogoče najti v številnih zgodovinskih in geografskih okoljih, kar se zdi presenetljivo glede na dejstvo, da številne kulture v katerih so takšne upodobitve nastale, niso priznavale takšnih odnosov (Evans, 1996; Green, 2002). Kulturološki in zgodovinski pogled na pojav pedofilije nakazujeta, da socialno ozračje pomembno vpliva na različne elemente, ki se jih pedofiliji in posameznikom s pedofilijo pripisuje, kar daje podlago različnim odzivom v primeru srečanja s pojavom v nekem socialnem okolju (Gentry, 2006). V moderni evropski družbi je tema še vedno tabu, posameznikom s pedofilijo pa družba pripisuje številne negativne atribute, zaradi katerih pa so le-ti podvrženi stigmatizaciji (Jahnke, Imhoff in Hoyer, 2014).

Koncept pedofilije v širšem pogledu zajema tako fizično kot sentimentalno preferenco do (predpubescentnih) otrok v smislu romantičnega in/ali spolnega interesa. Vprašanje o etiologiji pedofilskih tendenc še ni razjasnjeno, a raziskave kažejo na vpliv socialnih (Camilleri in Quinsey, 2008) in bioloških faktorjev (Cantor et al., 2008; Feierman, 1990). Na podlagi hipoteze, da tako splošni kot znanstveni pogled temeljita na teorijah sprejetih v klinični praksi (glej Evans, 1996; Šramel, 2014), ta zaključna naloga poglobljeno predstavlja področje pedofilije prek trenutnih smernic za obravnavanje pojava v varovanju duševnega zdravja. Tekom zaključne naloge je poudarek predvsem na:

1) diagnostičnih kriterijih – ki izhajajo iz kritične znanstvene analize pedofilije;

2) preiskovalnih metodah ter standardiziranih preiskovalnih sredstvih – ki pomagajo ugotoviti oziroma potrditi pedofilsko preferenco;

3) in na postopkih zdravljenja – ki se osredotočajo na zmanjšanje posameznikovih pedofilskih tendenc ter psihosocialnih obremenitev.

Diagnostični kriteriji (angl. diagnostic criteria, str. 7-10) za pedofilijo so tako v klinični kot v širši znanstveni stroki utemeljeni na podlagi specifičnih sindromov (kar oseba občuti, opaža) in prepoznavnih znakov (kar je možno ugotoviti pri osebi s preiskavami). Kot osnovna smernica akademskih razprav o diagnostičnih kriterijih so v nalogi opredeljeni moderni medicinski diagnostični priročniki za duševne motnje – DSM-IV (APA, 2000), DSM-V (APA, 2013) in MKB-10 (WHO, 2008). Vsi trije opozarjajo, da ima pedofilija lahko specifične (negativne) posledice na fizičnem, emocionalnem, mentalnem ter socialnem nivoju posameznikovega življenja (WHO, 2008), kar implicira na idejo, da je takšno stanje potrebno obravnavati kot posebno vrsto zdravstvenega stanja, ki je (lahko) bolezensko.

Pri preiskovalnih metodah obravnave oseb pri katerih predpostavljamo, da imajo pedofilske tendence, v kliničnopsihološki praksi obstajajo številna *standardizirana preiskovalna*

sredstva (angl. standardized assessment tools, str. 11-17). Ta nam omogočajo bolj strukturiran oris posameznikovega stanja, saj: (1) dajejo pregled nad zgodovino posameznikovih spolnih vedenj, (2) natančneje opisujejo komponente pri spolnem vzburjenju, (3) merijo stopnjo spolnih fantazij na podlagi njihovih pogostosti ter intenzivnosti in (4) preverjajo prisotnost/stopnjo kognitivnih distorzij ali drugih duševnih motenj. V tej zaključi nalogi so predstavljena naslednja standardizirana sredstva: psihiatrično diagnosticiranje z intervjujem ter z opazovanjem; psihodiagnostične lestvice, testi, vprašalniki; in psihofiziološka sredstva, med drugim podrobneje laboratorijske meritve spolnih hormonov (angl. sex hormone profiling), ocenjevanje reakcijskih vzorcev in percepcije sugestivnega gradiva (angl. viewing (reaction) time assessment – VT), opazovanje ter merjenje temperature penisa, njegove prekrvavitve ter volumna (angl. phallometric assessment), in nevrološke ter nevrofiziološke metode za preučevanje nevronske aktivnosti in/ali možganske strukture.

Glede na diagnostične kriterije in na podlagi dognanj pridobljenih z opravljenimi preiskovalnimi metodami, klinična stroka lahko identificira sindrome, ki so izraženi pri posamezniku in poda mnenje o potrebnih intervencijah oziroma načrtuje primerno zdravljenje. *Postopki zdravljenja* (angl. treatment procedures, str. 18-23) pedofilije v varstvu duševnega zdravja lahko vključujejo kirurške, farmakološke ter psihoterapevtske intervencije. Kirurške metode so v današnji praksi redko uporabljene, saj se preferira farmakološko zdravljenje z na primer CPA (ciproteron acetat), MPA (medroksiprogesteron acetat), LHRH (analogi gonadotropin sproščujočega hormona), SSRI (selektivni inhibitorji ponovnega privzema serotonina), ki daje podobne "kastracijske učinke", t. j. zmanjšanje spolnih tendenc na splošno. Namen psihoterapevtskih intervencij pa je, za razliko od ostalih dveh skupin intervencij, izboljšati mentalni status posameznika ter konstruktivno razreševanje problemov, s katerimi se posamezniki s pedofilijo srečujejo. Takšne intervencije temeljijo na različnih psihoterapevtskih pristopih, ki se med seboj precej razlikujejo. Zaključna naloga zajema opis psihoterapevtskih intervencij, ki temeljijo na behavioristično vedenjskem pristopu (tehnike kondicioniranja), kognitivno-behaviorističnem vedenjskem pristopu, na psihoanalitičnem pristopu, ter na humanističnem pristopu. Med postopke zdravljenja pa uvrščamo tudi module splošnega svetovanja ali spolnega izobraževanja, treninge socialnega učenja, treninge asertivnosti, družinsko terapijo, ter zdravljenje odvisnosti od pornografije (Jerković in Maurović, 2004).

Na podlagi splošnega prepričanja, da je kakšna koli situacija v smislu romantičnih ali seksualnih razmerij med (predpubescentnim) otrokom in odraslo osebo moralno sporna, so posamezniki, ki so pri sebi prepoznali spolno preferenco do otrok, postavljeni v okolje, kjer morajo izražati svoje tendence v skladu s socialnimi normami, če se želijo izogniti (negativnim) sankcijam s strani avtoritete (Evans, 1996). V družbi, ki pedoseksualno vedenje močno obsoja ali kjer se posameznikov s pedofilijo ljudje bojijo, je smiselno pričakovati, da

se številni posamezniki raje odločijo zanikati in/ali skrivati svoja nagnjenja v izogib negativnim družbenim posledicam, ki bi jih za njih lahko imelo razkritje spolnih nagnjenj do otrok (Jahnke, Philipp and Hoyer, 2014; Primorac, 2002). S tem ko družba vedenje bodisi promovira bodisi ga ne dopušča (oziroma ga celo zdravi) vzpostavlja sistem vrednot, ki se nanašajo na vsakega posameznika znotraj nje. Posledično, mora prevzeti odgovornost, da bistveno vpliva tudi na posameznikovo (duševno) zdravstveno stanje in osebno percepcijo tega stanja (Evans, 1996; Drofenik, 2002). Pripisovanje (zgolj) negativnih atributov posameznikom s pedofilijo lahko tako pomembno vpliva na življenja številnih oseb, ki so pri sebi prepoznali spolno/romantično preferenco do otrok. Razumevanje razlik med pedofilijo in spolnim izkoriščanjem otrok bi lahko v širšem družbenem smislu pripomoglo k bolj razumevajočim pogledom na pedofilijo, saj implicira, da niso problematične pedofilske preference kot take, pač pa negativne posledice na (a) psihosocialnem in/ali (b) funkcionalnem nivoju življenja posameznika (APA, 2013). Po mojem mnenju, se takšno razumevanje izogne diskriminatorni ideji, da so vsi posamezniki s pedofilijo kršitelji dejanj zoper spolno nedotakljivost otrok (na neposreden ali posreden način), kar je po moji oceni preveč stereotipno. Čeprav v zaključni nalogi opozarjam, da je obravnava pedofilije v duševno-zdravstvenem varstvu vsekakor smiselna in potrebna, menim, da bi bolj razumevajoč odnos do pedofilskih tendenc morda lahko pomembno zmanjšal družbeno distanco, na podlagi katere tako pedofilija kot spolno izkoriščanje otrok (pre)pogosto ostaneta posameznikova skrivnost. Slednje pa bi lahko pozitivno pripomoglo k sistematičnemu razreševanja problemov, ki se navezujejo tako na pedofilijo kot na spolno izkoriščanje.

Švab, Bernik in Kuhar (2010) opozarjajo, da je raziskovanje seksualnosti v naši državi še vedno v zaostanku glede na (nekatere druge) države zahodne družbe. Tudi pri obravnavanju kliničnih diskurzov o pedofiliji v Sloveniji ugotavljam, da je v smislu raziskovanja in zdravljenja pedofiliji posvečeno bolj malo pozornosti tako s strani državnih kot tudi privatnih institucij. Primarna institucija, kjer lahko posameznikom s pedofilijo v Sloveniji nudijo profesionalno kliničnopsihološko pomoč je Ambulanta za spolno zdravje; Univerzitetni klinični center Ljubljana.

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