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Preventing Sexual Abuse: Perspectives of Minor-Attracted Persons About Seeking Help

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Abstract

The primary aim of this exploratory research was to gain information from minor-attracted persons (MAPs) about their (a) formal and informal experiences with help-seeking for minor attraction, (b) perceived barriers to seeking help for concerns about minor attraction, and (c) treatment priorities as identified by consumers of these services. A nonrandom, purposive sample of MAPs ($n = 293$, 154 completed all questions) was recruited via an online survey. Results show that 75% of participants did seek formal help from a professional; however, just less than half of them found the experience to be helpful. Characteristics of helpful therapeutic encounters included nonjudgmental attitudes, knowledge about minor attraction, and viewing clients in a person-centered and holistic way. Barriers to help seeking included uncertainty about confidentiality, fear of negative reaction or judgment, difficulties finding a therapist knowledgeable about MAPs, and financial constraints. Understanding or reducing attraction to minors were common treatment goals, but participants also prioritized addressing general mental health and well-being related to depression, anxiety, loneliness, and low self-esteem. Implications for effective and ethical counseling and preventive interventions for MAPs are discussed.

Keywords

minor-attracted person, pedophilia, help seeking, therapy, prevention

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About one in five American adults report childhood sexual abuse (CSA), with wide-ranging and long-lasting impacts on physical and mental health, making prevention of CSA a critical public health goal (Briere & Elliot, 2003; Dube et al., 2005; Wolf, Nochajski, & Farrell, 2015). Because sexual attraction to children is a risk factor for sexually abusing (Finkelhor & Araji, 1986; Hanson & Bussiere, 1998), early interventions for people with attraction to minors should be part of a comprehensive prevention strategy. The stigma associated with sexual interests in children or young teens can result in avoidance of help seeking (Freimond, 2013; Jahnke, 2018; Lasher & Stinson, 2017; Pattyn, Verhaeghe, Sercu, & Bracke, 2014). To reduce the barriers to preventive treatment for minor-attracted persons (MAPs), we must better understand how to provide relevant services and improve access to service delivery for this difficult-to-reach population.

First, we would like to clarify our use of the term MAP. This language has been developed not by the authors, but by B4UAct, an organization established in 2003 as a collaborative effort between mental health professionals and individuals attracted to children or adolescents. On their website, they define MAP (B4UAct, 2018): "We use this term to refer to adults who experience feelings of preferential sexual attraction to children or adolescents under the age of consent." The term MAP serves here as an alternative to clinical constructs such as "pedophile" (which is a psychiatric diagnosis and would exclude some MAPs), or "pedohebophile" (which is not an accepted diagnostic category according to the American Psychiatric Association, but is used by some researchers and practitioners to describe sexual preference for prepubescent and/or pubescent youngsters; Bailey, Hsu, & Bernhard, 2016). The term MAP is preferred by consumers and is used descriptively here to avoid labels that sound either pejorative or diagnostic.

Minor Attraction

Pedophilia is described as an exclusive or primary sexual attraction to prepubescent children in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013), and carries with it a great deal of stigma in our society (Imhoff, 2015; Jahnke, 2018; Jahnke & Hoyer, 2013; Jahnke, Imhoff, & Hoyer, 2015). The word "pedophile" is often used synonymously with the term "sex offender," though not all people convicted of sex crimes against minors meet criteria for pedophilic disorder (APA, 2013), and not all people with pedophilia have sexually abused a child (Kingston, Firestone, Moulden, & Bradford, 2007; Seto, 2008). Some individuals, who refer to themselves as "MAPs" or "virtuous pedophiles," do not act on their attractions for a variety of reasons; they understand and appreciate why sexual abuse is harmful to children and they do not want to violate or take advantage of their relationships with youngsters (Mitchell & Galupo, 2016). The scholarly literature about nonoffending MAPs is small but growing, and although they remain an understudied and somewhat misunderstood population, we are learning more about individuals who have sexual interests in children and teenagers (Cantor & McPhail, 2016; Lasher & Stinson, 2017).

Much of what is known about minor attraction comes from studies of people convicted of sex crimes, and, therefore, differences between offending and nonoffending MAPs have been difficult to document. It is estimated that up to 4% to 5% of adult men acknowledge some pedohebephilic interests or tendencies across a range of indicators (e.g., from those who have ever had a sexual fantasy about a child, to those who have had sexual contact with a child; Ahlers et al., 2011; Dombert et al., 2016; Seto, 2008). Like most of us, MAPs typically become aware of their sexual interests during adolescence (B4UAct, 2011b; Bailey et al., 2016; Buckman, Ruzicka, & Shields, 2016). Some describe a recognition that as they grew older, their sexual attractions did not. Some studies have found that among MAPs, about 42% report a primary attraction to prepubescent youngsters, possibly meeting *DSM-5* criteria for pedophilia (Mitchell & Galupo, 2016; Piché, Mathesius, Lussier, & Schweighofer, 2016). Recent Internet research recruiting more than 1,100 participants from websites for adults with sexual interest in children has shed light on our understanding of the spectrum of sexuality for persons self-identified as MAPs (Bailey et al., 2016). In general, the researchers found that few MAPs reported sexual interest in infants or preschoolers, that the average age to which they were most attracted to either gender was 12 years old, and that individuals attracted to male minors endorsed less sexual interest in adult partners than those attracted to females (Bailey et al., 2016). About 12.5% of the respondents reported that they had been convicted of a sexual offense involving contact with a minor or for viewing child pornography, suggesting that the majority of MAPs utilizing informal Internet supports have not been convicted of unlawful sexual behavior (Bailey et al., 2016). The limited research about MAPs in nonforensic samples suggests that they have higher education and socioeconomic status than those convicted of sex crimes, which may reflect a greater willingness and opportunity to engage in formal or informal help seeking through various professional or online resources (B4UAct, 2011a; Mitchell & Galupo, 2016).

Formal and Informal Help Seeking

Formal help seeking involves taking initiative to obtain assistance from medical or mental health professionals, whereas informal helping seeking is typically described as support from family, friends, or other associates (Pattyn et al., 2014). People endorsing higher levels of perceived stigma expect to encounter stereotyping or discrimination, and tend to internalize negative self-narratives that deter them from formal and informal help seeking (Pattyn et al., 2014). MAPs report that barriers to seeking and receiving professional counseling include affordability and accessibility (especially for teens or young adults who rely on financial assistance from parents), concerns about confidentiality, and challenges finding therapists who are willing to see clients with minor attraction and who have the expertise to help them (Buckman et al., 2016; Houtepen, Sijtsema, & Bogaerts, 2016; Levenson, Willis, & Vicencio, 2017).

However, other obstacles also exist, as elucidated in qualitative (Buckman et al., 2016; Freimond, 2013; Houtepen et al., 2016) and quantitative (B4UAct, 2011a; Levenson et al., 2017; Piché et al., 2016) surveys of MAPs. For instance, the societal

rhetoric about people who abuse children (e.g., "monsters," "predators," and "deviants," along with declarations that they are not amenable to treatment and will inevitably reoffend) is rather damaging to the self-concepts of MAPs, who internalize these stigmatizing perceptions (Buckman et al., 2016; Jahnke, 2018). The shame and secrecy that result from this stigma prevent MAPs from reaching out to find role models, professionals, or confidants who might offer support or advice about how to deal with minor attraction and achieve a satisfying and healthy life (Beier, 2016; Buckman et al., 2016; Piché et al., 2016).

Many therapists are unfamiliar with the disorder of pedophilia and, therefore, may not feel prepared to work with people attracted to children (Lasher & Stinson, 2017). Also, revulsion about sexual abuse of children can interfere with a professional's ability or willingness to provide appropriate therapy services (Jahnke, 2018; Jahnke & Hoyer, 2013; Stiels-Glenn, 2010). MAPs are often viewed as a threat, and perceived to be unable or unwilling to change; therapists might avoid working with such clients due to negative feelings, doubts about whether therapy can help, or fears of liability (Jahnke & Hoyer, 2013; Jahnke, Philipp, & Hoyer, 2015; Stiels-Glenn, 2010). When clinicians respond to MAPs in ways that are judgmental or invalidating, or when they disclose information that does not fall under mandatory reporting laws to "err on the side of caution," clients can feel betrayed and reluctant to seek further help. However, though therapists who work primarily with people convicted of sex crimes might be more willing to work preventatively with MAPs, they may be inclined to disbelieve claims of nonoffending and erroneously apply sex-offender treatment models. They might paternalistically prioritize risk-management approaches over collaborative client-centered counseling methods (B4UAct, 2011a, 2017). Although prevention might be a goal for some MAPs who seek counseling, many primarily seek help for other related issues, such as depression or anxiety.

Studies suggest that many MAPs who visited a counselor had negative experiences that dissuade them from further help seeking. These include judgmental therapists, breaches of confidentiality, lack of compassion, presumptions of criminal behavior, or insistence on treatment goals driven by the therapist rather than the patient (B4UAct, 2011a; Houtepen et al., 2016; Levenson et al., 2017; Van Horn et al., 2015). Importantly, this means that some MAPs who wish to understand their own sexuality and avoid harming children may be unwilling to speak openly with a professional knowledgeable enough to help them. MAPs who wanted psychological services but did not receive them reported an exacerbation of mental health symptoms such as depression, suicidality, withdrawal and isolation, lost productivity, fear and anxiety, hopelessness, and substance abuse (B4UAct, 2011a). Furthermore, a small group (3%-4%) said that after being unable to obtain counseling, their attraction to youngsters escalated and they were later convicted for a sexual crime.

In surveys of clients in U.S. treatment programs for sexual offending, formidable barriers to obtaining help prior to arrest were revealed by those struggling with paraphilic disorders, especially those with pedophilia (Levenson et al., 2017; Piché et al., 2016). They identified a lack of access to competent and affordable counseling services and suggested that online or telephone resources would be a less threatening

alternative to provide informational materials or anonymous support. Embarrassment and fear typically prevented these individuals from reaching out for help, but when they did seek help, they reported often feeling judged or misunderstood. A few had encountered compassionate counselors who unfortunately seemed to lack the knowledge and competence to deliver effective interventions (Levenson et al., 2017; Piché et al., 2016).

A voluntary treatment program in Germany called the Dunkelfeld Project was designed to reach out proactively to adults and teens with sexual preferences for children through public service advertisements. After the intervention, researchers observed some decreases in emotional deficits, offense–supportive cognitions, and risk-related behaviors; and some individuals reported an increase in sexual self-regulation (Beier et al., 2009; Beier et al., 2015; Beier et al., 2016). In contrast, in the United States, mandatory child abuse reporting laws deter MAPs from seeking professional help (whether they are at risk to act out or not). Prevention of child sexual abuse in the United States, therefore, has mainly involved tertiary prevention strategies, such as criminal justice sanctions, registration and monitoring policies for convicted offenders, and treatment programs mandated by probation or parole conditions.

Current Study

The goal of the current research is to inform efforts to prevent sexual victimization of children, as well as to improve the well-being of MAPs. If perspectives of MAPs about help seeking were better understood, interventions could be designed to successfully engage MAPs in competent, ethical, and relevant services. The specific aims of this exploratory study were to obtain MAP perspectives about (a) experiences with help-seeking for minor attraction, (b) perceived barriers to seeking help, and (c) treatment priorities as identified by consumers of these services. No specific hypotheses were proffered, and questions were designed to elicit information and are analyzed primarily using descriptive analyses.

Method

A nonrandom, purposive sample of MAPs ($n = 293$, 154 completed all questions) was recruited from three organizations: "Stop it Now!" (United States and United Kingdom), "Virtuous Pedophiles" (international), and "Lucy Faithful" (United Kingdom). These groups provide online support, resources, education, and interaction designed for MAPs who are concerned about their sexual interest in children. Stop it Now! and Lucy Faithful also operate telephone hotline services. The organizations agreed to provide a link for our online survey to their members through their websites, online forums, and email distribution lists. The link could also be forwarded to other MAPs as a snowball sampling strategy.

Surveys were completed online and were anonymous and confidential. The survey was constructed on the surveymonkey.com platform, designed for online data collection. The first page of the survey contained an authorization for informed consent. The

survey was designed not to launch unless participants endorsed that they were above 18 years of age and clicked "yes" giving consent to participate. The survey included questions about sexual attraction to minors, prior help-seeking behavior, obstacles to help seeking, treatment needs, and demographics. The help-seeking questions were a modification of the general Help-Seeking Questionnaire (Wilson, Deane, Ciarrochi, & Rickwood, 2007), used with permission by the author, Dr. Debra Rickwood.

Given the anonymous and confidential nature of the survey, it was anticipated that the risk to subjects would be minimal if no incriminating questions were asked about information that could trigger mandatory reporting of child abuse in the United States. We did not ask whether participants had ever engaged in abuse of children or whether they had ever been accused, arrested, or convicted. Consistent with anonymous online surveys, participants were not asked to sign a consent form, and consent was implied by clicking a button to agree to participate in the survey. It was expected that the survey posed no greater risk than would be encountered by discussion of these issues in other anonymous settings. Based on these protections, this project was approved by a university institutional review board.

Consideration was given to the complexities of online data collection such as usability testing, pilot testing, challenges in reaching desired populations, and detecting fraudulent responses (Miner, Bockting, Romine, & Raman, 2011; Teitcher et al., 2015). To engage their support in disseminating the survey to their members, the survey was vetted and beta tested prior to launch through personal contacts from the partner organizations. Because the primary intent of the current survey was to recruit nonoffending MAPs,[1] an early draft of this survey was sent for feedback to three MAPs in leadership positions in the forums from which we planned to recruit. They read the survey and offered useful suggestions for wording questions and avoiding language that might sound judgmental, presumptuous, or otherwise off-putting. Their suggested revisions were incorporated, and then they pilot tested the survey online through SurveyMonkey, and subsequent minor changes were made to increase clarity and user friendliness.

We were sensitive to the challenge in reaching this population due to stigma, shame, and fear, which is why we sought to distribute the survey through organizations who had successfully developed trust with their MAP constituents. Because we did not offer incentives for taking the survey, we were not especially concerned about fraudulent responding for personal gain. Also, because our recruitment was targeted through the online forums that cater to this population, there was little risk of fraudsters randomly accessing our survey for some other purpose. We did alter settings in SurveyMonkey to protect against multiple responses from the same IP address, and added wording in the consent asking participants to agree to take the survey only once.

Descriptive analyses are used to report prevalence of relevant variables. Some bivariate correlational and comparative analyses were conducted. Several open-ended prompts were asked so participants could write narrative responses, and some illustrative quotes are included here to supplement the descriptive findings. A full thematic qualitative analysis will be reported elsewhere (Grady, Levenson, Mesias, Kevanagh & Charles, 2018).

Table 1. Sample Demographics.

Item	*M*	%	
Age ($n = 141$)	36 (range 18-80)		
Gender ($n = 146$)		91	Male
		5	Female
		4	Transgender ($n = 2$ trans M, 1 trans F) Gender nonconforming ($n = 3$)
Marital status ($n = 146$)		16	Currently married
		6	Divorced
		3	Separated
		1.4	Widowed
		58	Single
		5	Living w/romantic partner
		10	In a relationship not living together
Racial background ($n = 143$)		92	White
		8	Minority
Education ($n = 144$)		10	Did not graduate HS
		6	GED
		27	HS graduate
		38	College graduate
		19	Graduate degree
Country ($n = 121$)		43	United States
		37	United Kingdom
		3	Canada
		17	Other

Note. M = male; F = female; GED = graduate equivalency diploma; HS = high school.

Results

A total of 293 individuals took the survey but because many skipped various questions, the sample size is different for each question. Table 1 depicts the sample demographics for those who answered those questions. Most participants were male (91%) with 5% female and the rest identifying as transgender or gender nonconforming. The average age was 36 years, spanning a range of up to 80 years old. The majority said they were single, but 16% were currently married and about 10% had been previously married; about 15% were in a long-term relationship. The sample was overwhelmingly White (92%) and highly educated, with 57% having a college or graduate degree and 27% having a high school diploma. Nearly half of the participants were located in the United States (43%), with 37% in the United Kingdom and 20% in other countries.

The primary aims of the research were to gain information from MAPs about their (a) formal and informal experiences with help seeking for minor attraction, (b) perceived barriers to seeking help, and (c) treatment priorities as identified

by consumers of these services. The univariate descriptive analyses below reflect multiple choice or Likert-type questions. Nearly three quarters of the respondents endorsed an attraction to prepubescent children 12 years or less, or attraction to minor teens aged 13 to 15 years. More than half said they were attracted to teens aged 16 to 17 years. This is consistent with other research reporting a spectrum of victim age diversity among people with hebephilia and pedophilia (Stephens, Seto, Goodwill, & Cantor, 2018). Half said they were exclusively or primarily attracted to minors, 20% said they had equal attraction to minors and adults, and about 28% indicated stronger attraction to adults than minors. About half said they were exclusively or primarily attracted to males. Consistent with prior research (Bailey et al., 2016), those attracted to male minors endorsed less sexual interest in adults than those attracted to female minors.

Formal and Informal Help-Seeking Experiences

Many did seek help about their sexual interests, with 75% saying they sought services from some sort of mental health professional and 47% saying they tried to seek help from a website or Internet forum. Some had called a phone helpline, consulted a medical doctor, or confided in a religious leader. Half the respondents rated the experience as helpful or very helpful, but about one third said the professional was not helpful for them (see Table 2).

For those who went to a professional such as a counselor, medical doctor, or religious advisor, 71% said they had five or more sessions, with 18% having two to four sessions and 11% going only once. When asked what was most helpful about the experience, given the following options to endorse, 81% said the professional listened and seemed to understand, 55% felt the professional was not judgmental, 52% said they were offered hope that they could change their thoughts or behavior, 50% said they were offered practical solutions for changing thoughts or behavior, and 34% said the professional viewed them as a whole person with numerous interpersonal needs, instead of simply addressing their sexuality.

Respondents from the United States were more likely to seek formal professional help than those from other countries, $\chi^2(3, N = 120) = 9.533$, $p < .05$. Formal help seeking showed no significant differences between those endorsing sexual attraction to prepubescent children and those who did not, $\chi^2(1, N = 147) = 0.480$, $p > .05$. Younger age was associated with formal help from a mental health professional, $r(138) = -.43$, $p < .01$. More years of education was inversely associated with seeking formal help from a mental health professional, $r(141) = .27$, $p < .01$. Years of education was inversely correlated with perceived barriers to help seeking, including fears of being reported to authorities, $r(142) = -.26$, $p < .01$, and fears that confidentiality would not be respected, $r(142) = -.23$, $p < .01$, but financial or transportation obstacles were not significantly associated with age or education. Age was inversely correlated with the following barriers: fears of being reported to authorities, $r(139) = -.31$, $p < .01$; concerns about confidentiality, $r(139) = -.28$, $p < .01$; and being unsure how to find a therapist, $r(139) = -.35$, $p < .01$.

Table 2. Formal and Informal Help-Seeking Experiences.

Question	%
Please describe your sexual interest in minors (check all that apply)	*N* = 183
Attraction to prepubescent children aged 12 years or less	67%
Attraction to minor teens aged 13-15 years	74%
Attraction to minor teens aged 16-17 years	60%
Have you ever tried to seek help about your sexual interest in minors? If yes, who?	*N* = 186
Website or Internet forum	47%
Phone helpline	28%
Counselor/therapist/social worker/psychologist	75%
Medical doctor	16%
Religious leader (priest, rabbi, minister, etc.)	19%
How helpful was the professional?	
Helpful or very helpful	49%
Not helpful	33%
Have you ever sought counseling for any other personal or emotional challenges besides concerns related to your sexuality?	*N* = 179, 50%
Currently, does anyone in your personal life know about your minor attraction?	*N* = 182
No	47%
Friend	37%
Parent	23%
Family member	24%
Spouse/partner/girlfriend/boyfriend	19%
Other	14%
How often do you talk to someone in your personal life about your minor attraction?	Never
Friend	50%
Parent	68%
Family member	73%
Spouse/partner/girlfriend/boyfriend	66%
Other	75%

Note. Percentages may not add up to 100% because some participants endorsed more than one category.

An open-ended prompt invited participants to discuss their experiences with professional helpers. Some described positive experiences and relief in finding the right counselor: "It's become like a drug, like gambling and I've struggled to stop. I hate myself for it and I WILL stop now I've found professional help and support from my family." But others spoke of therapists making false assumptions:

> I am constantly insulted and degraded that virtually every person in society with normal adult attractions assumes that I am a liar with ulterior motives, that I struggle not to hurt children, and that one day I will inevitably slip and do just that.

In terms of informal help seeking, many participants indicated that they were isolated with few outlets for support. About 47% said that nobody in their personal lives currently knows about their minor attraction, though up to 37% did acknowledge that someone is aware (see Table 2). However, the majority said that they never talk to another individual about their minor attraction. The most likely source of informal support was a friend rather than a family member. In response to the question "have you ever tried to talk to anyone about your sexual interest," no significant differences were found between those endorsing sexual attraction to prepubescent children and those who did not, $\chi^2(1, N = 148) = 1.749, p > .05$. Respondents from the United States would more likely talk to an informal support about their sexual interests than those from other countries, $\chi^2(3, N = 121) = 26.398, p < .05$.

In narrative responses about informal supports, some spoke of the helpfulness of online forums, after a lifetime of secrecy:

> Since the discussion the other day I have been able to discuss the problem fully with the Stop-It-Now councillor [sic], with members of my family and a close circle of my friends. It is like a dam has been opened. I don't know if this in itself will help in any way but it feels like a huge step forward.

Another believed that addressing minor attraction in sex education in schools might have encouraged him to seek help:

> For me my teen pornography consumption started in high school. I knew I was a hebephile but dared not even admit it to myself . . . If some information about where I could talk with someone about this or where I could find help been provided discreetly (snuck into a biology lesson or something) I would perhaps have reached out earlier than I did now.

Perceived Barriers to Help Seeking

Participants were asked about choosing not to seek formal help in two different ways. First, they were asked "If you chose not to seek help from a professional to talk about your sexual interests or related concerns, what were the reasons? Check all that apply." Positive responses were indicated by endorsing the items that applied to them (see Table 3). Next, they were asked to endorse concerns about help seeking on a scale of 0 (*not true at all*) to 4 (*very true*; see Figure 1).

The most commonly endorsed barriers to help seeking were concerned about being reported to police or other authorities, followed by fear of a negative reaction, and concern that confidentiality would not be respected (see Table 3). For instance, 66% worried that they would get in trouble of some sort, and 72% expressed concerns that they would be judged:

> I think mandated reporting laws keep the vast majority of MAPs that would like to seek treatment, from seeking it . . . I don't think most of us know exactly what we can and can't say, how sensitive the therapist may or may not be, so we opt to stay away.

Table 3. Reasons for Not Seeking Formal Help ($n = 135$).

Item	Yes (%)
Concern about being reported to police or other authorities	72
Fear of negative reaction	69
Concern that confidentiality would not be respected	67
I believe I can control my behavior and not act in illegal or abusive ways	56
Unsure how to find a knowledgeable professional	47
Financial obstacles	23
I was a minor at the time and did not want my parents to know	19
Geographical or transportation obstacles	13

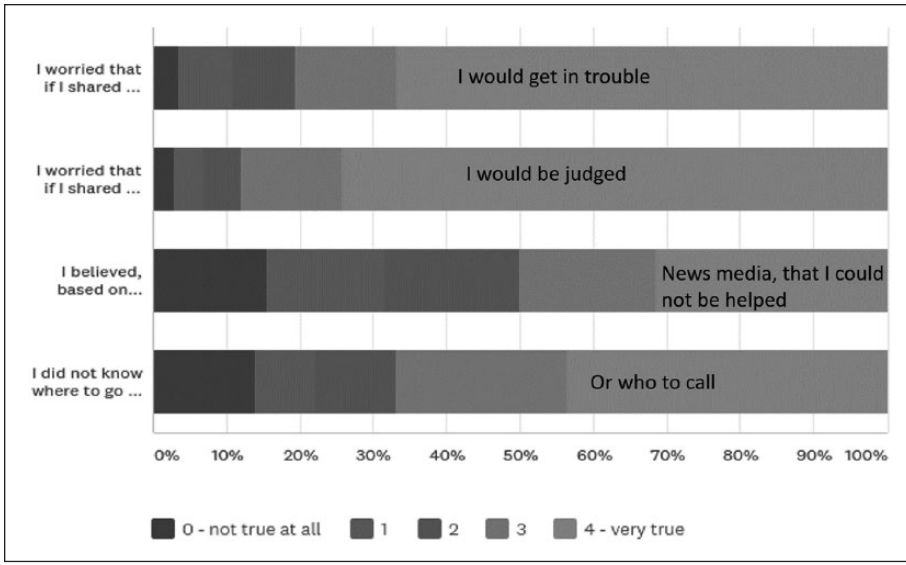

Figure 1. Concerns about help seeking: Participant ratings on a scale of 0 (*not true at all*) to 4 (*very true; n* = 177).

Others described actual breaches of confidentiality:

> I was reported to social services for being a MAP, despite saying that I had no intention to act on my urges . . . She suggested to me that I couldn't control my urges and that it was only a matter of time before I raped a child. If professionals saying things like that could be prevented in the future, that would be nice.

More than half said that they did not seek help because they believed they could control their behavior and not act in illegal or abusive ways: "The public perception of us needs to change, to let others know that people with these attractions aren't doomed

to act on them." Another concurred, "I am not a danger to kids just because I'm attracted to them. Just like men aren't a danger to women, just because they are attracted to them." Others were unsure how to find a knowledgeable professional, and two thirds endorsed that it was true or very true that they did not know where to go or who to call for help:

> I don't exactly want to call all psychologist offices in the area asking if they want to talk about my Pedophilia; being able to find them online and knowing they're available for that type of problem would make getting in contact less terrifying.

Many said that therapy was financially out of reach: "Financial barriers are the largest concern and that holds true for me in general health care. If you can't afford to see to your general well-being, you surely can't afford most options for therapy."

In response to the prompt asking participants to elaborate about barriers to help seeking, one respondent stated,

> How about fear of being turned in? How about fear of being revealed through breaks in confidentiality (which DO happen to us, but almost never to anyone else)? How about a series of institutions designed to treat us as criminals instead of human beings? How about an army of mental health providers who cannot begin to place themselves in our shoes? How about how frequently mental health providers REFUSE to work with us at all?

Geographical and transportation obstacles also emerged as concerns, and nearly one in five said that they wanted to seek help as a teenager but could not without assistance from parents.

About half of participants endorsed that they believed, based on news media reports, that they could not be helped. Others voiced the hope that they could find the help they desperately needed and wanted: "To some people, having the attraction is a curse and not something the person wants. It's hopefully very obvious to professionals but I just want to point out that there is probably no one else hating me more than myself." Similarly, another participant shared this: "We have to get rid of the stigma. I'm not a bad person. I want to change. I'm not alone in this." And finally, " . . . life would be a lot easier if society understood that having these attractions isn't a choice."

Treatment Priorities

Participants were asked to rate a number of items in response to the question, "What would you want helping professionals to know about your goals for counseling? Please rate the following items using a scale of 0 (*not a goal for me at all*) to 4 (*a very important goal for me*)." The items are listed in Figure 2. Understanding and reducing attraction to minors emerged as prominent priorities, but close behind were concerns about learning to have a healthy, satisfying life with close, authentic relationships despite the minor attraction.

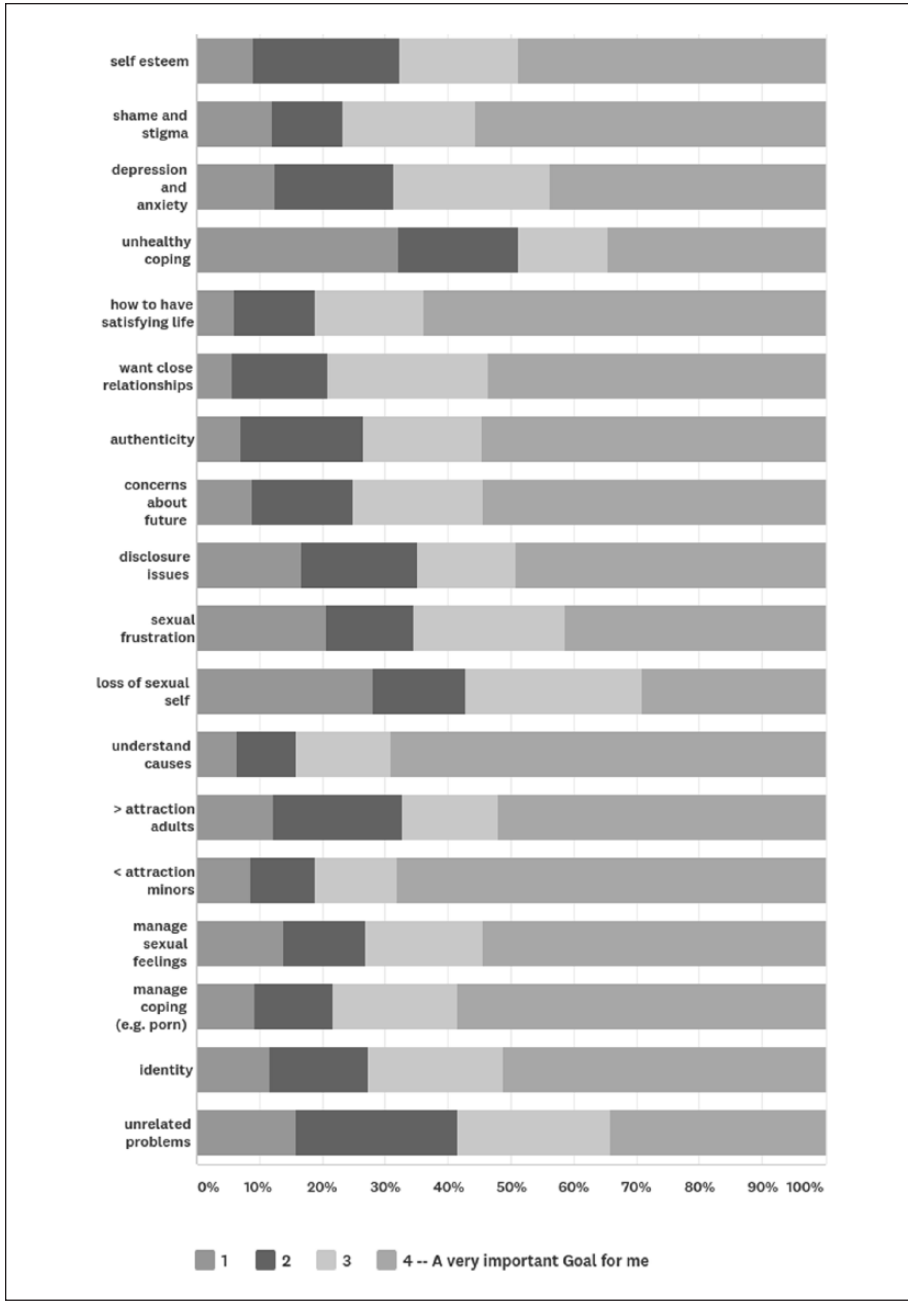

Figure 2. Goals for counseling ($n = 149$).

> For me, I have impeccable self-control. I won't offend. I need help coping with the life-sentence of being alone with no companion, no one to love, no one to cherish, and give my life to. I want the same thing everyone else wants. But through no fault of my own, I can't have that. Guess I need help with being bitter, as well.

Other goals that were important to many participants included managing sexual feelings and coping behaviors such as pornography use, dealing with shame and stigma, and working on one's sense of identity affected by societal views of minor attraction:

> While I believe sexuality is mutable to some extent, I am convinced that my primary attraction is fixed. I need help more in learning how to cope with accepting myself as I am. I hate myself a lot even though I have never acted on my attraction (except downloading pornography in the past).

A majority said they would want to work on goals unrelated to sexual interest, identifying depression, anxiety, and low self-esteem as important therapeutic areas. A smaller proportion identified sexual frustration, along with sadness about the lack of opportunities for sexual gratification and unhealthy coping strategies such as drug or alcohol use, as topics of concern.

We also asked a similar question in a slightly different way:

> Some MAPs say that their concerns about other people's (expected) reactions to their sexual interests have contributed to other kinds of personal or emotional issues, either in the past or in the present. At any time in your life, have you experienced the following?

Participants were asked to rate the items using a scale of 0 to 4, with 0 being *not true at all* and 4 being *very true* (see Figure 3). Many suffered from depression, anxiety, low self-esteem, and loneliness, and some struggled with related behavioral or interpersonal challenges such as difficulty concentrating, anger, feeling disengaged from others, and abusing drugs or alcohol.

Perhaps the most striking response was that 30% had suicidal thoughts and 23% had made one or more suicide attempts (see Figure 3; for this item, the instructions read the following: use the scale to click 0 for no, or the number of attempts made). For instance, one stated,

> To even think about it for the length of this survey brings high anxiety and depression. I know I would never be viewed the same way by others, even people who have given me high compliments. To seek treatment takes a great deal more courage, something I haven't always had. The attraction makes me feel suicidal.

Another said,

> I feel a lot of pain and hopelessness. The negative stereotypes and the stigma of MAPs echoes all around me constantly. I am in school currently and it is very difficult to be in a

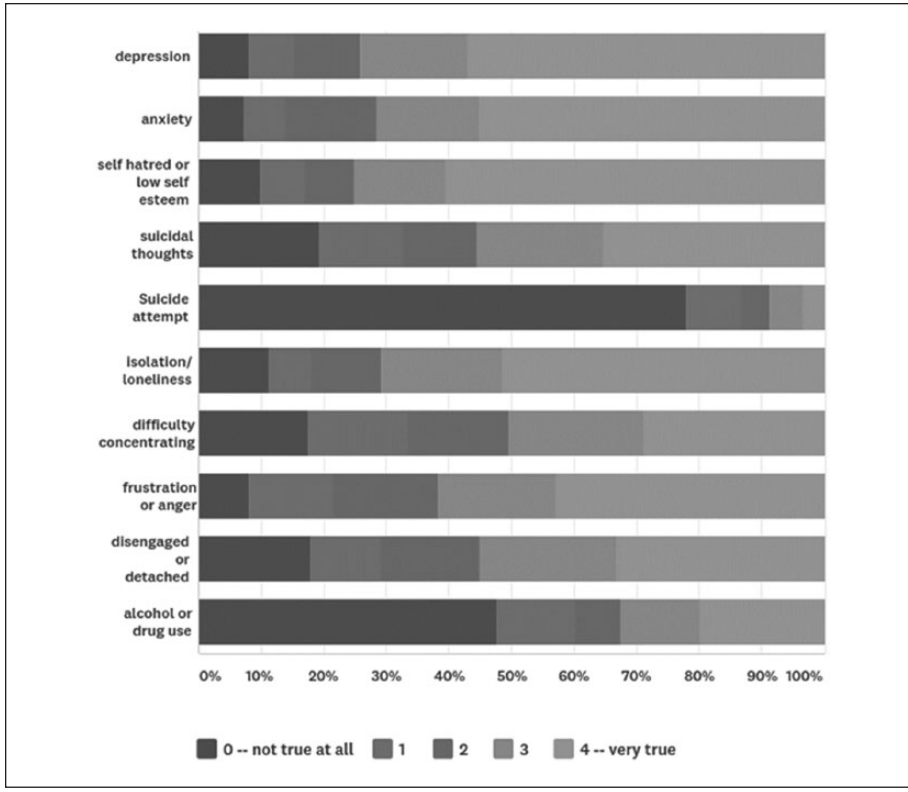

Figure 3. Other mental health concerns related to or stemming from the minor attraction ($n = 152$).

> class like Abnormal Psychology and to hear the professor as well as other students in class make thoughtless comments when the discussion is about pedophilia . . . I feel very desolate and alone. I think about suicide every day.

The despair and despondence of some participants was quite evident:

> Seeking help is a joke; in reality if anyone knew, my life and that of my family would be ruined forever and I would probably have to commit suicide as there are hardly any worse things looked down upon by society.

An open-ended prompt asked what mental health professionals should know about MAPs. One respondent focused on separating the person from the behavior and said,

> I think when a young MAP has a lot of internalized prejudices, the mental health professional should show them that being a MAP doesn't make one a danger or in any

> way more likely to break any laws or be a bad person. Any mental health professional should also be open to talk and learn from MAPs.

Another stressed the importance of client-centered counseling:

> I think it's very important that the first thing a mental health professional does is listen when MAPs describe their attractions and experiences. Like those attracted to adults, all MAPs are different and may feel their attraction in different ways and express this attraction in different ways, so therapists should not seek to box in their clients or make assumptions without hearing what their client has to say.

Discussion

Summary of Findings

The first aim of this study was to gather information about formal and informal experiences with help seeking for minor attraction. Findings reveal that the majority of participants did seek formal support from a professional. However, just less than half of them found this experience to be helpful, with one third stating definitively that it was not. They noted that therapists/professionals who listened well, were nonjudgmental, offered hope, and saw the MAP as a whole person with multiple needs beyond his or her sexual attraction was most helpful. Many sought help from a website or an Internet forum, and the anonymous protection of the Internet makes online support groups ideal for stigmatized populations. Isolation was common, as most indicated that they never actually discuss these issues or share their feelings with anyone in their lives. As other surveys have found, MAPs tend to feel isolated and alone in dealing with their feelings, burdened by shame, fear, and expectations of being misunderstood, or worse, shunned. Not being able to be one's authentic self breeds loneliness and psychological distress, and these results underscore the need for more helping professionals willing to provide competent and compassionate care for this hidden population.

Our second aim was to understand perceived barriers to seeking help for minor attraction. The concern raised most often by participants was fear of confidentiality being betrayed in some way, including being reported to police or other authorities. In addition, they also noted their fears of a negative reaction and judgment. Some identified logistical barriers, such as knowledge of resources and financial constraints. Also noteworthy is that about one in five participants wanted to seek help during their adolescence but could not do so without parental assistance. Many did not seek help because they felt that they could control their behavior and would not act on their attractions, despite presumptions often made by professionals.

The final goal of the study was to understand treatment priorities for MAPs as identified by consumers themselves. Although understanding and reducing their attraction to minors was a common treatment goal, the participants also noted their wish to have a balanced and satisfying life that included intimate relationships with others. Many wanted help with addressing identity issues and healthy coping behaviors, and

improving general mental health symptoms related to depression, anxiety, and low self-esteem. These priorities make sense when considering findings from qualitative interviews of MAPs in the Netherlands, where participants had much lower average scores (6.2 out of 10) on a subjective well-being scale, compared with the average score of 7.9 for other residents in the Netherlands (Houtepen et al., 2016).

Implications for Treatment and Prevention

These findings are consistent with extant research, and important implications can be gleaned from this study. The first is that therapists, physicians, and other professionals need education and training to be prepared to respond to issues of minor attraction in a competent, caring, nonjudgmental, and client-centered fashion. Although it is not realistic to expect every therapist to develop the expertise to provide full services to MAPs, initial responses can be improved through exposure to information that challenges stereotypes, assumptions, and judgments about MAPs. Furthermore, professionals need clarification about mandatory child abuse reporting laws to allow for ethical decision making. Informed consent procedures should ensure accurate and explicit conversations about the limits of confidentiality so that MAPs may engage in a therapeutic process that is transparent and allows for self-determination, beneficence, and nonmaleficence (American Psychological Association, 2017; B4UAct, 2017; National Association of Social Workers, 2018).

It is also critical for professionals to evoke their client-centered clinical skills when working with MAPs. The most helpful characteristics of professionals encountered by MAPs were consistent with the abundance of research about the common factors of effective psychotherapy: Therapeutic alliance, collaboration, positive regard, and empathy are among the aspects of counseling that foster the best results (Prescott, Maeschalck, & Miller, 2017; Wampold, 2015). There are profound psychological costs associated with an internalized belief that one's true self must remain hidden and that authenticity is not possible (Jahnke, 2018; Pachankis, 2009). Thus, listening with a nonjudgmental stance while offering hope and viewing the person holistically is essential to a positive therapy outcome. This can be especially challenging for therapists faced with a client who acknowledges attractions to children. However, research suggests that even a short education and training program for psychotherapists about MAPs can reduce stigmatizing attitudes and increase empathy (Jahnke, Philipp, et al., 2015).

Along with efforts to improve effective therapy for those at risk to abuse children, it is also crucial to reduce barriers to help seeking. Such strategies can address the stigma associated with minor attraction through public service announcements and educational information provided in medical and mental health service locations (Beier et al., 2009; Houtepen et al., 2016). Dialogue about minor attraction in sexual education courses provided in schools has also been suggested (Houtepen et al., 2016). Although potentially controversial, these prevention strategies might pave the way for readiness to seek help and support, either formally or informally. Moreover, these strategies may increase willingness of behavioral-health professionals to work with

MAPs. This is especially important because social isolation and lack of intimacy can be a risk factor for offending. "Until then, many individuals with pedophilic preferences remain standing at the edge of society, waiting for self-regulation to fail" (Houtepen et al., 2016, p. 63).

Finally, a crucial step in primary prevention lies in clarifying and rebuking stigmatizing labels (Willis, 2018). As discussed previously, the disorder of pedophilia is often confounded with illegal sexual contact with children, and instigates use of pejorative words such as "deviant," "monster," and "pervert." Although some MAPs will meet *DSM-5* criteria for pedophilia, others will not, and scholars have criticized the *DSM*'s narrow focus and limited applicability to the heterogeneous MAP population (Bailey et al., 2016; Imhoff, 2015; Marshall, 1997; Mitchell & Galupo, 2016; Seto, 2012). In fact, given the mounting research on the lived experience of minor attraction, some scholars have argued that attractions to minors might be considered a sexual orientation (Bailey et al., 2016; Seto, 2012). Affirmative cognitive behavioral therapy (CBT) allows for the safe exploration of one's sexuality and acceptance of self (Austin & Craig, 2015; Pachankis, 2009), which is important in reducing shame and stigma and creating a positive self-narrative. This goal can be achieved while reinforcing appropriate boundaries and self-regulation, and offers a new paradigm for preventing sexual abuse of children.

Limitations

Any self-reported data have inherent limitations. Especially with a stigmatized or shamed participant group, these include potential impression management or desirable responding. MAPs who choose to respond to research solicitations may be different in important but unknown ways from those who do not participate in research. Nonoffending MAPs may be different from those convicted of sex crimes, but because we elected not to ask potentially incriminating questions about arrests, convictions, or abusive contact with children, we are unable to ascertain those differences in this study. Importantly, we recruited through online support forums (Stop It Now!, VirPed, and Lucy Faithfull Foundation), and individuals who visit those sites are probably more likely to seek help than those not in contact with such organizations. Therefore, it is not surprising that a majority of our participants had sought help, and this rate is likely higher than might be found in a random survey of MAPs. It is possible that only a minority of individuals attracted to children are interested in help, and they were overrepresented due to our recruitment strategy.

The sample size, though sufficient for these descriptive and comparative statistics, was moderate and may not be representative of the full population of MAPs. The sample is international, and there may be discreet geographical differences in experience that were beyond the scope of these analyses. Although we took steps to minimize conditions that might induce fraudulent responding, we have no way to confirm the veracity of responses. Nevertheless, the study adds to the growing literature about help-seeking behavior and treatment needs of MAPs, and because our findings are consistent with those from other studies, we believe that the results contribute valuable knowledge to the understanding of this hidden population.

Conclusion

Ultimately, it is hoped that this project will contribute to prevention of child sexual abuse by promoting compassionate, relevant, and effective psychotherapy services that are accessible and available for those wishing to maintain an emotionally healthy and nonvictimizing lifestyle. The knowledge gained from the survey and narrative responses can help improve engagement in counseling, clarify treatment needs, and deliver appropriate clinical services for people with minor attraction. In this way, MAPs can receive supportive services that address their mental health and psychosocial needs, reinforce their sense of self-efficacy and motivation to *not* abuse children, and encourage willingness to seek help if they believe themselves to be at risk for sexual contact with minors.

Importantly, many respondents indicated that concerns about the limits of confidentiality in a therapeutic setting were primary barriers to help seeking. This is probably most true in the United States. Mandatory reporting laws make it extremely difficult to envision a preventive program in the United States without a change in policy to allow for confidential help seeking. Some states now require a mental health professional to report viewing of child pornography, even without a contact victim. Therapists lobbied against such a requirement, citing concerns that MAPs would be discouraged from seeking preventive services, and that counselors would be placed in a position of breaching their ethical commitments (Clark-Flory, 2016). Although mandatory reporting laws are designed to protect children, they may paradoxically increase risk when individuals avoid seeking help due to stigma and fear of consequences (Beier, 2016; Jahnke, 2018; Lasher & Stinson, 2017). Also, they may deprive individuals of mental health enhancement and relief from the distress caused by their minor attraction (Beier, 2016). We encourage continued advocacy for access to mental health treatment for those who wish to improve their well-being or prevent themselves from harming children.

Finally, we hope to emphasize that clinical services for MAPs are valuable not only as a means to prevent child abuse but also to further the quest of helping professionals to provide client-centered and nonjudgmental care to all who seek it. By emphasizing MAP well-being and highlighting their own perceptions of treatment priorities, we do not intend to minimize the importance of prevention, to ignore risk, to suggest evasion of mandatory reporting laws, or to excuse child sexual abuse. We believe that research can shed light on the inner experience of MAPs, and that this understanding can inform the development of competent, ethical, compassionate services. People do not choose their attractions, though they can choose whether to act on them. We hope that by engaging in this conversation, we can contribute to effective counseling that is grounded in science for individuals with minor attraction.

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Note

1. As noted, we allowed snowball sampling in an effort to increase our reach to include as many minor-attracted persons (MAPs) as possible. Although our intention was initially to recruit nonoffending MAPs, when we began to explore the narrative responses, it was clear that many participants had indeed been arrested and/or convicted for sex crimes. This was apparent because they referenced being in court-mandated treatments. We elected to keep these cases in, as they provided informative data about obstacles to help seeking prior to offending.

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