Review Article

Can Nonoffending Pedophiles Be Reached for the Primary Prevention of Child Sexual Abuse by Addressing Nonoffending Individuals Who Are Attracted to Minors in the United States? New Strategies With The Global Prevention Project

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This paper introduces a new prevention strategy against child sexual abuse (both offline and online) in the United States. The Global Prevention Project is a supportive treatment program designed for nonoffending minor-attracted persons who reside in the community. Attraction to minors and the underlying scientific terms (pedophilia/hebephilia) are discussed and a framework is provided for how to implement such a program in the United States. Our treatment modality is described to provide transparency in our clinical work. We discuss challenges encountered in this domain with possible solutions and the legal ramifications of preventing child sexual abuse behaviors by targeting nonoffending individuals.
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What is child sexual abuse (CSA) and how do we prevent it? CSA is an altogether too common experience that impacts ~12.7% of children worldwide.[1] For the purpose of this article, CSA is defined as any sexual behavior by an adult directed toward a prepubertal or pubertal child (who is therefore too young to consent). According to Finkelhor et al,[2] CSA has been experienced by over 6% of a nationally representative youth sample in the United States. CSA encompasses a wide range of possible behaviors; contact CSA necessitates the presence of a physical victim, whereas noncontact CSA, in addition to voyeurism and exhibitionism, typically refers to behaviors engaged in online, such as consuming child sexually exploitative material (CSEM, formerly referred to as child pornography), online solicitation of minors, and/or exposing minors to sexualized materials.[3,4] There is much debate as to whether or not the viewing of CSEM constitutes CSA, as some people believe that the act of viewing is not sexually abusing children itself. However, the act of viewing can create a demand for material that is created through CSA. Noncontact CSA is of significant clinical, legal, and scientific relevance—as these behaviors are growing in incidence and prevalence and are not well understood.[3,5] We will refer specifically to individuals who engage in noncontact CSA throughout this paper, as they are a group that can be targeted for intervention services in the United States.

EPIDEMIOLOGY OF SEXUAL OFFENDING AGAINST CHILDREN

Sexual offending against children can have devastating effects on victims. Statistical studies have repeatedly demonstrated that ~1 in 4 girls and 1 in

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7 boys will experience sexual abuse before their 18th birthdays.[1,6] More recent statistics put this number at ~6% of the American population of youth, which makes it a significant public health concern.[2,7] The cost of CSA is significant, not only in terms of psychological and medical harm to the victim, but also in the form of incarceration and postoffense treatment and supervision costs for the taxpayer. The consequences of CSA on victims are often significant and long-lasting, with victims at increased risk of developing posttraumatic stress disorder, major depressive disorder, anxiety disorders, and also dissociative disorders.[8,9] In addition, CSA can result in lasting cognitive, physiological, and neurobiological alterations in victims, including alterations in the hypothalamic-pituitary-adrenal (HPA) axis, levels of oxytocin as measured in cerebrospinal fluid in adulthood, hippocampal and amygdalar volume changes, and changes in cortical thickness.[9]

In a landmark study published in 2018, Letourneau et al[7] estimated that the lifetime economic burden to society of both fatal and non-fatal new cases of CSA identified in 2015 is ~$9.3 billion. This cost includes medical, physical, and psychological services provided after exposure to CSA and criminal justice costs associated with judicial action taken toward the offender.[10] If we were to put a price tag on the cost of CSA, it would show that we are succeeding in increasing the cost and creating more victims, rather than effectively reducing or preventing it. In order to effectively prevent CSA, we must understand who is engaging in these behaviors and *why*.

PSYCHIATRIC CHARACTERISTICS OF SEXUAL OFFENDERS AGAINST CHILDREN

Sexual offenders against children—both contact and noncontact—must be differentiated on the basis of the presence of an underlying sexual preference disorder, specifically pedophilia and/or hebephilia. Surrogate or "replacement" offenders sexually offend against children for reasons other than sexual preference, including lack of access to appropriately aged peers, reduced social competence, and general antisocial tendencies. Pedophilic offenders do so out of a pedophilic sexual preference for prepubertal children.[11] Research has identified pedophilia as both a relevant and important risk factor in the perpetration of CSA.[12] However, while it may be a risk factor, it is not a necessary criterion. As it is currently understood, pedophilia increases the likelihood that a person will engage in child sexual abusive behaviors, but there are other factors to consider. It is important that any prevention programs or efforts should either include information about this sexual preference (and the related pedophilic disorder) or offer services specific to this group. Unfortunately in the United States currently, there is a noticeable lack of prevention programming that addresses pedophilia or the individuals who experience it.[4,13] The Prevention Project Dunkelfeld (PPD) is an established program that works for the primary prevention of CSA by targeting individuals with pedophilia and/or hebephilia who reside in the community for services. In recent years, multiple new initiatives have been undertaken outside of the United States (eg, Stop it Now!, the Lucy Faithfull Foundation, StopSO, Tulir, Pedohelp, among others), highlighting the necessity of working with the population of nonoffending pedohebephilic individuals (ie, nonoffending minor-attracted persons or NOMAPs) to most effectively increase wellness and decrease risk factors associated with offending behavior. In this article, we focus on a program in the United States, The Global Prevention Project (TGPP), that is currently striving to meet the needs of this population. However, in this section, we first briefly discuss what is known about the NOMAP population.

Recent research from Germany [from the Neurobiological Mechanisms Underlying Pedophilia and Child Sexual Abuse (NeMUP) Research Consortium (http://www.nemup.de) which examines neural mechanisms underlying pedophilia and sexual offending against children] and North America has begun to raise questions about some long-standing assumptions about the nature of pedophilia, namely by the identification and inclusion of noncontact offending and nonoffending pedophilic samples. The NeMUP project together with the PPD were able to differentiate between types of offending behavior (contact vs. noncontact). This led to an increased awareness of a subgroup of *nonoffending* pedophilic men about whom we knew very little.

What we have learned suggests that there are distinct mental health needs among NOMAPs or those with only noncontact offense histories, and that these needs differ from those who have a history of previous contact offenses. A study comparing

the clinical characteristics between convicted and nonconvicted pedophilic sexual offenders against children (in which all participants had previously engaged in a contact sexual offense against a child) suggests that there are few differences between these groups. Specifically, both groups endorsed increased rates of affective disorders, substance use disorders, and Cluster B and C personality disorders.[14] Furthermore, when noncontact only offenders with pedophilia and nonoffending individuals with pedophilia were combined into 1 group, researchers found that mood disorders (in particular major depression) and anxiety disorders (in particular social phobia) were more often present than in pedophilic men who had engaged in contact offenses. Substance use disorders were actually most common among *nonpedophilic* individuals with histories of CSA contact offenses. Personality disorders were common among noncontact offending pedophilic men, specifically avoidant personality disorder.[15]

What this demonstrates is that not all pedophilic individuals are the same. The very limited research done to date has demonstrated that nonoffending individuals with pedophilia do exist and most likely have very different treatment and support needs than those individuals with pedophilia who have engaged previously in sexually abusive behaviors with children. Nonoffending pedophilic individuals have a very real need for psychoeducational and possibly also psychotherapeutic treatment services, but until recently there was very little information on what this treatment should address. Cantor and McPhail[16] suggested addressing stigma-related stress (eg, social and interpersonal problems, emotion dysregulation, and reduced access to life opportunities) and the very real experience of loneliness and social rejection when working with the nonoffending population. We are witnessing a burst of new research in this field, laying the groundwork for the development of effective services for NOMAPs.[13,17] For a deeper discussion of the specific psychiatric diagnoses common in individuals with pedophilia (with or without offense histories), please see Cantor and McPhail,[16] Gibbels et al,[18] and Gerwinn et al.[15]

With the Fifth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) came the separation of paraphilias from paraphilic disorders to recognize that attractions and behaviors are 2 separate phenomena and do not always co-occur. The DSM-5 states that "the term *paraphilia* denotes any intense and persistent sexual interest" other than attraction "to physically mature and consenting human partners." Diagnosis of a *paraphilic disorder* requires "a paraphilia that is currently causing distress or impairment to the individual, or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others."[19 (pp 685–686)] However, it is important to note that the DSM-5 also states that, "[a] paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not necessarily justify or require clinical intervention."[19 (p 686)] This is a crucial point for therapists and helping professionals to understand, specifically those who are interested in or seeking to work with minor-attracted persons (MAPS) (those with pedohebephilia). This article will describe such a program, which has been developed to meet the treatment needs of community-dwelling, nonoffending pedophilic men in the United States, namely TGPP.

PROGRAMS SPECIFIC TO NOMAPS

Many programs exist to treat sexual offenders against children, but they are mainly offered in correctional or forensic settings and are typically offered as a method to reduce the risk of reoffense. These programs also do not always allow for differentiation of treatment, with mixed offense groups often the norm.[3,13,17,20–22] There is not enough space here to detail all the different theoretical treatment frameworks and treatment options currently in use for treating sexual offenders or their effectiveness; therefore, readers are referred to Gibbels et al[18] for an overview of current clinical practices in working with various sexual offender groups. Several meta-analyses are also available that detail treatment effectiveness with offender populations in greater depth, such as a 2019 article by Gannon et al.[23] The inherent limitation in these treatment groups is that they are all offered post-offense, with the goal to reduce recidivism risk. We describe 2 programs that were developed to offer direct treatment and support options to nonoffending and potential (and in specific circumstances—*dark-field: offenses not known to authorities*) offender groups. While this is not an exhaustive list of all preventive treatment and

support services available to this population, it is our hope to demonstrate the utility and viability of these types of programs in the United States—with specific focus on TGPP. We also present a framework through which we could achieve a primary prevention approach to CSA. For a more thorough review of all available programs that seek to prevent CSA from multiple perspectives worldwide, the reader is referred to the book *Sexual Crime and Prevention* edited by Lievesley et al,[24] in particular the chapter on global prevention programs by Christiansen and Martinez-Dettamanti.[25]

The PPD—Germany

The PPD was the first attempt to prevent sexual offending against children by targeting potential and dark-field offenders for preventive treatment.[26–29] After an extensive media campaign that was developed with support from a focus group of treatment-seeking pedophilic men launched in 2004, the first treatment groups were offered at the clinic in Berlin, Germany. This treatment model is based on the Berlin Dissexuality Therapy (BEDIT) program and has been used in Germany in the 11 clinical site network comprising the PPD. The PPD targets self-identified and self-referring pedophilic and/or hebephilic men who are not (yet) known to the legal system, and it can provide treatment to the so-called "dark-field" offenders, those who are engaged in offending behaviors but are unknown to legal authorities. Due to strict therapist-client confidentiality laws in Germany, the therapist is legally obligated not to break confidentiality, even when the client admits to potentially illegal behaviors. As the client is currently in therapy, the system assumes a greater benefit of maintaining confidentiality in order to continue motivating the client to engage in treatment, rather than end a potentially useful therapeutic alliance in order to intervene legally.[18]

Therapy is provided primarily in a group format with the option of individual therapy should the client request it. Clients meet in-person and assume pseudonyms for the purposes of maintaining anonymity and confidentiality. Therapists come from a myriad of different clinical backgrounds, but they must all undergo additional training in sexual health as part of being certified in the BEDIT manual.

BEDIT consists of 12 modules that cover topics such as motivation, emotion regulation, coping and other problem-solving strategies, and prevention measures. The core model of the system is cognitive behavioral therapy, which is focused on reduction of risk behaviors in order to reduce the risk that clients will either begin or continue offending.[18] Results from the ongoing evaluation of this program indicate that it is needed, with 8479 total contacts with the network as of September 2017, and 804 men ultimately receiving therapy. However there are still concerns about its effectiveness, with the first study of treatment completers showing that 5/25 CSA offenders and 29/32 users of CSEM still reported engaging in the behaviors.[30] As these are the first studies that have included treatment completers (until now, all of the published reports involved interim data), there is still much to examine about the effectiveness of the PPD program. No claims can yet be made about overall effectiveness as the sample sizes are still too small for such comparisons. With the push to invest in evidence-based prevention efforts worldwide, if this program continues to be found effective, how do we implement and evaluate a similar program in the United States?

TGPP—United States

The PPD and TGPP are similar in one key aspect—they offer services to nonoffending pedohebephilic men living in the community. They do differ, however, in one major way: whereas the PPD can and does target dark-field offenders,[26–28] TGPP's MAP Wellness Curriculum is primarily designed for nonoffending pedohebephilic cisgender (ie, those whose identified gender matches their biological sex), transgender (ie, those whose identified gender and biological sex are not necessarily identical), and nonbinary (ie, those where there is fluidity in the identified gender) individuals who are in distress about their attractions and/or are experiencing the psychological burdens that come with being minor-attracted, but express a commitment to never sexually offend. Reporting occurs when required, with therapists adhering to the mandatory reporting laws in their specific jurisdictions. Research has recently demonstrated that NOMAPs exist as individuals who experience

sexual attraction to children but who have had no (known) sexual contact with a child and also typically express a strong desire never to engage in those behaviors.[16] Despite mandatory reporting laws and requirements as a significant clinical limitation in the United States, TGPP is making strides as the first such open program to meet the needs of this population.

Outreach Activities

The TGPP program consists of several different but overlapping components, all of which are designed to increase outreach to the nonoffending community and global community at large, to provide resources to clinicians working with this population, and to offer treatment to clients who identify as pedohebephilic and desire interventive services.

The outreach component consists of an ongoing series of podcast interviews, led by author C.C., with a wide range of individuals and is meant to provide information about attraction to minors and prevention services to a broad audience. Interviewed individuals include nonoffending pedohebephilic cisgender, transgender, and nonbinary persons, family members, and partners of nonoffending pedohebephilic persons, individuals who identify as NOMAPs, individuals with offense histories (overlapping with the criminal justice system), as well as fellow clinicians, journalists, writers, and researchers from the global scientific community. Readers can access the podcast series at https://thepreventionpodcast.com. (Author disclosure: G.T. was interviewed twice for this podcast; the first podcast was released to the public on April 18, 2019 and the second on May 21, 2021. Content overlaps with this manuscript, but there was no financial gain).

Resources for clinicians interested in the TGPP program include training workshops for staff and an informational website (http://theglobalpreventionproject.org) with details about the program and the diagnoses of those treated and how those diagnoses are defined. The TGPP treatment program for nonoffending pedohebephilic persons is described more fully below.

The core assumption at the heart of TGPP is that "attraction is not action" and that simply having a paraphilia does not justify the need for a person to seek preventive treatment. This is a crucial point for the treatment community to understand, as most experiences from treatment-seeking nonoffending pedohebephilic men suggest that clinicians assume a "risk to offend" attitude when working with this population.[17,21,22] Therefore, any programs that seek to work with this population should be well-versed not only in the range of possible attractions to minors (eg, nepiophilia-preference toward infants, pedophilia, hebephilia, ephebophilia-preference toward postpubescent teenagers), but also in the most current research in order to provide the most effective treatment services possible. This statement leads us to ask what makes TGPP so unique among treatment providers who work with the broad spectrum of minor-attracted individuals.

TGPP follows in the footsteps of the PPD by providing global psychoeducational support for individuals who admit to experiencing attractions to minors (this includes all of the groups mentioned in the preceding paragraph). It is intended to guide clinicians who are providing group therapy or psychoeducational support, but it can also be used in individual therapy sessions in both inpatient, intensive outpatient, and outpatient settings. We assume a model of outpatient settings in this article.

TGPP Curriculum

TGPP's curriculum consists of 12 psychoeducational modules designed to address several underlying issues related to the experience of NOMAPs, including the presenting symptoms of distress and depression (including suicidality), and in some cases, the presence of sexual preoccupation or hypersexuality. The psychological burdens that accompany minor-attraction (eg, depression, self-hatred, suicidality, anxiety, paranoia, isolation, family estrangement) are addressed in detail throughout the curriculum, especially in the first 4 modules, to provide a humanizing foundation for treatment and aid participants in self-acceptance and eventually self-compassion. These psychological burdens are often the presenting issues that explain why a minor-attracted individual is seeking support from TGPP in the first place.

Simultaneously, this curriculum is designed to aid in the exploration of the individual's sexual orientation and attractions, including how to manage, regulate, and cope with these attractions in daily life, with specific attention paid to dealing with shame and guilt. A heavy focus on shame resilience is consistent with the research in this area, specifically the work of Cantor and McPhail,[16] in which they caution therapists to consider the

stigma-related stressors of anticontact, nonoffending MAPs. An entire module (IV) is dedicated to shame resilience and emotional intelligence and provides a foundation for the continuation of this work throughout the curriculum. In addition, several modules include stigma-reduction efforts as key elements in the treatment of NOMAPs. Discussion and education about risk and "the legal line" is consistently provided throughout the curriculum when appropriate. As previously mentioned, the focus of the curriculum comes from a stigma-reducing, humanizing approach to MAP wellness; therefore, risk of offending is not assumed, but instead current research on the risk and protective factors around sexual offending (online and offline) is discussed and participants are encouraged to identify these factors for themselves, with the help of facilitating clinicians. Finally, later modules encourage the exploration of what healthy (relatively speaking) sexuality and satisfying relationships mean to each participant as an integral part of MAP wellness and the goal to increase the overall quality of life of participants. Although the intention of TGPP in creating the *Giving Voice to the Voiceless: A Minor Attracted Person (MAP) Wellness Curriculum* was to improve the overall wellbeing of MAP lives globally, the program holds the belief that the byproduct exceeds any effort for prevention of CSA.

IMPLEMENTATION ISSUES AND CHALLENGES

Recently there have been calls to provide these services throughout the United States.[13,17,20–22] We hope to provide readers with guidance based on our experiences working with NOMAPs. The issues highlighted below are themes we encountered in implementing and replicating the TGPP MAP Wellness group in New York State.

(1) Mandatory reporting: this is one of the most—if not the most—relevant issues in working with this population in the United States. Given that every jurisdiction operates under some variation of mandatory reporting (here referring to those behaviors which, if admitted to, would trigger an automatic report from the treatment provider to either the local child protection agency/state register and/or the local authorities), it is extremely important for the treatment provider working with NOMAPs to understand a key differentiation that *does not* trigger a report. When a client admits to experiencing minor-attraction or pedophilia/hebephilia, this does not imply the existence of CSA/CSEM behaviors. Simply admitting to the preference does not mean the client has acted upon it in any way. Therefore, mandatory reporting applies *only* to admitted behaviors (and those behaviors are dependent upon the jurisdiction), *not* admitted sexual preferences. This is an exceptionally tricky line to walk for the therapist working with NOMAPs, as the general tendency is to assume that NOMAP clients have either already acted upon their attractions or will imminently do so.[16,17,20–22] For example, the TGPP groups use an informed consent process that explicitly details what mandatory reporting is and how to deal with disclosures in group sessions. This transparency allows for group members to be aware from the outset of how the group facilitator will address utterances that may cross the mandatory reporting boundary. The informed consent process explains that—at least in New York State—any mention of a previous contact offense that is unknown to authorities in which a victim is identifiable will trigger the reporting process. However, as of the writing of this article, the admission in New York State of using CSEM/CSA imagery—while criminal—is not a reportable behavior within therapeutic settings unless there is evidence of, or reason to believe there are or were, contact offenses.

(2) Client confidentiality: this concerns how to interact with and maintain treatment knowledge of MAPs. This also goes hand-in-hand with mandatory reporting, as filing a mandated report requires the treatment provider to break the client's treatment confidentiality. At what point should one break confidentiality? Should you include the client in the process? These are questions best covered in an ethics course and discussed with legal counsel before offering services. However, a more relevant question is: should the treatment provider expect to work with the client's legal name? Or is it possible for the client to provide a pseudonym? This issue assumes the use of health insurance programs,

in which the legal name of the patient must be provided. However, if the client is willing and able to cover treatment costs out-of-pocket or if the group is offered free of cost, then concerns about confidentiality are reduced (although not entirely resolved). The legal constraints should be discussed with appropriate personnel before seeing any clients and legal protection should be sought to protect both client and provider.

(3) Clinician training: another major consideration is clinician training. This does not simply refer to the treatment provider's academic degree [eg, licensed mental health counselor (LMHC/LCMHC) vs. social worker (LMSW/LCSW) vs. PhD/PsyD/MD], but rather to the specialized set of knowledge required to work with MAPs. There are currently no programs in the United States that prepare a clinician to work specifically with this group, nor is there a process that certifies that providers have specialized training and are prepared to work with this population. Hence, it is up to individual treatment providers to seek out materials and any additional training on their own if they wish to work in this domain. It also requires the provider to build rapport with the clients by first establishing trust—a key variable to develop as demonstrated by Levenson et al.[22] TGPP has developed its own training modules based on years of experience treating MAP clients.

(4) Program structure: another issue is whether to offer the program online or in-person. Due to the high-risk nature of this type of treatment, clinicians must decide whether to offer treatment in an in-person or online setting. If treatment is to be offered in-person, due consideration must be given to the following issues among others: where the treatment office will be located, who will staff it, what time of day treatment will be offered (so as to adequately deal with high-traffic volume times), in what format the treatment will be offered (group vs. individual), and whether other treatment groups will be seen as well (will it be a multidisciplinary practice?). In light of the COVID-19 pandemic crisis, telehealth appears to be increasing in popularity with clients. As such, clinicians' familiarity with or training in use of telehealth programs is generally a plus.

CONCLUSIONS AND FUTURE DIRECTIONS

The goal of this article was to introduce and establish TGPP as a viable treatment option for nonoffending pedohebephilic individuals living in the community. As has been previously demonstrated, CSA/CSEM behaviors are a significant cost to both (potential) victims and society, therefore all measures to potentially prevent them must be undertaken. This necessarily means we must not only act to prevent future reoffense, but we must also intervene *before* the first offense to prevent an individual from becoming an offender in the first place. TGPP is the first such program in the United States to openly offer treatment services to NOMAPs, specifically focusing on the mental health needs of this population. What makes TGPP unique is its approach to prevention, namely that "prevention IS the intervention" and the understanding that simply because an individual may experience minor-attraction does not mean that the person has previously offended—or has any desire to do so in the future.

Offering these services in the United States does not come without its challenges. Due to the nature of mental health treatment provision and laws regarding mandatory reporting and confidentiality, it is impossible to offer treatment to individuals residing in the "dark-field" in the United States. However, it is still completely possible to offer those services to NOMAPs. Clinicians should first seek legal counsel when planning to work with this population to fully understand the legal requirements for mandatory reporting and when to break confidentiality in their jurisdiction. This is highlighted through jurisdiction-dependent reporting requirements for CSEM use. In some states, this is not a reportable offense in and of itself, but in others, it is. Therefore, having associated legal counsel and representation is crucial to prevent an unnecessary breach of clients' confidentiality.

Finally, appropriate training and clinical understanding of this population is vital to providing adequate and meaningful treatment to clients. This requires a significant investment in research, as we are only now beginning to understand some of the relevant differences between those who have and those who have not offended. TGPP is furthering the way in treatment provision with the understanding that through treatment, we can begin to examine and understand this population better. Researchers and clinicians must cooperate to

address questions about preference origins, risk to offend, treatment needs, treatment efficacy, and biological/behavioral differences related to offense status. The authors are embarking on a new collaborative initiative to achieve a better understanding of these issues by evaluating the first data on the effectiveness of the TGPP MAP Wellness Curriculum program. This initiative seeks to provide rigorous empirical data on the NOMAP population, treatment needs, clinician experiences, and effectiveness of the MAP Wellness curriculum to reduce offense risk and increase quality of life among NOMAPs.

REFERENCES

1. Stoltenborgh M, van Ijzendoorn MH, Euser EM, et al. A global perspective on child sexual abuse: meta-analysis of prevalence around the world. Child Maltreat. 2011;16:79–101.
2. Finkelhor D, Turner H, Ormrod R, et al. Violence, abuse, and crime exposure in a national sample of children and youth. Pediatrics. 2009;124:1411–1423.
3. Seto MC. Pedophilia and Sexual Offending Against Children: Theory, Assessment, and Intervention, 2nd ed. Washington, DC: American Psychological Association; 2018.
4. Seto MC, Wood JM, Babchishin KM, et al. Online solicitation offenders are different from child pornography offenders and lower risk contact sexual offenders. Law Hum Behav. 2012;36:320–330.
5. US Department of Justice. Child pornography. Washington, DC: US Department of Justice. Updated May 28, 2020. Available at: https://www.justice.gov/criminal-ceos/child-pornography. Accessed December 20, 2020.
6. Finkelhor D. How widespread is child sexual abuse? Child Today. 1984;13:18–20.
7. Letourneau EJ, Brown DS, Fang X, et al. The economic burden of child sexual abuse in the United States. Child Abuse Negl. 2018;79:413–422.
8. De Bellis MD, Spratt EG, Hooper SR. Neurodevelopmental biology associated with childhood sexual abuse. J Child Sex Abus. 2011;20:548–587.
9. Nemeroff CB. Paradise lost: the neurobiological and clinical consequences of child abuse and neglect. Neuron. 2016;89:892–909.
10. Fang X, Brown DS, Florence CS, et al. The economic burden of child maltreatment in the United States and implications for prevention. Child Abuse Negl. 2012;36:156–165.
11. Tenbergen G, Wittfoth M, Frieling H, et al. The neurobiology and psychology of pedophilia: recent advances and challenges. Front Hum Neurosci. 2015;9:344.
12. Seto MC. The motivation-facilitation model of sexual offending. Sex Abuse. 2019;31:3–24.
13. Levenson JS, Willis GM, Vicencio CP. Obstacles to help-seeking for sexual offenders: implications for prevention of sexual abuse. J Child Sex Abus. 2017;26:99–120.
14. Gibbels C, Sinke C, Kneer J, et al. Two sides of one coin: a comparison of clinical and neurobiological characteristics of convicted and non-convicted pedophilic child sexual offenders. J Clin Med. 2019;8:947.
15. Gerwinn H, Weiss S, Tenbergen G, et al. Clinical characteristics associated with paedophilia and child sex offending—differentiating sexual preference from offence status. Eur Psychiatry. 2018;51:74–85.
16. Cantor JM, McPhail IV. Non-offending pedophiles. Curr Sex Health Rep. 2016;8:121–128.
17. Levenson JS, Grady MD. Preventing sexual abuse: perspectives of minor-attracted persons about seeking help. Sex Abuse. 2019;31:991–1013.
18. Gibbels C, Kneer J, Hartmann U, et al. State of the art treatment options for actual and potential sexual offenders and new prevention strategies. J Psychiatr Pract. 2019;25:242–257.
19. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Arlington, VA: American Psychiatric Publishing; 2013.
20. Lasher MP, Stinson JD. Adults with pedophilic interests in the United States: current practices and suggestions for future policy and research. Arch Sex Behav. 2017;46:659–670.
21. Grady MD, Levenson JS, Mesias G, et al. "I can't talk about that": stigma and fear as barriers to preventive services for minor-attracted persons. Stigma Health. 2019;4:400–410.
22. Levenson JS, Grady MD, Morin JW. Beyond the "ick factor": counseling non-offending persons with pedophilia. Clin Soc Work J. 2020;48:380–388.
23. Gannon TA, Olver ME, Mallion JS, et al. Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness. Clin Psychol Rev. 2019;73:101752.
24. Lievesley R, Hocken K, Elliot H, et al. Sexual Crime and Prevention. London: Palgrave Macmillan; 2018.
25. Christiansen C, Martinez-Dettamanti M. Prevention in action: exploring prevention initiatives and current practices. In: Lievesley R, Hocken K, Elliott H, et al, editors. Sexual Crime and Prevention. London: Palgrave Macmillan; 2018:27–56.
26. Beier KM, Ahlers CJ, Goecker D, et al. Can pedophiles be reached for primary prevention of child sexual abuse? First results of the Berlin Prevention Project Dunkelfeld (PPD). J Forens Psychiatry Psychol. 2009;20:851–867.
27. Beier KM, Neutze J, Mundt IA, et al. Encouraging self-identified pedophiles and hebephiles to seek professional help: first results of the Prevention Project Dunkelfeld (PPD). Child Abuse Negl. 2009;33:545–549.
28. Schaefer GA, Mundt IA, Feelgood S, et al. Potential and dunkelfeld offenders: two neglected target groups for prevention of child sexual abuse. Int J Law Psychiatry. 2010;33:154–163.
29. Beier KM, Grundmann D, Kuhle LF, et al. The German Dunkelfeld Project: a pilot study to prevent child sexual abuse and the use of child abusive images. J Sex Med. 2015;12:529–542.
30. Mokros A, Banse R. The "Dunkelfeld" Project for Self-Identified Pedophiles: a reappraisal of its effectiveness. J Sex Med. 2019;16:609–613.