“Finally, I get somewhere to go”: Christoffer Rahm of the Karolinska Institutet on conducting outreach and providing services to perpetrators

Alec Saelens
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Alec Saelens: could you please introduce yourself professionally, and describe the problem you're addressing with your work?

Christoffer Rahm: I'm a psychiatrist and researcher based in Stockholm, working in the Stockholm Health Care Services in specialized psychiatry, and at Karolinska Institutet, where I have a research group. I also work as a Psychiatric Expert in the Swedish Judicial Council and at the Ethics Review Board in Sweden. My research group has been working for 10 years to find methods to prevent sexual violence, especially child sexual abuse, and to understand the mechanisms behind it better.

We have developed and evaluated new online and in-person, psychotherapeutic and pharmacological interventions for primary, secondary, and tertiary prevention. One of our unique characteristics is that we implemented a randomized control trial methodology which evaluates efficacy, safety, and how well an intervention is appreciated by clients. It has now spread in the research community.

We were early in implementing the so-called Patient and Public Involvement Strategy in our research with a group connected to us consisting of representatives from important stakeholders in society, such as law enforcement, prison probation service, victims, and survivors, but also individuals with a sexual interest in minors, and to always try and anchor our strategic decisions with them.

Alec Saelens: Regarding the work that you're doing with Prevent It and the cognitive behavioral therapy program that you've developed, who are you specifically bringing attention to and who is the main audience you're working to educate?

Christoffer Rahm: I started with Prevent It because of an observation I did in a previous research study in which I reached out to people who call helplines because they have sexual urges involving children. The study ran between 2014 and 2018 and I evaluated a new medicine, a testosterone-lowering medication to see its effect on risk factors for committing sexual abuse. It was an effective study. I observed that most individuals who seek our help via helplines are in their mid-thirties.

When I asked them about the age of onset of their pedophilic urges, that was in their mid-teenage years. They had around 20 years of walking around with these thoughts before they sought help for the first time. During these 20 years, much can happen, and they can do all kinds of things before they get the courage to seek help. I ask them, "What do you think society and healthcare should do to reach out to you earlier to have better opportunities to do real prevention?"

Many said, "Well, don't sit and wait in your offices for us to come to you. You should come to us." They described these online communities that exist for individuals with sexual orders involving children who seek child sexual abuse material or seek contact with others who have the same ideas. They described how it worked and that it's almost like social media but for these kinds of thoughts and fantasies. It becomes like a filter bubble around it, and it fosters cognitive distortions and negative consequences.

I decided to create an intervention, in which I actively seek these individuals in these forums on the dark web. Said and done, I constructed a cognitive behavioral therapy program (CBT) called Prevent It. I helped to find these perpetrator forums and we set up a study to actively engage these, to try and get these clients' interest.

We had a placebo-controlled trial, which is a good study designed to evaluate effects, and negative effects too. It ran from 2018 to 2020 with participants from all over the world and was well appreciated. It effectively reduced their urges and behaviors, but also related behaviors and thoughts. It was also an anonymous intervention.

We have developed revised versions of Prevent It to reduce attrition and tailor the program to specific populations. These adaptations are currently being evaluated in several languages. However, towards the end of the initial Prevent It project, we observed that some high-risk individuals, while showing improvement, still required additional support after completing the program.

To address this, we created a new intervention called Mi Bridge, specifically for the highest-risk individuals. Mi Bridge is based on motivational interviewing and aims to encourage these individuals to transition from anonymous online interactions to seeking face-to-face treatment at local healthcare facilities. In these settings, they can access medication and psychosocial interventions more effectively tailored to their needs. The rationale behind this approach comes from our pharmacological trial, which demonstrated that the medication Degarelix has a strong positive effect on high-risk individuals.

After one year of silence, after the first study was concluded, we went online again to announce that we now have a revised version. We were met with reactions, like, "Oh, we've been waiting for you. Finally, I get somewhere to go," because, in most countries, there is nothing for these individuals. It was a positive thing for us to see that the community had waited for us to come back.

Alec Saelens: What does a placebo look like in the context of testing through the trials to assess and evaluate the efficacy of the CBT methods?

Christoffer Rahm: We used a pharmacological placebo in the first trial. You remove the active ingredients from the medication, but everything else stays the same. It is the same principle for a psychological placebo. You check the screening and entry, interview procedures, and informed consent. You see the videos, you read modules, you have weekly contact with a therapist, you do home exercises, all of that.

You talk about topics related to child sexual offending and the need for refraining from it but don't include what we believe are the active constituents in CBT, such as exposure training, cognitive restructuring, and constructive feedback on home exercises. We also asked them in

the end, "Do you think you have had active therapy or just a sham therapy?" They gave the same level of correct answers. We asked them how they appreciated the warmth, empathy, and interest. It was the same, with good ratings for both. We want to see the specific effects of the important exercises in therapy.

Alec Saelens: What makes your approach distinct? Is it taking inspiration from any other work that has been done? Also, why do you approach it in the way that you do?

Christoffer Rahm: My first experience with this field was when I trained to become a psychiatrist, and I worked at a Child and Adolescent Psychiatry Unit where I met a girl who was anxious because she had been a victim of sexual abuse and couldn't sleep. I didn't know what to do, because the damage was already done. I could only help her to accept her destiny and to feel better.

The next clinical rotation I had was at a sexual medicine clinic, where a bus driver appeared at the clinic and sought help for sexual urges involving minors. It was especially one girl on the bus that he started falling in love with. After the first meeting with him, I went back to my office and tried to read up on what to do with this man with good scientific evidence.

Almost nothing was published in this field 10 years ago, but several authors called for high-quality research. That was when the spark was lit up. I had been studying schizophrenia, the most researched area in psychiatry. I visited Melbourne, Australia, where they invented this concept of ultra-high-risk clinics, where people with a high risk of converting into psychosis could get preventative support for not ending up with schizophrenia or bipolar disorder. They also had outpatient clinics for people who were at risk of committing violence, and to end up in forensic psychiatry, a preventative clinic for that. I was inspired by the Melbourne tradition and schizophrenia research when I changed fields. There are many resemblances between schizophrenia and pedophilic disorder. Both are lifelong conditions and are associated with heavy stigma.

Some people fear healthcare and medications with various side effects. I had that mindset and it has been one of my guiding principles to see what has been done previously in schizophrenia research, learn from their mistakes and insights, and move it over to pedophilia research. It has contributed to advancing some of the research, to get it up to speed with the rest of frontier psychiatric research. These are two of the most stigmatized conditions, so I don't compare them with patients. Also, another similarity is they have neurodevelopmental origins.

Alec Saelens: Is there anything else that is important to highlight in terms of the frameworks, and metrics that you use to test the success of your work?

Christoffer Rahm: Yes. Since this is a very young and small research field, we cannot rely on bibliometric measures to understand how important the research is, because there's so little citing. Instead, it's better to list the kinds of discoveries you've made.

What is key to getting people to enter the programs, go through them, and have high inclusion rates, is to have a thought-through ethical groundwork, be transparent with clients, and have a good dialogue with the surrounding society, such as journalists and via our patient public involvement strategy.

Another inspiring thing was this pedophile hunter group in Sweden, which used a different ethical compass and methods but had similar goals to reduce sexual offending against children. I have had several meetings with them to understand their backgrounds and their thinking, to see if there's anything we can learn, and how our arguments stand against theirs. Being open to all kinds of interactions with the surrounding society is beneficial. We have in-depth dialogues with the police to listen to their experience, insights, and challenges.

The Australian research I mentioned has done prevention research for 15 or 20 years when it comes to psychotic disorders. They conclude that we do some good for the client's psychosocial experience and situation, but we don't change the long-term course of the disorders. They prevent suicidal acts, substance misuse, homelessness, et cetera, but don't manage to change the psychiatric condition itself, which has led them to understand that with the same money, energy, and attention, you can do more if you start in the other end of the spectrum, with the most disordered ones.

Alec Saelens: If I understand correctly, there's harm reduction downstream, and what you're suggesting is that there's a need to understand psychotic disorders and pedophilic tendencies of the most high-risk individuals upstream, and try and develop some interventions before anything happens.

Christoffer Rahm: Both, and not only focusing on before it happens. I know that's a popular narrative, and I also use it with prevention, but look at it more closely. What we need to do something about quickly is all these individuals that walk around in society that are abusing children now. Not tomorrow, next year, but now, and to reach out to them, because law enforcement only gets a few percent of them.

A majority are willing to seek help if it is done in a way that they can rely on, interventions that make them stop abusing and exploiting children. No one does that. There is this picture that funding organizations don't want to give money to that kind of intervention, because they don't want to be associated with that patient group.

That's a wrong strategy, it should be highly prioritized. Not to say that it should be done instead of taking them to court and sending them to prison. The police I've worked with in several countries agree with me that these two strategies should be applied at the same time because they know very well that they don't reach out to all abusing individuals out there. With healthcare, we could reach even more if it can be done anonymously.

There is anonymous treatment, but the effect is too little, even medications have better effects. We should also have anonymous injection clinics as they have for intravenous substance use, where people can come and get medical help or interventions if they have an offending behavior, as a complement to law enforcement.

Alec Saelens: What are the main factors of how someone develops predispositions or pedophilic tendencies that you think people in society need to understand?

Christoffer Rahm: First, I must say as a scientist, we don't know what leads to pedophilia, but it seems like pedophilic orientation is established at an early age of the individual's development, maybe as early as around birth. Around the start of puberty, you understand your sexual interests, preferences, and what you're attracted to.

It is often said that this is a lifelong condition. It hasn't been studied with good methods. Some subtypes have more of a fluctuating or temporary course. Biomedical research indicates that it might be a contributing factor to aberrant androgen levels at an early age that affects the brain and brain maturation. For the few who have been victimized, it seems like an important experience that they accredit their pedophilia to but it cannot explain things on a bigger group level.

You can end up with pedophilic behaviors and thoughts in other ways, with different backgrounds and careers. For example, if you lose control of your sexuality and get hypersexual, start to use pornography, masturbate with an uncontrollable frequency, and repeatedly do sexual things you later regret. You can change your sexual behaviors, and start clicking on links on pornography sites that lead to material that you don't identify with being attracted to when you first do this.

Whether it is you want to see sexual acts involving animals, or sadistic sexual acts, or whether it is all kinds of the most extreme, there, you find the children. The more extreme, the younger the children. If you do that for more than two years, you fulfill the diagnostic criteria for pedophilia.

Alec Saelens: Did you try something through your research and the methods and interventions you've developed that did not work, that led you to learn something valuable to help shape your work?

Christoffer Rahm: Yes, we've made mistakes along, we've thought things along the way that we've later needed to rethink. One thing is a bit controversial, quite many people in the field say there is this huge population of non-offending individuals with sexual interest in minors.

In our programmes we've met and talked to more than 700 individuals with sexual interest in minors, with those who seek help. If you talk in-depth with them, almost all of them did things to a child, whether it is to use child sexual abuse material or to have had some kind of sexual interaction, even though the child isn't aware of it. Quite a few have acted out penetrative violence against a child.

All these other kinds of sexual interactions with children are common among individuals with sexual urges involving children. For someone unfamiliar with the field, that doesn't come as a surprise, maybe because that's a stereotype. Within the field, there is a little bit of naivety. I know that adds to the stigma, but facts are more important than opinions. Let's instead handle the facts in a non-stigmatizing and correct way.

Alec Saelens: Besides funding, what other challenges or limitations do you face in the work that you're doing?

Christoffer Rahm: There's a lot of talk about barriers in this field, barriers for people seeking help, barriers for getting funding for research, barriers for talking about this, and all of that. There are barriers to conducting research in the field, methodologically, that are quite important and interesting. It has to do with the legislation in different countries, it scares off individuals to seek help if you have too strict mandatory reporting laws.

For example, in some countries, you need to report everyone to authorities that have a sexual interest in children, whether they have committed an offense or not. Then there is this grayscale leading up to no reporting at all in very few countries. That is where both researchers, when they

design studies, get obstructed. It's a major hurdle for the Ethical Review Board to approve research applications.

It is also a discussion point with your university on handling the information you get. You will get a lot of information about the individuals who hurt children or children who have been harmed if you're involved. During the 10 years, we developed protocols that are approved by the Swedish Ethics Review Board, and work well according to the legal departments at the university and the law enforcement.

We have been able to develop a set of standard operating procedures around this. We could do more to stimulate other researchers and there might be ethical considerations, where you feel that you need to prioritize, either to support the adult person seeking help or the more symbolic child that needs help to be protected. You need to take care of both.

A major challenge in preventing these offenses is that so few are reported, and even fewer individuals at risk of offending seek help. This is perhaps the biggest reason why prevention remains ineffective, despite the tools available to law enforcement and treatments in healthcare. Researchers in the field have identified stigma as one of the primary barriers to this underreporting.

Alec Saelens: What strategies do you think are effective to change society's perspective to create a more complex, nuanced narrative around this issue?

Christoffer Rahm: Before we start deconstructing these stigmas let's remind ourselves of the group processes leading up to stigma. It might help individuals, even if they're only five years old, to understand that there is a yes and a no, a right and a wrong in this and that you pay the price of stigma to make it clear that sexual acts between children and adults are not right in any context.

The black-and-white attitudes in society can sometimes protect children from harm. Let's deconstruct stigma cautiously, and instead introduce a slightly different way of talking about it, without relativizing the severity of the topic.

I've been in several conversations with people from all kinds of backgrounds around this topic, and one of my more pessimistic conclusions is that it is hard to expect, even from a liberal and well-educated society like the Swedish, to have a nuanced, objective discussion around this

topic. We can take it step by step. My responsibility as a researcher and healthcare professional is trying to be neutral and evidence-based.

I don't have any ambitions to play a politician or influencer. It may need someone with a sexual interest in minors who goes up to the stage, takes the microphone, and speaks for himself. A famous face. Maybe it should come from that background.

There's a heavy wind towards them when they try to change the picture of themselves. I try to stay neutral and do the best I can in the conversations I have, but I don't know if society can change, or maybe should change the public discourse. I know that law enforcement has a nuanced picture. Many politicians can have two thoughts in their minds at the same time.

I'm impressed by the Swedish Royal Queen who has been courageous in supporting research projects like mine and other initiatives. Other inspirational people like Ylva Johansson, the European commissioner, have used their power to make a change. She understands people's feelings but can still act constructively.

Alec Saelens: What is the best way to approach stakeholder engagement and partnerships in this space? Leaving aside the general public's more anecdotal understanding, knowledge, or experience about this.

Christoffer Rahm: What we need when we talk to politicians and decision-makers, is like a handbook on how society should work to respond to the high numbers of child sexual abuse and how to get around all of the opinions.

If you get the evidence on the table, no politician would dare not act by evidence-based guidelines. That's my thought when I've talked to politicians from far right to far left, and in the middle. Both conservatives, liberals, and socialistic politicians want to make a change around this, but they also ask, "How do we do that?" Since there is no clear evidence on the table, they do what they have in their political agenda, whether it is to incarcerate more and to play tougher against them, or whether it is to give more treatment on the other end.

There is a framework from the World Health Organization (WHO) on how to combat sexual violence against children and women. It recommends a public health approach, addressing risk factors on different societal levels and with stakeholders working together. It is a theoretical framework, it needs to be empirically tested, but let's do that. Let's not have it as a brochure on the shelf that no one cares about.

People feel for this topic, but they don't know what to do, and that's when they get nervous and paralyzed because they don't want to do wrong. Many people will follow if we say what works and doesn't. The problem is that we have not, with that whole prevention research tradition, been able to show that any of our interventions reduce the incidence of child sexual abuse in society.

We can talk about therapy, and school-based interventions, but we can't show that we reduce the numbers. We need to have a different focus as researchers.

Alec Saelens: What is missing in this space? What's the gap that people should fill?

Christoffer Rahm: Make one person per society responsible for this question and have him or her removed from the position if he or she doesn't reduce the numbers. This question doesn't have a natural home in any political department. In some countries, it is in healthcare or the judicial department, and in Sweden, we have it almost in the cultural and work climate department. If no one is responsible, no one feels they have their knife against their throats to fix something and get things going. Then you get this mumbling and opinionating all the time and someone has to take care of it.

If we compare it to the COVID pandemic, there were identified individuals at specific positions in almost all countries who were responsible for fixing it and felt pressure from the public and the politicians. After a while, it formed a network of public health experts between countries. That is a model, you cannot translate it 100%, of course, but if we gave, like in Sweden with the Public Health Authority, the task to change the development so the numbers start to go down instead of continuously racing, that would change something.

Alec Saelens: Thank you so much for sharing your time and insights with me today.

Alec Saelens is a former journalist who supports SJN and its partners track solutions journalism's impact on society and the industry. In his former role, he researched and consulted on the connection between solutions journalism and revenue. He is co-founder of The Bristol Cable, the UK's pioneering local media cooperative. Before SJN, he was a researcher and coach for the Membership Puzzle Project and an analyst for NewsGuard.

***This conversation has been edited and condensed.*