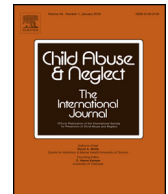




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Stigmatizing attitudes towards people with pedophilia and their malleability among psychotherapists in training[☆]

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ABSTRACT

Offering counseling and psychotherapy to patients with pedophilia is considered an essential part of sexual abuse prevention by many experts in the field. Yet, professionals' willingness to offer treatment might be compromised by stigmatizing attitudes towards these patients. In the present study, we developed and tested a 10-min online intervention (including educational material and a video about a person with pedophilia) to reduce stigma and increase motivation to work with this particular patient group. Psychotherapists in training were either assigned to the anti-stigma intervention group ($n=68$) or the control group ($n=69$) that received information about violence-free parenting. In the anti-stigma condition, agreement with the stereotypes controllability and dangerousness, anger, reduced pity and social distance were significantly reduced after the intervention, compared to the control group, while motivation to work with this group remained unchanged. The effects persisted, though slightly reduced in size, for perceived controllability, anger and social distance at follow-up. Our results suggest that stigmatizing attitudes, negative affective responses and social distance regarding people with pedophilia among psychotherapists in training can be positively influenced by a low-cost intervention. Practical implications of these findings for high quality health care and child sexual abuse prevention are discussed.

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Introduction

Child sexual abuse, defined as a sexual contact offense between an adult and a minor, is highly prevalent worldwide (Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). According to a recent meta-analysis, about 13% of girls and 6% of boys have experienced sexual abuse during their childhood (Barth, Bermetz, Heim, Trelle, & Tonia, 2012). As the experience of child sexual abuse is known to be associated with a large range of negative consequences for the affected children's mental and physical health (Briere & Elliott, 2003) and high costs for the community (Shanahan & Donato, 2001), research has been dedicated to find new and effective ways of child sexual abuse prevention (e.g., Zeuthen & Hagelskjær, 2013).

Many experts argued that focusing on the identification, counseling and treatment of potential offenders may be a very helpful and worthwhile approach to significantly reduce the occurrence of child sexual abuse (Beier, Ahlers, et al., 2009; Beier, Neutze, et al., 2009; Finkelhor, 2009; Osterheider et al., 2011). Although not all people who are pedophilic (i.e., have a sexual

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attraction to prepubescent children, [Dombert et al., 2014](#); [Seto, 2008, 2012](#)), commit such acts, pedophilia is nevertheless one of the most important risk factors for child sexual abuse ([Hanson & Bussière, 1998](#)). This makes people with pedophilia (PWP) an obvious target for child sexual abuse prevention (e.g., psychotherapy). Yet, psychotherapists may not be willing to and/or may not feel qualified enough to contribute to these efforts.

In a German survey, more than 95% of the responding psychotherapists were unwilling to work with patients diagnosed with pedophilia for various reasons, some of them relating to negative feelings and attitudes towards this patient group ([Stiels-Glenn, 2010](#)). In a recent public health survey of 352 clinical practitioners (medical doctors, psychologists, psychotherapists and other health care personnel) in Finland, 65% rated their skills and knowledge, and 38% their personal attitudes as poor or insufficient concerning the treatment of PWP ([Alanko, Haikio, Laiho, Jahnke, & Santtila, 2014](#)). Conversely, in a survey conducted and published by a US-based network of mental health specialists and people with a sexual interest in children, a large number of PWP named the expectation to be treated in a stigmatizing way by the professional as one of the primary reasons for their previous reluctance to seek help ([Kramer, 2011](#)). Therefore, reducing stigma against PWP among health care professionals must be considered an important prerequisite for timely child sexual abuse prevention and treatment targeting PWP.

A stigma is defined as a negatively valued attribute that makes its carrier “different from others, [...] in the extreme, a person who is quite thoroughly bad, or dangerous, or weak” ([Goffman, 1963](#), p. 3). People respond to stigmatized others on a cognitive, emotional and behavioral level ([Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012](#); [Rusch, Angermeyer, & Corrigan, 2005](#)), also identified as stereotypes (e.g., the belief that someone is dangerous), prejudice (e.g., agreeing with the belief that someone is dangerous and/or feeling angry towards another person) and discrimination (e.g., refusing to talk or work with someone). Stigma against people with a mental illness is a widespread problem with serious adverse consequences for the stigmatized individuals, including, most notably, reducing quality of life and self-esteem ([Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001](#)), and creating an obstacle for high quality health care ([Corrigan, 2004](#)). To prevent the harmful effects of stigmatization to take its toll on people with a mental illness, a multitude of stigma reduction interventions have been tested ([Dalky, 2012](#); [Heijnders & Van Der Meij, 2006](#)). Such programs have focused primarily on attitudes towards patients suffering from schizophrenia or mental illness in general ([Dalky, 2012](#)), and none of them have yet addressed concerns regarding PWP (see also [Jahnke & Hoyer, 2013](#)). Despite this, the abundant literature on the effectiveness of previous anti-stigma programs can and should inform the development of new programs directed at other stigmas.

[Corrigan et al. \(2001\)](#) suggested three strategies to categorize the literature on interventions targeting stigma of mental illness: protest, education and contact. Protest campaigns center on “highlight[ing] the injustices of various forms of stigma and chastise offenders [i.e., stigmatizers] for their stereotypes and discrimination” ([Corrigan & Shapiro, 2010](#), p. 910). However, it was found that such campaigns seem to be ineffective or even have a worsening effect on people's attitudes ([Corrigan & O'Shaughnessy, 2007](#)), what may be interpreted as a sign of psychological reactance ([Corrigan et al., 2001](#)). Educational strategies challenge common stereotypes and misperceptions, separating (stigmatizing) myths from reality ([Corrigan et al., 2001](#)). Empirically, attitudes towards people with mental illness have been discovered to be more favorable among the more educated ([Link, Cullen, Frank, & Wozniak, 1987](#)), and educational interventions have been shown to decrease mental illness stigma ([Penn, Kommana, Mansfield, & Link, 1999](#)), at least in the short term ([Corrigan et al., 2002](#)). The largest and most stable effects concerning more positive attitudes towards people with a mental illness, however, appear to be achieved by enabling contact between members of the general public and people with a mental illness ([Corrigan et al., 2001](#)). In general, people who report being familiar with people with a mental illness showed a more favorable reaction to this group ([Angermeyer & Dietrich, 2006](#); [Corrigan, Edwards, Green, Diwan, & Penn, 2001](#); [Link & Cullen, 1986](#)).

Pedophilia belongs to the most stigmatized and rejected mental disorders ([Feldman & Crandall, 2007](#)). Fourteen percent of the participants in a large and heterogeneous German sample agreed that PWP should better be dead and 39% recommended imprisonment, even though the instruction emphasized that the individual in question had never committed a sexual (or other) crime (while only 3% or 5%, respectively would respond similarly when alcohol abusers are concerned, [Jahnke, Imhoff, & Hoyer, 2014](#)). Among an English-speaking sample, as much as 27% agreed that PWP should better be dead and 49% recommended imprisonment (compared to 9% or 6%, respectively demanding similarly drastic measures for sexual sadists, or 21% and 8%, respectively, when people with antisocial tendencies are concerned, [Jahnke et al., 2014](#)). Moreover, many members of the population falsely believe that pedophilia is a controllable disorder in the sense of [Weiner \(1985\)](#), implying that PWP can exert, at least to some degree, volitional control over whom they feel sexually attracted to ([Jahnke et al., 2014](#)). Hence, these individuals may not see pedophilia as a true mental disorder (see also [Imhoff, 2014](#)), and are thus unable or unwilling to afford it the same level of concern or deservingness of treatment that they do to other mental disorders. Even more problematic, the public seems to be uninformed about the conceptual differences between pedophilia and child sexual offending, assuming that the vast majority of, or even all PWP irrevocably engage in sexual activities with minors ([Feelgood & Hoyer, 2008](#); [McCartan, 2004, 2010](#)), although this is not the case. While we have very little information about PWP who never commit sexual crimes, this group must be expected to exist and to potentially make up a large proportion of PWP as a population ([Goode, 2010](#); [Schmidt, 2002](#)).

Given the huge stigma directed at them, we expect many PWP to be reluctant about disclosing their sexual interests and potentially related problems to other people, including health care professionals. Although people with mental health training generally hold more positive attitudes towards people with a mental illness than those without special training ([Peris, Teachman, & Nosek, 2008](#)), they are not immune to stigmatizing attitudes that exist in their social environment and may be less motivated or capable to offer high quality treatment as a result ([Schulze, 2007](#)). In a German sample of

psychotherapists, only very few participants agreed to be willing to treat PWP and a number of them justified this decision with negative attitudes towards this group (Stiels-Glenn, 2010). Thus an intervention targeting such overly pessimistic or stigmatizing views could help increasing their willingness to offer therapy. While it needs to be addressed that reluctance to treat PWP could be due to numerous other reasons, most prominently a lack of knowledge or experience in the field (Stiels-Glenn, 2010), an anti-stigma intervention could nevertheless be effective in sensitizing practitioners to the needs and problems of such clients. This in turn might motivate therapists to engage in specialized training about the treatment of PWP, or to acquire the knowledge that has previously been missing. Also, very importantly, this could help practitioners to establish a better therapeutic relationship with their patients (which may in turn promote therapy success; Martin, Garske, & Davis, 2000).

At this point, we would like to address ethical concerns that fellow researchers or practitioners might see in creating an anti-stigma intervention for the stigma against PWP: We do not think that child sexual abuse is acceptable in any way, nor do we believe that PWP never present any danger to children. On the contrary, we feel that our efforts to de-stigmatize pedophilia among health care professionals can contribute to the goal of protecting children from sexual abuse. In this respect, health care providers such as psychotherapists can make a huge contribution to children's safety if they accept and approach PWP in a respectful way without condoning behaviors that are against the law and/or might put children at risk of harm (Jahnke & Hoyer, 2013; Jahnke et al., 2014; Seto, 2012). In line with these assumptions, recent data from a German prevention project (Beier et al., 2014) revealed that CBT approaches could indeed change dynamic risk factors for sexual offenses against children among $n=53$ undetected PWP (while no changes occurred for waiting list controls, $n=22$). With regard to child sexual offending, 20% of previous offenders continued abusive behaviors, while 0% of the nonoffenders with pedophilia started offending during the one-year treatment project (note that significant decreases in offending could not be detected due to low base rates).

The Present Study

We argue that a stigma reduction program for psychotherapists that addresses stigma against PWP can be helpful to correct stereotyped assumptions about PWP especially with regard to dangerousness and controllability, reduce negative feelings and social distance towards PWP, and increase willingness to offer therapy and to specialize in treatment of PWP. To test these hypotheses in the most rigorous way, we designed a randomized controlled trial, where a sample of psychotherapists received an online link to either the anti-stigma intervention or received information about an unrelated program on responsible parenting (control group). To maximize the effectiveness of the intervention, we combined educational and contact strategies. The need for an educational focus in the intervention is documented in Beier, Hartmann, and Bosinski (2000) who detected a massive lack of qualified psychotherapists for patients with pedophilia in Germany. According to these authors, curricula for psychotherapists in training place little, if any, weight on the diagnosis and treatment of sexual disorders. In order to provide a sense of contact with a real individual behind the label "pedophilia" whilst guaranteeing safety and anonymity for this person, we included a video about a young man with a sexual interest in children. As recent evidence indicates (Clement et al., 2012; Reinke, Corrigan, Leonhard, Lundin, & Kubiak, 2004; Ritterfeld & Jin, 2006), the presentation of a person with a mental illness on video-tape (indirect contact) is helpful in reducing stigma, though typically yielding smaller effect sizes compared to direct face-to-face contact (Corrigan et al., 2012).

Methods

Participants

Psychotherapists in training for cognitive-behavioral therapy (CBT) were approached at eight German CBT institutes and received invitation letters to our study via their respective postgraduate institute ($N=137$). In some cases, they were additionally contacted by a member of the research staff during psychotherapy courses. All participants gave informed consent. Participants were mostly female (82.5%) and between 24 and 53 years old ($M=30.34$, $SD=5.39$). Some affirmed having had contact with PWP in their personal life (7.4%) or professionally as, for instance, a member of the treatment staff in a hospital or clinic (18.2%). The majority of participants did not have children of any age (78.8%) or below the age of consent in Germany, which is 14 (82.4%). According to student statistics from one of the participating institutes (IAP-TUD GmbH), the participants in our sample compare to other psychotherapists in training with respect to age, gender and parental status. In order to avoid making a sizeable number of participants identifiable (and thus creating ethical problems as well as compromising willingness to give truthful responses), we did not assess further information, such as the name of the institution that each participant belonged to or detailed information regarding their level of training.

Procedure

Questionnaires and interventions were implemented online using the software package SoSci Survey (Leiner, 2013). Data were collected before the anti-stigma/control intervention (pretest), directly after the intervention (posttest) and after a time period of more than one week but less than two months (follow-up). The two data sets were linked by a code that participants created themselves. For the follow-up survey, psychotherapists in training received login information one week after the

pre/post-test invitations had been sent out, (again, via their postgraduate institutes). Participants received no payment. Sixty-eight psychotherapists in training were assigned to the anti-stigma intervention group and 69 to the control group. Among the psychotherapists in training who completed pre- and post-test assessments, 35.8% (29.4% in the anti-stigma condition and 42.0% in the control condition) dropped out before the follow-up test or did not comply with the required intermission period of at least one week between the first two assessments and the follow-up test. The time interval between post assessment varied considerably, ranging from one week to 64 days ($M = 18.33$, $SD = 12.78$).

Anti-Stigma and Control Intervention

The education component of the anti-stigma intervention consisted of short texts challenging typical myths about pedophilia by describing it as a condition that one can neither choose nor change (controllability stereotype), and that, for many PWP, does not lead to child sexual abuse or child pornography offenses (dangerousness stereotype). Further texts provided general information about diagnostic criteria and therapeutic interventions. Video-based contact was implemented using excerpts from the Austrian documentary “Outing” (Moser, Neumann, Meise, & Reider, 2012) where a young male student with an unpixelated face talks about his sexual interest in children, and his therapeutic experiences (minutes: 02:14–03:38; 08:25–09:23; 15:45–16:47). Video footage included, for instance, the following statement, “In the years before [my stationary psychotherapy] I thought about killing myself regularly. Mainly because of my pedophile fantasies.” Another short section that we used showed the man talking to his psychotherapist about his desire to be accepted by others and his intention to never commit sexual offenses with children (minutes: 42:39–45:04).

Ideally, a control condition should share as many characteristics with the intervention group as possible. We designed a control condition that was similar to the anti-stigma condition in duration, content and structure by providing information related to child welfare and therapy. The contact component consisted of a short clip produced and broadcasted by a major German TV channel (Zweites Deutsches Fernsehen, 2012). More specifically, participants in the control condition received information about violence-free education and a course specifically designed for parents (“Starke Eltern, starke Kinder” [“Strong parents, strong children”]) to teach family conflict-management skills and promote violence-free parenting. The footage included short interviews with the treatment staff, the parents and the children that were involved in this program (e.g., one mother says “I was so angry that the only thing I could do was to lock myself in my bedroom and hope for someone else to come and calm down me and the child”).

Both experimental conditions were similar in length (anti-stigma intervention: 937 words and 6 min of video footage; control condition: 874 words and 5:08 min of video footage), and would take approximately 9:45 min (anti-stigma intervention) or 8:38 min (control condition) to complete for a reader with an average reading speed (i.e., about 250 words per minute, Jackson & McClelland, 1975).

Instruments

The stigma inventory: The stigma inventory measures stereotypes (controllability and dangerousness), affective responses (sympathy and anger) and discriminatory intention (social distance) as different aspects of stigma against PWP (see Table 3 for items). The scales assessing anger, perceived controllability, and social distance were taken from a recent study by Jahnke et al. (2014), where the latter two have shown high reliability (Cronbach's $\alpha \geq .82$; the variable anger consisted of only one item). The newly developed 4-item dangerousness scale showed acceptable reliability in this survey at pretest ($\alpha = .70$) and in an earlier testing on psychotherapy students (results available from the authors), while scores at posttest and follow-up were lower and require cautious interpretation ($\alpha = .66$, and $.61$ at pretest, posttest, and follow-up, respectively). Low scores on the dangerousness scale do not imply that the respondents believes PWP to be harmless, but indicate awareness of the fact that a sexual interest in children does not necessarily lead to corresponding sexual and criminal behavior. Every item could be rated on a 7-point Likert scale (0–6) ranging from *do not agree at all* to *completely agree*. Throughout the questionnaire, PWP are described as *people with a dominant sexual interest in children*.

Therapy motivation scale: We developed a therapy motivation scale to assess therapists' willingness to treat PWP who have never (item 1) or have already (item 2) committed a sexual crime or to participate in training to gain more knowledge about the treatment of PWP (item 3), respectively. Internal consistency of the scale was calculated for pretest, posttest and follow-up data and proved to be consistently high ($\alpha = .85$, $.83$, $.84$). Participants were asked to indicate their agreement with these statements on a 7-point Likert scale (0–6) with response categories ordered from *do not agree at all* to *completely agree*.

Assessing participants' satisfaction with the anti-stigma program: As part of the formative evaluation process, we explored participants' satisfaction with the anti-stigma program using a number of simple items concerning the adequateness of the information content, the interestingness of the texts and the video, the personal gain in knowledge and the relevance for one's own professional work (e.g., “How would you rate the information content of the texts?” with a 3-point response scale – too low, optimal, too high). There were no corresponding questions in the control group.

Statistical Analysis

To account for selective dropout across intervention groups and time, we fitted multilevel mixed models (Skron dal & Rabe-Hesketh, 2004). These models have recently gained popularity because they make much weaker assumptions than

Table 1Descriptive analysis of observed and model-based outcome variables with *t*-test for group differences at pretest level.

Variables	Control group (<i>n</i> = 69)				Treatment group (<i>n</i> = 68)				Between-group differences (pre-test)	
	Pretest	Posttest	Follow-up ^a	Follow-up (predicted)	Pretest	Posttest	Follow-up ^a	Follow-up (predicted)	<i>t</i> -test	
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i>	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i>	<i>t</i> (<i>df</i>)	<i>p</i>
Controllability	1.01 (1.14)	1.02 (1.16)	.98 (1.08)	1.06	0.95 (0.99)	0.45 (0.60)	0.53 (0.53)	0.62	0.35 (135)	.727
Dangerousness	2.32 (0.96)	2.37 (0.89)	2.11 (0.92)	2.17	2.10 (0.99)	1.72 (0.97)	1.78 (0.92)	1.84	1.27 (135)	.205
Sympathy	2.81 (1.51)	3.00 (1.57)	3.25 (1.53)	3.16	3.01 (1.46)	3.84 (1.46)	3.71 (1.41)	3.50	−0.80 (135)	.425
Anger	3.07 (1.97)	3.04 (1.94)	2.53 (1.85)	2.51	2.75 (1.61)	1.88 (1.61)	1.69 (1.40)	1.96	1.05 (130.536)	.295
Social distance	2.02 (1.36)	1.95 (1.35)	1.95 (1.24)	2.06	2.06 (1.08)	1.62 (1.00)	1.68 (1.08)	1.80	−0.19 (129.442)	.851
Motivation to treat	4.15 (1.53)	4.08 (1.59)	3.88 (1.59)	3.87	4.03 (1.65)	4.15 (1.54)	4.05 (1.53)	3.93	0.43 (135)	.672

Note: All scales range from 0 (“do not agree at all”) to 6 (“completely agree”).

^a Because of drop-outs, only *n* = 40 (control group) and *n* = 48 (intervention group) completed the follow-up assessment.

traditional procedures for dealing with missing values, particularly selective dropout (e.g., complete case analysis in repeated measurement ANOVA and LOCF, see [Schafer & Graham, 2002](#)). Using the expectation-maximization (EM) algorithm ([Little & Rubin, 2002](#)) they allow, if saturated for the joint effect of group and time, for the occurrence of group-specific dropout across time and consider the full data; i.e., information from all assessments of a patient irrespective of potential missings at other assessments. We used the XTMIXED procedure of Stata, version 12.1 ([Stata Corp, 2012](#)), fitted models with two dummy variables for the main effect of time, one for the main effect of group and two for the joint effect of time and group. Standard errors of regression coefficients were estimated with the robust Huber–White sandwich method, and random intercept models were fit to consider individual heterogeneity in outcomes.

Based on the saturated model we computed marginal predictions for both within subject effects and between subject effects (anti-stigma intervention vs. control intervention). Statistical significance was defined at the two-sided 5% level. We did not lower the alpha threshold for each outcome, as we tested separate hypotheses (see also [Bender & Lange, 2001](#); [Perneger, 1998](#)).

Results

As expected due to randomization, there were no significant between-group differences at baseline for age ($t(125.897) = 1.721, p = .088$), gender ($\chi^2(1) = .39, p = .501$), having children below the age of 14 ($\chi^2(1) = .623, p = .658$), and the time interval between post assessment and follow-up assessment ($t(86) = -0.078, p = .938$). Descriptive analyses of outcome variables at pretest, posttest and follow-up level can be found in [Table 1](#). A comparison of outcome variables showed no significant differences between control group and intervention group at pretest level (all *t*'s < 1.052, all *p*'s > .295, see [Table 1](#)). Further analyses showed that there are also no significant differences between the control group and the treatment group at pretest level and with respect to age, gender, parental status and time interval when non-completers are excluded from the analysis.

Participants' acceptance of the anti-stigma program was excellent, with the majority of participants agreeing that the written information (72.1%) and the video (86.8%) were highly interesting. Further, many agreed that the program has helped them to improve their knowledge (29.4% low or very low improvement, 33.8% moderate improvement, 36.8% high or very high improvement). It was common for participants to rate the provided information as relevant for their professional work (14.7% low or very low relevance, 23.5% moderate relevance, 61.7% high or very high relevance). The quantity of information that we delivered within this 10-min intervention was perceived as optimal by 85.3%, whilst 13.2% would have preferred to have received more information. Only one person reported that he or she would have preferred less information.

Pretest levels of agreement to each item from the stigma inventory are displayed in [Table 3](#). Compared to the responses from the general public reported in [Jahnke et al. \(2014\)](#), this sample of psychotherapists in training held considerably less stigmatizing views towards PWP (with, e.g., less than 3% agreeing that sexual interests in children is something that one can choose, and only 40% reporting to feel anger when they think of a person with pedophilia). With more than 40% of this sample indicating willingness to accept PWP in their neighborhood, and only a very small minority demanding drastic interventions (such as imprisonment) for PWP that have never committed a criminal offense, social distance also appeared to be much lower compared to the aforementioned results from the general public. Furthermore, a large part of our sample (80%) reported to be willing to treat PWP who have never offended before, and about half as much would also be willing to treat PWP who have committed a sexual crime in the past. Lastly, with 79% agreeing with the respective item, the motivation to attend vocational courses in order to learn more about the treatment of PWP was equally high.

We conducted analyses for changes within the control group and the intervention group individually, and regarding the interaction of both groups based on mixed effect models (see [Table 2](#)). As the outcome variables anger, social distance and motivation to work with PWP deviated substantially from the normal distribution, we conducted the same analysis for both the original dataset, and a second version of the dataset in which we had employed logarithmic square transformations in order to achieve normality. As both analyses yielded similar results for social distance, we only report results for the original dataset, as they are easier to interpret. For the two other variables, we report results based on log-transformed data.

Table 2

Model-based (mixed effect models) coefficients, significance values, confidence intervals and effect sizes for the change in main outcomes for control group ($n = 69$) and the intervention group ($n = 68$).

Outcome	Assessment ^a	Within control group				Within treatment group				Treatment \times control group			
		Coeff.	<i>p</i>	95% CI	<i>d</i>	Coeff.	<i>p</i>	95% CI	<i>d</i>	Coeff.	<i>p</i>	95% CI	<i>d</i>
Controllability	Posttest	.01	.80	[−.10, .13]	.01	−.50	<.01	[−.66, −.34]	−.47	−.51	<.01	[−.70, −.31]	−.48
	Follow-up	.05	.60	[−.14, .24]	.05	−.33	<.01	[−.52, −.14]	−.31	−.38	<.01	[−.65, −.11]	−.36
Dangerousness	Posttest	.05	.41	[−.07, .17]	.05	−.38	<.01	[−.52, −.24]	.39	−.43	<.01	[−.62, −.24]	−.44
	Follow-up	−.14	.25	[−.38, .10]	−.15	−.26	<.01	[−.46, −.07]	−.27	−.12	.44	[−.43, .19]	−.13
Sympathy	Posttest	.19	<.05	[.01, .37]	.13	.82	<.01	[.61, 1.04]	.56	.64	<.01	[.36, .91]	.43
	Follow-up	.35	.07	[−.03, .72]	.23	.48	<.01	[.18, .79]	.33	.14	.57	[−.34, .62]	.09
Anger ^b	Posttest	.07	.53	[−.14, .27]	.05	−.64	<.01	[−.89, −.38]	−.52	−.70	<.01	[−1.03, −.38]	−.57
	Follow-up	−.11	.41	[−.37, .15]	−.09	−.57	<.01	[−.81, −.33]	−.46	−.46	<.05	[−.82, −.11]	−.38
Social distance	Posttest	−.07	.12	[−.16, .02]	−.06	−.45	<.01	[−.55, −.35]	−.37	−.38	<.01	[−.51, −.24]	−.31
	Follow-up	.04	.73	[−.18, .26]	.03	−.27	<.01	[−.44, −.09]	−.22	−.30	<.05	[−.58, −.02]	−.25
Motivation to work with PWP ^b	Posttest	−.01	.80	[−.09, .07]	−.01	−.04	.43	[−.15, .06]	−.05	−.03	.64	[−.16, .10]	−.04
	Follow-up	.10	.20	[−.05, .25]	.13	.05	.55	[−.12, .23]	.07	−.05	.69	[−.27, .18]	−.06

Note: Coeff., coefficient for change from base level for factor levels; CI, confidence interval; PWP, people with pedophilia.

^a Outcome variables at posttest or follow-up were compared to pretest levels as reference.

^b Results based on log-transformed data.

Table 3

Agreement (in percent) with items at pretest level ($N = 137$).

Item	Agree	Uncertain
Controllability		
A dominant sexual interest in children is something that one can choose.	2.19	6.57
People with a dominant sexual interest in children have taken a deliberate decision to have these interests.	2.19	5.11
People have the choice whether they have a dominant sexual interest in children or not.	5.84	9.49
Dangerousness		
Many people with a dominant sexual interest in children never have sexual contact with a child.	49.64	32.12
Somebody with a dominant sexual interest in children is a perverted sexual predator.	9.49	16.79
A dominant sexual interest in children will sooner or later lead to child sexual abuse.	18.25	22.63
People with a dominant sexual interest in children can control their sexual behavior towards children.	49.64	26.28
Affective reactions		
When I think of a person with a dominant sexual interest in children I feel sympathy.	37.23	21.9
When I think of a person with a dominant sexual interest in children I feel anger.	40.15	17.52
Social distance^a		
Would have these persons as friends.	21.90	21.9
Would accept these persons in my neighborhood.	40.88	18.25
Would accept these persons as colleagues at work.	48.18	14.6
Would talk to them.	80.29	10.95
These persons should be incarcerated.	2.92	13.14
These persons should better be dead.	0.73	3.65
Motivation to work with PWP		
I am willing to offer psychotherapy to people with a dominant sexual interest in children, who have never committed a sexual crime.	79.56	9.49
I am willing to offer psychotherapy to people with a dominant sexual interest in children, who have committed a sexual crime.	37.96	16.79
I would like to attend vocational courses to treat people with a sexual interest in children.	78.83	7.3

^a Instruction: "How do you feel about interacting with people who are dominantly sexually interested in children, but have never committed a crime?".

Looking at within-group differences from pretest to posttest, there was a significant effect indicating a reduction of agreement with stereotypes, of negative affective responses and social distance in the anti-stigma group. There was no change regarding the motivation to work with PWP. The differences between baseline measures and follow-up measures for the anti-stigma group were less pronounced, but effects remained significant for all outcome variables except motivation to work with PWP. In the control group, sympathy scores rose significantly from pretest to posttest (and failed short of reaching significance in the follow-up assessment with $p = .07$), while all other outcome variables did not change in a significant way.

Between-group comparisons indicated statistically significant differences between anti-stigma and control group in the outcome variables perceived controllability (from pretest to posttest and follow-up), perceived dangerousness (only from pretest to posttest), sympathy (only from pretest to posttest), anger and social distance (both from pretest to posttest and follow-up). Across all significant outcomes, participants who had received the anti-stigma intervention were less likely to agree with stereotypes, reported a more favorable affective response and less social distance than participants from the

control group. According to Cohen's guidelines, significant effects were small to medium-sized. Further statistical analyses also revealed that having a child under the age of 14 did not impact the effectiveness of the intervention for all tested outcome variables.

Discussion

The present study was designed to test the effect of an anti-stigma intervention on attitudes towards PWP and the motivation to offer mental health services among psychotherapists in training. Results revealed a stigma-reducing effect of the intervention on all outcomes (but not on motivation to work with PWP) compared to the control group. Most effects remained significant until the follow-up, although slightly diminished. Furthermore, the participating psychotherapists in training were overall satisfied with the program and considered it to be interesting, informative and of high relevance for their professional work. Taking into account the brevity, simple applicability, and low costs of the intervention, this is a very promising result.

The anti-stigma program was partially successful in correcting stereotyped assumptions about PWP. Regarding participants' baseline-level beliefs concerning controllability of pedophilia, we found that the majority of our sample did not agree that pedophilia is something that one can choose. Nevertheless, people in the anti-stigma group were even less likely to believe in the controllability of sexual interests in children after receiving the intervention compared to the control group. While the effect remained significant until the follow-up assessment, the practical relevance of this result is unclear, as, at least in this sample of psychotherapists in training, only a very low number of participants held beliefs regarding controllability that needed correction from a stigma reduction perspective. The program may, however, have succeeded in making some participants more certain of their previous (correct) beliefs.

Participants' ratings regarding the actual threat that PWP pose to children were mixed. While most participants understood pedophilia and sexual abuse as distinct phenomena that are not necessarily related (which is in line with scientific evidence, [Dombert et al., 2014](#); [Seto, 2008](#)), a considerable number was uncertain or did not agree. Although the anti-stigma program helped to correct the stereotyped mix-up of legal and psychopathological terms, the effects were short-termed. The fact that not all effects remained stable until the follow-up assessment is, however, not an uncommon finding in the literature on stigma reduction ([Holzinger, Dietrich, Heitmann, & Angermeyer, 2008](#), but note that the failure to detect an effect at follow-up may have been due to low reliability of the scale). To sustain the effects, long-term (or repeated) multi-faceted interventions are needed, particularly since attitudes that have developed over a long time tend to be stable, so new information is often remembered in a way that is consistent with previous beliefs ([Corrigan & Penn, 1999](#); [Dalky, 2012](#); [Rusch et al., 2005](#)). We suggest including the evaluated online intervention as one component of a broader educational schedule about pedophilia (e.g., in psychotherapy training). Additionally, collaborating with experienced mental health professionals who are involved in therapy of PWP could offer a more interactive experience as well as the opportunity to address individual concerns.

The study furthermore showed that the affective responses sympathy and anger and the discrimination intention social distance towards PWP could be changed with an anti-stigma intervention. This is of high importance, as negative affective reactions and discrimination intentions are likely to complicate the development of a reliable and empathic therapeutic relationship. Maintaining an appreciative and respectful mindset towards PWP despite their risk of committing sexual offenses against children is a competence that is certainly necessary (although not necessarily sufficient) for high quality treatment.

This view is in line with our finding that the anti-stigma program, unexpectedly, failed to influence willingness to offer therapy and to specialize in treatment of PWP. While this effect could have been due to an inability of our instruments to detect such changes (see below for an in-depth discussion of floor and ceiling effects), it is also possible that stigma has only a subordinate effect on a therapist's decision to offer or decline treatment compared to other variables. More research addressing the reasons for rejecting to offer therapy for PWP, such as a lack of knowledge about this group ([Alanko et al., 2014](#); [Stiels-Glenn, 2010](#)), is needed to help reduce treatment barriers. In this regard, we would propose an intervention addressing stigma and providing evidence-based training for the treatment of PWP. Future research should also consider that a lack of motivation to offer treatment to PWP might be triggered by psychotherapists' fears to be stigmatized themselves.

It could be a sensible approach for future stigma research to ask whether participants would be willing to offer therapy, given that they had the necessary knowledge and the option to be supervised by an expert in this field. Participants' ratings concerning their motivation to work with PWP may also underestimate the typical rejection rate of PWP seeking treatment, as trainees may not, or only in rare cases, be given permission by their employers or psychotherapy institutes to decline treatment, which may promote a less selective attitude than the one that a typical self-employed psychotherapist working in the public health system might have. Also, psychotherapists in training may be more responsive to unusual cases (that they view as training opportunities) than experienced psychotherapists. These reasons (among others that will be discussed below, e.g., self-selection bias, social desirability) may explain why Stiels-Glenn's results paint a bleaker (and probably more realistic) picture of outpatient treatment availability for PWP in Germany (with only 4.7% of responding psychotherapists willing to offer treatment).

One of the major strengths of this research lies in the randomized controlled approach that makes it possible to assign attitude change to the anti-stigma program. In addition, the implementation of a follow-up assessment enabled an evaluation of the stability of these effects. Furthermore, the presented anti-stigma intervention is, to our knowledge, the first attempt to

apply evidence-based stigma reduction strategies to challenge stigmatization of PWP. To achieve optimal results, the program combined educational and contact strategies of stigma reduction that have been shown to be the most advantageous avenue to reduce stigma, with contact most likely being the more important component of the two (Corrigan et al., 2012; Rusch et al., 2005). Indirect contact established via a video, as in this study, has advantages in terms of broad dissemination at a cost-effective level, but is inferior to direct contact with regard to effect sizes (Corrigan et al., 2012). In this context, however, direct contact would have been likely to create problems from a practical and ethical standpoint, as a person with pedophilia might be highly suspicious of disclosing to a group of strangers, even psychotherapists (and justifiably so, given recent results on the pervasiveness of extreme stigma against PWP provided by Jahnke et al., 2014). Therefore, we consider indirect contact via videotape, like in the present study, to be the best (and most feasible) strategy to challenge stigma against PWP.

Yet, this study has some limitations that need to be addressed. As of now, the intervention program was tested only in a sample of psychotherapists in training, which limits generalizability of the results of this study. The sample we assessed is not representative for psychotherapists in training and cannot be used to derive general conclusions for this population (or other mental health specialists). Furthermore, the data indicated that our sample differed systematically from the majority of their fellow students and colleagues. Despite their (relatively) young age and short professional career, almost 20% of our study participants reported prior experiences with PWP. Also, most psychotherapists in training were not averse to work with PWP and showed neutral or moderately positive attitudes towards this group at pretest level. Hence, our data strongly suggest a sampling bias (Bayar, Poyraz, Aksoy-Poyraz, & Arikian, 2009), with psychotherapists being more likely to take part in the experiment if they already had a high personal or professional interest in the topic or already had relatively positive attitudes towards PWP. Psychotherapists in training who are strongly biased against PWP, or against even the subject matter in the control condition, however, might be motivated to not answer the survey due to disinterest or frustration with the topics presented. This sampling bias may not only threaten generalizability but also internal validity through floor or ceiling effects (as a decrease or increase in a dependent variable cannot be detected if participants already pile up at the low or high end of the scale). Therefore, we consider it likely that administering the anti-stigma program to an unselected sample of psychotherapists (e.g., during a psychotherapy course or an information session for the treatment staff of a hospital) would lead to an even greater decrease of stigma. Put into a special position by strict patient confidentiality laws in Germany, a psychotherapist might be among the few people, to whom a person with pedophilia could disclose his (or her) sexual interests, even when the person has committed undetected sexual offenses in the past. While anti-stigma interventions educating the general public about PWP could have merit, targeting a specific professional group whose attitudes, affective and behavioral reactions substantially determine to what extent PWP engage in professional help can be considered of key importance “in terms of the broad stigma change picture” (p. 967, Corrigan et al., 2012). Yet, police officers, judges, or other professionals working in the criminal justice system, mental health professionals like physicians or nurses, or relatives of a patient with pedophilia could also be considered meaningful target groups for stigma change. More research is needed to find out if this program is similarly effective for these groups.

Furthermore, like many controlled stigma reduction experiments, this study does not provide a measure for an actual behavioral change (Corrigan et al., 2012; Dalky, 2012). It is for instance not clear whether participants who completed the intervention would show more empathy to a real client with pedophilia or establish a stronger therapeutic alliance with this person in a real therapeutic setting. Further studies would be needed to determine whether the anti-stigma intervention has any measurable real-life consequences (such as more treatment adherence or client and/or therapist satisfaction).

Other methodological limitations concern the lack of standardization and experimental control in this online experiment (e.g., no control over monitor size, sound quality, the participants' physical and psychological condition or activities he or she might be engaged in during the assessment such as eating or listening to music) and the coordination of follow-up assessments. Yet, since participants were randomly selected to anti-stigma and control group and there was no difference regarding the time interval from posttest to follow-up test between groups, these two standardization problems seem to be relatively innocuous for internal validity.

Another unexpected result of our study was the observation that sympathy significantly increased in the control group from pretest to posttest, while their endorsement of stereotypes, other reported affective responses and social distance remained unchanged. As the control condition was designed to not influence stigma towards PWP this effect deserves an explanation, given that this was not a chance finding or methodological artifact. It is possible that drastic opinions, such as the idea that somebody would want another person to be dead because of his or her sexual preference may have prompted participants to feel more empathic towards PWP, while other not prejudicial ideas remained unchallenged.

Decreasing participants' tendency to give social desirable responses is of particular importance in every study that is based on self-ratings. Young psychotherapists are likely to recognize being generally empathetic, open-minded and non-judgmental towards people with mental disorders as an ideal they ought to fulfill to be respected and successful as mental health practitioners. While we cannot rule out that the mostly favorable reactions towards PWP among this sample of psychotherapists in training are due to social desirability bias, we approached this issue by assessing attitudes in a web-based format that is usually associated with a higher perceived anonymity compared to traditional pen-and-paper questionnaires (Kays, Gathercoal, & Buhrow, 2011; Ward, Clark, Zabriskie, & Morris, 2012).

In many countries (e.g., the US, the UK, and Canada) it is much more likely that treatment will be offered post offense, in part because of mandatory reporting. German law, on the other hand, does not require psychotherapists to report past offenses. In fact, doing so would be against the law for a therapist, and the act would be treated as a serious breach of secrecy. Therefore, at the moment our study is arguably more relevant for German practitioners. Yet, there exists a subgroup of PWP

who do not sexually abuse children and some of whom are clearly worried about offenses that they have not yet committed, but are at risk of committing (Cantor, 2014; Schaefer et al., 2010). This group might be eligible for treatment before an offense occurs even in countries with mandatory reporting laws.

Most psychotherapists, however, are trained too little to offer high quality therapy to patients with pedophilia, and the intervention presented here cannot (and is not meant to) substitute this lack of knowledge. Nevertheless, we believe that psychotherapists who are sensitized to the public health dilemma of PWP are likely to react with more empathy and understanding when a client with pedophilia asks for help (and more willing to assist the client in the search of a more qualified psychotherapist if needed). At present, specialized community-based treatment programs for PWP are, however, limited in number and can only offer group sessions (Beier, Ahlers, et al., 2009; Beier, Neutze, et al., 2009). More treatment options and more/better qualified psychotherapists are clearly required to help PWP deal with their sexual interest in ways that are not illegal and/or harmful to children.

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