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Non-Offending Minor-Attracted Persons: Professional Practitioners' Views on the Barriers to Seeking and Receiving Their Help

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ABSTRACT

Individuals who are attracted to minors but have abstained from sexual offending (non-offending minor-attracted persons) are an under-researched, hard-to-reach population. The current study explored professionals' perspectives of the barriers this population faces in seeking and receiving help and how these barriers can be reduced. Twenty professionals read an original vignette and answered a series of questions via an online survey. Using an inductive thematic analysis, the accessibility of treatment and perceived risk of disclosure emerged as the main barriers to seeking and receiving help. To reduce these barriers a number of potential solutions were suggested, including increasing publicity, educating the public, and offering enhanced training to professionals. This research should bolster future efforts to prevent child sexual abuse and contribute to strategies focused on helping non-offending minor-attracted persons manage their attraction in a pro-social way.

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Offenses can produce strong emotional reactions within individuals and society, particularly when those offenses are against children. Child sexual abuse (CSA) is possibly one of the only offenses where people collectively “feel the response before they deliberately consider the issue” (Harper & Harris, 2017, p. 117). This reaction will often extend to pedophilia too, despite the latter being a mental disorder rather than a criminal offense. The latest version of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) classifies pedophilia as a disorder of sexual preference, usually for children of prepubertal or early pubertal age (Section V F65.4) (World Health Organization, 2010).¹ It relates to the *attraction* these individuals experience, rather than any *actions* they may (or may not) have perpetrated. The conflation of pedophilia and CSA promotes the assumption that all pedophiles are criminals and a danger to society.

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¹We have chosen to focus on the definition of pedophilia from the ICD-10. This is not to be confused with pedophilic disorder from the Diagnostic and Statistical Manual of Mental Disorders (5th ed.) (American Psychiatric Association, 2013). The DSM-5 classifies pedophilic disorder as an adult (16 years or older) having recurrent sexual desires toward prepubescent children, where these desires have either been acted upon or cause the individual distress.

Not all individuals who have sexually offended against a child will meet the criteria for pedophilia; nor will all persons with pedophilic interests have sexually offended against a child. For the latter group of minor-attracted persons (MAPs),² many will remain offense-free for the entirety of their lives (Goode, 2010; Kramer, 2011), managing an attraction that cannot legally or morally be satisfied. If researchers can understand how MAPs remain offense-free, perhaps we can gain valuable insight into the prevention of CSA.

The importance of non-offending MAPs receiving psychological help

The pathway to sexual offending is a complex process involving a combination of personal and environmental factors (Pryor, 2001). Whilst not all MAPs will go on to offend, research suggests that minor-attraction is a strong predictor of CSA (Theaker, 2015). Sexual preference usually remains unchanged throughout an individual's lifespan, meaning non-offending MAPs can expect to present a lifetime risk of offending (Beier et al., 2009). In a survey of 193 self-identified non-offending MAPs (B4U-ACT, 2011a), a significant number had either considered or attempted suicide, with most feeling like they had no-one to talk to. Not receiving treatment left almost 50% feeling depressed, suicidal, isolated, self-loathing, anxious, and struggling to control their actions (B4U-ACT, 2011b). These striking results are consistent with other recent studies of MAPs. Levenson and Grady (2018), for example, found 30% of their sample had suicidal thoughts, whilst Cohen et al. (2019) found chronic suicidal ideation in 38.1% of their sample. Not only has research indicated the value of mental health treatment to help-seeking MAPs (Amelung, Kuhle, Konrad, Pauls, & Beier, 2012; Beier et al., 2009, 2015; Grossman, Martis, & Fichtner, 1999; Kim, Benekos, & Merlo, 2016), at some point in their lives the majority of MAPs *want* to speak to a mental health professional (B4U-ACT, 2011b). Potential obstacles, however, include fears of being misunderstood, mistreated or reported (B4U-ACT, 2011b).

Notably, most MAPs realize their sexual proclivities during late childhood or early adolescence (B4U-ACT, 2011a; Buckman, Ruzicka, & Shields, 2016; Freund & Kuban, 1993; Shaw, 1999). The act of sexual abuse, however, does not usually occur until much later. In a study by Piché, Mathesius, Lussier, and Schweighofer (2016), almost a decade elapsed between the onset of participants' deviant sexual fantasies and their first arrest; a substantial gap in which early intervention may have changed the course of events. It begs the question of whether there is a window of opportunity between realizing one's attraction and acting upon it (Theaker, 2015).

²The term 'minor attracted person' (MAP) has been used to reduce any stigma that may be caused by conflating pedophilia and child molestation (Freimond, 2013).

Potential barriers to help-seeking amongst MAPs

The decision to seek help is contingent on both internal and external factors. The latter may include (in)accessibility of services, (un)availability of treatment and the costs of receiving help (Buckman et al., 2016; Levenson & Grady, 2018). Internal, psychological determinants include internalized social norms, personal attitudes toward help-seeking, and mental health knowledge (Andrade et al., 2014; Levenson, Willis, & Vicencio, 2017; Rickwood, Deane, Wilson, & Ciarrochi, 2005). Research to date, reviewed next, suggests that MAPs will be influenced by a variety of these factors when seeking and receiving help.

In a recent study conducted by Mitchell and Galupo (2016), the accessibility of treatment and the quality of the treatment provider were found to be strong predictors of whether help was sought. Participants, taken from community men who had self-reported a sexual attraction to children, perceived mental health treatment as either inaccessible or ineffective due to a lack of understanding by the treatment provider. Several participants also expressed a level of distrust in the professional, with one participant claiming that the mental health community as a whole was not in a position to help due to a limited understanding of minor-attraction. These findings are supported in Grady, Levenson, Mesias, Kavanagh, and Charles (2018) where a prominent barrier to treatment cited by MAPs was a perceived lack of understanding by professionals about minor-attraction.

Piché et al. (2016) explored the help-seeking behavior of 100 men convicted or charged of a sexual offense. Participants answered a series of questions on their criminal history, problematic sexual fantasies, and prior help-seeking behavior. Only a minority sought treatment for their sexual fantasies prior to arrest, citing a combination of not knowing whom to talk to, restricted access to counseling services, and the fear of being arrested and labeled as a sexual deviant. This is despite the fact that the majority of respondents believed that engaging in a preventative intervention would have been beneficial.

Levenson et al. (2017) similarly explored the barriers to seeking and receiving psychological services in a sample of 372 men in treatment for sexual offending. Only one-in-five sought help prior to arrest, specifying concerns over confidentiality, social/legal consequences, personal shame or confusion, affordability, and challenges over finding competent therapists. Participants agreed that “there is really no place for help”, at least not until after arrest and incarceration (Levenson et al., 2017, p. 113).

As many of these results originated from a sample of convicted sexual offenders, they should be applied to non-offending MAPs with caution. The current authors are aware of only a handful of studies focusing directly on the needs of non-offending MAPs, mainly due to practical and ethical constraints in recruitment. Nevertheless, the extant research suggests that the concerns highlighted above are present in non-offenders too. For example, preliminary

analysis by Buckman et al. (2016) identified cost, confidentiality, and the difficulty in finding proficient therapists as the main barriers to accessing help.

Ajzen's (1991) Theory of Planned Behavior, a theoretical framework on decision-making, might explain why these factors have an impact on a MAP's decision to seek help. According to the theory, key predictors of intention and behavioral achievement include attitudes, subjective norms and perceived behavioral control (Ajzen, 1991). An attitude toward a behavior is one's favorable or unfavorable evaluation of it, whereas subjective norms are the perceived social pressures to perform the behavior or not. Perceived behavioral control is the individual's perception of the ease or difficulty of performing that behavior (i.e., their confidence in their ability to succeed). If attitudes and subjective norms are favorable toward the behavior, and perceived behavioral control is strong, the individual is more likely to carry out the behavior.

An individual's perceived behavioral control can reflect both past experiences and anticipated obstacles and is thought to influence behavior indirectly (through intentions) and directly (Ajzen, 1991). It may be that some offending MAPs had good intentions to seek help and to not offend but translating this into action was compromised by inadequacies in their perception of behavioral control. Following interviews with self-identified non-offending MAPs, Buckman et al. (2016) discovered that their participants felt like society saw them as a 'ticking time bomb', pre-destined to harm children. This idea of inevitability made it difficult for participants to remain hopeful.

The effect of stigma has been highlighted as the most powerful psychological deterrent in seeking help. The stigmatization of MAPs, while only recently an area of empirical interest, is alarmingly widespread (Imhoff, 2015). Of course, stigma may be a useful guide to normative behavior. Rather than a barrier, it could be viewed as a behavioral guide, aiding our understanding of what is and is not 'acceptable' behavior in our environment. In respect of the Theory of Planned Behavior, stigma may act as a positive social norm, facilitating intention to seek help. If, however, it is perceived as contaminating therapists and affecting their reactions to patients, it may act as an obstacle to perceived behavioral control.

In Levenson et al.'s (2017) study, the stigma associated with pedophilic interests led to shame and secrecy in their participants, preventing many from seeking professional counseling. As stigma is probably one of the main barriers to early disclosure and seeking help (B4U-ACT, 2011a; Clement et al., 2015; Grady et al., 2018), it is a barrier vital in understanding MAPs' help-seeking process.

The stigmatization of MAPs

The experience of stigmatization can have severe consequences on a person's mental health and psychological well-being (Cohen et al., 2019; Jahnke & Hoyer, 2013; Jahnke, Schmidt, Geradt, & Hoyer, 2015b). Worryingly, the resulting

social, emotional and cognitive problems MAPs experience are all factors that increase their likelihood of offending (Jahnke & Hoyer, 2013). The act of stigmatization can take many forms. For MAPs, this is likely to be expressed as fear, hatred, social isolation, and stereotyping (Harper, Bartels, & Hogue, 2016). These reactions are not just restricted to those who have committed an offense (Imhoff, 2015; Jahnke, Imhoff, & Hoyer, 2015a). In a comparative study of Americans and Germans, Jahnke et al. (2015a) discovered that a substantial number of participants agreed that people with pedophilia should be incarcerated as a preventative measure. Of the two groups, 14% and 28% agreed that people with pedophilia were better off dead, even if a criminal act had never been committed. McCartan (2004) found that 58% of his UK sample classified pedophiles as “evil” (p.333). In each of these samples, no sexual offense was mentioned, only the presence of a deviant sexual interest. These findings suggest that the ‘pedophile’ label is enough to evoke a visceral reaction void of all rationality (Harper & Harris, 2017).

These punitive attitudes can extend to the professional community as well. Stiels-Glen (2010) conducted a study of German psychotherapists, asking them whether they were willing to work with different types of offenders and individuals with pedophilia. Less than 5% confirmed that they would treat patients with pedophilia, with only one-fifth justifying their refusal as a lack of knowledge about the disorder. Others claimed to have negative feelings toward people with pedophilia, negative experiences with them in the past, and skepticism over their motivations for seeking therapy. This is consistent with the research conducted by B4U-ACT (2011b): out of the respondents who wanted professional help, over 75% were discouraged from seeking it because the information provided by the professional was negative, insulting, perpetuated stereotypes and demonized MAPs. The professionals themselves were also considered to be making judgmental, derogatory statements and displaying hostility toward MAPs.

It is not only the stigma toward MAPs which needs to be considered. Through offering treatment to this ‘marked’ group, there is the potential for the professional to experience stigma ‘by association’, otherwise known as courtesy stigma (Cantor & McPhail, 2016; Pescosolido & Martin, 2015). The clinicians who offer treatment to non-offending MAPs may be fearful of facing prejudice and discrimination themselves (Cantor & McPhail, 2016). When exploring the difficulties non-offending MAPs face in seeking and receiving help, it is therefore important to consider the specific hesitations of professionals in offering their services.

Unsurprisingly, these attitudes toward pedophilic interests have also hindered the promotion of preventative treatment (Harper & Harris, 2017). Little is known of the factors which reduce the likelihood of first-time offending, but there is extensive indicative evidence that mental health treatment reduces the risk of recidivism amongst convicted sexual offenders

(Grossman et al., 1999; Kim et al., 2016). It would be logical to apply the same reasoning to non-offending MAPs. Whilst there are few preventative treatment programs currently available, as discussed below the ones which are available have generated promising results.

Prevention of child sexual abuse

Researchers have called for the prevention of CSA to take a public health approach (e.g., see Becker & Reilly, 1999; Letourneau, Eaton, Bass, Berlin, & Moore, 2014). Public health approaches are comprehensive, long-term and involve a range of interventions from prevention strategies to treatment programs (Brown, O'Donnell, & Erooga, 2011). There are three levels to a public health model of prevention: primary, secondary, and tertiary. Regarding CSA, primary prevention would focus on preventing exposure to risk, thereby stopping the abuse before it even starts. One strategy would be to educate parents, children, schools and the community (Anderson, Mangels, & Langsam, 2004; Becker & Reilly, 1999; Munro, 2011). Secondary prevention of CSA is a targeted approach with individuals 'at-risk' of perpetration, for example by providing anonymous helplines or confidential treatment groups to those struggling with their attraction to children (McCartan, Merdian, Perkins, & Kettleborough, 2018). Tertiary prevention is a reactive response *after* the offense has occurred and focuses on preventing any further harm. This may be through offering treatment programs to convicted offenders.

Traditionally, CSA prevention initiatives are based on primary and tertiary approaches (McCartan et al., 2018); the focus is on populations at-risk of victimization or re-offending. We are aware of just a handful of projects based on secondary prevention. In Germany, there is the Prevention Project Dunkelfeld (PPD), which operates as a free, confidential treatment program offering counseling and group therapy to MAPs to help them remain offense-free. The goal of the PPD is to offer early intervention so that some first-time offenses are prevented from even occurring (Beier, 2016). By the end of December 2018, 10,499 people throughout Germany had contacted the project ("10,500 people asked for help," n.d.). Preliminary data reveal reductions in offense-supportive cognitions and improved sexual self-regulation (Beier et al., 2015).

Whilst there is no UK equivalent to the PPD, we are aware of two organizations which work directly with non-offending MAPs in the community: The Lucy Faithfull Foundation and the Specialist Treatment Organization for Perpetrators and Survivors of Sexual Offenses (StopSO). The Lucy Faithfull Foundation runs the 'Stop it Now!' (2018) prevention campaign, offering a confidential helpline to individuals concerned about their sexual thoughts and behavior toward children. The helpline is delivered by trained staff, specialist child protection professionals and experienced

practitioners. StopSO acts as an agency by connecting individuals who feel at risk of committing a sexual offense with a willing therapist. By 2016, 189 therapists had applied to join StopSO from across the UK (Grayson, 2016).

Non-offending MAPs are a hidden population, hard to access. The purpose of the current study was to explore the views of practitioners who are trained in helping non-offending MAPs. Currently little guidance exists for addressing the psychological needs of non-offending MAPs and it was hoped that through using a sample of professionals from StopSO and Stop it Now! further knowledge could be contributed. We focused on two distinct research questions: i) what barriers are non-offending MAPs perceived to face in seeking and receiving help; and ii) how can these barriers be reduced.

Method

Participants

A UK sample, comprising 20 professionals, was purposely recruited to complete an online survey. Braun and Clarke (2013) recommend that for participant-generated textual data, 10–50 surveys are sufficient for a small project. We therefore deemed this to be a sufficient-sized sample. Participants either worked on the Stop it Now! campaign, run by the Lucy Faithfull Foundation, or were registered therapists with the organization StopSO.³ The reason for this inclusion criterion was to ensure that data were only collected from professionals who had training/experience working with non-offending MAPs.

Four participants who worked as paid staff on Stop it Now! responded to an email request and completed the survey in full. The same approach was used to recruit therapists through the StopSO network, although individual therapists were also emailed directly if they appeared to match the inclusion criteria. We used the following online directories to reach individual therapists whom we thought met the study inclusion criteria: The Association for the Treatment of Sexual Addiction and Compulsivity (ATSAC), the British Association for Counseling and Psychotherapy (BACP), CounsellorsUK and UK Council for Psychotherapy (UKCP). A total of 115 therapists were emailed; all were either listed as psychosexual therapists with an interest in sexual addiction or specifically mentioned in their credentials being trained with StopSO. For the former group, the therapists were asked whether they had trained with StopSO before receiving an invitation to participate. Forty-four therapists responded confirming they were trained with StopSO, with 16 successfully completing the survey.⁴ This yielded a 36% participation rate.

³Stop it Now! and StopSO are the only organizations in the UK known to the authors as organizations dedicated to the prevention of CSA by helping non-offending MAPs manage their attraction.

⁴The remaining 28 respondents failed to start the survey for reasons unknown to the authors.

Table 1 provides a summary of participants' gender, age range, and professional affiliation. Of the 16 therapists registered with StopSO, six had not yet worked with non-offending MAPs and two revealed that they had "limited experience".

Materials

Case vignette

To provide participants with a concrete example of how a non-offending MAP may cope with his attraction toward children, we designed an original case vignette (see Figure 1). To add credibility to the story, the vignette was constructed from real individual cases found on the StopSO website (<http://www.stopso.org.uk/>) and Virtuous Pedophiles forum (<http://www.virped.org/>).

The purpose of using the vignette was to create a relative distance between the research and the participants (Hughes, 1998). We felt this distance was important as participants may have otherwise inhibited their responses due to concerns of revealing details of their own cases.

Survey questions

Participants were asked 11 questions in total, which were presented to them incrementally at fixed points during the vignette (Figure 1). Five questions focused on the potential barriers non-offending MAPs experience in seeking

Table 1. Participants' demographic information concerning gender, age range and professional affiliation.

Participant Number	Gender	Age	Professional Affiliation
1	Male	45–64	StopSO
2	Female	25–44	StopSO
3	Female	45–64	StopSO
4	Female	45–64	StopSO
5	Female	65+	StopSO
6	Female	45–64	StopSO
7	Female	25–44	Stop it Now!
8	Female	45–64	StopSO
9	Female	45–64	StopSO
10	Female	45–64	StopSO
11	Male	45–64	StopSO
12	Female	45–64	Stop it Now!
13	Female	65+	StopSO
14	Female	25–44	Stop it Now!
15	Male	45–64	StopSO
16	Male	45–64	StopSO
17	Male	65+	StopSO
18	Male	45–64	Stop it Now!
19	Male	65+	StopSO
20	Female	45–64	StopSO

Stage 1:

Mark, 28, is exclusively attracted to prepubescent young girls. He first noticed his sexual attraction at the age of 14 when he developed a crush on a girl he used to babysit. Despite his temptations, Mark has never had sexual contact with a child or viewed illegal images.

Now in his late 20s, Mark is finding it more and more difficult to control his behaviour. His friends and family are unaware of his secret and he's fearful his relationships will soon fall apart because he cannot talk to anyone about it.

1. In your opinion, would you say there are barriers that people like Mark experience in seeking help?
2. If you answered yes to the above question:
 - a. What barriers do you think are out there?
 - b. How do you think these can be overcome?
3. Paedophilia has become highly stigmatised in our society. How do you think this stigma can be reduced?

Stage 2:

After months of deliberation, Mark decided to contact a therapist. He used the first few sessions to discuss his feelings of depression and anxiety, but didn't reveal anything about his attraction towards children. He had read horror stories online and knew not all therapists would be willing to help him.

4. If someone like Mark was to approach a therapist to help him manage his attraction towards children, what qualities do you think are important for his therapist to have?
5. What treatment needs do you think someone like Mark would have, that would help him to remain offence-free?

Stage 3:

Towards the end of Mark's third session, he decided to disclose his secret to his therapist. Mark could tell his therapist felt uncomfortable and clearly didn't understand what he was going through. Mark decided not to return as he was unsure he could trust them to maintain his confidence and not report him to the authorities.

6. Why do you think some therapists refuse to help people like Mark?
7. How do you think more professionals can be encouraged to help people like Mark?
8. What made you willing to help people like Mark?
9. Do you experience stigma yourself from helping this population? If so, how do you manage this?
10. Based on your experience, have you identified any effective ways in which people like Mark can manage their attraction towards children?

Figure 1. Vignette stimulus case of 'Mark' with incremental questions.

and receiving help and three related to how these barriers might be reduced. Three related to how non-offending MAPs can be helped to remain offense-free.⁵

Procedure

Participants were emailed an invitation asking them to complete an online survey to “explore the help-seeking behavior of non-offending minor-attracted persons”. As an incentive, those who completed the survey were offered the chance to win a £50 voucher with internet-based retailer Amazon. Whilst this may have influenced the potential honesty of participants’ responses, we deemed the risk of this reduced considering the professional nature of the participants involved.

Participants were presented with the case vignette which was laid out in three ‘stages’. After reading the first stage, participants answered a series of questions. Participants were then directed to the second and third stages with the same procedure followed. This research was conducted in accordance with the British Psychological Society’s Ethics Guidelines for Internet-mediated Research (2017) and Code of Ethics and Conduct (2009).

Procedure for analysis and interpretation

Survey responses were analyzed using inductive thematic analysis, a method particularly suitable for participant-generated textual data (Braun & Clarke, 2013). We analyzed the responses within a realist framework – to be guided by the unique, personal experiences of the participants.

The first phase of the analysis involved repeatedly reading the survey responses and identifying initial codes that were of interest to the research questions. The next phase involved identifying relationships between codes and organizing them into potential themes and subthemes. Themes were identified at the semantic level, reflecting the explicit content of the participants’ responses. An academic peer then reviewed the original data and theme extractions to ensure they accounted for the data-set as a whole and not just the coded data. The themes were then defined in a way that concisely summarized the data.

⁵After analyzing the results we realized that the questions relating to how non-offending MAPs can be encouraged to remain offense-free did not fit in with the main purpose of our research: to focus on the barriers to seeking help and how these barriers can be reduced. We therefore decided to omit participants’ responses from the final write-up of this paper.

Results

Our findings are structured around the two research areas: i) what barriers non-offending MAPs are perceived to face in seeking and receiving help; and ii) how these barriers can be reduced.

The survey first asked if participants believed non-offending MAPs experienced barriers when seeking help. All participants answered ‘yes’ to this question. When asked whether stigma is a deterrent to help-seeking, all participants unanimously agreed, stating that “people hear ‘pedo’ rather than ‘help me’” (Participant 6) and “the strength of feeling against pedophilia is at ‘witch hunt’ proportions” (Participant 13). Some 40% of participants raised that they themselves experienced stigma as a result of their work. Of the remainder who had not been stigmatized against, 35% admitted to being cautious regarding whom they told and/or how they advertised their services. There were no major differences between participants’ responses depending on their different affiliations (StopSO and Stop it Now!).

Research question 1: What are the perceived barriers to non-offending MAPs seeking and receiving help?

Thematic analysis of participants’ responses uncovered two themes behind this research question: *accessibility of treatment* and the *perceived risk of disclosure*. Within each theme, two subthemes were identified (see Table 2).

Barriers due to the accessibility of treatment

This theme reflects participants’ perceptions of the difficulties faced by non-offending MAPs in accessing appropriate treatment, and comprised two sub-themes: *lack of professional help available* and *knowing where help can be found*.

Table 2. Themes and subthemes concerning professionals’ views to the barriers non-offending MAPs face in seeking and receiving help.

Theme	Subtheme	Definition	Frequency
Accessibility of treatment	Lack of professional help available	Some professionals refuse to help non-offending MAPs due to personal biases or inadequate training	14
	Knowing where help can be found	The help on offer is not well signposted and few will advertise their services	7
Perceived risk of disclosure	Personal consequences	Possibility of non-offending MAP being judged, shamed and ostracized	16
	Legal consequences	Uncertainty around confidentiality and safeguarding procedures	12

Lack of professional help available

Participant 8 noted that there are few services trained or willing to work with this client group. Some professionals may have a desire to help but feel unskilled, out of their depth, or ill-equipped to meet the client's needs (Participants 7, 18 and 20). Others may refuse to work with non-offending MAPs altogether due to their own judgments and biases; if the therapist struggles to suspend these negative beliefs, it will be difficult for them to engage with the work. Participant 1 explained, "Where there is a potential abuser, there is also a potential victim. Victims make a claim upon our empathy and it is difficult then simultaneously to feel empathy for an abuser."

Another reason therapists may be reluctant to work with non-offending MAPs is a fear of getting "embroiled in legal situations" (Participant 1). They may also be fearful for their own safety, associating MAPs with dangerous and violent behavior (Participants 3, 7 and 17).

Knowing where help can be found

There is a lack of information about the services available to non-offending MAPs and how they operate (Participants 18 and 19). Even with the appropriate help in place, if these services are not properly signposted non-offending MAPs will remain unaware regarding whom they should contact (Participants 5 and 17). Indeed, six participants admitted to not widely broadcasting the help they offer. This was explained as a way of either managing stigma or because they were fearful of losing potential clients (Participants 1, 9 and 10).

Barriers due to the perceived risk of disclosure

A disclosure of this nature carries potential risks to the non-offending MAP. Participants explored both the *personal* and *legal consequences of disclosure*.

Personal consequences of disclosure

Participants identified that the personal consequences of disclosure include being judged (by both the professional, friends and family), ostracized, shamed, and rejected. According to one participant, "in my experience friends and family will either be very supportive or totally judgemental and rejecting" (Participant 19). Fifty-five percent of the sample cited a negative reaction from family members as a possible deterrent to disclosure.

Legal consequences of disclosure

Fifty percent of participants acknowledged that a barrier to seeking help is the non-offending MAP's own fears that confidentiality will not be maintained. As noted by Participant 2, "It's something that is seen as a crime before a crime has been committed." It is these "general misconceptions" by some professionals which may lead to a non-offending MAP being reported to the authorities (Participant 3).

Whilst it is not possible to incarcerate someone because of their sexual thoughts, the client may be fearful of being subjected to restrictions and safeguarding actions if the professional assesses them as a risk to children (Participant 18). Drawing upon her own therapeutic experiences with clients who were known to the authorities, Participant 3 noted that “About half of them said that if they has [sic] known they could get help without being reported then they would have come”.

Research question 2: How can the barriers to seeking and receiving help be reduced?

Participants’ responses revealed three overarching themes to reducing the barriers to seeking and receiving help: *increasing publicity, educating the public* and *offering enhanced training*.

Reducing barriers through increasing publicity

Forty percent of participants recommended that increasing the advertising and publicity of services available to non-offending MAPs would help reduce the barriers to seeking help. It needs to be more widely known that there are therapists out there who will not report them (Participant 3). As one participant explained, “Services need to be better signposted, with an emphasis on confidentiality” (Participant 1). Participants also recommended more publicity around the extent of the problem, reaching out to non-offending MAPs to assure them that they are not the only ones (Participant 19). Indeed, Participant 7 thought efforts on a global scale should be better publicized, doubting many people were aware of Germany’s initiative regarding the PPD.

Increased levels of publicity should not only improve the visibility of services, but also help normalize the idea that help, rather than punishment, is a more appropriate course of action (Participant 1). Six participants cited the media (such as television and radio) as a powerful tool to reducing barriers, providing it is more responsible in its reporting and presents a balanced tone (Participant 1 contrasted the two UK television programs “The Paedophile Hunter” and “The Paedophile Next Door” as an example of this).

Reducing barriers through education

Forty percent of participants recommended wider education of the public, in the hope that talking about this issue would make it less taboo. Participant 7 stated, “a general ‘drip drip’ educative approach may result in ... people becoming more open minded, less judgemental and also services being more responsive and less reactive to cases.” Society needs a more educated understanding of the nature of pedophilia to realize that “non-contact paedophiles

exist and this status can be maintained” (Participant 3). Education should therefore focus on how we have “no choice what’s on our sexual template ... taking the focus away from shame and onto personal responsibility and choice” (Participant 10).

Participants’ suggestion of the means by which society can be educated ranged from social media campaigns to sex education in schools. Participant 14 also recommended showing people real-life case studies so they can develop a greater understanding of what these individuals are going through.

Reducing barriers through enhanced training

Participants identified that some therapists do not feel like they are working within their competencies when it comes to helping non-offending MAPs. Participant 19 stated that suitable training is crucial, as “Unless the therapist has an understanding of the different types of sexual addiction, paraphilia and offending behaviours ... they cannot respond appropriately”. Eighty percent of participants agreed that more appropriate training in the field is required, with one participant stating that he did not think sexuality was even covered in professional training; “it’s seen as a specialist area rather than a normal part of who we are” (Participant 10). Greater clarification is also required of the mandatory reporting laws (Participants 4 and 5).

The need for more training is not just limited to therapists and counselors. Training should also be offered to social workers, mental health workers, medical professionals, probation, and police so they know when to refer a client to a therapist rather than “throw the book at them” (Participants 3 and 12). Participant 3 highlighted that police, social workers, and children’s services in particular need to be taught that non-offending MAPs are not necessarily people who will inevitably offend. Indeed, Participant 19 admitted “My experience of social services staff is uniformly negative. They lack training, they are risk averse and sometimes openly prejudiced against offenders”.

Discussion and limitations

The literature on minor-attraction and the prevention of CSA has primarily focused on convicted sexual offenders. Whilst this may prove effective in reducing recidivism rates, the occurrence of a single offense means the damage has already occurred, usually resulting in a custodial sentence for the offender and severe physical and psychological effects for the victim. If more research focused on addressing the needs of MAPs, perhaps some individuals could be prevented from even engaging in that first-time offense. The current study sought to address this research gap by seeking insight from professionals who are trained in helping this population. Although this

avenue of research is still in its infancy, the data collected and themes identified complement the findings of previous qualitative and quantitative research (for example see Buckman et al., 2016; Grady et al., 2018; Levenson et al., 2017).

The harmful nature of stigma in relation to MAPs seeking help has been highlighted (Buckman et al., 2016; Levenson et al., 2017). Buckman et al.'s (2016) participants were very much aware of the 'ticking time bomb' concept society held in relation to minor-attraction and found it difficult to remain hopeful. All participants from the current study agreed that stigma is a major deterrent in seeking help. Participant 2 noted that society deals with minor-attraction by suggesting "horrific 'cures' ... without judge or jury". Linking this to the Theory of Planned Behavior (Ajzen, 1991), subjective norms via societal stigma may have contaminated therapists and negatively influenced participants' perceptions of their ability to engage with therapists.

Our findings do suggest that this stigmatization can have negative effects on the professionals working with this client-group, a barrier largely unaddressed in research to date. There is a professional risk in supporting a client with an attraction of this nature and some clinicians may fear a loss of work if they were to help. Participant 3 noted that "there is possible stigma to the work", admitting that he "only recently summoned up the courage to advertise", after working with this client group for four years. As highlighted by Cantor and McPhail (2016), the concerns over 'courtesy stigma' may be enough to deter professionals from offering support to this stigmatized group. The current study certainly suggests this. Future efforts must therefore focus on reducing the stigma experienced by both parties if preventative strategies are to succeed. Fortunately, organizations like StopSO and Stop it Now! are available in the UK, but even a preventative project like the PPD in Germany is still likely to face resistance unless this stigma is addressed. One solution may be to reduce stigma by providing peer-to-peer support, as done by Virtuous Pedophiles (2018), although naturally this must be accompanied by appropriate vetting procedures to ensure that peer support is provided by low-risk individuals.

There is also a considerable misunderstanding of minor-attraction in society, perhaps the greatest being that an attraction to minors inevitably leads to child abuse. Prior research attributes a certain amount of blame to the media, which has been known to categorize sexual offenders as a homogeneous group (Galeste, Fradella, & Vogel, 2012; Harris & Socia, 2016; Sample & Bray, 2006). The current participants highlighted the media as a major culprit for stigmatization, perpetuating myths of pedophilia. The overarching recommendation was to use educational resources as a means of reducing the stigma toward minor-attraction. As suggested by one participant, "We need a wider and more mature discussion within society to remove some of the stigma and shame people experience – in effect to normalise these issues as oppose to pathologising the individuals concerned" (Participant 18). With a more educated public

understanding of minor-attraction, perhaps rational debate might increasingly guide public responses to this problem.

Another problem highlighted in previous research is that professionals commonly misunderstand the diagnosis of pedophilia and are confused by the appropriate reporting laws (Levenson et al., 2017). This was an issue also noted by several participants in the current study. Clinical training must address the diagnostic criteria for pedophilia and clarify any ambiguity around mandatory reporting. If a framework for providing effective counseling to non-offending MAPs is offered, professionals may feel more equipped (and more willing) to help those with minor-attraction. Indeed, 80% of participants from the current study agreed that extra training was required, highlighting therapists' uncertainty over confidentiality and inexperience in the area of minor-attraction underpinning why some do not offer their services. Non-offending MAPs must also feel confident that they have found a proficient therapist (Buckman et al., 2016; Levenson et al., 2017). It is likely that offering enhanced training to therapists will not only increase the availability of services, but also increase non-offending MAPs' confidence in the help they are receiving.

The themes elicited from the current study have identified a number of areas for future research. Firstly, it would be useful to question the clinicians refusing to work with non-offending MAPs to further understand why this is. Whilst the current sample indicated that this is primarily due to a lack of training, there may be other factors involved which participants failed to consider because of their strong desire to help this client group. Once we have a greater understanding of where the reservations lie, future efforts can explore how these can be overcome.

A unique element of our study was also the use of an original vignette. Since this vignette was purpose-designed for the current study, it has only been used on a small sample of professionals. Future research should employ this with a larger sample of professionals which incorporates other organizations working with MAPs (e.g., the police service, probation, social services, and mental health workers).

There is also limited qualitative research focusing on how non-offending MAPs manage their attraction without offending. Research to date, including the current study, has primarily focused on the barriers preventing non-offending MAPs from seeking and receiving psychological services. Going forward, it would be useful to understand what sources of help non-offending MAPs do currently seek, if indeed any at all. Are there differences in how well non-offending MAPs cope depending on the help they receive? This is an important area of research worth exploring.

Surprisingly, participants failed to mention how MAPs often seek help for mental health concerns related to their minor attraction (such as depression and low self-worth), rather than the attraction itself. This is something

emerging from recent literature (B4U-ACT, 2011a; Levenson & Grady, 2018). This may have been due to the focused nature of the vignette and survey questions, and so something to account for in future research. Reflecting the hard-to-reach nature of the current population, our hoped-for sample size and make-up was different to what we eventually obtained. Regarding sample size, our final sample of 20 participants is on the lower end of the spectrum of 10–50 recommended by Braun and Clarke (2013) for small projects relying upon participants-generated textual data. A sample of 20 is however thought to be sufficiently powered (80%) to observe two themes where these are prevalent in at least 15% of the population (Fugard & Potts, 2015). Notwithstanding, it should be noted that a larger sample may detect additional, less prevalent themes that may be important.

The sample make-up is also a limitation to consider. The themes identified from the current study were based on the expertise of professionals in the field, rather than the clients themselves. While relatively unique in focussing on non-offending MAPs the current study is not unique in using a professional proxy sample (see Kettleborough & Merdian, 2017). Whilst MAPs in the community would certainly be better placed to give a more accurate representation of their experiences, there is limited research using this sample due to difficulties in recruitment and ethical concerns over disclosure. There would also be potential confounds to consider, such as biased responses and social desirability. Nevertheless, it is important the barriers identified in the current study are treated as *potential* barriers due to the nature of the sample. The next step is to further validate these themes with the non-offending MAP population, perhaps through online fora like Virtuous Pedophiles.

The focus on professionals is also a strength in that the sample has given an indication of why help is not so readily available. One of the barriers identified, for example, was professional reluctance to work with this client group. Who else is better placed to advise on these barriers than professionals themselves? An important consideration, however, is that there may have been professional bias in the data collected. All professionals had completed training to work with MAPs and they may have been influenced by research in the field. The number of clients helped by each participant is also unclear, although it is known that six participants had just completed the training with StopSO and were yet to receive a referral. Two participants also revealed that they had “limited experience”. For a minority of participants, the opinions offered in the survey may therefore not be based on clinical experiences with non-offending MAPs but from the training they have received. Nevertheless, the majority had experience dealing with non-offending MAPs and there were no major differences in the responses given between the participants who had and had not received referrals.

Conclusion

Whilst researchers and policy-makers will all agree that children are vulnerable individuals who must be protected from potential abusers, the means of preventing this abuse has certainly divided opinion. As a society, we are largely focused on punishment, and in the process we arguably overlook the importance of prevention.

It is not until recently that researchers have considered focusing on the needs of non-offending MAPs as a preventative action. In an attempt to understand the help-seeking process of non-offending MAPs, the current study explored what barriers professionals believe prevent this population from seeking and receiving help. Participants suggested that the main barriers are the accessibility of treatment and the perceived risks of disclosure. If publicity is increased, the public receives more education about minor-attraction, and professionals are offered enhanced training, these barriers may then reduce.

Participants also identified strategies to help non-offending MAPs remain offense-free. These were focused around developing the client's strengths and teaching the client tactics to avoid offending. One-half of participants suggested that a motivational, strengths-based approach, where the MAP focuses on the positive areas of their life, would reduce the likelihood of offending. There should be a positive focus on the MAP's job, family, friends and leisure activities so he can lead a balanced life with a broad spectrum of interests and relationships. In respect of avoidance tactics, participants suggested practical measures like downloading internet blocking software and avoiding drugs and alcohol. Participants also suggested keeping away from situations that are dangerous, such as avoiding being near schools and parks. A degree of vigilance is also required on the MAP's part, undertaking constant self-monitoring so he is aware of the triggers which might encourage him to offend. A good support network may also act as a protective factor. One participant noted that there is already a group called 'Circles of Support' for those who have sexually offended. A supportive network could be provided for un-convicted men with inappropriate sexual thoughts.

It is important to remember that many MAPs do not seek help to prevent offending; the help they seek is for mental health concerns, such as depression, low self-worth, and suicidality, which are related to their minor attraction and the stigma attached (B4U-ACT, 2011a). B4U-ACT has useful material on its website as a guideline for therapists and tips for choosing a therapist for MAPs seeking professional help.

The themes identified from the current study might contribute to future strategies aiming to address non-offending MAPs' needs and help them manage their attraction in a pro-social way. There are a number of practical challenges, however, which must be addressed before preventative strategies

can move forward. Most importantly, focus must now be on society's role in reducing CSA by addressing the stigma attached to minor-attraction. Otherwise, we risk non-offending MAPs going so far underground that they will become unreachable to the professional community.

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Disclosure of Interest

The authors confirm that they have no conflicts to report.

Ethical Standards and Informed Consent

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation [institutional and national] and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all patients for being included in the study.

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