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Challenges and Solutions to Implementing a Community-Based Wellness Program for Non-Offending Minor Attracted Persons

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ABSTRACT

Child sexual abuse is a significant public health concern that has long-lasting consequences for victims and their families and poses a significant financial cost to the public. Prevention efforts, including sex offender treatment programs, are intended to prevent further instances of sexual abuse. Most sexual offenses, however, are committed by individuals who are not yet known as sexual offenders, and therefore traditional sex offender treatment programs fall short of this goal. It is crucial to provide services to people who may be at risk for committing a sexual offense and those who have not offended, including those individuals who are attracted to children. While primary prevention programs such as Prevention Project Dunkelfeld and Talking for Change have begun to address this issue internationally, there are significant barriers to providing preventive services of this nature to non-offending minor attracted persons (NOMAPs) in the United States. Barriers include concerns about mandated reporting laws, stigmatization, and lack of knowledge by therapists about MAPs. This paper explores these barriers and provides solutions for practitioners to offer services to this population. This paper includes the development of specific programming for non-offenders and specialized training for clinicians who work with non-offenders as used by The Global Prevention Project.

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Introduction

Child sexual abuse (CSA) in all its forms is a public health crisis that impacts not only its child victims but also the society around it with its medical, psychological, and criminal justice costs (Fang et al., 2012; Letourneau et al., 2018). CSA can take two major forms, contact CSA (which necessitates the physical presence of a child victim) and non-contact CSA (which includes the consumption of Child Sexual Abuse Imagery [CSAI], online forms of exploitation and grooming behaviors, and/or use of chat/text apps and services; Seto, 2013). Non-contact CSA, especially the consumption of CSAI, has been increasing in frequency (FBI, 2020, May 28,) and should be included in the

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focus of prevention programs that address minor attraction (Seto, 2018). While methods exist in the form of sex offender treatment programs to intervene after the first offense has been committed, very few programs exist that address potential offending or that offer services to self-ascribed non-offending individuals, particularly in the United States.

Minor attracted persons (MAPs) are a critically underserved population that comprises individuals who experience pedophilia, hebephilia, and pedohebephilia (Cantor & McPhail, 2016; Stephens, Leroux et al., 2017; Stephens, Seto et al., 2017; Tenbergen et al., 2015). While minor attraction is a known risk factor for both first-time and recidivistic offending behavior (Gannon et al., 2019; Hanson & Morton-Bourgon, 2005; Seto, 2017a, 2018), this population rarely has access to services designed to reduce these and other risk factors and to increase protective factors such as psychological and sexual wellness (Grady et al., 2019; Knack et al., 2019; Levenson & Grady, 2019; Levenson et al., 2020, 2017; Liesley & Harper, 2022). This paper fills a critical gap in the practice literature regarding the provision of treatment and supportive services to non-offending minor-attracted persons, often referred to as NOMAPs, in the United States in a group format. While other forms of support services exist (B4U-Act, 2011; Grant et al., 2019; Shields et al., 2020), in the United States there is a noticeable lack of programs using a live (possibly in-person) group format to provide services. Our paper advances knowledge by discussing the challenges experienced in the development, launch, and implementation of a community-based group primary prevention program in the United States that addresses mental health issues associated with minor attraction to reduce the likelihood of first-time offending and provides solutions for how to address these issues in practice.

The nature and etiology of minor attraction

Minor attraction and pedophilia are related terms and are often found overlapping in the scientific literature. We use the term “minor attraction” throughout this paper to reflect the construct of pedohebephilia, or a form of sexual age orientation defined by a sexual preference for pre- and/or-pubescent children as defined by Cantor and McPhail (2016); see, Seto, 2008, Seto (2017b); Stephens, Seto et al., 2017 for more detailed information).

Minor attraction and child sexual abuse are distinct but related concepts. Contrary to what many believe, not everyone who commits an act of sexual abuse is necessarily minor attracted and not everyone who is minor attracted necessarily commits an act of sexual abuse (Seto, 2018; Tenbergen et al., 2015). While many perpetrators of sexual abuse do experience an attraction to children, some are motivated by a need to exert power and control over vulnerable people,

others by a pattern of sadistic arousal (Sullivan & Sheehan, 2016), or characterized by a lack of social skills and inability to initiate appropriate relationships with same-aged peers (Tenbergen et al., 2015).

While minor attraction is gaining popularity as a less-stigmatized term to pedophilia, here we must refer to pedophilia and its associated Pedophilic Disorder. There is an important distinction to make between pedophilia and Pedophilic Disorder in that “pedophilia” describes a sexual preference to children and “Pedophilic Disorder” is a mental health diagnosis (minor attraction is neither assessable nor diagnostic). According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; APA, 2013), in order for a person to be diagnosed with Pedophilic Disorder, that person must have, “over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges or behaviors involving sexual activity with a prepubescent child or children.” Someone who has been diagnosed with this disorder must have either acted on his or her urges or must be experiencing distress related to their fantasies, urges or behaviors in order to meet the criteria for Pedophilic Disorder. The DSM-5 definition of Pedophilic Disorder only includes an attraction to children who are 13 years old or younger. The term “hebephilia” is often the term used to describe individuals who are sexually attracted to children who are pubescent. Empirical support has been found for hebephilia as a phenomenon distinct from pedophilia, and some scholars even recommended adding hebephilic disorder to the DSM-5, but for now this has been left out (Cantor & McPhail, 2016; Stephens, Seto et al., 2017). Despite being left out of the DSM-5, hebephilia was included in the ICD-10 and ICD-11 under their definitions of pedophilia (Beier et al., 2015; W.H.O, 1992).

Barriers to support for NOMAPs

The discussion surrounding barriers has often focused on those experienced by MAPs as they search for, visit, and are possibly rejected from supportive services. However, while access to treatment is certainly an identified barrier and one that needs much more academic and clinical attention (Grady et al., 2019; Levenson & Grady, 2019; Levenson et al., 2020, 2017; Lievesley & Harper, 2022; McPhail et al., 2018), an often-overlooked related barrier is process to offering support for MAPs, especially in countries such as the United States. This section will briefly review the known barriers to treatment and support experienced by NOMAPs (non-offending minor attracted persons), as well as those experienced by service providers to facilitate the discussion of identified challenges for practitioners in this paper.

The most identified barrier as mentioned above is access to treatment and support services for NOMAPs (Grady et al., 2019; Levenson & Grady, 2019; Levenson et al., 2020, 2017). This entails not only a lack of available support

options – which is a major theme of this paper – but also includes barriers such as getting to support, lack of anonymity in support, lack of access to necessary internet connections, and lack of funds to pay for service.

Lack of training and education on the part of mental health and helping professionals is also something that has contributed to a lack of resources for MAPs. Many service providers are reluctant to work with this population because they come in with judgments and assumptions that they make about what it means to be a MAP. Assumptions are also made about the dangerousness of individuals who identify as being MAPs and assumptions that something will therefore need to be reported to authorities (Grady et al., 2019; Levenson & Grady, 2019; Levenson et al., 2020).

In addition to these common barriers, there is also a fear of vigilantism among MAPs if people were to find out about their attraction. Some of the members of the group that is the subject of this paper have even experienced this vigilantism themselves when they have been outed, even though no crime had been committed. While this is not a topic that has been studied in either NOMAPs or MAPs, extant literature on sexual offenders has identified that the stigma associated with having committed a sexual offense has led to people being harassed, losing friends and losing jobs, while some people have also had their property damaged and have been physically assaulted (Levenson et al., 2007; Tewksbury & Lees, 2007).

Review of current prevention programs

Sexual abuse prevention programs are typically categorized into primary, secondary, and tertiary prevention programs. There is some discrepancy as to how these types of programming are operationalized. For example, some older literature (Becker & Reilly, 1999) categorizes programs that aim to prevent offenses from initially occurring as being secondary prevention, whereas the Association for the Treatment of Sexual Abusers (ATSA) considers this type of a program to be primary prevention, per their website (<https://www.atsa.com/sexual-violence-prevention-fact-sheet>). Furthermore, the literature related to proactive programs similar to the program discussed in this paper, such as Prevention Project Dunkelfeld (PPD), has referred to this form of prevention as being primary prevention (Beier, Ahlers et al., 2009). For the purposes of this paper, we will refer to this type of a program as being a primary prevention program.

Secondary and tertiary prevention

Secondary and tertiary prevention efforts, in contrast to primary prevention programs, have become commonplace in mental health and in child welfare. Secondary prevention includes services provided immediately after an offense

has taken place and includes short-term therapy provided to victims to minimize the amount of harm done (ATSA Prevention Fact Sheet). Tertiary prevention efforts, on the other hand, include long-term services provided after the commission of a sexual offense. Tertiary prevention includes services provided to victims and typically includes traditional sex offender treatment programs, which can provide services to people who identify as being minor attracted –; however, participants in such programs almost always must have committed a sexual offense and are therefore mandated to receive treatment. Group therapy is the most common service provided in sex offender treatment programs, to allow participants to both challenge and to support one another (A. Beech & Fordham, 1997; A. R. Beech & Hamilton-Giachritsis, 2005). Sex offender treatment programs are usually not accessible to people who have not committed a sexual offense and it is also not entirely clear how helpful sex offender treatment would be for people who have not actually committed a sexual offense.

Primary prevention

In this progressive era, we do have programs that help non-offending MAPs to find help or treatment so that MAPs can achieve psychological and sexual wellbeing and the chances of any child being sexually abused can be reduced. Some of the different programs available explicitly for MAPs are Stop It Now!, B4U-Act, The Global Prevention Project</#funding-source;temp>, Prevention Project Dunkelfeld, and a new program in Canada called Talking for Change. A renewed focus on primary prevention is important because the majority of people convicted of a sexual offense are first-time offenders (Sandler et al., 2008). If a person's problematic sexual interests can be addressed before a person commits a sexual offense, there is the potential to reduce the prevalence of child abuse and thus reduce costs that are linked to child abuse, including depression and other physical and mental illnesses (Anda et al., 2006). Primary prevention programs have only recently begun to emerge as a potentially viable resource for combating child sexual abuse, especially in European countries like Germany and most recently in Canada, but such programs have not yet gained the same traction in the United States.

Stop It Now!

Stop It Now! is one of the resources available to non-offending MAPs. It was founded by Fran Henry, a survivor of CSA, in 1992. The past 29 years of work of Stop It Now! has revolved around Henry's mission to recognize CSA as a preventable public health problem and help any adult take responsibility to put a stop to any kind of CSA. Stop It Now! has created several programs that are based on adults taking

responsibility for CSA. This has shown that adults will act to prevent abuse, if they have access to accurate information, practical tools, guidance and support, and communities that will mobilize around prevention initiatives, including efforts that address the complexities of abuse closer to home (Grant et al., 2019).

By adults the visionaries of Stop It Now! mean parents, survivors, family members, law enforcement, professionals of all types, and also MAPs who engage in child sexual abuse behaviors. They believe that holding one accountable is a bold move in the process of prevention and that as a society no solution is possible without acknowledging the problem. Some of the programs that Stop It Now! provides are:

- (1) Help Services – Stop It Now! provides confidential help nationally through the helpline 1.888.PREVENT, e-mail, and chat services. They also have an interactive online help center “Ask Now!” which provides advice to anyone seeking it;
- (2) Prevention Education – Stop It Now! organizes, develops, and distributes trainings, events, media campaigns, and online educational materials;
- (3) Technical Assistance and Training (Circles of Safety) – Stop It Now! also provides trainings to any professional, youth-serving organizations, coalitions, and community-based programs who have the same mission of preventing CSA and providing help to non-offending MAPs;
- (4) Prevention Advocacy – Stop It Now! advocates for CSA to be addressed as a public health priority through increased investment in a full range of prevention strategies and provides any information to advocacy groups, media, and policymakers.

B4U-ACT

B4U-Act is a resource that is run by both mental health professionals and MAPs who share these common goals:

- (1) Publicly promote any and all kinds of resources and services to any adult or adolescent who is attracted to minors;
- (2) Provide means to other mental health professionals about how to help a non-offending MAP;
- (3) Create a community of providers who agree to serve MAPs and also follow the B4U-Act’s Principles and Perspectives of Practice;
- (4) Provide education to the general public about the hardships faced by MAPs.

B4U-Act organizes workshops, presentations, conferences, and professional speakers for anyone who is interested in learning more. They also collaborate with researchers and communicate with organizations and media and run support groups for MAPs and their families (B4U-Act, 2011).

The Global Prevention Project

TGPP is a global prevention-education effort that deals with any thoughts, fantasies, any attraction toward minors or any kinds of problematic behavior in those contexts in adult men and women. TGPP employs licensed clinicians and was founded by a CSA survivor and a licensed clinician in 2013. The motto that TGPP follows is “prevention is the only true intervention” (Christiansen & Martinez-Dettamanti, 2018; Lievesley et al., 2018).

TGPP provides preventive interventions, psycho-educational resources, and mental health support to any non-offending MAP who is struggling with problems related to pedophilia/hebephilia and seeks supportive services. The goal of this project is to have no more victims and to prevent all forms of CSA, including CSAI/CSEM use. The different groups that TGPP offers to help NOMAPs and their families in the prevention of CSA are:

- (1) Escalated Addiction – This is a weekly web-based support group for individuals who are likely to act out illegally because of their pornographic or sexual behaviors;
- (2) MAP Wellness Group – This is a weekly web-based support group for men, women, trans and non-binary individuals with and without history of sexual offenses toward minors, but who all identify as anti-contact (or non-offending, in the case of no offense history).

In addition to providing help to MAPs, TGPP also provides help or support groups to partners of MAPs, Partner Support, and people with mental disorders (Christiansen & Martinez-Dettamanti, 2018).

This curriculum – the MAP Wellness Curriculum – was created by the staff of The Global Prevention Project in 2016 (Christiansen & Martinez-Dettamanti, 2018). The current authors played no role in its development; however, the first and last authors were trained in its use by the developers in Summer 2020. The original wellness groups have run online since 2016 by TGPP clinicians and the underlying assumption of the wellness curriculum is that “attraction is not action” and that prevention is always better than intervention. The program takes a holistic approach to working with MAPs, specifically offering mental health support to those who identify as non-offending (NOMAP) or non-offending/anti-contact (NO/AC-MAP), including sections on healthy sexuality, effects of stigma, process of disclosure,

mental wellness, and legal issues. For a deeper discussion of the TGPP curriculum, the reader is kindly referred to Tenbergen et al. (2021), which explains the curriculum development, assumptions, methods, and process.

Prevention Project Dunkelfeld (PPD)

PPD was founded in Germany in 2005 to provide supportive treatment to pedophilic and hebephilic individuals (MAPs) residing in the community. Dunkelfeld is a German term that translates to dark field. The PPD differs in one relevant way from prevention efforts in other countries: individuals with “dark-field” or offenses that have not been identified can still seek treatment without fear of uniform mandatory reporting. The project adheres to the slogan “You are not guilty of your sexual desire, but you are responsible for your sexual behavior. There is help! Don’t become an offender!” Out of the 1,134 people who responded to PPD by 2010, 499 had completed the intake diagnostic procedure, and 255 were offered therapy. The therapy offered is divided into three categories. Patients are encouraged to stop denying their sexual inclination and integrate it into their self-concept and involve family in the therapeutic process. Cognitive behavioral therapy helps in improving coping skills, stress management, and sexual attitudes (Beier, Ahlers et al., 2009; Beier et al., 2015; Beier, Neutze et al., 2009; Schaefer et al., 2010). PPD helped researchers understand a lot about people who are attracted to minors and how they can be provided with treatment and other supportive services.

Public perceptions of MAPs

According to Blagden et al. (2017), stigmatization of minor-attracted tendencies can result in a reduced likelihood that a MAP will seek treatment, thus increasing their chances of committing a related crime. The lack of therapy tailored to MAPs has been linked with self-hatred and cognitive dissonance (Grady et al., 2019; Houtepen et al., 2016). Such self-hatred can lead to suicide attempts. Recent research suggests that one-quarter to one third of MAPs have reported at least one suicide attempt (Levenson & Grady, 2019). MAPs – as a marginalized group – are at a higher risk of mental health issues, according to the minority stress theory (Meyer, 2003). There is a common negative perception of fear, anger, and revulsion about MAPs, despite the fact that they might have never offended (Grady et al., 2019; Levenson & Grady, 2019). According to Jahnke, Imhoff et al. (2015) MAPs are generally considered to be perverted, pathetic, immoral, sick, dangerous, disgusting, and even if they have never sexually abused a child they are “better off dead.” According to a study done by Richards (2018), people have a perception that MAPs cannot get better so they should be killed. With this level of stigmatization, it is nearly impossible for non-offending MAPs to seek help because of the belief they will

be treated with judgment and disrespect (Grady et al., 2019). Stiels-Glenn (2010) conducted a study in Germany and found that 95% of psychotherapists would not provide treatment to pedophiles. A similar study in Finland showed that 65% psychotherapist would not work with pedophiles because of their lack of knowledge on the subject and 38% would not because of personal attitudes concerning pedophilia (Jahnke, Philipp et al., 2015).

Identified barriers and solutions to implementation

This section will detail the barriers we identified in replicating The Global Prevention Project's MAP Wellness Group in New York State. These barriers are those the authors experienced directly in the process of group replication and evaluation in New York State and therefore do not represent a systematic or comprehensive list. Rather, these are selected for discussion out of experience as the most relevant and meaningful for clinician and researcher replication in the United States. Barriers to implementation and challenges experienced within the group setting are discussed, along with associated solutions. The purpose of this section is to provide readers with a set of guidelines and principles for establishing a primary prevention style program in their own communities. Readers are encouraged to seek additional information about the program and associated curriculum at <http://theglobalpreventionproject.org>.

As mentioned by previous authors, mandatory reporting, client confidentiality, clinician training, program structure, and funding sources are key issues to be resolved when offering non-forensic treatment and supportive services to non-offending MAPs (Grady et al., 2019; Levenson & Grady, 2019; Levenson et al., 2020, 2017; McPhail et al., 2018; Tenbergen et al., 2021). In addition, the role of COVID-19 and its impacts on access to treatment and support services and symptoms of distress and behavioral manifestations must be addressed.

Mandatory reporting is the first – and usually most important – topic raised when working with non-forensic MAP clients. While this paper cannot provide a direct one-size-fits-all rule for how to handle mandatory reporting throughout the United States, we will describe our experiences in New York State and provide guidance on how to best address it in other municipalities. Our groups use an informed consent process that explicitly details what mandatory reporting is and how we deal with disclosures in group. This transparency allows for group members to be aware from the outset of how the group facilitator will address utterances that may cross the mandatory reporting boundary. The informed consent process explains that – at least in New York State – any mention of a previous contact offense wherein a victim is identifiable and for which an accusation does not yet exist, will trigger the reporting process. If the group facilitator sees or hears that a group member is heading down this pathway, the facilitator will “check-in” with the member

and guide them back to appropriate group discussion. It also holds that in New York State, simply mentioning or stating the use of Child Sexually Exploitative Material/Child Sexual Abuse Images (CSEM/CSAI) is not *currently* considered a reportable behavior. We must also mention that since this group specializes in providing support to MAPs, admitting to minor attraction alone is also not an offense.

Client confidentiality is closely related to mandatory reporting and is vital when working with MAPs. This group is designed to be an outpatient support group, similar in style to Alcoholics Anonymous – wherein the group itself is self-sustaining but uses a manualized curriculum to address common psychological and emotional themes present among MAPs. This group is not designed to be offered as a standalone treatment, rather as a supportive adjunct to standard psychotherapy. While some MAPs may benefit from the group alone, the majority often seek additional individual treatment. Therefore, this group does not require the use of insurance to cover group participation – it is free. This allows members to join without using formal legal names (though they may if they desire to) and no payment is required for participation. We do not ask for legal names, and intake information is filled out to the completeness appropriate for the participant. We do not consider this to be an issue with reporting since the group is designed to work with non-offending individuals. To keep these data secure, we maintain all data on a separate encrypted drive to which only the group facilitator and program director have access. Encrypted e-mail clients (e.g., Proton mail) are used for communication with group members and pseudonyms allow for privacy.

Clinician-training was another concern faced when developing and launching this MAP support group. Those who choose to offer such a group will need to address the following concerns: educational and clinical training of the group facilitator (e.g., Master's degree vs PhD); degree of training completed (in training or already licensed and independent); experience of the provider in working with MAPs (experience vs naïve); prior experience of the provider in traditional sex offender treatment roles (knowledge may be useful, but biases may exist). We encourage readers to think about the qualifications they would like in their group facilitators and recruit as necessary. Our group facilitator (1st author) in New York State is a licensed clinical social worker who has experience in sex offender treatment provision.

One of the major questions was the expense of every session. Usually, people with insurance add therapy sessions to their insurance, but considering the stigmatization around MAPs, it would be hard for non-offending MAPs who want to participate to out themselves to their insurance companies and face the consequences. The barrier of the expense to access this program was a major concept that was considered and addressed by making the group free of cost. The next major question addressed was whether the program would be in person or online. The

barrier to access the support session for non-offending MAPs who did not live in a certain radius or even the country was another thing hindering non-offending MAPs to access the program. Another thing that hindered them from accessing the program in person was related to stigmatization around the same. If it were to be in person not everyone would have been comfortable enough to out themselves to the therapists or people around them. Being online provided participants to use pseudo e-mails and names to keep their identity anonymous and for the team to maintain anonymity. As the group was in development, we opted to offer the group fully online; in part to address the barriers identified above as well as the risks and effects of the COVID-19 global pandemic, as our group came online in the fall 2020 when COVID was at the forefront of everyone's minds. While our intent has primarily been to provide supportive services to MAPs residing in New York State, the online format allowed us to open up the group to individuals outside of New York. We also thought that doing so would allow us to reach more people who are seeking services.

Each group has 12–13 members to keep the group small and to provide support to every member in the best possible way. After a few sessions, it was assessed based on the clinical judgment of the facilitator that the members of the group were at low risk for committing a contact offense. There is currently little research about risk factors for committing a sexual offense among those who have not offended and no current risk assessment instruments for this population, demonstrating a need for research in this area. Therefore, risk was assessed among prospective group members by determining the extent to which the presence of factors that would otherwise be known as static and dynamic risk factors among sexual offenders. Such factors included previous sentencing dates, compliance/investment in treatment and cognitive distortions/offense supportive cognitions (Hart et al., 2003; Thornton, 2002; Wong et al., 2003). If these factors were either not present when applicable or minimally present, individuals were deemed to be appropriate for participation in the group.

A final thought regarding barriers to supportive services for MAPs: the role of funding sources. Running these types of programs requires significant external funding resources to support staff acquisition and training, paid time to offer training for clinic staff, tools for group management (e.g., HIPAA/privacy-compliant therapy tools, access to secure online data storage, computers for access to facilitate group if unavailable, secure e-mail clients such as Protonmail), clinic support staff salary, among many other concerns. These costs do not cover the costs associated with research and treatment evaluation activities. While the authors acknowledge that initial funding for this work came from The Global Prevention Project, additional sources of funding to cover additional groups and research activities have consistently

been sought out from both public and private funding avenues. With this paper, the authors hope to strongly advocate for the allocation of funds in the United States to support these types of endeavors, especially independent replication and evaluation projects.

Conclusion

This paper is designed to help clinicians understand the challenges to working with MAPs in a primary prevention setting (i.e., the non-offending population and prior to any first contact offense) in New York State and the United States more broadly. Previous research has documented the lack of access to services and barriers to actual treatment provision in this population (Grady et al., 2019; Lasher & Stinson, 2017; Levenson & Grady, 2019; Levenson et al., 2020, 2017), but so far the literature is lacking concrete examples of a primary prevention service specifically designed for the non-offending MAP population with specific guidance on how to resolve these barriers and challenges. This paper hopefully provides clinicians with the necessary solutions to pursue such work on their own to address the issue of CSA prevention more adequately – in all its forms.

While many services do exist that address prevention in other forms (e.g., recidivism reduction, parental trainings, child-friendly, developmentally appropriate skills-based trainings), the United States is noticeably lacking services that would allow non-offending or those with only non-contact forms of offending behaviors to seek help in order to maintain both psychological wellness and reduce any risk factors for the transition to possible contact offending. Science is still attempting to identify risk factors for the onset of offending behavior (these are presumed to differ from those relevant for recidivistic offending), in the interim clinicians can still work to intervene with the non-offending population to reduce symptoms of distress and psychological impairment that may be relevant for transitional offending behaviors.

Mandatory reporting is a major issue when working with the non-offending /non-contact MAP population. States do differ regarding the legal protection afforded to clinicians when dealing with clients who admit to using CSAI material. This is a point very much worth addressing with legal counsel prior to offering any treatment or supportive services with this population. This paper cannot provide legal advice but can provide only examples of what the authors experienced during group development and launch. Client confidentiality is also closely related, since it is impossible to make a report about something for which the reporter has no identifying details or information. Pseudonyms are allowed in the group and due its cost-free nature, there is no need to include insurance information or other personally identifying information on the part of the client. This is quite important, as the non-offending /non-contact/anti-contact MAP population understandably seeks to remain

anonymous, especially in light of the consequences should they have their minor attraction disclosed without their permission [see work by Imhoff and Jahnke (2018), Jahnke and Hoyer (2013), Jahnke, Imhoff et al. (2015), and Jahnke, Philipp et al. (2015), with regard to popular opinions of pedophiles]. In order to maintain the anonymity and confidentiality of our group clients, we do not require personally identifiable information, unless the client specifically requests a personal consultation or referral to an individual therapist.

Clinician-training is a major component for developing and offering this form of primary prevention service. With clinician-training, we mean two things, namely the actual course of therapeutic training the person has (e.g., mental health counseling, social work, school psychology, clinical psychology, psychiatry, etc.) and the actual educational exposure the person has had to the topic of CSA and its prevention. Very few, if any, graduate-level programs offer training in the scientific and clinical understanding of minor attraction and its relationship to CSA and those that do typically offer it in either a forensic or criminal justice-structured curriculum (Lievesley & Harper, 2022; Lievesley et al., 2018). This does not allow for clinician trainees to experience working with this population outside of a forensic facility and typically results in therapists who neither know anything about the population and its needs, nor express any desire in working with them. This poses a myriad of challenges, but the authors have anecdotally found that simple exposure to students about the work leads to interest and experience. How a group should be structured is provided in the associated curriculum, but the actual training of the group facilitator can be left up to the individual creating the group. The person should have at least some of their graduate-level training completed (if not completely done – with a supervisor available to discuss complex group experiences), be willing to work with the population, and understand their needs and be able to experience compassion and empathy for non-offending MAPs.

In conclusion, it is entirely possible to offer primary prevention style services to non-offending, non-contact/anti-contact MAPs in the United States. While this type of service is still in its infancy in the United States, experience from the current group suggests that with support and guidance from legal counsel, it can be done. Research has documented repeatedly the need for services that intervene prior to the first offense in the United States (Sandler et al., 2008) and that current models of prevention that exist as secondary or tertiary levels simply do not intervene early enough and are not addressing the most relevant and salient aspects of prevention – preventing the first victim from ever being victimized. With more programs like The Global Prevention Project's MAP Wellness Program being offered to the MAP population, structured around their needs and desires, society might be able to succeed in its promise to keep children safe.

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Dr. Tenbergen is an Assistant Professor of Psychology with SUNY Oswego, specializing in research into the etiology of pedophilia and its translation into the prevention of child sexual abuse. She came to Oswego via Hannover, Germany, where she spent several years working with the German Prevention Project Dunkelfeld and the German national NeMUP Research Consortium (Neurobiological Mechanisms Underlying Pedophilia and Child Sexual Abuse). Her research interests focus primarily on understanding the risk factors for the onset of sexual offending against children and the translation of this knowledge for use in prevention against child sexual abuse in New York State.

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References

- Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., Dube, S. R., & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, 256(3), 174–186. <https://doi.org/10.1007/s00406-005-0624-4>

- APA. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.
- B4U-Act. (2011). *Mental health care and professional literature*. B4U-Act.
- Becker, J. V., & Reilly, D. W. (1999). Preventing Sexual Abuse and Assault. *Sexual Abuse, 11*(4), 267–278. <https://doi.org/10.1177/107906329901100403>
- Beech, A., & Fordham, A. S. (1997). Therapeutic climate of sexual offender treatment programs. *Sexual Abuse, 9*(3), 219–237. <https://doi.org/10.1177/107906329700900306>
- Beech, A. R., & Hamilton-Giachritsis, C. E. (2005). Relationship between therapeutic climate and treatment outcome in group-based sexual offender treatment programs. *Sexual Abuse, 17*(2), 127–140. <https://doi.org/10.1177/107906320501700204>
- Beier, K. M., Ahlers, C. J., Goecker, D., Neutze, J., Mundt, I. A., Hupp, E., & Schaefer, G. A. (2009). Can pedophiles be reached for primary prevention of child sexual abuse? First results of the berlin prevention project dunkelfeld (PPD). *Journal of Forensic Psychiatry & Psychology, 20*(6), 851–867. <http://dx.doi.org/10.1080/14789940903174188>
- Beier, K. M., Grundmann, D., Kuhle, L. F., Scherner, G., Konrad, A., & Amelung, T. The German dunkelfeld project: A pilot study to prevent child sexual abuse and the use of child abusive images. (2015). *The Journal of Sexual Medicine, 12*(2), 529–542. n/a-n/a. <https://doi.org/10.1111/jsm.12785>
- Beier, K. M., Neutze, J., Mundt, I. A., Ahlers, C. J., Goecker, D., Konrad, A., & Schaefer, G. A. (2009). Encouraging self-identified pedophiles and hebephiles to seek professional help: First results of the prevention project dunkelfeld (PPD). *Child Abuse & Neglect, 33*(8), 545–549. <https://doi.org/10.1016/j.chiabu.2009.04.002>
- Blagden, N., Perrin, C., Smith, S., Gleeson, F., & Gillies, L. (2017). “A different world” exploring and understanding the climate of a recently re-rolled sexual offender prison. *Journal of Sexual Aggression, 23*(2), 151–166. <https://doi.org/10.1080/13552600.2016.1264633>
- Cantor, J. M., & McPhail, I. V. (2016). Non-offending pedophiles [journal article]. *Current Sexual Health Reports, 8*(3), 121–128. <https://doi.org/10.1007/s11930-016-0076-z>
- Christiansen, C., & Martinez-Dettamanti, M. (2018). Prevention in action: Exploring prevention initiatives and current practices. In R. Lievesley, K. Hocken, H. Elliott, B. Winder, N. Blagden, & P. Banyard (Eds.), (pp. 27–56). *Sexual crime and prevention* (1). Palgrave Macmillan.
- Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse & Neglect, 36*(2), 156–165. <https://doi.org/10.1016/j.chiabu.2011.10.006>
- FBI. (Retrieved 12/20/2020 from 2020, May 28). *Child pornography*. US Department of Justice.
- Gannon, T. A., Olver, M. E., Mallion, J. S., & James, M. (2019). Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness. *Clinical Psychology Review, 73*, 101752. <https://doi.org/10.1016/j.cpr.2019.101752>
- Grady, M. D., Levenson, J. S., Mesias, G., Kavanagh, S., & Charles, J. (2019). “I can’t talk about that”: Stigma and fear as barriers to preventive services for minor-attracted persons. *Stigma and Health, 4*(4), 400–410. <https://doi.org/10.1037/sah0000154>
- Grant, B.-J., Shields, R. T., Tabachnick, J., & Coleman, J. (2019). “I didn’t know where to go”: An examination of stop it now!’s sexual abuse prevention helpline. *Journal of Interpersonal Violence, 34*(20), 4225–4253. <https://doi.org/10.1177/0886260519869237>
- Hanson, R. K., & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73*(6), 1154–1163. <https://doi.org/10.1037/0022-006x.73.6.1154>
- Hart, S., Kropp, P., Laws, D., Klaver, J., Logan, C., & Watt, K. (2003). The risk for sexual violence protocol (RSVP): Structured professional guidelines for assessing risk of sexual violence, Vancouver, Canada: BC Institute Against Family Violence.

- Houtepen, J. A. B. M., Sijtsema, J. J., & Bogaerts, S. (2016). Being sexually attracted to minors: Sexual development, coping with forbidden feelings, and relieving sexual arousal in self-identified pedophiles. *Journal of Sex & Marital Therapy*, 42(1), 48–69. <https://doi.org/10.1080/0092623X.2015.1061077>
- Imhoff, R., & Jahnke, S. (2018). Determinants of punitive attitudes toward people with pedophilia: Dissecting effects of the label and intentionality ascriptions. *Archives of Sexual Behavior*, 47(2), 353–361. <https://doi.org/10.1007/s10508-017-1048-8>
- Jahnke, S., & Hoyer, J. (2013). Stigmatization of people with pedophilia: A blind spot in stigma research. *International Journal of Sexual Health*, 25(3), 169–184. [10.1080/19317611.2013.795921](https://doi.org/10.1080/19317611.2013.795921)
- Jahnke, S., Imhoff, R., & Hoyer, J. (2015). Stigmatization of people with pedophilia: Two comparative surveys. *Archives of Sexual Behavior*, 44(1), 21–34. <https://doi.org/10.1007/s10508-014-0312-4>
- Jahnke, S., Philipp, K., & Hoyer, J. (2015). Stigmatizing attitudes towards people with pedophilia and their malleability among psychotherapists in training. *Child Abuse & Neglect*, 40, 93–102. <https://doi.org/10.1016/j.chiabu.2014.07.008>
- Knack, N., Winder, B., Murphy, L., & Fedoroff, J. P. (2019). Primary and secondary prevention of child sexual abuse. *International Review of Psychiatry*, 31(2), 181–194. <https://doi.org/10.1080/09540261.2018.1541872>
- Lasher, M. P., & Stinson, J. D. (2017). Adults with pedophilic interests in the United States: current practices and suggestions for future policy and research. *Archives of Sexual Behavior*, 46(3), 659–670. <https://doi.org/10.1007/s10508-016-0822-3>
- Letourneau, E. J., Brown, D. S., Fang, X., Hassan, A., & Mercy, J. A. (2018). The economic burden of child sexual abuse in the United States. *Child Abuse & Neglect*, 79(May 2018), 413–422. <https://doi.org/10.1016/j.chiabu.2018.02.020>
- Levenson, J. S., Brannon, Y. N., Fortney, T., & Baker, J. (2007). Public Perceptions About Sex Offenders and Community Protection Policies. *Analyses of Social Issues and Public Policy*, 7(1), 137–161. <https://doi.org/10.1111/j.1530-2415.2007.00119.x>
- Levenson, J. S., & Grady, M. D. (2019). Preventing sexual abuse: Perspectives of minor-attracted persons about seeking help. *Sexual abuse : a journal of research and treatment*, 31(8), 991–1013. <https://doi.org/10.1177/1079063218797713>
- Levenson, J. S., Grady, M. D., & Morin, J. W. (2020). Beyond the “ick factor”: Counseling non-offending persons with pedophilia. *Clinical Social Work Journal*, 48, 380–388. <https://doi.org/10.1007/s10615-019-00712-4>
- Levenson, J. S., Willis, G. M., & Vicencio, C. P. (2017). Obstacles to help-seeking for sexual offenders: Implications for prevention of sexual abuse. *Journal of Child Sexual Abuse*, 26(2), 99–120. <https://doi.org/10.1080/10538712.2016.1276116>
- Lievesley, R., & Harper, C. A. (2022). Applying desistance principles to improve wellbeing and prevent child sexual abuse among minor-attracted persons. *Journal of Sexual Aggression*, 28(1), 1–14. doi:10.1080/13552600.2021.1883754.
- Lievesley, R., Hocken, E., Elliot, H., Winder, B., Blagden, N., Banyard, P. (Ed.). (2018). *Sexual Crime and Prevention* (1 ed.). Palgrave Macmillan.
- McPhail, I. V., Stephens, S., & Heasman, A. (2018). Legal and ethical issues in treating clients with pedohebephilic interests. *Canadian Psychology/Psychologie Canadienne*, 59(4), 369–381. <https://doi.org/10.1037/cap0000157>
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697. <https://doi.org/10.1037/0033-2909.129.5.674>
- Richards, K. (2018). Born this way? A qualitative examination of public perceptions of the causes of pedophilia and sexual offending against children. *Deviant Behavior*, 39(7), 835–851. <https://doi.org/10.1080/01639625.2017.1335526>

- Sandler, J. C., Freeman, N. J., & Socia, K. M. (2008). Does a watched pot boil? A time-series analysis of New York State's sex offender registration and notification law. *Psychology, Public Policy, and Law*, 14(4), 284–302. <https://doi.org/10.1037/a0013881>
- Schaefer, G. A., Mundt, I. A., Feelgood, S., Hupp, E., Neutze, J., Ahlers, C. J., Goecker, D., & Beier, K. M. (2010). Potential and dunkelfeld offenders: Two neglected target groups for prevention of child sexual abuse. *International Journal of Law and Psychiatry*, 33(3), 154–163. <https://doi.org/10.1016/j.ijlp.2010.03.005>
- Seto, M. C. (2008). *Pedophilia and sexual offending against children: Theory, assessment, and intervention* (Vol. 1). American Psychological Association.
- Seto, M. C. (2013). *Internet sex offenders*. APA.
- Seto, M. C. (2017a). The motivation-facilitation model of sexual offending. *Sexual Abuse*, 31(1), 3–24. <https://doi.org/10.1177/1079063217720919>
- Seto, M. C. (2017b). The puzzle of male chronophilias. *Archives of Sexual Behavior*, 46(1), 3–22. <https://doi.org/10.1007/s10508-016-0799-y>
- Seto, M. C. (2018). *Pedophilia and sexual offending against children: Theory, assessment, and intervention* (2nd ed.). American Psychological Association.
- Shields, R. T., Murray, S. M., Ruzicka, A. E., Buckman, C., Kahn, G., Benelmouffok, A., & Letourneau, E. J. (2020). Help wanted: Lessons on prevention from young adults with a sexual interest in prepubescent children. *Child Abuse & Neglect*, 105, 104416. <https://doi.org/10.1016/j.chiabu.2020.104416>
- Stephens, S., Leroux, E., Skilling, T., Cantor, J. M., & Seto, M. C. (2017). Taxometric analyses of pedophilia utilizing self-report, behavioral, and sexual arousal indicators. *Journal of Abnormal Psychology*, 126(8), 1114–1119. <https://doi.org/10.1037/abn0000291>
- Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2017). Evidence of construct validity in the assessment of hebephilia. *Archives of Sexual Behavior*, 46(1), 301–309. <https://doi.org/10.1007/s10508-016-0907-z>
- Stiels-Glenn, M. (2010). The availability of outpatient psychotherapy for paedophiles in Germany. *Recht und Psychiatrie*, 28, 74–80.
- Sullivan, J., & Sheehan, V. (2016). What motivates sexual abusers of children? A qualitative examination of the spiral of sexual abuse. *Aggression and Violent Behavior*, 30, 76–87. <https://doi.org/10.1016/j.avb.2016.06.015>
- Tenbergen, G., Martinez-Dettamanti, M., & Christiansen, C. (2021). Can nonoffending pedophiles be reached for the primary prevention of child sexual abuse by addressing nonoffending individuals who are attracted to minors in the United States? New Strategies With The Global Prevention Project. *Journal of Psychiatric Practice*, 27(4), 265–272. <https://doi.org/10.1097/prs.0000000000000561>
- Tenbergen, G., Wittfoth, M., Frieling, H., Ponseti, J., Walter, M., Walter, H., Beier, K., Schiffer, B., & Kruger, T. H. C. (2015). The neurobiology and psychology of pedophilia: Recent advances and challenges [Review]. *Frontiers in Human Neuroscience*, 9, 344. <https://doi.org/10.3389/fnhum.2015.00344>
- Tewksbury, R., & Lees, M. B. (2007). Perceptions of punishment: how registered sex offenders view registries. *Crime & Delinquency*, 53(3), 380–407. <https://doi.org/10.1177/0011128706286915>
- Thornton, D. Constructing and testing a framework for dynamic risk assessment. (2002). *Sexual Abuse*, 14(2), 139–153. discussion 195-137. <https://doi.org/10.1177/107906320201400205>
- W.H.O. (1992). *International statistical classification of diseases and related health problems* (Vol. 1). World Health Organization.
- Wong, S., Olver, M. E., Nicholaichuk, T. P., & Gordon, A. (2003). *the violence risk scale: Sex offender version (VRS-SO)*. Regional Psychiatric Centre and University of Saskatchewan.