

UNDERSTANDING THE TREATMENT BARRIERS FOR MINOR-ATTRACTED
PERSONS LIVING IN THE COMMUNITY

By

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MINOR-ATTRACTED PERSONS IN THE COMMUNITY

Abstract

Understanding the treatment barriers for minor-attracted persons living in the community

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Abstract: The current research involved two studies aimed at gaining a better understanding of people with sexual interest in children (referred to as Minor Attracted Persons or MAPs) living in the community. An online anonymous survey was used to examine treatment motivation and its correlates in MAPs. Higher levels of maladaptive coping decreased treatment motivation and this association was further intensified by higher levels of internalized sexual stigma. A second online anonymous survey of Canadian mental health clinicians was conducted to examine willingness to provide psychotherapy and explicit stigma towards MAPs. Clinicians with forensic specialization expressed a higher willingness to provide psychotherapy to MAPs compared with general clinicians and those with a sexology specialization. Overall, there were no significant differences across clinician groups on explicit stigma, except for feelings of anger towards MAPs.

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Chapter 1 – General Introduction

Sexual interest in children refers to both pedophilia (sexual interest in prepubescent children who have not experienced secondary sex characteristic development as a result of puberty) and/or hebephilia (sexual interest in pubescent children who are beginning to develop secondary sex characteristics in the early stages of puberty). Individuals can experience sexual interest in both prepubescent and pubescent children, termed pedohebephilia (see Blanchard et al., 2009). Sexual interest in children can exist without experiencing distress or impairment, signifying the “absence” of a “disorder;” because pedophilic disorder is diagnosed when an individual experiences an extended period of sexual fantasies or urges involving prepubescent children that cause significant distress or impairment or when they have acted on these sexual urges (American Psychiatric Association, 2013). The *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition* criteria may still be met if an individual is not distressed by their sexual interest in children (and would not perceive themselves as qualifying for a diagnosis), but it causes substantial distress in others or contributes to significant negative impacts (e.g., losses in lifestyle, such as relationship or job loss; American Psychiatric Association, 2013).

The prevalence of sexual interest in children is estimated to be between 1 and 5% in the general population; however, establishing the population prevalence of pedophilic disorder is challenging because large-scale epidemiological studies do not exist (American Psychiatric Association, 2013; Seto, 2008, 2009). Individuals with sexual interest in children prefer to be referred to as minor-attracted persons (MAPs; B4U-ACT, 2019) as it is argued that the term is associated with less stigma than other commonly

used expressions, such as “pedophile” (Imhoff & Jahnke, 2018; Levenson & Grady, 2018). Using this term also allows for an explicit separation between sexual interest and behaviour in an effort to identify individuals who have not acted on their sexual interest and do acknowledge the harm caused by childhood sexual abuse (Cohen, Ndukwe, Yaseen, & Galynker, 2018; Kramer, 2011). As a brief aside, the term MAP can encompass people with ephebophilia (sexual interest in adolescent minors, approximately between 15 and 17-years old), which is not perceived as atypical (Seto, 2017). The present thesis utilizes the term MAPs to refer to people with sexual interest in children. The author of the thesis recognizes that using this acronym may contribute to the sexual interest in children attribute becoming a master status for this population (i.e., reducing them from a full person; Hughes, 1945); however employing the MAP term throughout is a conscious decision based on the reasons outlined above as well as reflecting the current literature base.

The present research encompasses two studies aimed at gaining a better understanding of MAPs¹. The first study (Chapter 2) involved examining the association between maladaptive coping and treatment motivation in MAPs. Measures of past mental health treatment experience and internalized sexual stigma were utilized to investigate how these factors may influence the relationship between maladaptive coping and treatment motivation. The second study (Chapter 3) aimed to investigate explicit clinician stigma towards MAPs, including clinicians’ willingness to provide psychotherapy to this

¹ The thesis is a subset of a larger project funded by Public Safety Canada by co-lead investigators Dr. Skye Stephens (Saint Mary’s University) and Ian McPhail (University of Saskatchewan). Study 2 is conducted as part of a larger study in collaboration with Dr. Ainslie Heasman (Centre for Addiction and Mental Health), in addition to the two investigators co-leading Study 1. The hypotheses and research findings outlined here only capture a portion of the overall project aims.

population. Given the significant stigma experienced by this population, it is important to understand how clinicians view MAPs. Strong help-seeking behaviour may be irrelevant if clinicians are unwilling to provide assessment and/or treatment services to this population. The present thesis contributes to current research by aiming to gain a better understanding of the MAP population in terms of their motivation for treatment, as well as exploring explicit clinician stigma towards MAPs as barriers to accessing treatment. The overarching aim of both studies involved understanding the needs of MAPs living in the community and their desire to engage in treatment as well as the willingness of clinicians to provide these services and the potential stigma they may hold.

Understanding Minor-Attracted Persons Living in the Community

There is often conflation between individuals who have committed sexual offenses against children and those who have sexual interest in children, demonstrating the need to differentiate between sexual interest and offending behaviour (Feelgood & Hoyer, 2008; Harrison, Manning, & McCartan, 2010)². Sexual interest in children is a significant factor in major theoretical models of childhood sexual abuse and is one of the strongest predictors of recidivism (e.g., Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005; Seto & Lalumière, 2001) as well as a risk factor for perpetration in community samples (Turner, Hoyer, Schmidt, Klein, & Briken, 2016). Despite this association, sexual interest in children is not synonymous with contact sexual offending. There exist individuals who have committed sexual offenses against children who do not have sexual interest in children and this group likely accounts for at most 60% of

² Of note, some may argue that sexual interest cannot occur without sexual behaviours that are not necessarily considered offending behaviour (e.g., sexual fantasies, prolonged staring). For the purposes of the present thesis research, the targeted sexual behaviour explicitly considers contact sexual offending against children (i.e., contact offending does not include the use of child sexual exploitative materials).

individuals who have committed sexual offenses against children (Cantor & McPhail, 2016; Schmidt, Mokros, & Banse, 2013; Seto, 2008; see Table 1). This suggests that there are other motives for engaging in childhood sexual abuse (e.g., access to children, Colton, Roberts, & Vanstone, 2010; Sullivan & Beech, 2004; poor parental solicitude, Daly & Wilson, 1980; dysfunctional family dynamics, Dong, Anda, Dube, Giles, & Felitti, 2003). In addition, there are MAPs living in the community with sexual interest in children who have made a conscious decision to not act on their sexual interests (e.g., Dombert et al., 2016; Feelgood & Hoyer, 2008; Murray, 2000) and report experiencing no difficulty refraining from engaging in childhood sexual abuse (e.g., Bailey, Bernhard, & Hsu, 2016; Cacciatori, 2017).

Nonetheless, the evidence on sexual interest in children has been developed extensively through the thorough investigation of individuals who have committed sexual offenses against children, highlighting the paucity of understanding MAPs who have abstained from committing childhood sexual abuse. Therefore, it is important to explore this latter MAP community population further, including those who experience difficulties regarding the management of their sexual interest in children, to dedicate supports to ensuring this avoidance is maintained.

The aforementioned distinction between sexual interest and behavior can assist with understanding the heterogeneity within the MAP population. As previously mentioned, there are MAPs who report not experiencing difficulty managing their sexual interest (e.g., Bailey, Bernhard, & Hsu, 2016; Cacciatori, 2017; Goode, 2010; Grady, Levenson, Mesias, Kavanagh, & Charles 2018; Houtepen et al., 2016). There are also MAPs who have committed childhood sexual abuse but have never been involved in the criminal justice system (i.e., offenses remain undetected) as well as MAPs who have

previously offended and were detected and are no longer involved in the criminal justice system. Further, there are MAPs who have not sexually offended, but are struggling in the community to remain offense-free. This group of MAPs may also have unaddressed mental health needs related to difficulties managing their sexual interest in children (either directly related to their sexual interest or other mental health issues that are exacerbated due to their sexual interest). Establishing this heterogeneity has resulted from MAPs who are living in the community and have demonstrated their commitment to engaging in research. This variability within the MAP population emphasizes the importance of understanding the differentiating factors that contribute to preventing the onset of committing childhood sexual abuse. It is important to note that sexual interest in children is considered an important factor because of its established robustness in the sexual recidivism literature (e.g., Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005; Seto & Lalumière, 2001), but the factors that contribute to the onset (and relatedly, the prevention of the onset) of sexual offending against children remain largely unknown.

Engaging Community MAPs in Research

Anonymous research examining the rates of childhood sexual abuse perpetration within MAPs living in the community has been conducted, demonstrating the willingness of this population to engage in research aimed at understanding their sexual interest and the potential correlates related to sexual offending against children (Bailey, Bernhard, & Hsu, 2016; Bailey, Hsu, & Bernhard, 2016). As mentioned above, if someone sexually offended against a child and indicated sexual interest in children (including the child who was abused), this would presumably meet the diagnostic criteria for pedophilic disorder; however, there are individuals who offend against children who do not report sexual

interest in children (e.g., Colton et al., 2010; Sullivan & Beech, 2004; Daly & Wilson, 1980; Dong et al., 2003). One example of community MAP research examining possible correlates of childhood sexual abuse was conducted by Bailey, Bernhard, and Hsu (2016). They reported that 15% of their sample of men with sexual interest in children (aged 14 years or below) had committed adjudicated (i.e., detected) sexual offenses. Of the 1,102 men included, 6% of participants committed a child sexual exploitative materials offense, 7% committed a contact sexual offense with a child 14 years or younger, and 2% reported both offenses. It is important to highlight that Bailey and colleagues (2016) were unable to enquire about undetected contact offending or undetected viewing child sexual exploitative materials in their study.

The next set of studies to be discussed were based on a sample from the Berlin Project Prevention Dunkelfeld (childhood sexual abuse prevention program) and demonstrate higher rates of childhood sexual abuse perpetration compared to Bailey and colleagues. The MAPs within the following samples may differ from others with this sexual interest as they have actively sought childhood sexual abuse prevention programming in order to address difficulties managing their sexual interest in children (in an effort to prevent the onset or stop the persistence of childhood sexual abuse perpetration). This suggests that these studies may contain a sampling bias as there are MAPs in the community who are managing well and would not be represented in the percentages mentioned below (i.e., would not seek treatment) as well as MAPs who are struggling but would not take such initiative (e.g., B4U-ACT, 2011a). Therefore, although there is a notable group of MAPs who have committed childhood sexual abuse, the necessity of identifying MAPs who have not engaged in childhood sexual abuse perpetration should not be neglected. Further, even if MAPs have offended, they may

struggle to receive mental health services if they are not currently involved with the criminal justice system. The robustness of sexual interest in children as a predictor of childhood sexual abuse (e.g., Hanson & Morton-Bourgon, 2005; Seto, 2008) highlights the importance of dedicating efforts to assessing and treating individuals who possess this risk factor and are motivated to seek support, yet limited research exists focusing on MAPs living in the community.

In one of these studies, Beier, Neutze, et al. (2009) indicated that 75% of their community sample, comprised of individuals who endorsed sexual interest in prepubescent and/or pubescent children, committed childhood sexual abuse or other child exploitation in their lifetime and roughly 34% were (at the time of manuscript publication) under criminal investigation, facing charges, or serving their sentence. In a study conducted by Beier, Ahlers, et al. (2009), 42% of the community MAP sample had been involved in the criminal justice system due to the perpetration of childhood sexual abuse offenses. Beier et al. (2015) also reported a significant proportion of their community MAP sample had childhood sexual abuse perpetration history, whereby 77% (in the treatment group) and 82% (in the control group) had committed sexual offenses. The two sets of frequencies represent the application of a non-randomized waiting list control research design: the sample was divided between the portion who participated in the Berlin Project Prevention Dunkelfeld treatment program (i.e., treatment group) and those who did not receive treatment (i.e., control group). Most of the sample who had committed a sexual offense reported viewing child sexual exploitative materials and perpetrating contact childhood sexual abuse offenses (40%); 11% committed childhood sexual abuse only and 29% reported only committing offenses related to child exploitative materials.

The difference in percentages across these studies emphasizes the possibility of underreporting childhood sexual abuse, particularly in community samples. For example, despite the large proportion of the sample having committed childhood sexual abuse, 8% of the treatment group and 5% in the control group within the Beier et al. (2015) study were involved with the criminal justice system as a result of committing child exploitative material offenses and 13% (treatment group) for childhood sexual abuse offenses. The significant portion of MAPs who have committed childhood sexual abuse within these studies should not minimize the group of MAPs who have refrained from offending.

There is a small body of literature that has examined differences between MAPs who have and have not perpetrated childhood sexual abuse, having utilized both forensic and community samples. For example, compared to MAPs who have committed childhood sexual abuse, those who refrained from sexually offending against children displayed higher functioning with respect to measures of psychopathology, loneliness, offense-supportive attitudes, self-efficacy, and social desirability; in addition to being less likely to have received psychotherapy or having been hospitalized for psychiatric reasons (Cohen et al., 2018; Jahnke, Schmidt, Geradt, & Hoyer, 2015). In addition, MAPs who have not committed childhood sexual abuse reported experiencing fewer challenges managing their sexual interest in children and were less likely to identify themselves as being at risk to children (Cohen et al., 2018; Schaefer et al., 2010). Notably, these individuals have reported lower levels of sexual fantasies and a lower behavioural propensity towards engaging in childhood sexual abuse compared to individuals who did perpetrate childhood sexual abuse (Mitchell & Galupo, 2016; Schaefer et al., 2010), yet high rates of sexual fantasies have been reported elsewhere (Dombert et al., 2016; Schmidt, Gykiere, Vanhoeck, Mann, & Banse, 2014). Greater inhibitory control, when

measured neurologically and behaviourally, has also been displayed by nonoffending versus offending MAPs (Kärgel et al., 2016). Further, nonoffending MAPs have demonstrated a greater opposition to child-adult sexual behaviour and better management of their sexual arousal and behaviour in comparison to individuals who have committed sexual offenses against children (Cantor & McPhail, 2016; Mitchell & Galupo, 2018). In highlighting the heterogeneity within the MAP population, it is evident that a central distinction in those who engage in offending behaviour is related to the management of their sexual interest. In sum, research suggests that dedicating efforts towards supporting MAPs who are experiencing these difficulties may contribute to preventing the onset of childhood sexual abuse and improving mental health functioning (Beier et al., 2015); however, the impact of prevention programs on offending more broadly is in need of further rigorous evaluation.

Treatment for MAPs

There are compelling arguments supporting sexual interest in children as immutable to change, possessing a strong biological basis, and identifying this interest as a sexual orientation (e.g., Bailey, 2015; Cantor, 2015; Lalumière, 2015; Mokros & Habermeyer, 2015; Seto, 2012). This means that any treatment effort should explicitly focus on helping individuals effectively cope with their sexual interest in children in a manner that improves their quality of life and is incompatible with offending behaviour. This established research base highlights the importance of adhering to treatment strategies dedicated to helping MAPs cope with, rather than attempting to change, their sexual interest.

In order to consider treatment motivation in MAPs, it is first important to establish what types of treatment programming could be available to MAPs who are motivated to

seek support regarding the management of their sexual interest. This type of programming is considered a secondary prevention approach as it identifies individuals who are at risk of perpetrating childhood sexual abuse because of their sexual interest in children but have not offended (for a full review of the tiered childhood sexual abuse prevention strategies see van Horn et al., 2015)³. It is arguably important to clarify that secondary prevention strategies are specifically targeting groups of individuals who have been identified as at risk for perpetrating childhood sexual abuse and therefore this prevention model should be differentiated from those that are targeting the general public (i.e., primary prevention strategies) or those who target individuals after they have offended (i.e., tertiary prevention strategies).

An example of a secondary prevention strategy is Stop It Now!, which provides brief therapy to MAPs who express concern regarding the management of their sexual interest in children (van Horn et al., 2015). Treatment providers affiliated with this program may also make recommendations to seek additional support from forensic outpatient services (van Horn et al., 2015). Another example of a secondary prevention effort is the Berlin Project Prevention Dunkelfeld. This initiative has developed an extensive treatment program in Germany that adheres to a cognitive-behavioural approach and includes elements related to evidence-based practices for sexual offending treatment, such as Relapse Prevention, the Self-Regulation Model, and the Good Lives

³ For the purposes of the thesis, the term secondary prevention programming will be used to highlight services that are targeting individuals who are identified as at risk for childhood sexual abuse perpetration rather than targeting the general public. Some childhood sexual abuse prevention models do identify services that intervene prior to the occurrence of childhood sexual abuse as primary prevention strategies and would, therefore, consider programming targeting individuals at risk of committing childhood sexual abuse a primary prevention strategy (e.g., Fortson, Klevens, Merrick, Gilbert, & Alexander, 2016).

Model (Pithers, 1990; Ward & Gannon, 2006; Ward & Hudson, 2000; Ward, Hudson, & Keenan, 1998), while also incorporating discussions related to pharmacological treatment for paraphilias (i.e., sex-drive reducing medication to manage the intensity of, as opposed to changing, sexual interests; Beier & Loewit, 2011). The treatment program is comprised of 12 modules, covering the following topics: psychoeducation, acceptance, motivation, perception, emotions, sexual fantasies and behaviours, empathy and perspective-taking, curriculum and schemas, coping and problem solving, social relationships, intimacy and trust, planning for the future, and protective measures.

Instead of, or in addition to, participating in these types of formal treatment programming, MAPs may seek informal support (Pattyn, Verhaeghe, Sercu, & Bracke, 2014) by relying on online communities (e.g., Virtuous Pedophiles [<https://www.virped.org>], B4U-ACT [<http://www.b4uact.org>]). Although it is ill-advised to equate online communities with professional treatment, as some are less focused on preventing the occurrence of sexual offending against children (some are even veiled as “support,” but appear to condone offending behaviour), research has demonstrated that informal supports, such as online communities, can still be of benefit (Goode, 2010; Pattyn et al., 2014). For example, MAPs have speculated that connections with MAP-related organizations may have prevented their perpetration of childhood sexual abuse and provide validation, support, and helpful management strategies (Blagden et al., 2018; Grady et al., 2018). Despite recognizing their potential value, it remains an empirical question whether online support communities help people desist from offending.

Lastly, MAPs may choose to seek treatment for issues beyond or exacerbated by their sexual interest, such as seeking support related to depression, anxiety, loneliness, low self-esteem, anger, substance abuse, and isolation (Levenson & Grady, 2018). They

may choose to access such support via formal or informal mechanisms, similar to what is described above.

Treatment effectiveness. The Berlin Project Prevention Dunkelfeld is one of the only treatment options that has been subjected to examinations of effectiveness. The high response rate to the Berlin Project Prevention Dunkelfeld media campaign (Beier, Ahlers, et al., 2009; Beier, Neutze, et al., 2009) identified MAPs living in the community possessing a strong interest in seeking professional help, which then led to the development of a treatment program by Beier and colleagues (2015). The Berlin Project Prevention Dunkelfeld program focuses on dynamic risk factors (i.e., criminogenic needs) that have previously been identified as treatment targets for reducing sexual recidivism risk in programs offered to individuals who have committed sexual offenses against children, as these factors are amenable to change (e.g., Beech, Mandeville-Norden, & Goodwill, 2010; Marshall & Barbaree, 1988). The mainstay of the program is a 12-month group-based Cognitive Behaviour Therapy program.

In line with treatment programming targeting sexual recidivism, Beier et al. (2015) addressed the dynamic risk factors mentioned above in their treatment program aimed at MAPs living in the community. Program participants were recruited following their communication with Beier and colleagues' research office. From 2005 to 2011, 596 men were screened for enrolment in the Berlin Project Prevention Dunkelfeld treatment program. Individuals were excluded if they were currently involved in the criminal justice system, had an exclusive sexual preference for adults, or were experiencing untreated mental illness (i.e., untreated psychotic and mood disorders) as well as substance abuse. Although untreated mental illness was an exclusion factor, this did not include paraphilic disorders. This resulted in 319 participants being eligible for enrolment, including 142

refusing and 38 dropping out of treatment. At the time of manuscript publication, 69 had completed and 21 were still undergoing the program. Following treatment, participants displayed lower levels of dynamic risk factors associated with contact sexual offenses; specifically, reduced emotional loneliness, emotion-oriented coping, victim empathy deficits, offense-supportive attitudes, self-efficacy coping deficits, identification with children and sexual preoccupation (the last of which translated to an increase in sexual self-regulation; Beier et al., 2015; Engel, Körner, Schuhmann, Krüger, & Hartmann, 2018). Engel et al. (2018) also demonstrated within subject change on dynamic risk factors at another treatment site but failed to include a control group in their study. The Network's treatment program is recognized as a success as a secondary prevention program in decreasing dynamic risk factors associated with sexual offending (e.g., McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010).

A recent re-analysis of the Beier et al. (2015) data challenged this conclusion, in which effect sizes estimates and corresponding 95% confidence intervals were calculated, revealing limited empirical support for the Project's treatment program reducing the aforementioned areas of dynamic risk (Mokros & Banse, 2019). Briefly, Beier et al. (2015) revealed within subject change on dynamic risk factors by comparing treatment participants with non-matched controls who had not received the Berlin Project Prevention Dunkelfeld programming. Through Mokros and Banse's (2019) consideration of the treatment x time interaction, a median effect size of 0.30 was calculated, yet the corresponding confidence intervals all included zero and remained statistically underpowered (as was the original analysis). This re-examination failed to identify a significant main effect for treatment, nor an interaction, as originally reported by Beier et al. (2015). These findings suggest that participation in the Berlin Project Prevention

Dunkelfeld treatment program does not result in significant changes to dynamic risk, calling into question the efficacy of secondary prevention (König, 2015). Further consideration of the Network's treatment program's effectiveness is required – not that efforts should be abandoned – but rather higher quality studies, which are not underpowered, are needed (Mokros & Banse, 2019).

Despite the emergence of these findings, there is still a recognized need within with clinical and research community for treating MAPs who self-identify as having difficulties managing their sexual interest in children and removing potential obstacles to this treatment (e.g., Levenson & Grady, 2018; McPhail, Stephens, & Heasman, 2018). If there is support for pedophilic disorder as a mental health diagnosis, then there should be dedicated resources for providing treatment and treatment outcomes beyond risk should be assessed. For example, stigma-related stress and mental health functioning are relevant to treatment (e.g., B4U-ACT, 2011a; Beier et al., 2015; Cacciatori, 2017; Jahnke & Hoyer, 2013; Jahnke, Schmidt, et al., 2015; Kramer, 2011; Meyer, 2003) but have yet to be examined.

The Effects of Stigma

One meaningful barrier to seeking treatment among MAPS is the significant stigmatization, but its explicit connection to sexual offending is unknown. Stigma occurs when individuals are negatively labeled, stereotyped, excluded or isolated (i.e., separation of “us” versus “them”), lose status, and/or are discriminated against (Link & Phelan, 2001). There is variation in both the operationalization and measurement of stigma (e.g., Fox, Earnshaw, Taverna, & Vogt, 2018; Link, Yang, Phelan, & Collins, 2004), but there is consensus that different types of stigma do exist. One useful framework of stigma has

been proposed by Fox et al. (2018) that differentiates two approaches: one type of stigma that is imposed by society onto a targeted group while the other type of stigma is defined by the group who identifies with the stigmatized attribute (see Corrigan & Watson, 2002). Although this may be a useful conceptualization, it is important to note that there are great challenges in separating out individuals' perceptions of their felt stigma from having experienced actual events of being stigmatized (Livingston & Boyd, 2010). Various research studies have dedicated significant efforts to conceptualizing stigma in different ways (e.g., Cechnicki, Angermeyer, & Bielańska, 2011; Link, 1987; Luoma et al., 2007; Meyer, 1995, 2003; Quinn & Earnshaw, 2013), however, some scholars argue that it is misinformed to categorize these concepts as mutually exclusive (Livingston & Boyd, 2010).

To simplify the efforts of conceptualization, stigma can be classified based on three levels. Self-stigma involves individuals internalizing or endorsing the stereotypes associated with the stigmatized attribute, leading them to diminish their personal value. Secondly, societal stigma involves society accepting and validating stereotypes about the stigmatized attribute. Lastly, structural stigma involves systems or institutions imposing restrictions on individuals who identify with the stigmatized attribute (see Corrigan, Kerr, & Knudsen, 2005; Herek, 2007). When individuals internalize stigma, it can cause behavioural modifications in response to the anticipation of negative reactions from others, which can occur regardless of whether they have experienced stigmatizing events (e.g., Herek, 2007; Quinn & Earnshaw, 2013). For example, stigma can influence decisions regarding seeking support from formal healthcare providers as well as informal support from loved ones (Pattyn et al., 2014).

The stigmatization of MAPs. In understanding the role of stigma in the decision to seek treatment, it is important to briefly consider the literature on the minority stress model. This model was developed by Meyer (2003) to understand the prejudice and social stressors faced by individuals who identify as lesbian, gay, and bisexual and how these experiences can adversely impact mental health. It has been proposed that multiple consequences can result from experiencing discrimination, leading to amplified vigilance of expected stigma, the internalization of the observed negative societal views, and efforts to hide one's sexual orientation. Further, MAPs have reported portraying their sexual identities differently when in public compared to their private life (Cash, 2016). Research has demonstrated that identifying as a sexual minority can negatively impact quality of life, as stigmatized sexual minorities display higher rates of emotional difficulties (Meyer, 2003; Hatzenbuehler, 2009).

Jahnke and colleagues (Jahnke & Hoyer, 2013; Jahnke, Imhoff, & Hoyer, 2015) have applied the minority stress model to MAPs to support their investigation of the stigmatization of this population. Although sexual interest in children is a sexual interest that is illegal if acted on, MAPs likely face similar conflicts to those of other sexual minorities, such as discrimination, prompting hyperawareness to anticipated stigma, internalization of negative societal views, and concealment of true sexual identity as described in the minority stress model (Meyer, 2003).

There is strong evidence supporting the significant stigmatization resulting from having sexual interest in children. For example, Furnham and Haraldsen (1998) identified that the public perceives sexual interest in children as different from other atypical sexual interests (i.e., paraphilias) by demonstrating a lower level of tolerance, potentially because the interest would result in illegal behaviour against children – a population that

is considered quite vulnerable – in addition to the individual being morally condemned. This stigmatization propels a strong public desire to socially avoid MAPs (Feldman & Crandall, 2007; Jahnke, Imhoff, & Hoyer, 2015; Jahnke, 2018b). One reason for these negative perceptions may be due to the conflation of sexual interest and behaviour reported in media coverage of sexual offending (e.g., Harper & Hogue, 2015, 2017; Levenson et al., 2017). Further, Jahnke (Jahnke, Imhoff, & Hoyer, 2015; Jahnke, 2018b) reported that the public expressed robust feelings of fear, anger, and disgust as well as perceived danger in their consideration of MAPs despite the absence of criminal behaviour. Interestingly, smaller degrees of social distance and perceived abnormality were displayed when community participants were informed that abstaining from childhood sexual abuse offending occurred because of internal (i.e., immoral) rather than external motivation (i.e., avoiding punishment; Jahnke, 2018b).

In addition to the public's documented perceptions, MAPs have also reported difficulties processing and accepting how they are viewed by society (Blagden et al., 2018; Grady et al., 2018; Levenson & Grady, 2018; Levenson et al., 2017). For example, they described internalizing society's negative reactions to MAPs and acknowledging that these perceptions have led to suicidal thoughts and feelings of isolation (Blagden et al., 2018; Levenson & Grady, 2018). There is also a tendency for this population to self-stigmatize, whereby MAPs misjudged the amount of discrimination felt by the general public, such as believing that most people would endorse incarcerating MAPs despite being offense-free (Jahnke, Imhoff, & Hoyer, 2015). Further, MAPs may avoid engaging in behaviours that risk revealing their sexual interest (e.g., avoiding certain topics of conversation), which Jahnke, Schmidt et al., (2015) surmise could prevent opportunities for MAPs to challenge their assumptions regarding perceived stigmatization.

Despite the strong evidence of stigmatization, attempts to inform the public's perception of sexual interest in children have resulted in positive findings. Significant reductions in public perceptions of danger, thoughts regarding intention and deviance (i.e., judgments about sexual interest in children as a choice) as well as punitive attitudes towards MAPs have been reported following exposure to thorough research expertise or humanizing narrative offered by this population (e.g., Harper et al., 2019; Rüscher, Angermeyer, & Corrigan, 2005). The modality and language used within these attempts have also proved to be important. For example, presenting information about MAPs using narrative humanization has been successful in challenging both implicit and explicit stigmatization regarding sexual interest in children (Harper, Bartels, & Hogue, 2018). Similarly, avoiding the use of "pedophilia" (rather than stating "sexual interest in children") can also decrease punitive attitudes and perceived dangerousness and intentionality of MAPs (Imhoff, 2015; Imhoff & Jahnke, 2018). In some cases, the general public has been open-minded regarding their response to MAPs, demonstrating impartiality, or even positive reactions, such as countering their assumptions and acknowledging the benefits of intervention for self-identified MAPs (Theaker, 2015). Public endorsement of sexual interest in children as rooted in a clinical and medical condition that is beyond one's control (i.e., biologically-based) has also been reported (Imhoff, 2015). By characterizing a human attribute as immutable (i.e., biological), individuals may decrease their feelings of blame and support greater social inclusion (Chandler, 2017). Notably, framing sexual interest in children as a biological attribute may lead to increases in the stigmatization of MAPs. Research in other contexts has shown that framing a human attribute as a "neurological problem," for example, leads to increases in sympathy, but harsher punishment as there is a presumption that if the

“problem” cannot be fixed (i.e., attribute cannot change), individuals within this population should be perceived as more dangerous (Chandler, 2017); although other research suggested the opposite effect – that a biological cause for offending behaviour reduced sentences (e.g., Aspinwall, Brown, & Tabery, 2012; Scurich & Appelbaum, 2016). When considering stigma, individuals who engage in offending behaviour that has genetic versus environmental etiology are more often linked to negative judgments of blame and punishment (Robbins & Litton, 2018). Notwithstanding these reframing efforts mentioned above, myths persist that result in the conflation of sexual interest and behaviour (e.g., Jahnke & Hoyer, 2013), even within the research community (e.g., the use of *potential offenders* within a study by Schaefer et al., 2010). Therefore, the desire for MAPs to seek and participate in treatment regarding the management of their sexual interest may be influenced by their (anticipated) experiences of stigma.

Chapter 2 – Treatment Motivation in MAPs

What is Treatment Motivation?

The present study examines treatment motivation and its correlates in MAPs. Drieschner et al. (2004) summarized determinants of treatment motivation as an individual's perceived suitability for treatment (i.e., does the individual believe they are an appropriate candidate for treatment), which encompasses an individual's current level of distress, the anticipated outcome of treatment, and acceptance that there is a problem in need of attention. Some individuals may be perceived by others to be in need of treatment; however, they may not view themselves to be in need as they are not distressed by their problem, do not foresee treatment to be beneficial and/or do not perceive themselves as having a problem. Further, perceived costs of treatment and external pressure may also impact treatment motivation. Individuals may be deterred by the anticipated financial costs or negative psychological impacts incurred from seeking treatment (e.g., stress) yet may be motivated to seek treatment due to encouragement or ultimatums from loved ones, employers, or the legal system (see Drieschner et al., 2004). In sum, the decision to seek treatment is complex.

Treatment motivation encompasses readiness and self-efficacy to change. Readiness to change is a marker of motivation or a willingness to alter problematic behaviours, thoughts, or emotions (e.g., Carey, Purnine, Maisto, & Carey, 1999). The second component of treatment motivation is self-efficacy. Bandura (1977) considered the perceptions of self-efficacy to be attributed to one's own confidence that they can fulfill what is needed to yield the preferred outcome as well as an expectation that their behaviour will result in the preferred outcome – which implies that self-efficacy can

govern forthcoming behaviour. Such expectations may influence the initiation of coping strategies, the amount of effort put forth, and the amount of time dedicated to managing the identified problem (Bandura, 1997). Lasher and Stinson (2017) proposed that MAPs may present with self-efficacy deficits, similar to other stigmatized populations (Pachankis, 2007). Further, research has identified a negative relationship between the anticipated difficulty of coping with sexual urges and the perceived success with managing behaviour when a risky situation is encountered (Pollock, 1996). Alternatively, if MAPs do not experience difficulty refraining from childhood sexual abuse perpetration, they may endorse higher levels of self-efficacy and feel confident maintaining this abstinence, thereby expecting their nonoffending behaviour to be maintained.

Help-seeking behaviours and treatment motivation in MAPs. Help-seeking behaviours have been demonstrated by some MAPs through their decision to seek support regarding the management of their sexual interest in children, such as through the Berlin Project Prevention Dunkelfeld. The previous discussion of this initiative considered the effectiveness of the Berlin Project Prevention Dunkelfeld treatment program, but the following information will consider the help-seeking behaviours of MAPs in association with this Network. Beier and colleagues (Beier, Ahlers, et al., 2009; Beier, Neutze, et al., 2009) launched a media campaign within Germany that produced a considerably high response rate (476 individuals made contact within the first 18 months of the program and 808 within the first 38 months). The data were collected from June 2005 to August 2008, when the German population ranged from 81,602,741 to 81,065,757, respectively (United Nations Population Division, 2019). Using the 1-5% prevalence rate (American Psychiatric Association, 2013), it is estimated that 810,657 to 4,080,137 people in Germany would have sexual interest in children during this timeframe. Ninety percent of

the sample reported experiencing some level of distress, with 43% identifying these feelings as very strong (Beier, Neutze, et al., 2009). Further, just over half of the sample reported seeking social support and endorsed similar rates for professional support (Beier, Neutze, et al., 2009), while 86% had confided in a loved one about their sexual interest in children (Beier, Ahlers, et al., 2009). Of those who had not disclosed their sexual interest, a quarter reported a desire to do so (Beier, Ahlers, et al., 2009). According to the latest data available through the Network's website (March 2018), 9,515 MAPs had initiated contact in an effort to seek help. Within this group, 2,894 attended the Network's program site in search of a diagnosis and/or support, 1,554 were offered therapy, 925 initiated therapy, 360 successfully completed therapy, 345 were currently enrolled in treatment (at the end of March 2018), and 80 were involved in treatment aftercare (Prevention Network "Kein Täter werden," n.d.). Overall, these findings provide clear evidence indicating some MAPs are motivated to seek mental health support and/or treatment for their sexual interest.

There is also evidence of help-seeking behaviours in MAPs beyond the established programming that exists in Germany. For example, Levenson & Grady (2018) reported high levels of seeking support within their community sample of MAPs. The majority (75%) had consulted with a clinician and nearly half (47%) had consulted a website or forum on the internet regarding the management of their sexual interest; other support services included calling a phone line (28%) and seeing a religious leader (19%) or a medical doctor (16%). Lower levels of support seeking have been reported by Levenson et al. (2017), with only 12% of their convicted sample of MAPs having sought professional support, yet 20% reported attempts to confide in loved ones. Within this

latter sample, MAPs reported being motivated to seek professional support because of their concerns regarding engaging in childhood sexual abuse.

Despite research suggesting help-seeking behaviours among MAPs, there are several factors that could impact MAPs' decision to seek treatment. In the Levenson and Grady (2018) study, more than half of community MAPs chose not to seek treatment because they felt they were able to manage their sexual interest and did not express concern about their ability to refrain from childhood sexual abuse perpetration. These feelings of control and management have also been reported elsewhere (e.g., Bailey, Bernhard, & Hsu, 2016; Cacciatori, 2017; Goode, 2010; Grady et al., 2018; Houtepen et al., 2016; Levenson et al., 2017). Therefore, researchers, and society more generally, must remember that it is inappropriate to assume that MAPs require treatment to abstain from offending – as study participants have advocated, “You assume a MAP needs help which is a little blind and irritat[ing]” (Grady et al., 2018, p. 5) and “[i]t sounds like you are ... [making] the erroneous assumption that all [MAPs] are in need of emotional support. This is not the case, many of us overcame that state long ago and are now emotionally stable” (Goode, 2010, p. 116). Notwithstanding the significant proportion of MAPs who share this perspective, some have such concerns (Beier, Neutze, et al., 2009), but choose not to pursue treatment (B4U-ACT, 2011a). For example, significantly higher rates of childhood trauma and stronger sexual interest in children have been found in convicted MAPs who sought help regarding their sexual interest (Levenson et al., 2017). This finding suggests that a factor that might contribute to MAPs seeking help, and by extension treatment motivation, is the presence of maladaptive coping strategies regarding the management of their sexual interest in children.

Coping strategies can be defined as “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p.141). Different approaches have been taken to categorize coping strategies, such as distinguishing between problem-focused (i.e., addressing a stressful situation) and emotion-focused (i.e., addressing the associated negative emotions related to the stressful situation) techniques (e.g., Aldwin & Revenson, 1987) or active (i.e., attempts to manage a stressful situation) and avoidant techniques (i.e., attempts to avoid confronting the stressful situations; e.g., Billings & Moos, 1980). As the present study is interested in the impact of MAPs’ difficulties managing their sexual interest in children – the distinction between maladaptive and adaptive coping strategies can also be considered (Carver, 1997). Coping strategies can be categorized maladaptive if they have the potential to cause harm (e.g., substance use), whereas strategies may be viewed as adaptive if they have the potential to lead to positive results (e.g., reaching out for help/support). This conceptualization of coping strategies – distinguishing between maladaptive and adaptive – will be used in the present study. The present study is interested in understanding the association between maladaptive coping and treatment motivation.

Coping with Sexual Interest in Children

As discussed in Chapter 1, MAPs are a highly stigmatized population (e.g., Jahnke, Imhoff, & Hoyer, 2015; Jahnke, 2018a, 2018b) and research has strongly supported the adverse impact of stigma on stress (e.g., Link & Phelan, 2006; Miller & Kaiser, 2001; Rüscher et al., 2009). Stigmatized individuals can engage in emotional, cognitive, physiological, or behavioural coping strategies, which can either be automatic

or voluntary and maladaptive or adaptive, in an attempt to ameliorate experiences of stress (Miller & Kaiser, 2001). Despite knowing that MAPs are stigmatized, there is limited research examining the coping strategies MAPs utilize to manage stress in response to their sexual interest in children. This is an important consideration as it has been proposed that the effects of stigma only materialize if an individual does not feel equipped to cope with the problem at hand (Biddle et al., 2007; Miller & Kaiser, 2001).

When an individual possesses a stigmatized attribute (i.e., a hidden stigma), they are motivated to keep it a secret from others (Clement et al., 2015; Corrigan & O'Shaughnessy, 2007). Based on the evidence supporting the stigmatization of MAPs, this population possesses a hidden stigma, which increases their desire to not disclose sexual interest because of the potential personal and professional consequences if it is revealed (e.g., loss of family or job; Grady et al., 2018; Kramer, 2011; Levenson, Willis, & Vicencio, 2017). Efforts to conceal this hidden stigma, coupled with the internalization of the negative beliefs of others, is associated with poor mental health (Jahnke & Hoyer, 2013; Jahnke, Schmidt, et al., 2015; Meyer, 2003). Further, MAPs have reported low mood (Houtepen et al., 2016), the presence of a mental health history (e.g., Schaefer et al., 2010) and high levels of suicidal ideation and suicide attempts (B4U-ACT, 2011a; Cohen et al., 2018; Levenson & Grady, 2018). Overall, MAPs have endorsed experiencing some level of distress related to committing childhood sexual abuse (e.g., Beier, Neutze et al., 2009). Interestingly, there have been equal levels of experienced stigma (comprised of self-esteem, social confidence, and social distance) and emotional distress reported by MAPs who have and have not perpetrated childhood sexual abuse (Cohen et al., 2018). Contrarily, other research has identified such distress to be a precursor to offending behaviour. For example, Levenson et al. (2017) reported that 39%

of the convicted sample of individuals who had sexually offended against children and/or adults were concerned about their sexual interest prior to their perpetration of sexual assault. Of note, this subsample included MAPs as well as non-MAPs as sexual interest could include other paraphilias in addition to sexual interest in children. Nonetheless, this association could suggest that MAPs who have committed childhood sexual abuse did so as a result of maladaptive coping related to the management of their sexual interest. Notably, the clear majority of the purposeful sample of individuals who had been convicted of sexual offenses (including both those who had sexual interest in children and adults) used by Levenson et al. (2017) were not concerned about their sexual interest prior to committing their sexual offense; however it is not clear whether MAPs and non-MAP study participants had offended against children or adults.

Levenson and Grady (2018) identified that MAPs' difficulties may manifest as experiences of shame and guilt, or engaging in maladaptive coping strategies (e.g., substance abuse). Further, these challenges could be specific to accepting the absence of companionship and love (if endorse exclusive sexual interest in children). One MAP within their community sample stated that they had no concerns about acting on their sexual interest but struggled with the realization that they were unable to have a loving companion in their life (see also Cash, 2016). Relatedly, MAPs reported experiencing sexual frustration because of the illegality of acting on their sexual interest. Difficulties coping related to self-acceptance were also apparent, as MAPs reported experiencing depression, anxiety, loneliness, difficulty concentrating, feelings of disengagement, anger, and low self-esteem (see also Cash, 2016). It is important to note that, although these findings have been framed causally, this is a cross-sectional study, and sequencing cannot be established (i.e., symptoms resulting from sexual interest in children versus sexual

interest in children resulting in symptoms). Nonetheless, seeking support for these types of emotional or personal issues has been reported by MAPs as an important component of treatment (Levenson et al., 2017).

In a qualitative study conducted by Grady et al. (2018), community MAPs reported employing “alternative” behaviours to avoid perpetrating childhood sexual abuse or watching legal age content as a mechanism to alter their sexual interests. In addition to these arguably more creative strategies, most of the study sample reported engaging in masturbation as a sexual coping strategy. Beyond those coping strategies that were sexual in nature, MAPs also managed their sexual interest through distraction, reducing the amount of time spent using pornography, increasing face-to-face interactions with adults as well as tasks focused on productivity (e.g., work, studying), and praying, while one MAP reported engaging in self-harm as a coping strategy. It is important to note that some of the alternative behaviours discussed would be adaptive (e.g., social support), whereas others might be problematic (e.g., viewing child sexual exploitative materials). Nonetheless, research has begun to uncover the coping strategies that MAPs are employing when they find it difficult to manage their sexual interest, but it remains unknown whether high levels of treatment motivation do exist when these individuals are experiencing difficulties coping.

Moderators of the Proposed Coping and Treatment Motivation Association

The relationship between maladaptive coping and treatment motivation is likely not linear but complex, as other factors may influence the proposed association between maladaptive coping and treatment motivation. Within the broader mental health literature, past treatment experiences and experiences of stigma have both been proposed as potentially affecting decisions around seeking mental health services (Kushner & Sher,

1991) and could impact someone's treatment motivation even if they are struggling to cope.

Past treatment experiences. The impact of past mental health treatment experience might moderate the association between maladaptive coping and treatment motivation, as some MAPs who have sought out treatment have encountered negative judgment or a lack of professional competence (Cacciatori, 2017; Cash, 2016; Jahnke & Hoyer, 2013; Grady et al., 2018; Houtepen et al., 2016; van Horn et al., 2015). For example, regardless of whether treatment was mandated or voluntary, half of MAPs surveyed reported clinicians having made erroneous assumptions during their treatment (e.g., that client would care about a child for the sole purposes of committing childhood sexual abuse) and two-thirds felt that these claims negatively affected their care (i.e., reducing the likelihood of returning for further treatment, inhibiting treatment goals; B4U-ACT, 2011b). In addition, MAPs have found that some clinicians presume that all MAPs show an inevitable risk to public safety or risk to assault children (Cacciatori, 2017; Grady et al., 2018; Jahnke & Hoyer, 2013). For example, one MAP shared that a clinician breached confidentiality by reporting them to social services as it was assumed that they would not be able to control their sexual urges and ultimately go on to perpetrate childhood sexual abuse (Levenson & Grady, 2018). There have also been occasions where MAPs were told not to continue their treatment with a clinician, otherwise, they would be reported to the police, thereby being left without assistance or resources (e.g., Levenson et al., 2017). In addition to MAPs' own experiences, clinicians have also endorsed holding these beliefs as they have reported a low willingness to treat MAPs (Stiels-Glenn, 2010).

Other research provides evidence for MAPs encountering positive treatment experiences. In a study focused on examining community MAPs' experiences of seeking support for the management of their sexual behaviour, Levenson & Grady (2018) reported that 49% of their sample who sought treatment found their clinician to be helpful. Specifically, they felt listened to and understood (81%), believed their clinician to be non-judgmental (55%), and felt that they were viewed holistically, rather than solely as a MAP (34%). Further, the MAPs felt their clinicians demonstrated hopefulness in MAPs' own ability to change their thoughts or behaviour (52%) and believed their clinicians provided helpful options for changing their thoughts or behaviours (50%). Some MAPs reported that they felt relief in having found both professional and social support and likened this positive experience with a clinician to be aligned with finding treatment for addictive behaviours, such as drug use or gambling. Comparable levels of such benefits of feeling understood (21%) and hope for change from their clinician (14%), not feeling judged (18%), and receiving helpful options for changing thoughts or behaviour (16%) have also been reported elsewhere (Levenson et al., 2017). Almost half of one convicted MAP sample rated their past support as above average in helpfulness (Levenson et al., 2017). Therefore, the evidence does suggest that past treatment experiences can have a significant impact on MAPs' perceptions of treatment. When MAPs seek treatment from clinicians who are supportive and addressed them with compassion and understanding (Cacciatori, 2017; Levenson & Grady, 2018; Levenson et al., 2017), they may express greater treatment motivation. Overall, the larger literature suggests that past experiences seeking mental health services could affect future treatment-seeking decisions (Kushner & Ster, 1991).

Stigma. As previously discussed, there is extensive evidence supporting the negative public perception of MAPs as well as this population's own perceptions and experiences of stigmatization (e.g., Feldman & Crandall, 2007; Furnham & Haraldsen, 1998; Freimond, 2013; Grady et al., 2018; Jahnke, Imhoff, & Hoyer, 2015; Jahnke, 2018b; Levenson & Grady, 2018; Levenson et al., 2017). The presence of such stigma is problematic as research has established that stigma is a significant barrier for help-seeking regarding mental health problems (Biddle et al., 2007; Clement et al., 2015; Mental Health Commission of Canada, 2012; Shrivastava, Johnson, & Bureau, 2012). Specific to the MAP population, it has been reported that anticipating stigma from clinicians does interfere with the decision to pursue treatment (Grady et al., 2018; Houtepen et al., 2016; Levenson & Grady, 2018). Despite this, Jahnke, Schmidt, et al. (2015) did not find an association between treatment motivation (measured by willingness to seek treatment) and a fear of being discovered or perceived social avoidance, yet it is important to recognize that the study occurred in Germany, which does not have mandatory reporting laws as elsewhere (e.g., North America). Regardless, MAPs have admitted that the concealment of their sexual interest did perpetuate secretive behaviour and increased the risk of childhood sexual abuse (Houtepen et al., 2016).

Therefore, experiences and perceptions of stigma may impact motivation to engage in treatment for MAPs as individuals are unlikely to engage in help-seeking behaviours if they feel skeptical of the response they may receive. This is an important consequence to consider as it is likely that, similar to some mental health disorders (e.g., psychosis), not seeking support or treatment when experiencing distress can lead to an exacerbation of symptomology (e.g., Marshall et al., 2005).

Present Study

In sum, there is evidence supporting the potential association between maladaptive coping and treatment motivation in MAPs living in the community. Previous research has revealed help-seeking behaviours in MAPs and that decisions around pursuing treatment may be tied to MAPs' perceived management of their sexual interest in children (e.g., Beier, Ahlers, et al., 2009; Beier, Neutze, et al., 2009; Levenson & Grady, 2018); however, the impact of coping on treatment motivation has not been explicitly examined. Further, past research has suggested the influence of past treatment experiences and sexual stigma impacting the relationship between maladaptive coping and treatment motivation. Studies have reported MAPs having both positive and negative experiences while seeking/receiving treatment as well as stigmatization regarding their identification as a MAP and that these encounters did impact decisions to seek (further) treatment (e.g., B4U-ACT, 2011b; Cacciatori, 2017; Jahnke & Hoyer, 2013; Grady et al., 2018; Houtepen et al., 2016; Levenson & Grady, 2018; Levenson et al., 2017; van Horn et al., 2015). The present study examined the impact of maladaptive coping strategies on treatment motivation and whether past treatment experiences and internalized sexual stigma impact this association. As data were collected anonymously, participants could reflect on their past treatment experiences and their effect on treatment motivation without pressure to provide socially desirable responses as evident in previous studies (e.g., Drapeau et al., 2004, 2005).

The present study examined three hypotheses. Firstly, it was predicted that there would be a positive association between maladaptive coping strategies and motivation for treatment: it was predicted that higher levels of self-perceived maladaptive coping would be associated with higher levels of self-perceived treatment motivation. Moreover, it was

anticipated that two factors – past treatment experiences and internalized sexual stigma – would moderate the association between maladaptive coping and treatment motivation. Specifically, it was expected that the association between maladaptive coping and treatment motivation would be attenuated if past experiences with treatment were negative, even if MAPs reported engaging in a higher degree of maladaptive coping regarding their sexual interest. Further, it was expected that the association between maladaptive coping and treatment motivation would also be weakened if MAPs reported high levels of internalized sexual stigma, despite maladaptive coping (see Figure 1).

Previous research has considered help-seeking behaviours in MAPs and, although seeking treatment and treatment motivation are likely correlated, they are not necessarily one and the same. For example, individuals may seek help at the urging of others, but possess low motivation for treatment. Therefore, the consideration of treatment motivation in MAPs is of significance and has yet to be examined in this population. By exploring treatment motivation within MAPs and its connection to maladaptive coping, efforts can be dedicated to exploring the barriers that may interfere with MAPs receiving support, if desired.

Method

A priori power analyses were not conducted due to the novelty of the present study and the absence of a suitable effect size in past research. With that said, a sample size of 1,000 MAPs was initially proposed since a similar data collection strategy was employed as was used by Bailey, Bernhard, and Hsu (2016). As the present study is part of a larger project, data collection was ceased for the thesis research study in order to adhere to academic timelines, but did continue onward, which is one of the reasons the

present study's sample size is less than what was originally anticipated. Post-hoc power calculations were computed for each of the analyses and reported below.

Participants

Individuals identifying as MAPs were eligible to participate in an anonymous online survey if they were able to understand the English language, were 18 years of age or older, and reported a sexual interest in children (i.e., sexual interest in children under the age of 15). There were originally 313 cases in the dataset and participants were excluded if they did not complete the survey ($n = 100$), which also filtered out those with no sexual interest in children, leaving 207 participants as 6 failed to answer this question (identifying their sexual interest in children). The study was approved by the Research Ethics Boards at Saint Mary's University and the University of Saskatchewan.

Characteristics of the study participants are presented in Table 2. Participants ranged in age from 18-71 years old ($M = 31.64$, $SD = 12.39$). The majority (82.8%) identified as Caucasian and the next largest group identified as a different ethnicity than listed (i.e., they selected "other"). Most of the sample were single (67.0%) and the next largest group were married (10.2%). Most of the sample indicated their gender as male (77.1%), with 6.8% reporting their gender as female. Within the sample, 9.7% reported having been diagnosed with a paraphilic disorder by a medical professional.

Variables and Measures

Demographics. Demographic information on age, ethnicity, relationship status, sex, gender, and mental health diagnosis history were collected to describe participant characteristics.

Sexual interest in children. Sexual interest in children was measured using adapted versions of the Kinsey Scale. The Kinsey Scale was originally developed to

assess exclusivity regarding gender interest (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). In this research, the original Kinsey Scale was adapted by Ian McPhail to classify individuals as having sexual interest in children. Participants completed two adapted Kinsey Scales: the first Kinsey Scale assessed sexual interest in prepubescent children, relative to sexual interest in adults and the second scale assessed sexual interest in pubescent children, relative to sexual interest in adults.

In the present study, each adapted Kinsey Scale was dichotomized to indicate whether sexual interest in children was endorsed (coded as 1) or not (coded as 0). When dichotomized, 96.6% ($n = 200$) of the sample reported sexual interest in prepubescent children and 92.8% ($n = 192$) reported sexual interest in pubescent children. Within the sample, 10.6% ($n = 22$) reported sexual interest in either prepubescent or pubescent children and 89.4% ($n = 185$) reported a sexual interest in both prepubescent and pubescent children.

Treatment motivation. The 19-item Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES; Miller & Tonigan, 1996) was adapted by the author of the thesis as a first measure of treatment motivation, as there exists no measure of treatment motivation for MAPs. The SOCRATES was initially developed to assess treatment motivation in individuals who were experiencing difficulties regarding their alcohol use. The SOCRATES was adapted to align with motivation for treatment in MAPs, by changing the focus of the questions to examine individuals' current management of their sexual interest in children; therefore instructions provided with the SOCRATES asked participants to complete the items in relation to coping with sexual interest in children. The individual scale items were only adapted in order to shift their focus from drinking alcohol to managing sexual interest in children. The scale contains a five-point Likert

scale ranging from *NO! Strongly disagree* (1) to *YES! Strongly agree* (5), including a middle/neutral point of *Undecided or unsure* and scores could range from 19-95.

The SOCRATES contains three factors that were used in the present study: Recognition (i.e., whether the individual recognizes there is a problem; 7 items), Ambivalence (i.e., whether the individual is uncertain about the problem; 7 items), and Taking Steps (i.e., whether the individual has taken steps to make positive changes regarding the problem; 5 items). Example items include, “I really want to make changes to how I manage my sexual interest in children” (Recognition factor); “Sometimes I wonder if I am having trouble managing my sexual interest in children” (Ambivalence factor), and “I have already started making some changes to how I manage my sexual interest in children” (Taking Steps factor). All factors have demonstrated strong test-retest reliability in previous research (Miller & Tonigan, 1996). The validity of the original SOCRATES has been assessed by evaluating its accuracy when the scale has been translated from English. For example, using a Korean-language version of the SOCRATES, the Recognition and Taking steps factors have been positively correlated with drinking behaviours and the Ambivalence factor as negatively correlated (Chun, Cho, & Shin, 2010). The SOCRATES has also demonstrated concurrent and predictive validity when used with military service members who were involved in substance abuse treatment (Mitchell & Angelone, 2006).

In the present study, items were tallied under their respective factors, with higher scores indicating greater association with the factor. Higher scores on Recognition suggested MAPs were aware that they were experiencing problematic behaviour regarding the management of their sexual interest, felt motivated to make a change, and anticipated issues if they did not make a change. Contrarily, MAPs who scored low on the

Recognition factor were in denial that they were experiencing a problem and had no desire to make a change. Higher scores on the Ambivalence factor suggested that MAPs were contemplating if they should seek treatment, suggesting greater uncertainty, openness or reflection, whereas a low score indicated that these MAPs were not questioning whether they could manage their sexual interest in children. In other words, higher scores on the Ambivalence factor was indicative of higher treatment motivation (as reflected by greater uncertainty) when compared to lower scores, which would suggest denying that a problem exists. Lastly, higher scores on the Taking Steps factor reflected that MAPs were already engaged in activities that created positive changes and may have already experienced some success, leading to greater motivation, whereas lower scores indicated that MAPs were not currently engaged in activities to change problematic behaviour (see Center for Substance Abuse Treatment, 1999). Essentially, higher scores on all three measures were indicative of greater treatment motivation. Within the present study, the three factors of the SOCRATES, Recognition ($\alpha = .92$), Ambivalence ($\alpha = .87$), and Taking Steps ($\alpha = .91$), demonstrated very good to excellent internal consistency.

Self-efficacy. The Specific Self-Efficacy for Modifying Sexual Interest in Children (SSIC Scale; Tozdan, Jakob, Schuhmann, Budde, & Briken, 2015) is a six-item questionnaire that assesses self-efficacy related to sexual interest in children. The scale contains a five-point Likert scale ranging from *I agree not at all* (1) to *I agree totally* (5) and has demonstrated good internal reliability and construct validity (Tozdan et al., 2018). Previously, this scale has been used to explore the association between MAPs' understanding of the immutability of their sexual interest in children and self-efficacy (Tozdan et al., 2018); however, in the present study, this measure was used to assess self-efficacy with respect to treatment motivation. Further, past research that has utilized the

SOCRATES recommended also including a measure of self-efficacy (e.g., Miller & Tonigan, 1996). Scores on the SSIC Scale could range from 6 to 30, with higher scores being indicative of higher self-efficacy (Tozdan & Briken, 2015b). The internal consistency of the SSIC Scale was questionable ($\alpha = .62$) but rose considerably when one item (“I have very little influence on the fact that I feel sexually attracted to children”) was deleted ($\alpha = .86$). Although the original authors of this scale obtained high internal consistency (Tozdan et al., 2015), it was decided that a modified version without the mentioned item would be used to achieve greater internal consistency in the present study.

Maladaptive coping strategies. No scale exists that examines coping strategies used by MAPs, so the Brief COPE (Carver, 1997) was adapted by the author of the thesis. The original Brief COPE was adapted from the full COPE inventory (Carver, Scheier, & Weintraub, 1989), which is a 60-item scale. The Brief COPE assesses coping reactions across 28-items using a four-point Likert scale ranging from *I haven't been doing this at all* (1) to *I've been doing this a lot* (4), with higher scores indicating a greater degree of frequency in engaging in the respective coping strategy. The Brief COPE contains 14 subscales, eight measuring adaptive coping strategies and six measuring maladaptive strategies. Example items include, “I've been turning to work or other activities to take my mind off things” (maladaptive strategy) and “I've been concentrating my efforts on doing something about the situation I'm in” (adaptive strategy). The measure has demonstrated adequate internal, convergent, and discriminant validity (Carver, 1997).

In the present study, participants were asked to complete the Brief COPE items specifically in relation to coping with sexual interest in children, but the individual scale items were not adapted. Only the items that address maladaptive coping were used in this

study to create a total score as the hypotheses focused specifically on the influence of maladaptive coping on treatment motivation. The Brief COPE is not meant to produce an overall score, but to reveal a dominant coping strategy for the individual assessed (Carver, 2007); however, a total score was calculated as has been done in previous research (e.g., Meyer, 2001). The total score for the maladaptive subscale ranged from 12 to 48 and a higher score suggested a greater degree of maladaptive coping. The maladaptive subscale demonstrated good internal consistency ($\alpha = .81$) in the present study.

Past treatment experiences. Participants were asked about their past treatment experiences, specific to seeking support from a treatment provider for their sexual interest in children, using questions developed specifically for the present study. Participants were asked if they had sought treatment to address their sexual interest in children, if they had disclosed their sexual interest in children to their treatment provider, and to rate how positive the experience was on a 100-point Likert scale from *Extremely negative* to *Extremely positive*, with a higher score indicating a more positive experience. This rating of their experience was used to assess the influence of past treatment experiences on the relationship between maladaptive coping and treatment motivation.

Internalized sexual stigma. No scale exists that examines internalized sexual stigma for MAPs, so the Measure of Internalized Sexual Stigma for Lesbians and Gay Men (MISS-LG; Lingardi, Baiocco, & Nardelli, 2012) was adapted by Ian McPhail for this population. The original authors of the scale comprised separate scales (MISS-G and MISS-L) to tailor the questions specifically to lesbians and gay men but have published the scale under name MISS-LG. This scale has previously demonstrated good internal consistency and convergent validity (Lingardi et al., 2012).

The adapted MISS-LG (referred to as the Internalized Sexual Stigma Scale) contains 13 items that includes items from both scales (i.e., items 1, 4, 5, 7, 8, 9, 10, 12, and 13 adapted from items that appeared in both the MISS-G and the MISS-L; items 2, 3, and 6 were adapted from the MISS-G, and item 11 was developed to reflect the internalized sexual stigma within MAPs). Given the challenges with disentangling aspects of stigma as a result of the inconsistencies of definitions used within this research area (Livingston & Boyd, 2010), only the total score was used to assess the influence of internalized sexual stigma on the relationship between maladaptive coping and treatment motivation, rather than considering the subscales as well. Within the Internalized Sexual Stigma Scale, participants were asked about their past experiences of internalized sexual stigma, including perceptions of acceptance and harassment, with corresponding answers of *Strongly disagree* to *Strongly agree* on a seven-point Likert scale (with *Somewhat agree*, *Somewhat disagree*, and *Neither agree nor disagree* added) and scores could range from 13-91. A higher score suggested a higher degree of internalized sexual stigma. Example items are, “If it were possible, I would do anything to change my sexual attraction to children” and “At school and/or work, I pretend to be interested in adults (pretending to be attracted to women or showing typically adult interests)”. The total scale demonstrated very good internal consistency ($\alpha = .85$).

Procedure

As previously mentioned, the data utilized in the thesis (i.e., in both studies) is part of a larger study funded by Public Safety Canada, with Dr. Skye Stephens and Ian McPhail as co-investigators (see footnote 1). Dr. Stephens and Ian McPhail assumed primary responsibility for contacting and corresponding with online MAP community forums to post recruitment information as well as promoting the survey through their

professional social networks. The sample was recruited from Dr. Stephens' and Ian McPhail's professional social networks (e.g., professional Twitter accounts and websites) as well as online communities geared towards MAPs: Virtuous Pedophiles (<https://www.virped.org>), Visions of Alice (<https://alichelovers.net>), GirlChat (<https://www.annabelleigh.net>), and BoyChat (<https://www.boychat.org>). Previous research on MAPs in the community have been successfully utilizing this recruitment strategy (e.g., Bailey, Bernhard, & Hsu, 2016; Bailey, Hsu, & Bernhard, 2016; Cacciatori, 2017). Participants were asked to complete a battery of self-report measures examining treatment motivation (including self-efficacy), coping strategies, past treatment experiences, and internalized sexual stigma. In addition, limited demographic information was collected to ensure anonymity.

Data Analysis

The data were exported from Qualtrics into SPSS and appeared to be normally distributed; all skewness values were within -2.00 and +2.00 and kurtosis values were within -7.00 and +7.00. There were a few univariate outliers identified on the Brief COPE, as these participants' scores were beyond the Upper Inner Fence of their respective box and whisker plots. Given the research questions within this study and the potential uniqueness of the MAP population, these outliers were retained in the sample. No multivariate outliers were identified as centred leverage values were below 1, which suggests that there were no cases that caused concern regarding their overall influence on the statistical models performed in the present study (Cook & Weisberg, 1982).

To investigate the main hypotheses, analyses were conducted using SPSS Version 24 and Version 3 of the PROCESS macro for SPSS (Hayes, 2018) to examine moderation, which utilized a bootstrapping of 5000 samples at a 95% confidence interval.

PROCESS macro Model 1 (simple moderation model) was used and several models were tested. In the moderation analyses, maladaptive coping was used as a predictor variable and regressed separately onto the three factors of the SOCRATES scale as well as the SSIC Scale (measuring treatment motivation). Past treatment experiences and internalized sexual stigma were entered separately as moderators. A website created by Jeremy Dawson (Dawson, n.d.) was used to depict significant moderation results and divided the study sample into “low” versus “high” levels of maladaptive coping strategies as well as “low” versus “high” levels of internalized sexual stigma. The interactions of treatment motivation and either proposed moderator was entered in three respective blocks. Prior to the moderation analyses, intercorrelations among the items were examined to assess the bivariate associations between all variables of interest.

Results

Demographic and Descriptive Information

Descriptive statistics and correlations of composite variables are presented in Table 3. Participants reported an average score of 20.72 ($SD = 6.43$) regarding their use of maladaptive coping strategies. Average treatment motivation scores across the SOCRATES were: Recognition factor ($M = 12.93$, $SD = 6.03$), Ambivalence factor ($M = 15.65$, $SD = 6.61$), and Taking Steps factors ($M = 12.00$, $SD = 5.48$). The average self-efficacy score was 8.70 ($SD = 3.99$). As the mean rating for past treatment experience was above 50 in the 0 to 100 range provided in the survey question ($M = 61.74$, $SD = 33.91$), the rating of past treatment experience was neutral, though closer to a positive, rather than negative, rating. Participants reported an average score of 54.87 regarding internalized sexual stigma ($SD = 14.27$).

As shown in Table 2, there were large significant positive correlations among the three SOCRATES factors, Recognition, Ambivalence, and Taking Steps, suggesting that the three factors of treatment motivation were positively associated. Further, higher levels of treatment motivation were significantly and positively associated with higher levels of self-efficacy.

Notably, medium to large significant correlations also emerged between maladaptive coping and the different factors of treatment motivation. Higher levels of maladaptive coping were positively associated with higher levels of motivation for treatment (i.e., all three factors of the SOCRATES), but not self-efficacy. Higher levels of maladaptive coping were significantly positively associated with internalized sexual stigma. Higher levels of internalized sexual stigma were also positively correlated with treatment motivation and self-efficacy.

Moderation Models for Maladaptive Coping and Treatment Motivation

Moderated regressions were used to examine the association between maladaptive coping strategies and treatment motivation (the three factors of SOCRATES and self-efficacy) and whether the relationship was influenced by past treatment experiences and internalized sexual stigma (see Table 4).

Recognition. The overall model examining whether past treatment experiences moderated the association between maladaptive coping and the Recognition factor was significant, $F(3, 56) = 6.58, p = .001, R^2 = .26, 1 - \beta = .97$ (see Table 4). Higher levels of maladaptive coping were associated with greater recognition of difficulty managing sexual interest in children. The main effect of past treatment experiences was not

significant and did not significantly moderate the association between maladaptive coping and recognition.

The next overall model examining whether internalized sexual stigma moderated the association between maladaptive coping and the Recognition factor was significant, $F(3, 195) = 28.96, p < .001, R^2 = .31, 1 - \beta = 1.00$ (see Table 4). As above, the main effect of maladaptive coping was significant and there was a significant main effect of internalized sexual stigma as well. As internalized sexual stigma increased, participants reported greater recognition for the need to manage their sexual interest in children. Internalized sexual stigma did not significantly moderate the association between maladaptive coping and recognizing difficulty managing sexual interest in children.

Ambivalence. The overall model examining the moderation of past treatment experiences on the association between maladaptive coping and the Ambivalence factor was significant, $F(3, 56) = 3.70, p = .017, R^2 = .17, 1 - \beta = .83$ (see Table 4). As above, higher levels of maladaptive coping were significantly associated with MAPs' uncertainty regarding being in control of their sexual interest in children. As previously mentioned, higher scores on the Ambivalence factor is suggestive of higher treatment motivation (as reflected by greater uncertainty) when compared to lower scores, which would mean denying that a problem exists. Past treatment experiences were not significantly associated with feelings of ambivalence nor did they moderate the relationship between maladaptive coping and ambivalence.

The overall model examining the moderation of internalized sexual stigma on the association between maladaptive coping and the Ambivalence factor was significant, $F(3, 196) = 34.73, p < .001, R^2 = .35, 1 - \beta = 1.00$ (see Table 4). Greater use of maladaptive

coping strategies was significantly related to greater ambivalence and increased levels of internalized sexual stigma were associated with greater feelings of ambivalence.

Internalized sexual stigma significantly moderated the relationship between maladaptive coping and treatment motivation (see Figure 2). For both high and low levels of internalized sexual stigma, the relationship between maladaptive coping and the Ambivalence factor remained the same; however, a difference emerged at high levels of maladaptive coping. More specifically, greater maladaptive coping decreased feelings of ambivalence (i.e., treatment motivation) and this was exacerbated by higher levels of internalized sexual stigma.

Taking Steps. The overall model examining the moderation of past treatment experiences on the association between maladaptive coping and the Taking Steps factor was significant, $F(3, 56) = 5.21, p = .003, R^2 = .22, 1 - \beta = .93$ (see Table 4). The main effects of maladaptive coping and past treatment experiences were each associated with MAPs' engagement in making positive changes regarding the management of their sexual interest in children. Greater maladaptive coping and more positive past treatment experiences were associated with higher levels of the Taking Steps factor. Past treatment experiences did not significantly moderate the relationship between maladaptive coping and taking steps towards positive change.

The overall model examining the moderation of internalized sexual stigma on the association between maladaptive coping and the Taking Steps factor was significant, $F(3, 196) = 24.38, p < .001, R^2 = .27, 1 - \beta = 1.00$ (see Table 4). Maladaptive coping and internalized sexual stigma were each independently significantly associated with MAPs' likelihood in taking steps towards making positive changes regarding the management of their sexual interest in children.

Experiences of internalized sexual stigma significantly moderated this relationship (see Figure 3), which followed the same pattern as what was found for the Ambivalence factor. At low levels of maladaptive coping, the association between maladaptive coping and the Taking Steps factor remained the same for both low and high levels of internalized sexual stigma; the difference emerged at high levels of maladaptive coping. More specifically, greater maladaptive coping decreased taking steps towards positive change (i.e., treatment motivation) and this was exacerbated by higher levels of internalized sexual stigma.

Self-efficacy. The overall model examining the moderation of past treatment experiences was not significantly associated with self-efficacy, $F(3, 56) = 1.06, p = .375, R^2 = .05, 1 - \beta = .27$. Nonetheless, the overall model examining the moderation of internalized sexual stigma on the impact of maladaptive coping and self-efficacy was significant, $F(3, 195) = 5.05, p = .002, R^2 = .07, 1 - \beta = .91$. Higher levels of internalized sexual stigma were associated with a greater degree of self-efficacy, but maladaptive coping was not significantly associated with self-efficacy. Further, internalized sexual stigma did not moderate the relationship between maladaptive coping and self-efficacy.

Discussion

The present study is the first to thoroughly examine the concept of treatment motivation and its correlates among MAPs. Briefly, higher levels of maladaptive coping were associated with a greater degree of treatment motivation among MAPs. Although this finding was consistent across the three factors of the SOCRATES (i.e., Recognition, Ambivalence, and Taking Steps), there was a non-significant association between maladaptive coping and self-efficacy. There was only a significant main effect of past treatment experiences on treatment motivation with regards to the Taking Steps factor,

whereby more positive treatment experiences increased treatment motivation; however, this result should be interpreted with caution given the small sample of MAPs ($n = 60$; 29%) who disclosed their sexual interest in children to a treatment provider. Past treatment experiences were not a significant moderator in any of the analyses. Further, there was a positive association between internalized sexual stigma and all facets of treatment motivation. There was a main effect of internalized sexual stigma across all four measures of treatment motivation, whereby increased sexual stigma was associated with increased treatment motivation. Internalized sexual stigma moderated the association between maladaptive coping and both Ambivalence and Taking Steps factors, but not the Recognition factor.

Maladaptive Coping and Treatment Motivation

Different measures of treatment motivation were used to assess whether multiple factors of readiness to change were influenced by the presence of maladaptive coping. Overall, MAPs reported relatively low levels of treatment motivation across the four measures, which is somewhat incongruent with past research (e.g., Beier, Ahlers, et al., 2009; Beier, Neutze, et al., 2009; Levenson & Grady, 2018). Notably, the present study offered a more nuanced measure of treatment motivation, whereas past studies considered help-seeking behaviours in terms of MAPs reaching out for help and reporting motivation to engage with mental health services. Further, these previous studies did not quantifiably examine treatment motivation, but rather inferred motivation via response rates to treatment programming initiatives, such as the Berlin Project Prevention Dunkelfeld, or inquired about frequencies of help-seeking behaviours. It is, therefore, worthwhile to further explore why the average treatment motivation scores were in the lower range in the present study, given previous research findings. Levenson and colleagues (Levenson

& Grady, 2018; Levenson et al., 2017) have reported a vast range (12-75%) of their sample had sought professional support, which demonstrates the variation in help-seeking behaviours in MAPs. Individuals seek treatment for all sorts of reasons, and it is erroneous to assume that because someone attends for treatment, they are motivated to seek treatment (e.g., make changes to their problematic thoughts and behaviours).

As predicted, maladaptive coping was significantly associated with increases on all three factors of the SOCRATES (i.e., Recognition, Ambivalence, Taking Steps). This finding is unsurprising given that these factors were highly correlated with each other and with the Brief COPE, the measure of maladaptive coping. This finding is also consistent with several previous findings. Specifically, previous research demonstrated high levels of help-seeking behaviours in MAPs living in the community (Beier, Ahlers, et al., 2009; Beier, Neutze, et al., 2009; Levenson & Grady, 2018), which could imply that these individuals were experiencing difficulties regarding the management of their sexual interest in children, leading them to engage in maladaptive coping strategies. Further, Levenson and Grady (2018) reported that MAPs were engaging in behaviours that were potentially indicative of maladaptive coping, such as abusing substances or distraction.

Maladaptive coping was not significantly associated with the measure of self-efficacy in the present study. This result was initially surprising, given previous research has used this measure of self-efficacy, as it is specific to MAPs, and provided evidence for self-efficacy particular to sexual interest in children (Tozdan & Briken, 2015a). Further, past research that has used the SOCRATES recommended including a self-efficacy measure (e.g., Miller & Tonigan, 1996). As self-efficacy considers one's confidence level that efforts will yield the preferred outcome (Bandura, 1977), it is possible that this facet of treatment motivation may not be relevant to MAPs living in the

community. It is also possible that when answering the SSIC Scale questions, participants may have interpreted the meaning of the items as being related to MAPs' confidence in changing, as opposed to managing, their sexual interest in children. If participants interpreted the SSIC Scale questions as related to confidence in their ability to change their sexual interest, this would be inconsistent with the generally accepted understanding that the interest is stable (e.g., Grundmann, Krupp, Scherner, & Beier, 2016; Seto, 2012). This interpretation is somewhat consistent with the SSIC Scale scores being in the lower range ($M = 9.16$, $SD = 4.20$, scores can range from 5-20). Tozdan and Briken (2015a) suggested that MAPs believing in the controllability their sexual interest in children may be tied to motivation to change their sexual interest, leading to potential changes in behaviours, while also creating susceptibility to self-stigma, which can negatively impact self-efficacy related to sexual interest in children (Briken, Federoff, & Bradford, 2014). A final reason for the non-significant association could be because the SSIC Scale may not have translated well to an English-speaking population as it has not been validated in English (personal communication, S. Tozdan, November 23, 2017). These limitations may be the reason for the low internal consistency of the total scale found within the present study, which required one item to be removed.

The influence of past treatment experiences. Overall, there was no association between past treatment experiences and treatment motivation with one exception. The exception was that MAPs who reported more positive past treatment experiences had engaged in higher levels of taking steps towards positive change. This finding is both logical and arguably consistent with past literature (e.g., Kushner & Ster, 1991; Levenson & Grady, 2018). Understandably, if MAPs have positive encounters with clinicians while in treatment, they will be more motivated to make positive changes after treatment has

concluded and problems reemerge. In addition, it is likely that past therapists would have encouraged people in therapy to continue to take positive steps towards behaviour change so that these gains could be maintained.

It is important to note that only 60 MAPs within the sample had previously disclosed their sexual interest in children to a treatment provider and reported on that experience, which suggests these results should be interpreted cautiously, particularly where moderation is concerned. Despite this small subsample, the low number of individuals in the sample who sought treatment for sexual interest in children (29%) does fall within previously cited ranges of the proportions of MAPs who pursued support from a treatment provider (23%-75%; B4U-ACT, 2011b; Levenson & Grady, 2018; Levenson et al., 2017). Within the present study, the average rating for past treatment experiences was neutral, although weighted more positively than negatively ($M = 61.74$, $SD = 33.91$, range of 0-100). Although past research has not quantified treatment experiences in this format – for example, Levenson & Grady (2018) asked overall whether MAPs found treatment helpful – the present rating is reflective of MAPs' mixed experiences with treatment. Specifically, past literature has reported MAPs encountering both positive (e.g., B4U-ACT, 2011b; Cacciatori, 2017; Cash, 2016; Jahnke & Hoyer, 2013; Grady et al., 2018; Houtepen et al., 2016; van Horn et al., 2015) and negative (e.g., Cacciatori, 2017; Cash, 2016; Levenson & Grady, 2018; Levenson et al., 2017) experiences with treatment. In comparison, Levenson & Grady (2018) described that 186 MAPs (63%) reported seeking help from informal and formal support; 49% found their disclosure to be helpful. It is also possible that MAPs within the present sample may have found it challenging to assign one numerical value to their past treatment experience as this population has reported both positive and negative experiences regarding treatment (e.g.,

Beier, Ahlers, et al., 2009; Cacciatori, 2017; Cash, 2016; Jahnke & Hoyer, 2013; Houtepen et al 2016; Levenson & Grady, 2018; Levenson et al., 2017; van Horn et al. 2015). Future research should strive to dedicate efforts to focusing specifically on MAPs who have disclosed their sexual interest to their treatment provider and, perhaps, with the integration of qualitative research, more fruitful findings would emerge.

The influence of internalized sexual stigma. Maladaptive coping was found to be associated with higher levels of internalized sexual stigma. This finding was unsurprising as it aligns strongly with the previous literature on MAPs (e.g., Grady et al., 2018; Jahnke, Imhoff, & Hoyer, 2015), the extensive research supporting the negative impacts of stigma on stress (e.g., Link & Phelan, 2006; Miller & Kaiser, 2001; Rüscher et al., 2009), and the efforts stigmatized individuals will take by using various coping strategies in an attempt to manage their stress (Miller & Kaiser, 2001).

The association between maladaptive coping and stigma is also consistent with the modified labeling theory, which applies to mental disorders (Link et al., 1989). The experience of being labeled with an attribute (i.e., identifying as a MAP) can create consequences for the individual, such as experiencing stigma when interacting with others as well as maladaptive coping (Link, 1982). The modified labeling theory proposes that, following the receipt of a mental disorder label, individuals may employ coping strategies related to hiding their efforts associated with seeking treatment, withdrawing from others for fear of rejection, and striving to educate others about the challenges they are facing as an avenue to address negative judgment (Goffman, 1963; Schneider & Conrad, 1980). Arguably, the first two coping strategies can be considered maladaptive as concealment and withdrawal are likely to contribute to poor mental health (Kawachi & Berkman, 2001) and have been endorsed by MAPs (e.g., Blagden et al., 2018; Levenson & Grady,

2018). An important caveat to the application of the modified labeling theory to MAPs is that the presence of sexual interest in children alone is not a mental disorder but is being applied in this context to further substantiate the association between maladaptive coping and stigma.

Internalized sexual stigma was found to be significantly associated with treatment motivation, whereby higher levels of internalized sexual stigma were associated with greater ambivalence regarding the management of one's sexual interest in children as well as a higher likelihood of taking steps towards positive change. The strength of these relationships, as evidenced by the coefficients of determination, were quite strong as internalized sexual stigma explained 35% and 27%, respectively, of the variance in the Ambivalence and Taking Steps factors. These findings may appear misaligned with previous literature as experiences with stigma are recognized by MAPs as a significant barrier to seeking treatment (e.g., B4U-ACT, 2011a; Cacciatori, 2017; Kramer, 2011), but this may reflect that seeking treatment and treatment motivation are slightly different constructs.

It would be expected that experiencing less stigma would reduce barriers to seeking treatment, as identified in previous literature. Experiences of stigma that arise from one's recognition of oneself as a MAP are presumed to strongly influence decisions around treatment (Cantor & McPhail, 2016). Nonetheless, previous research did not explicitly examine how stigma was associated with treatment motivation nor was stigma measured within the sexual minority research lens. Rather, stigma and help-seeking behaviours have previously been considered in a qualitative nature (e.g., Cacciatori, 2017; Grady et al., 2018) or through descriptive statistics (e.g., B4U-ACT, 2011a; Levenson et al., 2017). For example, 78% MAPs who responded to a survey feared a negative

response from a clinician and reported this as a reason for not seeking treatment (B4U-ACT, 2011a) – but this was not considered in relation to stigma or treatment motivation. In contrast, Jahnke, Schmidt, et al. (2015) did not find an association between willingness to seek treatment and a fear of being discovered or perceived social avoidance.

Although these findings are somewhat perplexing, it is hypothesized that the positive association between internalized sexual stigma and treatment motivation may be facilitated by attempts to resolve experiences of cognitive dissonance. Festinger (1962) proposed that when individuals have encountered conflicting experiences (e.g., thoughts, feelings, behaviour), they will attempt to change the pieces of information they have control over (i.e., dissonance-reducing changes) to achieve consistency. For example, individuals will alter their private beliefs (either through internal justification or external pressure) to align with public beliefs. When faced with equivalent choices, individuals will perceive the chosen course of action (i.e., the thought, feeling, or behaviour they have altered) as more attractive than the option they have no control over, suggesting that cognitive dissonance can be a motivating factor to pursue an originally unappealing option by increasing its perceived desirability (Brehm, 1956; Festinger, 1962).

The concept of cognitive dissonance can be applied to the present study's findings. Specifically, MAPs may have changed their attitudes towards treatment, which many have previously viewed as negative – at least partially because of stigmatization (Levenson & Grady, 2018; Levenson et al., 2017) – by drawing on their internal motivation for change (Jensen, 1979). Cognitive dissonance induces a negative emotional state that motivates individuals to reduce this conflict through behavioural change (i.e., MAPs seeking treatment regarding the management of their sexual interest in children; Harmon-Jones & Harmon-Jones, 2007). Therefore, although initially counterintuitive, an

explanation for increased levels of reported internalized sexual stigma contributing to increases in treatment motivation is supported through the principles of cognitive dissonance.

Internalized sexual stigma was the only variable that was significantly associated with self-efficacy. As mentioned above, this was an unanticipated finding given the established connection between self-efficacy and treatment motivation in other populations (e.g., smoking cessation; Clyde, Tulloch, Reid, Els, & Pipe, 2015; Hughes & Naud, 2016). It was expected that, as the SSIC Scale was developed specifically for MAPs, this measure would be significantly related to maladaptive coping, given the robust presence of stigma and poor mental health within this population (e.g., B4U-ACT, 2011a; Cohen et al., 2018; Grady et al., 2018; Jahnke, 2018a; Jahnke, Imhoff, & Hoyer, 2015; Levenson & Grady, 2018). Since self-efficacy is a recognized component of treatment motivation (Bandura, 1997), the significant association between internalized sexual stigma and self-efficacy is likely explained by the principles of cognitive dissonance (Festinger, 1962).

Lastly, internalized sexual stigma moderated the relationship between maladaptive coping and the Ambivalence and Taking Steps factors, but not the Recognition factor. When MAPs reported low levels of maladaptive coping, there was no difference in treatment motivation across both low and high levels of internalized sexual stigma. When MAPs reported high levels of maladaptive coping, high internalized sexual stigma was associated with lower treatment motivation compared with low levels of internalized sexual stigma. These findings are in line with the present study hypotheses. Specifically, MAPs suffering less internalized sexual stigma reported greater treatment motivation regardless of their use of maladaptive coping strategies. This relationship highlights the

significant influence of internalized sexual stigma on treatment motivation, which persists whether or not MAPs experience difficulties coping with their sexual interest in children.

By quantifying MAPs' use of maladaptive coping strategies, the present study emphasizes that some MAPs engage in maladaptive approaches to manage their sexual interest in children. It would therefore be valuable to assess the adaptive strategies that MAPs are using to avoid experiencing difficulties managing their sexual interest in children. This would also provide the opportunity to highlight MAP success stories, which could offer efforts to reduce the stigmatization towards this population. For example, Harper et al. (2019) found that an individual's narrative of their identification as a MAP and the absence of services dedicated to supporting their desire to abstain from sexually offending were both successful in reducing stigma within the general public, when compared to an informative condition, which involved receiving scientific evidence on sexual interest in children. Previous research has established that past treatment experiences positively affect treatment motivation whereas stigma impacts treatment motivation negatively (Houtepen et al., 2016; Levenson & Grady, 2018); the present study contributes to the literature by assessing how these factors interact with maladaptive coping. Specifically, past treatment experiences did not appear to impact treatment motivation, but this may have resulted from the small sample size used within the analyses. Contrarily, internalized sexual stigma did significantly impact treatment motivation, whereby higher levels of stigma were associated with decreased ambivalence regarding MAPs' controlling sexual interest in children as well as a decreased likelihood of taking steps towards positive change.

Limitations and Future Research

The present study is not without limitations, especially given the reliance on a cohort research design using self-report data and a convenience sample. Of particular note is the reliance on self-report measures and the potential for bias in subjectively measuring these constructs in oneself. Although cohort designs are vulnerable to selection bias, they can be beneficial for investigating more novel attributes (Song & Chung, 2010), such as sexual interest in children.

Further, as MAPs are a highly stigmatized group, as demonstrated both through past (e.g., Feldman & Crandall, 2007; Furnham & Haraldsen, 1998; Freimond, 2013; Grady et al., 2018; Jahnke, Imhoff, & Hoyer, 2015; Jahnke, 2018a, 2018b; Levenson & Grady, 2018; Levenson et al., 2017) and present research findings, and it is possible that the MAPs who participated in the present study may not be a generalizable representation of all MAPs. As with past studies (e.g., Beier, Ahlers et al., 2009; Beier, Neutze et al., 2009; Beier et al., 2015; Cacciatori, 2017; Levenson & Grady, 2018; Levenson et al., 2017), the present study's recruitment platforms (i.e., online MAP communities and/or following researchers who specialize in this population) may be attracting MAPs who are more motivated to learn about themselves and their sexual interests as well as to seek help and/or engage in treatment compared to those who are not communicating with such platforms. If this is what has occurred, it is concerning because of the relatively low range of treatment motivation levels reported in the present study. Alternatively, the present study sample could align with past MAP samples, which included individuals who were coping well and possess no concerns about refraining from childhood sexual abuse perpetration (e.g., Bailey, Bernhard, & Hsu, 2016; Cacciatori, 2017; Dombert et al., 2016; Feelgood & Hoyer, 2008; Levenson & Grady, 2018; Murray, 2000), hence their low motivation for treatment.

There were two methodological limitations that are worth considering. As no scales exist that measure treatment motivation, coping, or internalized sexual stigma in MAPs, measures were adapted for this study and, therefore, have not been validated with the MAP population. This is a limitation as the original measures were not specifically intended for use within the MAP population and may reveal themselves to be inappropriate for measuring their respective constructs, which may affect the present study findings. With that said, the scales did display good to excellent internal consistency and do provide improvements on how past research measured stigma (e.g., using frequencies rather than evaluating stigma through established sexual minority research). Secondly, the failure to find significant results between maladaptive coping and self-efficacy may have resulted from the utility of the SSIC Scale within the present study. Besides the scale having not been validated in English (personal communication, S. Tozdan, November 23, 2017), there are also potential limitations regarding the SSIC Scale's measurement of self-efficacy in relation to MAPs controlling, rather than changing, their sexual interest. Future research should strive to establish the psychometric properties of this measure in an English-speaking MAP demographic.

A fourth limitation of the present study is the operationalization of coping strategies as maladaptive (in comparison to adaptive). It is evident that this conceptualization is quite archaic and perhaps judgmental as well, given that certain strategies that have been labeled as maladaptive (e.g., avoidance) may be adaptive in certain contexts (e.g., engaging in work-related activities to avoid thinking about situations one cannot control). Instead of assigning positive or negative valence to coping strategies, it may be more beneficial to describe coping strategies as either primary (i.e., used most often) versus secondary (i.e., used less often) or automatic (i.e., used without

much thought) versus voluntary (i.e., used more consciously) approaches instead (Miller & Kaiser, 2001) and future research could aim to investigate such methods to further understand MAPs' coping mechanisms.

As with any human attribute, identifying as a MAP is only one aspect of these individuals. Clinicians, researchers, and society as a whole are encouraged to be aware of this caveat when considering this population and avoid perceiving MAPs solely as a reflection of their sexual interest in children, which can then contribute to efforts to reduce further stigmatization. There is a notable risk within the scientific research community to acquire an assumption of perpetration or to view MAPs primarily within the lens of their sexual interest in children rather than within their treatment needs more generally (B4U-ACT, 2011a; Harper et al., 2019). Future research could consider the strength of MAPs' sexual minority identity (Meyer, 2003) to see if this conceptualization affects treatment motivation.

Conclusion

These findings add to the developing literature base examining the needs of MAPs living in the community by bringing greater awareness to the challenges faced by this population. This supports the need for dedicating efforts toward the development of assessment and treatment services (e.g., screening tools, treatment programming), while also recognizing that many MAPs are managing well, as has been documented in previous studies (e.g., Grady et al., 2018; Houtepen et al., 2016; Levenson & Grady, 2018; Levenson et al., 2017).

Having investigated the association between maladaptive coping and treatment motivation in MAPs living in the community, a natural second step would be examining clinicians' stigma against this population as a potential barrier to treatment. After all,

strong levels of treatment motivation by MAPs regarding the management of their sexual interest in children may be irrelevant if clinicians are not prepared to provide assessment and treatment services to this population.

Chapter 3 – Treatment Provision for MAPs

Given the response of MAPs to treatment programs in other countries and the previous findings on treatment motivation, the question arises as to whether mental health clinicians in Canada are both qualified and willing to provide treatment to MAPs. It has been suggested that MAPs may have difficulty finding a clinician because of the potential stigmatization of their sexual interest (e.g., B4U-ACT, 2011; Cacciatori, 2017; Grady et al., 2018; Jahnke, 2018a; Jahnke & Hoyer, 2013). Therefore, it is important to examine clinicians' willingness to treat MAPs and the presence of clinician stigma towards this population in order to ascertain whether there are clinicians who are able and willing to provide comprehensive treatment services to this population. Of interest is whether the background training and competency of the clinician (e.g., clinicians who are forensically-trained might have more or less stigmatizing attitudes towards MAPs compared to general clinicians) affects' willingness to treat MAPs. This is important because, although MAPs may possess a strong desire to seek support, clinician stigma may interfere with the provision of treatment for this population.

MAPs' Perceptions of Clinician Stigma

It appears that the MAP community is skeptical of clinicians' knowledge regarding sexual interest in children, and the possibility of being further stigmatized by clinicians (B4U-ACT, 2011a, 2011b; Grady et al., 2018; Jahnke, Schmitt, et al., 2015). This skepticism is rooted in the broader consideration of sexual and gender identities as the psychiatric field has a rather poor history in relation to treating these populations (e.g., Lambda Legal, 2010; Risher et al., 2013; Willging, Salvador, & Kano, 2006a; Willging, Salvador, & Kano, 2006b). For instance, 88% of community MAP survey participants responding to an online questionnaire did not feel that mental healthcare

providers possessed a solid understanding of sexual interest in children (B4U-ACT, 2011a). Similar findings were reported by Houtepen et al. (2016), whereby only half of the MAP community sample reported seeking treatment for their sexual interest, and within the treatment group, there was a perception of insufficient clinician support. Further, B4U-ACT (2011a) survey respondents also questioned whether they would be treated ethically (46%), with respect (54%), without judgment (62%), and if confidentiality would be respected (51%), if professional help was sought out.

A second B4U-ACT survey reported that more than half of participants declared initially wanting to see a mental health clinician regarding their sexual interest in children, however, they decided against it, because of worries that they would be treated negatively, be reported to authorities, or be misunderstood (B4U-ACT, 2011b). Further, 40% felt discouraged from seeking professional mental health treatment due to an experience with a clinician that they perceived as stigmatizing (B4U-ACT, 2011b). In addition, half of one MAP community sample surveyed elsewhere did express a willingness to pursue professional help, although only 36% believed that a healthcare provider would understand their needs (Jahnke, Schmitt, et al., 2015).

Despite these strong negative anticipated or experienced reactions, there is a pool of MAPs who do report positive experiences from seeking treatment. This perspective was evident in Study 1 as participants provided an average rating of past treatment experience that was weighted more positively ($M = 61.74$, $SD = 33.91$). Past research suggests that MAPs who were persistent in finding a suitable clinician felt compassion and understanding from their treatment provider (Cacciatori, 2017). In addition, MAPs have recognized that professional help may be beneficial (Dombert et al., 2016) and have reported that their clinicians have been helpful (Levenson & Grady, 2018). Despite these

examples of treatment success, there remains a strong indication of fear and skepticism felt by the MAP population with regards to the ability of clinicians to provide adequate assessment and treatment related to sexual interest in children.

Clinicians' Perspectives of MAPs

Although the perceptions of MAPs are important to consider, it is equally important to examine whether clinicians hold stigmatizing attitudes toward this population and if there is hesitation in clinicians' desire to assess and treat MAPs. Cantor (2014) asserted that despite extensive experience, clinicians may hold conflicting perspectives towards this population, which may contribute to negative judgments and/or unwillingness to treat MAPs. For example, clinicians may experience difficulty maintaining client confidentiality while upholding their ethical and legal responsibilities regarding child protection as well as strive to appreciate the complexities of clinical decision-making given the paucity of empirical research focused on MAPs living in the community (Cantor, 2014). In addition, clinicians may be reluctant to provide treatment to MAPs out of fear for potential prejudice and discrimination resulting from treating this population (i.e., courtesy stigma; Cantor & McPhail, 2016; Ostman & Kjellin, 2002).

There is currently a lack of literature examining clinician stigma towards MAPs in Canada, as the majority of studies examining MAPs have been conducted in countries without mandatory reporting laws that are similar to Canada (e.g., Alanko, Haikio, Laiho, Jahnke, & Santtila, 2014 as cited in Jahnke, Philipp, & Hoyer, 2015; Jahnke, Philipp, Hoyer, 2015; Stiels-Glenn, 2010). Despite the lack of information about Canadian clinicians, experts do advocate for more acceptance from healthcare professionals regarding MAPs in an effort to work towards prevention strategies targeting childhood sexual abuse (e.g., Beier, Ahlers, et al., 2009) and to support the mental health needs of a

highly stigmatized population, yet professional help geared towards supporting this population is lacking (Seto, 2012).

Jahnke, Philipp, and Hoyer (2015) conducted one of the only studies examining the stigmatization of MAPs by mental health clinicians. The study demonstrated significant changes amongst psychotherapists-in-training in their emotional responses (i.e., controllability, dangerousness, affective reactions, and maintaining social distance) in reaction to MAPs with the introduction of an anti-stigma intervention. Participation in the intervention also resulted in reducing beliefs about the controllability of sexual interests, however, these beliefs were not commonplace before the intervention. Regardless of the greater understanding achieved, the intervention had no impact on the willingness to provide treatment to MAPs. Complicating the issue further, clinicians have reported perceiving sexual interest in children as having a greater biological underpinning and consider it to be more pathological (i.e., clinical) when compared to other paraphilias (Fuss, Briken, & Klein, 2018), suggesting that healthcare professionals may possess similar levels of stigmatization towards MAPs as demonstrated by the general population (e.g., Feldman & Crandall, 2007; Furnham & Haraldsen, 1998; Jahnke & Hoyer, 2013; Jahnke, 2018b; Jahnke, Imhoff, & Hoyer, 2015).. Therefore, given the significant stigmatization of MAPs within public perception, it can be expected that stigmatized views exist within the healthcare profession as well.

Depending on what training clinicians have regarding their experience working with forensic populations or in clinical sexology, their perceptions of MAPs could differ. Cantor (2014) surmised that clinicians with sexology specialization may focus their clinical work more closely on physiological symptoms associated with the presenting sexual issue (e.g., lack of sexual desire), whereas general clinicians may focus on

diagnostic considerations of the presenting sexual issue (e.g., “do the symptoms meet diagnostic criteria for male hypoactive sexual desire disorder?”). These differing foci highlight the potential influence of competency and experience on clinical practice decisions.

Clinicians’ professional backgrounds vary resulting in different competencies. For example, the Nova Scotia Board of Examiners in Psychology requires psychologists to provide services within “areas of competence as defined by verifiable training and experience” (The Nova Scotia Board of Examiners in Psychology, 2010, p. 2). As competency may influence clinical work, professional background and experience may also impact clinician stigma and willingness to treat a population. For example, Jahnke (2018a) asserted that clinicians with forensic specialization may experience greater difficulty in dissociating childhood sexual abuse behaviour from sexual interest in children, given that a significant proportion of clients in their care have offended. Other mental health research has also reported clinicians holding negative perceptions towards the populations they treat compared to how the general public perceives these clinical populations (e.g., Nordt, Rössler, & Lauber, 2006). In contrast, research on clinicians’ perceptions of individuals with involvement in the criminal justice system has demonstrated that clinicians are very comfortable working with offending populations but have lower regard and respect for these clients compared to those not involved with the criminal justice system (Bandara et al., 2018). Further, it is also possible that clinicians with forensic specialization hold less stigma because of their greater exposure to sexual offending behaviour, which may result in encountering atypical sexual interests in the presence of offending behaviour (Cantor & McPhail, 2016; Seto, 2008), and as a result may be more comfortable providing treatment to MAPs than general clinicians.

Another important caveat to the consideration of clinicians' willingness to treat MAPs is that the absence or presence of stigma is not the sole contributor behind clinical decision-making. For example, clinicians may feel unqualified (Lasher & Stinson, 2017), endorse skepticism regarding treatment efficacy (Jahnke & Hoyer, 2013; Jahnke, Philipp, & Hoyer, 2015), or possess discomfort discussing sexual content (Day, Thurlow, & Woolliscroft, 2002; Moore, 2018). With that said, it is important to assess the presence of potential stigma in clinicians, who may encounter MAPs within their clinical practice, and determine its effect on providing assessment and treatment services for this population.

Present Study

Due to the paucity of research in this area as well as the variability in definitions regarding professionals' own understanding of sexual interest in children (McCartan, 2011), there is a significant need to investigate clinicians' perceptions of MAPs and related stigma, which can contribute to the development of effective assessment and treatment services for this population. The second study in the thesis examined explicit stigma of MAPs held by registered Canadian mental health clinicians.

It was hypothesized that clinicians with forensic specialization would differ in willingness to treat MAPs and explicit stigma (i.e., stigma which is assessed by self-report measures) compared with the other two clinician groups (i.e., general clinicians and those with sexology specialization). Due to the exploratory nature of this study, there was uncertainty regarding how the training backgrounds and experience would affect the level of comfort and understanding of MAPs. For example, it was possible that clinicians who are forensically-trained would have fewer stigmatizing attitudes towards MAPs

compared to clinicians who possess general or sexological competencies and/or training. This result could occur due to the clinicians with forensic specialization possessing greater knowledge and understanding of MAPs, as well as paraphilias more generally. Alternatively, clinicians with forensic specialization could have a greater likelihood of conflating sexual interest and behaviour given the greater exposure these clinicians have to individuals who have been convicted of sexual offenses, resulting in higher ratings of perceived risk (i.e., stigma; Jahnke, 2018a; Levenson & Grady, 2018). Variation in clinician understanding of sexual interest in children, including misperceptions regarding etiology and treatment needs, was expected. This uncertainty in outcomes necessitated the importance of conducting an exploratory analysis of explicit clinician stigma towards MAPs in order to more fully understand whether there are mental health clinicians who are willing to treat this population.

Method

An *a priori* power analysis conducted using G*Power v3.1.9.3; Faul, Erdfelder, Lang, & Buchner, 2007) suggested that a minimum of 800 participants was required to have 95% power to detect small effects. This, of course, is a very large sample size, which resulted from inputting the effect size of 0.1 from Jahnke, Philipp, and Hoyer (2015) and the desire to split the sample into three groups.

Participants

All registered mental health clinicians residing and practicing in Canada were eligible to participate in the anonymous online survey if they provided mental health services in the past 12 months or were enrolled in a training program that allowed them to become a registered mental health clinician. Potential participants were informed that it

was *not* a requirement for participation that they had seen MAPs as part of their clinical work. It was anticipated that most of the study sample would be comprised of psychologists due to the professional networks of the authors, however, clinicians from other disciplines (e.g., psychiatrists, social workers, occupational therapists) were encouraged to participate as well and an effort was made to recruit a broad range of mental health professionals. There were 400 cases in the dataset and participants were excluded if they did not complete the survey ($n = 110$), leaving a total of 290 participants for inclusion in the present study. The study was approved by the Research Ethics Boards at Saint Mary's University, the University of Saskatchewan, and the Centre for Addiction and Mental Health.

Characteristics of the study participants are presented in Table 4. Participants ranged in age from 23-79 years old ($M = 39.30$, $SD = 11.90$), but it is important to note that a significant number of participants (41.0%) did not provide their age. Almost three quarters identified as female. The majority (52.1%) of the sample identified as White – North American (e.g., Canadian, American) and the next largest group was White – European (e.g., English, Italian, Portuguese, Russian). More than half of the sample was registered as a mental health clinician in Ontario, which was unsurprising given that all the authors have strong professional and social ties within the province, in addition to the population of the province. Approximately one third reported having either a Master's or Doctoral degree as the highest degree their professional designation was based on.

Most of the sample declared their mental health profession (or as a student/trainee) to be Psychologist (38.6%) or Social Worker (21.4%). The number of years practicing as a registered mental health clinician ranged from 0-51 ($M = 11.41$, $SD = 10.63$). It should be noted that trainees (including postdoctoral students) were instructed

to enter 0 for this question unless they were registered with their regulatory body. Students ($n = 119$) were asked to input the number of hours they have worked under a registered mental health clinician, which ranged from 0-10,000 ($M = 763.64$, $SD = 1580.41$). Most participants either did not have training and/or experience providing assessment and/or treatment services to individuals with a sexual interest in children (55.2%) and some (16.6%) were unsure.

Variables and Measures

Demographics and experience. Background questions were developed by the study authors to capture basic demographic information (i.e., age, identified gender, ethnicity) as well as information about participants' work as mental health clinicians. Specifically, participants were asked their mental health profession (students were asked to indicate the profession they were training in), the population for which they provide mental health services, the Canadian province or territory in which they were currently registered (or hoping to register), the highest degree on which their professional designation was based (students were asked to indicate the degree they were currently working towards), the number of years they had been practicing as a registered healthcare professional, their declared competency, and their ability to provide assessment and/or treatment to clients of various clinical populations. Participants were to check all client groups that apply, so percentages did not tally to 100 as categories were not mutually exclusive. All questions were developed based on the literature as well as knowledge from experts in this field and were designed to assess competency/experience of clinicians. See Appendix A for background questions.

For the main independent variables in the study, participants were asked about areas of competency and experience providing assessment/treatment to different client populations. As presented in Table 5, participants were able to endorse more than one area of competency as well as the clinical population(s) for whom they provide assessment and/or treatment. Due to the possibility that clinicians had declared competency in a clinical area in which they had not worked clinically, as well as the possibility of clinicians not having declared competency in a clinical area, but still had provided assessment and/or treatment services in this area, questions about both competency and assessment/treatment provision experience were asked.

Participants were asked about their competency to work with different clinical populations as well as their experience providing assessment and/or treatment to these populations, both questions were used to create comparison groups to investigate the study hypotheses. Frequencies for competencies and assessment/treatment provision experience are presented in Table 5. Almost everyone declared competency and experience working with those with general mental health issues (e.g., depression, anxiety; 98.9% regarding competency and 97.9% regarding experience) and more than half indicated competency and experience working with clients who have been in conflict with the law for reasons other than sexual offending or sexual behaviour problems (e.g., violent offending; 59.9% regarding competency and 58.6% regarding experience). The third most reported competency was with clients who have committed sexual offenses (41.9% regarding competency and 40.7% regarding experience).

To examine the impact of competency and assessment/treatment provision experience on clinician stigma, six variables were considered. Three variables were created for competency: clinicians endorsing competency to work with clients with

general mental health issues (e.g., depression, anxiety) and/or couples' therapy were considered to have a general clinical competency ($n = 96, 33.1\%$); clinicians endorsing competency to work with clients in conflict with the law and/or clients who had committed sexual offenses were considered to have a forensic competency ($n = 173, 59.7\%$), and clinicians endorsing competency to work with clients with paraphilic interests, sexual interest in children, sexual health problems, and/or sex therapy were considered to have a sexology competency ($n = 15, 5.2\%$). The same three categories of variables were created with respect to assessment/treatment provision experience: general clinical ($n = 88, 30.3\%$), forensic ($n = 173, 59.7\%$), and sexology ($n = 23, 7.9\%$). If a participant endorsed any forensic competency or assessment/treatment provision experience, this would have "trumped" their general clinical and/or sexology training/experience and they would be categorized in the forensic specialty group. Following this hierarchy, if a participant endorsed any sexology competency or assessment/treatment provision experience, this would override their general clinical training/experience and they would be categorized in the sexology specialty group. If clinicians did not endorse any forensic or sexology training/experience, they would be categorized in the general clinical specialty. Of note, 6 participants failed to provide their competency and/or assessment/treatment provision experience and were subsequently excluded for the main analyses.

Willingness to provide psychotherapy to MAPs. A three-item scale was developed by Jahnke, Philipp, and Hoyer (2015) to assess psychotherapists' feelings regarding treating MAPs. Items were rated on a 7-point Likert scale from *Do not agree at all* (0) to *Completely agree* (6). Scores can range from 0-18, with higher scores indicative of higher willingness to provide psychotherapy to MAPs. Items include, "I am willing to

offer psychotherapy to people with a dominant sexual interest in children, who have never committed a sexual crime,” “I am willing to offer psychotherapy to people with a dominant sexual interest in children, who have committed a sexual crime,” and “I would like to attend vocational courses (e.g., continuing education) to treat people with a sexual interest in children.” The Therapy Motivation Scale has demonstrated high internal consistency (Jahnke, Philipp, & Hoyer, 2015), but validity has not been assessed. Within the present study, the Therapy Motivation Scale demonstrated good internal consistency ($\alpha = .88$).

Two follow-up questions were added by the study authors to the two questions assessing willingness to provide psychotherapy to individuals who have a dominant sexual interest in children who have and have not committed a sexual crime. The questions were added to examine the reasons why participants would be unwilling to treat this population for those who selected *Do not agree at all* (0), or response options 1 or 2 on the two Therapy Motivation Scale questions assessing willingness to provide psychotherapy to MAPs.

Explicit stigma. The Stigma Inventory assesses explicit stigma towards MAPs using 15 items on a 7-point Likert scale from *Do not agree at all* (0) to *Completely agree* (6; Jahnke, Imhoff, & Hoyer 2015). Scores can range from 0-90, with higher scores indicating greater stigma towards MAPs. The Stigma Inventory includes four subscales: Controllability (i.e., the stereotype about sexual compulsiveness; three items), Dangerousness (i.e., the stereotype about danger; four items), Affective reactions (i.e., sympathy and anger; two items), and Social distance (i.e., discrimination; six items). Example items include, “A dominant sexual interest in children is something that one can choose” (Controllability subscale); “Many people with a dominant sexual interest in

children never have sexual contact with a child” (Dangerousness subscale; this item is reverse scored); “When I think of a person with a dominant sexual interest in children I feel sympathy” (Affective reactions subscale); “How do you feel about interacting with people who are dominantly sexually interested in children, but have never committed a crime? Would have these people as friends” (Social distance subscale; this item is reverse coded). This scale has demonstrated high reliability (Jahnke, Imhoff, & Hoyer, 2015; Jahnke, Philipp, & Hoyer, 2015), although validity has not been assessed. The internal consistency of the total Stigma Inventory was high ($\alpha = .88$). Across the four subscales, internal consistency ranged from questionable to excellent: Controllability ($\alpha = .90$), Dangerousness ($\alpha = .65$), Affective reactions ($\alpha = .58$), and Social distance ($\alpha = .82$). To address these low internal consistencies, it was decided that the item “People with a dominant sexual interest in children can control their sexual behavior towards children” under the Dangerousness subscale should be deleted ($\alpha = .70$). Further, the two items comprising the Affective reactions subscale were examined separately, which is the same approach used by Jahnke, Philipp, and Hoyer (2015).

Procedure

Registered Canadian mental health clinicians were recruited to participate in an online anonymous survey regarding a wider project on their working knowledge of mandatory reporting laws and decision-making with respect to identifying the duty to report childhood sexual abuse (see footnote 1). As part of the survey, clinicians’ willingness to provide psychotherapy and explicit stigma towards MAPs were assessed, which were the data used for the present study; therefore, the recruitment strategy and study procedure for the present study is contained within the wider project. The authors of the larger study (i.e., Dr. Ainslie Heasman, Ian McPhail, and Dr. Skye Stephens) have

worked in forensics and sexology in both clinical and research capacities for several years and have established professional networks across three provinces. The authors used their professional connections to recruit participants and advertised the study on their social media accounts (e.g., LinkedIn, Twitter) and professional websites. In some cases, directors of clinical psychology graduate school programs were also contacted. To contribute, the author of the thesis sent direct emails to her professional network to recruit participants.

Participants were also recruited through listservs, including clinicians who, potentially, worked with MAPs, relevant provincial/territorial and national organizations supporting various clinical disciplines (e.g., occupational therapists, physicians, psychologists, psychotherapists/counsellors, social workers). A total of 92 mental health/clinician agencies were contacted. Because of the logistics involved in this type of recruitment strategy (e.g., multiple levels of approval needed, restricted access to membership emails and/or bulletins, high non-response rate), it is unclear how many agencies circulated the study recruitment information, despite nine agencies explicitly agreeing to do so. Lastly, a snowballing recruitment technique was utilized, whereby the study authors relied on participants to advertise the survey to their colleagues as a method of generating further engagement. The survey was posted on Qualtrics and participants were given the option to enter a draw to receive one of five \$250 Amazon gift cards in exchange for completing the survey (with the caution that entering the draw would identify them).

Data Analysis

The data were exported from Qualtrics into SPSS and appeared to be normally distributed; all skewness values were within -2.00 and +2.00 and kurtosis values were

within -7.00 and +7.00. There were univariate outliers in terms of years of experience (including the number of hours for students) as well as across the subscales (and relevant individual items) of the Stigma Inventory (i.e., Controllability, Dangerousness, sympathy, anger, and Social Distance), but given the nature of the research, these outliers were retained in the sample. To address the unequal sample sizes across groups, Levene's test of the assumption of equality of variance was computed; differences in population variances in the competency and assessment/treatment provision experience groups were not significant for all five ANOVA analyses. However, when the Therapy Motivation Scale items were examined individually, Levene's test was significant on item 2 regarding competency, $F(2, 240) = 4.98, p = .008$ and assessment/treatment provision experience, $F(2, 239) = 5.58, p = .004$, respectively⁴. Given the unequal sample sizes, the sample weighing in favour of clinicians with forensic specialization, and the robustness of ANOVA analyses to violations of homogeneity, the data were left as collected; no further efforts were taken to reduce variance.

To investigate the main hypotheses, analyses were conducted using SPSS Version 24. Using the three competency categories and three assessment/treatment provision experience categories, participants' total and item scores on the Therapy Motivation Scale and the subscale scores on the Stigma Inventory were compared using univariate ANOVAs to determine if there were statistically significant differences between general clinicians, and those with forensic or sexology specialization regarding their willingness to provide psychotherapy to MAPs and their explicit stigma towards this population.

⁴ As non-parametric results for the thesis findings were examined and produced the same results, parametric results are reported.

Bonferroni post-hoc tests were computed to further analyze the significant differences in mean scores.

Results

Demographic and Descriptive Information

Descriptive statistics of composite variables by competency and assessment/treatment provision experience are presented in Table 6. The average total Therapy Motivation Scale score was 8.31 ($SD = 6.06$), despite the range representing the full possibility of scores (i.e., 0-18). This suggests that although there was some variation, on average, participants were in the mid-range regarding their willingness to provide psychotherapy to MAPs. The total Stigma Inventory score was averaged at 31.79 ($SD = 14.16$), and the range of scores remained within the lower end of the scale (i.e., 1-71 in the present study, though the range could be 0-90). The average scores for the subscales (and relevant items) of the Stigma Inventory were: Controllability ($M = 1.23$, $SD = 1.34$), Dangerousness ($M = 1.94$, $SD = 1.23$), Sympathy ($M = 3.14$, $SD = 1.66$), Anger ($M = 2.44$, $SD = 1.63$), and Social distance ($M = 2.41$, $SD = 1.16$).

Prior to conducting the univariate ANOVAs, intercorrelations among the total scores for Therapy Motivation Scale and the Stigma Inventory subscale mean scores were examined. There was a significant moderate association ($r = -.30$, $p < .001$); greater levels of explicit stigma were associated with decreased willingness to provide psychotherapy to MAPs.

Reasons for Not Providing Psychotherapy to MAPs

When participants indicated that they would not be willing to provide psychotherapy services to MAPs, they were asked to indicate their reasoning via follow-up questions. Participants stated that they would not be willing to provide services to

MAPs, who have not committed a sexual crime, because they lacked experience with MAPs (38.6%), lacked knowledge about MAPs (31.7%), disliked or held moral opposition to MAPs (7.6%), possessed uncertainty regarding their legal obligations (11.4%), possessed uncertainty regarding their ethical obligations (8.6%), expressed difficulty being objective about MAPs due to personal factors (e.g., being a parent, being close to someone who was victimized; 15.9%), or for other reasons (e.g., already had several areas of specialty; discomfort; given their moral opposition, were concerned about the long-term impact on their health; were providing services to individuals who have been victimized, or worked with children; 7.2%).

Participants indicated that they would not be willing to provide services to MAPs, who have committed a sexual crime, because they lacked experience with MAPs (41.0%), lacked knowledge about MAPs (36.6%), disliked or held moral opposition to MAPs (13.1%), possessed uncertainty regarding their legal obligations (11.0%), possessed uncertainty regarding their ethical obligations (9.0%), expressed difficulty being objective about MAPs due to personal factors (e.g., being a parent, being close to someone who was victimized; 20.7%), or for other reasons (e.g., child psychologist, greater training in assessment rather than treatment; have provided services though struggled because of feelings of inexperience, or developed other clinical interests; 7.2%).

Competency, Experience, Training and Clinician Stigma

Willingness to provide psychotherapy to MAPs. There was a significant main effect of competency on willingness to provide treatment to MAPs, $F(2, 240) = 16.59, p < .001, \eta_p^2 = .121$. A Bonferroni post-hoc test was conducted to explore this significant finding. This test revealed that clinicians with forensic competency were more willing to provide psychotherapy to MAPs ($M = 9.99, SD = 5.77$) compared to general clinicians (M

= 5.68, $SD = 5.68$), $M_{diff} = 4.30$, $p < .001$, $d_{Cohen} = 0.75$ [$CI_{95\%} = 0.47, 1.22$] and clinicians with sexology specialty ($M = 5.79$, $SD = 4.77$), $M_{diff} = 4.20$, $p = .027$, $d_{Cohen} = 0.73$ [$CI_{95\%} = 0.18, 1.29$]; see Figure 4.

The three items on the Therapy Motivation Scale were subsequently individually examined to address whether the overall finding was driven by the fact that forensic clinicians would be more willing to provide psychotherapy to MAPs. Regarding the item, “I am willing to offer psychotherapy to people with a dominant sexual interest in children, who have never committed a sexual crime,” there was a significant main effect of competency, $F(2, 278) = 12.50$, $p < .001$, $\eta_p^2 = .083$. A Bonferroni post-hoc test was conducted to explore this significant finding. As would be expected based on their area of expertise, this test revealed that clinicians with forensic competency expressed a higher willingness to provide psychotherapy to MAPs who had committed a sexual crime ($M = 3.32$, $SD = 2.24$) compared to general clinicians ($M = 1.96$, $SD = 2.11$), $M_{diff} = 1.37$, $p < .001$, $d_{Cohen} = 0.62$ [$CI_{95\%} = 0.36, 0.88$]. There was no significant difference between clinicians with forensic competency and clinicians with sexology competency, ($M = 2.20$, $SD = 2.18$), $M_{diff} = 1.13$, $p = .172$, $d_{Cohen} = 0.41$ [$CI_{95\%} = -0.14, 0.96$].

Regarding the item, “I am willing to offer psychotherapy to people with a dominant sexual interest in children, who have committed a sexual crime,” there was a significant main effect of competency, $F(2, 240) = 22.08$, $p < .001$, $\eta_p^2 = .155$. A Bonferroni post-hoc test was conducted to explore this significant finding. This test revealed that clinicians with forensic competency were more willing to provide psychotherapy to MAPs ($M = 3.21$, $SD = 2.23$) than general clinicians ($M = 1.44$, $SD = 1.87$), $M_{diff} = 1.77$, $p < .001$, $d_{Cohen} = 0.84$ [$CI_{95\%} = 0.56, 1.12$], and those with sexology

competency ($M = 1.21, SD = 1.58$), $M_{diff} = 1.99, p = .002, d_{Cohen} = 0.92$ [$CI_{95\%} = 0.36, 1.48$].

Regarding the item, “I would like to attend vocational courses (e.g., continuing education) to treat people with a sexual interest in children,” there was a significant main effect of competency, $F(2, 240) = 22.08, p < .001, \eta_p^2 = .155$. A Bonferroni post-hoc test was conducted to explore this significant finding. This test revealed that clinicians with forensic competency were more interested in continuing education ($M = 3.53, SD = 2.18$) than general clinicians ($M = 2.22, SD = 2.17$), $M_{diff} = 1.31, p < .001, d_{Cohen} = 0.59$ [$CI_{95\%} = 0.04, 1.14$]. There was no difference in interest between clinicians with forensic competency and clinicians with sexology competency, ($M = 2.64, SD = 1.82$), $M_{diff} = 0.89, p = .430, d_{Cohen} = 0.57$ [$CI_{95\%} = 0.11, 1.04$].

In addition, willingness to provide psychotherapy to MAPs was considered with respect to assessment/treatment provision experience. There was a significant main effect of assessment/treatment provision experience on willingness to provide psychotherapy to MAPs, $F(2, 239) = 21.51, p < .001, \eta_p^2 = .153$. A Bonferroni post-hoc test was conducted to explore this significant finding. This test revealed that clinicians with experience in forensic assessment/treatment were more willing to provide psychotherapy to MAPs ($M = 10.16, SD = 5.67$) compared to general clinicians ($M = 5.08, SD = 5.47$), $M_{diff} = 5.08, p < .001, d_{Cohen} = 0.92$ [$CI_{95\%} = 0.63, 1.21$]; see Figure 5. There was no difference in willingness to provide psychotherapy to MAPs between clinicians with forensic assessment/treatment experience and clinicians with sexology assessment/treatment experience, ($M = 7.10, SD = 5.30$), $M_{diff} = 3.07, p = .058, d_{Cohen} = 0.54$ [$CI_{95\%} = 0.08, 1.01$].

The three items on the Therapy Motivation Scale were also examined individually with regards to assessment/treatment provision experience. Regarding the item, “I am willing to offer psychotherapy to people with a dominant sexual interest in children, who have never committed a sexual crime,” there was a significant main effect of experience, $F(2, 277) = 13.53, p < .001, \eta_p^2 = .089$. A Bonferroni post-hoc test was conducted to further explore this significant finding. This test revealed that clinicians with forensic experience were more willing to provide psychotherapy to MAPs ($M = 3.30, SD = 2.24$) compared to general clinicians ($M = 1.80, SD = 2.03$), $M_{diff} = 1.50, p < .001, d_{Cohen} = 0.69$ [$CI_{95\%} = 0.43, 0.96$]. There was no difference in willingness to provide psychotherapy to MAPs between clinicians with forensic assessment/treatment experience and those with sexology experience, ($M = 2.91, SD = 2.25$), $M_{diff} = 0.39, p = 1.00, d_{Cohen} = 0.17$ [$CI_{95\%} = -0.26, 0.61$].

Regarding the item, “I am willing to offer psychotherapy to people with a dominant sexual interest in children, who have committed a sexual crime,” there was a significant main effect of experience, $F(2, 239) = 24.89, p < .001, \eta_p^2 = .172$. A Bonferroni post-hoc test was conducted to explore this significant finding. This test revealed that clinicians with forensic experience were more willing to provide psychotherapy to MAPs ($M = 3.23, SD = 2.20$) compared to general clinicians ($M = 1.22, SD = 1.73$), $M_{diff} = 2.01, p < .001, d_{Cohen} = 0.98$ [$CI_{95\%} = 0.69, 1.27$] and those with sexology experience ($M = 2.48, SD = 2.25$), $M_{diff} = 1.23, p < .001, d_{Cohen} = 0.56$ [$CI_{95\%} = 0.1, 1.02$].

Regarding the item, “I would like to attend vocational courses (e.g., continuing education) to treat people with a sexual interest in children,” there was a significant main effect of experience, $F(2, 245) = 15.27, p < .001, \eta_p^2 = .111$. A Bonferroni post-hoc test

was conducted to explore this significant finding. This test revealed that clinicians with forensic experience expressed a greater interest in continuing education ($M = 3.64$, $SD = 2.14$) compared to general clinicians ($M = 2.06$, $SD = 2.13$), $M_{diff} = 1.58$, $p < .001$, $d_{Cohen} = 0.74$ [$CI_{95\%} = 0.46, 1.02$] and those with sexology experience ($M = 2.43$, $SD = 1.86$), $M_{diff} = 1.21$, $p = .044$, $d_{Cohen} = 0.57$ [$CI_{95\%} = 0.11, 1.04$].

Overall, examining the individual items of the Therapy Motivation Scale revealed similar findings when the scale was examined as a total score: clinicians with forensic specialization were significantly more willing to provide psychotherapy to MAPs and attend continuing education compared to general clinicians and those with sexology specialization.

Explicit stigma towards MAPs. There was no significant main effect of competency on explicit stigma towards MAPs, $F(2, 239) = 1.51$, $p = .224$, $\eta_p^2 = .015$. Further, no significant differences were found when the subscales were examined: Controllability, $F(2, 246) = 0.31$, $p = .733$, $\eta_p^2 = .003$; Dangerousness, $F(2, 254) = 1.60$, $p = .205$, $\eta_p^2 = .012$; Sympathy, $F(2, 234) = 0.76$, $p = .468$, $\eta_p^2 = .006$, and Social Distance, $F(2, 246) = 1.91$, $p = .150$, $\eta_p^2 = .015$.

One exception was the item assessing anger towards MAPs, which revealed a significant main effect of competency, $F(2, 241) = 6.85$, $p = .001$, $\eta_p^2 = .054$. A Bonferroni post-hoc was conducted to explore this significant finding. This test revealed that clinicians with forensic competency expressed less anger towards MAPs ($M = 2.17$, $SD = 1.68$) compared to general clinicians ($M = 2.98$, $SD = 1.45$), $M_{diff} = -0.80$, $p = .001$, $d_{Cohen} = 0.51$ [$CI_{95\%} = 0.23, 0.78$], no difference in anger was found between clinicians with forensic competency and those with sexology competency ($M = 2.18$, $SD = 1.60$), $M_{diff} = -0.01$, $p = 1.00$, $d_{Cohen} = 0.24$ [$CI_{95\%} = -0.31, 0.79$].

Similarly, there was no significant main effect of assessment/treatment provision experience on explicit stigma towards MAPs, $F(2, 194) = 2.28, p = .105, \eta_p^2 = .023$. Further, no significant differences were found when the subscales were examined: Controllability, $F(2, 246) = 0.26, p = .770, \eta_p^2 = .002$; Dangerousness, $F(2, 254) = 1.30, p = .274, \eta_p^2 = .010$; Sympathy, $F(2, 233) = 0.28, p = .757, \eta_p^2 = .002$, and Social Distance $F(2, 246) = 2.96, p = .054, \eta_p^2 = .024$. Because of the non-significant findings and minimal effect sizes, Bonferroni post-hoc tests were not conducted.

As with competency, there was a main effect of experience on anger, $F(2, 241) = 7.03, p = .001, \eta_p^2 = .055$. A Bonferroni post-hoc was conducted to explore this significant finding. This test revealed that clinicians with forensic experience expressed less anger towards MAPs ($M = 2.18, SD = 1.66$) compared to general clinicians ($M = 2.99, SD = 1.46$), $M_{diff} = -0.80, p = .001, d_{Cohen} = 0.51 [CI_{95\%} = 0.23, 0.78]$; no difference in anger was found between clinicians with forensic experience and those with sexology experience ($M = 2.06, SD = 1.63$), $M_{diff} = 0.13, p = 1.00, d_{Cohen} = -0.01 [CI_{95\%} = -0.62, -0.61]$.

Discussion

The purpose of the present study was to examine whether there were registered mental health clinicians practicing within Canada who were willing to treat MAPs as well as to determine whether they held explicit stigmatizing attitudes towards this population. Overall, the results demonstrated that competency and assessment/treatment provision experience significantly and positively affected willingness to provide psychotherapy to MAPs: clinicians with forensic specialization (in consideration of competency and assessment/treatment provision experience) had significantly higher willingness to provide psychotherapy to MAPs compared to general clinicians and those with sexology

specialization, this effect being large across both comparisons. Contrary to the hypotheses, there were no significant differences regarding competency or assessment/treatment provision with respect to the Stigma Inventory, except for differences on anger towards MAPs.

Willingness to Treat MAPs

The only study to have assessed willingness to provide psychotherapy to MAPs, did so in consideration of participation in an anti-stigma intervention through a randomized controlled trial (Jahnke, Philipp, & Hoyer, 2015). Compared to present study findings, the sample of psychotherapists-in-training reported lower levels of willingness to provide psychotherapy to MAPs, $M_{diff} = 4.28$, $d_{Cohen} = 0.78$ [CI_{95%} = 0.51, 1.05]. As it was not explicitly mentioned within Jahnke, Philipp, and Hoyer (2015), it is presumed that these psychotherapists-in-training did not possess forensic and/or sexology specialization; therefore the presence of these clinicians in the current study sample may have contributed to higher levels of willingness to provide psychotherapy to MAPs compared to those reported by Jahnke, Philipp, and Hoyer (2015).

It is unsurprising that willingness to provide psychotherapy to MAPs was greater in clinicians with a forensic specialty, as this clinician group is likely most familiar with individuals who have been convicted of sexual offending against children. Therefore, it is possible that clinicians with forensic specialization do not discriminate between offending and nonoffending groups and react to all MAPs, even those who have not offended in the same way as those who have (Jahnke, 2018a). There is also a strong possibility that MAPs are seeking services through forensic programs that advertise themselves as offering assessment and treatment to individuals who are struggling with their sexual interests and/or behaviours. For example, the author of the thesis is aware of some

forensic sexual behaviour outpatient clinics that offer assessment and treatment services to MAPs who have not been convicted of a sexual offense in aid of preventing childhood sexual abuse. Therefore, it may be that clinicians with a forensic specialty can offer more appropriate services to this population due to their training, despite no reported differences in levels of explicit stigma across the three examined competencies or assessment/treatment provision experience categories. Lastly, the finding that forensic clinicians are most interested in attending continuing education courses is logical as clinicians who have decided not to treat MAPs (e.g., general clinicians), likely would not be interested in further education.

Reasons to not treat MAPs. When prompted for the reasons behind not providing services to MAPs, participants were most likely to cite limited experience and/or knowledge of MAPs, followed by expressing difficulty maintaining objectivity due to personal factors (e.g., being a parent, being close to someone who has been victimized). The implication of this finding suggests that more training is needed regarding understanding MAPs as a clinical, rather than forensic, population. Seto (2012) has suggested that professional help geared towards supporting MAPs is lacking. Further training may increase clinicians' areas of competency, as well as offer potential gains in assessment and treatment experience. In addition, training programs could increase clinicians' comfort level working with MAPs in general clinical settings, especially if these issues fall within their current scope of practice (e.g., if a client is seeking treatment for depression but has sexual interest in children). Of course, it is both logical and promising that clinicians with forensic specialization were most interested in continuing education (i.e., additional training) to treat MAPs.

Explicit Clinician Stigma Towards MAPs

Although stigma levels related to competency and assessment/treatment provision experience have not been explicitly examined in previous research, literature has surmised potential differences across such groups (e.g., Cantor, 2014; Jahnke, 2018a). Within the present study, there was only one significant difference across clinician groups regarding explicit stigma and this occurred from the question considering anger. Clinicians with forensic specialization were significantly less likely to feel anger towards MAPs compared to general clinicians. This is an interesting finding that may align with forensic clinicians having more experience with this population, but further research, especially within a qualitative framework, would certainly be beneficial in examining the meaning behind these feelings of anger.

There are two possible explanations for the absence of statistically significant differences in stigma between competency and assessment/treatment provision experience groups. Firstly, it is possible that participants responded in a socially desirable manner when completing questions that assessed stigma. This possibility is consistent with the finding of a restricted range for the Stigma Inventory scores as the maximum individual total score was 71, despite the scale possessing a maximum score of 90 (the average score within the sample was 31.79). Interestingly, the pattern of results suggests that general clinicians (both in consideration of competency and assessment/treatment provision experience) reported the highest average stigma scores and those with sexology specialization (again both in consideration of competency and assessment/treatment provision experience) reported the lowest scores, though this was not statistically significant, despite medium-sized effects ranging from 0.52-0.59. This finding is perhaps related to clinicians with sexology specialization possessing the most open-mindedness

with regards to paraphilias compared to other clinicians who may prefer not to discuss sexual topics (Moore, 2018), even if they possess forensic specialization. Future research may seek to employ implicit measures of stigma to better capture underlying perspectives of MAPs and to examine whether implicit attitudes correlate with explicit attitudes. A second reason for the present study findings is that differences between competency and assessment/treatment provision groups on explicit stigma may not exist (i.e., the reason for finding no significant differences between groups is that there are no significant differences between groups).

Not unlike other areas of healthcare, there is a multitude of reasons why clinicians may decide not to offer treatment to this population that exist beyond holding stigmatizing beliefs towards MAPs. Firstly, clinicians may be unfamiliar with sexual interest in children and therefore feel unqualified (i.e., lack knowledge, competence) to assess and treat MAPs (Lasher & Stinson, 2017), despite demonstrating compassion towards this population (Cacciatori, 2017; Levenson et al., 2017; Piché, Mathesius, Lussier, & Schweighofer, 2016). Further, professional training programs may not cover the assessment and treatment of pedophilia in their academic curriculum, which contributes to structural stigma (Corrigan et al., 2005; Herek, 2007) as the deficit creates a workforce that is unprepared and reluctant to assess and/or treat complex and marginalized populations. This perspective was demonstrated within the present study as participants reported lacking experience and/or knowledge as reasons for not providing services to MAPs. Secondly, clinicians could possess negative perceptions about MAPs' ability or willingness to change or have liability concerns (Jahnke & Hoyer, 2013; Jahnke, Philipp, & Hoyer, 2015). These past findings possibly align with the present study's findings of clinicians with forensic specialization reporting lower feelings of

anger when compared to general clinicians. Thirdly, clinicians could experience a general discomfort in examining sexological topics and therefore demonstrate a preference for not providing assessment or treatment services that could potentially migrate into these discussions (Moore, 2018). Fourthly, clinicians offering services to nonoffending MAPs would theoretically also assess and treat individuals convicted of sexual offenses against children. Clinicians who work with individuals victimized by childhood sexual abuse have expressed discomfort learning details about such abuse (Day et al., 2002), which was also reported in the present study findings, and this uneasiness may transfer in discussing perpetrated childhood sexual abuse as well. Lastly, clinicians treating individuals convicted of sexual offenses against children may have low expectations regarding the treatment effectiveness for this population (e.g., Lasher & Stinson, 2017), given the inconclusive findings some sexual offending treatment programs have yielded (e.g., Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005). Therefore, it is unfair and inappropriate to concretely conclude that the willingness of clinicians to assess and treat MAPs is solely due to the stigmatization of this population.

Limitations and Future Research

Despite the present study's promising findings, there are some limitations that should be considered. Due to the use of self-report data, a convenience sample, and the reliance on a cohort research design, the present findings should be interpreted with caution. Further, the desire to respond in a socially desirable manner, coupled with the use of explicit scales, may have influenced clinicians' report of their views and willingness to provide psychotherapy to MAPs. With that said, this study provides a first look at Canadian clinicians' willingness to provide psychotherapy to MAPs and their

explicit stigma towards this population and given the novelty of this research area, self-report cohort data is most appropriate.

Secondly, the study sample was heavily weighted towards Ontario clinicians, females, psychologists, and those with a forensic specialty. As previously discussed, this representation is strongly influenced by the study authors' professional connections as forensic-clinical psychologists (or in training programs with this focus). Relatedly, there were few clinicians within the sample endorsing a sexology competency and/or who possessed assessment/treatment provision experience in this field, which may have influenced the results. Despite attempts to access a more representative sample through a systematic recruitment process of inviting agencies that support various clinical disciplines (e.g., psychiatrists, social workers, occupational therapists), it is unclear how successful this component of the recruitment process was as many agencies did not respond to the initial invitation, and it is evident that these efforts did not yield a strongly heterogeneous sample. There were also notable challenges regarding the logistics of this recruitment strategy (e.g., multiple levels of approval needed, restricted access to membership emails and/or bulletins) and differences regarding regulated versus registered mental health professions across Canadian provinces. Future research should strive to seek a more representative clinician sample, perhaps by recruiting all clinicians, regardless of registration or regulation status.

Conclusion

Despite these limitations, the present study does add to the developing literature base examining the needs of MAPs living in the community by bringing greater awareness to the willingness to treat, and levels of explicit stigma held by Canadian mental health clinicians. By assessing declared competency as well as

assessment/treatment provision experience, the present study captures clinicians' previous clinical training as well as the experience they have gained through their clinical work.

The present study provides promise in the consideration of developing assessment and treatment services for MAPs in the Canadian community given the relatively low levels of reported explicit stigma.

Chapter 4 – General Discussion

Understanding how to best support MAPs is an area of research in need of further attention. The present thesis findings contribute to the current literature on MAPs by further examining the potential treatment barriers for this population. Treatment motivation was associated with higher levels of maladaptive coping, and internalized sexual stigma moderated this relationship within two of the four measures of treatment motivation. Specifically, higher levels of maladaptive coping decreased feelings of ambivalence and this was exacerbated by internalized sexual stigma. Greater maladaptive coping was also associated with taking steps towards positive change, which again was intensified by higher levels of internalized sexual stigma. The effects of maladaptive coping and internalized sexual stigma significantly influence treatment motivation, which is an important finding in understanding the needs of MAPs living in the community.

Canadian mental health clinicians' competency and experience were significantly and positively associated with willingness to provide psychotherapy to MAPs. When they expressed unwillingness, the most frequently endorsed reasons were limited experience or knowledge of MAPs and difficulty maintaining objectivity due to personal factors. When considering willingness to provide psychotherapy to MAPs across the three groups of clinicians, those with forensic specialization demonstrated significantly greater willingness compared to general clinicians and those with sexology specialization. When assessing explicit stigma across these three groups, there were no statistically significant differences, which provides promise for future efforts dedicated to further understanding and supporting this population. More specifically, as neither competency, or experience, influenced levels of explicit stigma, interested clinicians with clinical, sexology, and

forensic specializations could participate in secondary prevention programming, following relevant training.

Implications

The results of these two studies suggest that there are two main implications when contemplating the development and provision of assessment and treatment services for MAPs. Firstly, there is the consideration of targeting appropriate services to MAPs. Even though some MAPs report difficulties managing their sexual interest in children, many do not possess the desire to seek formal support (i.e., do not endorse difficulties or distress regarding their sexual interest). One clinical implication of a lower range of treatment motivation highlights the importance of bringing greater awareness to MAPs who are managing well regarding their sexual interest in children. With that said, those MAPs who do report engaging in maladaptive coping regarding the management of sexual interest should receive further attention as the present findings demonstrate that there is an evident association between difficulties coping and decreases in treatment motivation.

An important question that may arise from the consideration of MAPs' management of their sexual interest in children is how to assess the risk of offending (i.e., onset of sexual abuse), which would likely be something that clinicians would need to consider. For example, some may view that MAPs who seek treatment regarding the management of their sexual interest in children may be at elevated risk of offending compared with the general population, as the decision to see treatment may have resulted from experiencing other risk factors for sexual offending, such as sexual preoccupation. For example, participants involved in the Berlin Project Prevention Dunkelfeld did report experiencing sexual preoccupation prior to participating in the treatment program and

levels decreased post-treatment (Beier et al., 2015). In another study, Quayle and Taylor (2003) did raise the possible contribution of cognitive distortions and the use of child exploitative sexual materials as facilitators to contact sexual offending against children, but emphasized that causality remains unknown. Nonetheless, research has yet to be conducted that examines the risk for the onset of childhood sexual abuse perpetration in MAPs, as the current literature base has remained focused on correlates of sexual interest in children (e.g., Bailey, Bernhard, & Hsu, 2016). It is possible that personality disorders may contribute most significantly to childhood sexual abuse perpetration as Seto (2008) asserts that when the presence of sexual interest in children is coupled with antisocial personality characteristics, risk is elevated due to reduced inhibition associated with sexual interest and opportunistic sexual tendencies.

While considering the development of services for community MAPs, it is important to recognize the possibility of increasing stigma towards this population when dedicating efforts solely towards supporting MAPs through the lens of childhood sexual abuse prevention. Education and training efforts should strive to incorporate a holistic perspective of MAPs within their programming to ensure that there is both an emphasis on MAPs who are managing well regarding their sexual interest in children, while also addressing the significant mental health needs of this population that may or may not be related to their sexual interest. Treatment programming dedicated to MAPs could also educate MAPs regarding the inability of changing their sexual interest in children, but they do possess the ability to control their sexual behaviour. This perspective could assist with addressing maladaptive coping strategies, by helping MAPs recognize what factors they do and do not have control over. Nonetheless, as MAPs reported concerns about stigma as a barrier to seeking treatment, program developers and facilitators should strive

to mitigate this concern in their programming advertisements to increase potential MAP participants' desire to attend by ameliorating anticipated experiences of stigma.

The second clinical implication stemming from the thesis suggests a need for developing educational programming for interested clinicians. The findings of a mid-point willingness to provide psychotherapy to MAPs amongst Canadian clinicians offers the opportunity to develop psychoeducational initiatives (e.g., workshops) to those interested in expanding their clinical scope of practice. In Germany, which has arguably spearheaded the development of the MAP research base, there is a recognized dearth of qualified clinicians who can offer services to this population (Beier, Hartmann, & Bosinski, 2000 as cited in Jahnke, Philipp, & Hoyer, 2015), suggesting that Canada may also be lacking clinicians who feel comfortable providing these services. Study 2 findings demonstrated that, although there was not a statistically significant difference in explicit stigma scores across mental health clinicians, there is still evidence of stigma. Specifically, some participants reported a fear of MAPs offending as a motive for not wanting to treat this population. Further, significantly lower feelings of anger were reported by clinicians with forensic specialty compared to general clinicians. Education initiatives could focus on helping clinicians, who may encounter MAPs within their general clinical work, become more comfortable discussing paraphilic interests and allow for a greater understanding of Canadian mandatory reporting laws related to childhood sexual abuse (see McPhail et al., 2018). Meaningful results could emerge from these training efforts by allowing MAPs opportunities for positive and supportive disclosure in professional clinical environments, which can have important benefits for their mental health (Chaudoir & Quinn, 2010).

Psychoeducational and training programs could focus on highlighting success stories of MAPs to encourage clinicians to view this population beyond focusing solely on their sexual identity as well as sharing the experiences of MAPs who have previously sought professional support. Further, programs could offer information about the neurobiology behind sexual interest in children and the evidence supporting this interest as a stable sexual interest (e.g., Bailey, 2015; Cantor, 2015; Lalumière, 2015; Mokros & Habermeyer, 2015; Seto, 2012) as a mechanism for expanding clinicians' knowledge of MAPs. Lastly, programming for clinicians could incorporate strategies regarding how best to support MAPs both in terms of managing their sexual interest, and more generally, mental health (e.g., how to navigate conversations around sexual interest in children when collecting a psychosocial history as part of a general mental health assessment). Providing clinicians with information about effective treatment programming for MAPs and how best to access these resources would also be of benefit.

Regardless of the prevention-focused literature that identifies sexual interest as an important risk factor in sexual recidivism (e.g., Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005; Seto & Lalumière, 2001; Turner et al., 2016) and some MAPs reporting distress related to committing childhood sexual abuse (e.g., Beier, Neutze et al., 2009), there are also unquestionable benefits to dedicating further efforts to understanding the needs of MAPs living in the community due to the high rates of poor mental health displayed by this population (e.g., B4U-ACT, 2011a; Cohen et al., 2018; Houtepen et al., 2016; Levenson & Grady, 2018; Schaefer et al., 2010). By allowing MAPs to feel more comfortable discussing their sexual interest in children, and their difficulties managing this interest, and having this disclosure met with professional warmth, understanding, and appropriate treatment efforts, the prevalent mental health issues within this population can

be addressed. Childhood sexual abuse is a preventable public issue, regardless of how clinicians treat MAPs, but developing programming to assist clinicians in offering services to MAPs who are struggling would likely reduce the notable treatment barriers identified within this population.

Future Directions

The current research on MAPs is rapidly expanding and researchers have continued to make novel contributions to this area. Building on the current study findings, there are two lines of research that should be considered in the future. Firstly, the concepts considered within the thesis could benefit from investigation through a qualitative lens as quantitative research only captures a limited portion of the experiences of participants. Given the noted heterogeneity within MAPs, future research could aim to explore maladaptive coping, treatment motivation, past treatment experiences, and internalized sexual stigma through qualitative research. Qualitative research focused on mental health clinicians' perceptions of MAPs, and related efforts towards the development of assessment and treatment services for this population is also a valuable initiative (see Goodier & Lievesley, 2018 for a promising example of this). Involving both MAPs and mental health clinicians in future qualitative research endeavours is advisable as well to ensure that the research questions in this area are proven to be beneficial to these populations from the research's inception (i.e., community-based participatory research; Leung, Yen, & Minkler, 2004).

Secondly, this body of research could benefit from striving to view MAPs more holistically rather than characterizing them only by way of their sexual interest in children. One strategy for doing so could be through a greater understanding of how MAPs are managing successfully and using these findings to reduce the notable stigma targeting this

population. Future research could also strive to consider the management strategies of MAPs outside of their sexual interest, given the poor mental health of this population, as well as assess MAPs' abilities to cope with the demonstrated internalized sexual stigma. A complementary approach to this proposed research could include gaining information from clinicians who serve MAPs within their clinical practice in order to provide strategies for working with this population. Further research is also needed to investigate the reasons behind the greater feelings of anger towards MAPs reported by general clinicians, and the expertise of clinicians who provide services to MAPs may provide insight into this reported emotion.

It is evident that efforts need to be dedicated to reducing barriers related to treatment for MAPs who are struggling with managing their sexual interest, but also who are seeking mental health support related to identifying as a MAP. Future research interested in eradicating childhood sexual abuse, and offering support to a highly stigmatized population, requires the tailoring of psychoeducation and training initiatives to mental health clinicians, which would allow MAPs to feel more comfortable when they seek support.

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Table 1*Distinguishing between Sexual Interest in Children and Sexual Offending Against**Children Populations*

Sexual Interest	Committed Sexual Offense(s) Against a Child	
	Yes	No
Sexual interest in children	50-60% ^a	Prevalence Unknown ^b
No sexual interest in children	40-50% ^a	---

^aCantor & McPhail, 2016; Schmidt, Mokros, & Banse, 2013; Seto, 2008

^bPrevalence of having sexual interest in children without childhood sexual abuse perpetration is unknown, but studies have examined this population using cohort research designs (e.g., Cohen, Ndukwe, Yaseen, & Galynker, 2018; Grady, Levenson, Mesias, Kavanagh, & Charles 2018; Levenson & Grady, 2018)

Table 2*Study 1 Participant Characteristics, N = 207*

Variable	<i>M (SD) or %</i>
Age (<i>n</i> = 196)	31.64 (12.39)
Ethnicity (<i>n</i> = 204)	
Caucasian	82.8% (<i>n</i> = 169)
African American	1.0% (<i>n</i> = 2)
Asian	2.0% (<i>n</i> = 4)
First Nations	1.5% (<i>n</i> = 3)
Other ethnicities (e.g., mixed ethnicities, Middle Eastern, and Hispanic)	12.7% (<i>n</i> = 26)
Relationship status (<i>n</i> = 206)	
Single	67.0% (<i>n</i> = 138)
Dating	6.3% (<i>n</i> = 13)
In a committed relationship	5.8% (<i>n</i> = 12)
Common law or living with a partner	1.5% (<i>n</i> = 3)
Engaged	1.9% (<i>n</i> = 4)
Married	10.2% (<i>n</i> = 21)
Divorced	4.9% (<i>n</i> = 10)
Other (e.g., polyamory, separated)	2.4% (<i>n</i> = 5)
Sex at birth (<i>n</i> = 203)	
Male	89.7% (<i>n</i> = 182)
Female	10.3% (<i>n</i> = 21)
Gender (<i>n</i> = 205)	
Man	77.1% (<i>n</i> = 158)
Woman	6.8% (<i>n</i> = 14)
Transwoman	2.0% (<i>n</i> = 4)
Transman	2.4% (<i>n</i> = 5)
Gender fluid/gender queer	5.9% (<i>n</i> = 12)
Other (e.g., agender or indifferent, “attack helicopter ^a ”, bisexual, or questioning)	5.9% (<i>n</i> = 12)

Medical professional diagnosis	
Neurodevelopment disorder (e.g., intellectual disability, autism spectrum disorder, ADHD)	23.2% (<i>n</i> = 48)
Schizophrenia spectrum or other psychotic disorder	4.3% (<i>n</i> = 9)
Bipolar disorder	8.2% (<i>n</i> = 17)
Depressive disorder (e.g., major depressive disorder, dysthymia)	28.5% (<i>n</i> = 59)
Anxiety disorder (e.g., phobia, social anxiety, panic disorder)	27.1% (<i>n</i> = 56)
Obsessive-compulsive disorder	9.7% (<i>n</i> = 20)
Trauma- or stressor-related disorder (e.g., post-traumatic stress disorder)	9.7% (<i>n</i> = 20)
Dissociative disorder (e.g., dissociative identity disorder, depersonalization/derealization disorder)	5.3% (<i>n</i> = 11)
Eating or feeding disorder (e.g., bulimia, anorexia)	2.9% (<i>n</i> = 6)
Sleep-wake disorder (e.g., insomnia disorder, narcolepsy)	4.3% (<i>n</i> = 9)
Paraphilic disorder (e.g., pedophilic disorder, exhibitionistic disorder)	9.7% (<i>n</i> = 20)
Sexual dysfunction (e.g., erectile disorder)	2.4% (<i>n</i> = 5)
Gender dysphoria (i.e., gender identity disorder)	8.7% (<i>n</i> = 18)
Disruptive, impulse-control or conduct disorders	1.9% (<i>n</i> = 4)
Substance-related or addictive disorders	4.3% (<i>n</i> = 9)
Neurocognitive disorder (e.g., Alzheimer's)	---
Personality disorder (e.g., borderline personality disorder, antisocial personality disorder)	7.2% (<i>n</i> = 15)
I have never been diagnosed with a mental disorder	39.6% (<i>n</i> = 82)

^aMale who dreams of being a helicopter

Table 3*Descriptive information and intercorrelations for all Study 1 variables, N = 207*

Variable	<i>M</i> (<i>SD</i>)	Range	1	2	3	4	5	6	7
1. Maladaptive coping ^a	20.72 (6.43)	12-43	1.00						
2. Treatment motivation – Recognition factor total ^b score	12.93 (6.03)	7-32	.51***	1.00					
3. Treatment motivation – Ambivalence factor total ^b score	15.65 (6.61)	7-33	.52**	.76***	1.00				
4. Treatment motivation – Taking Steps factor total ^b score	12.00 (5.48)	5-25	.45**	.57***	.81***	1.00			
5. Self-efficacy ^c	8.70 (3.99)	5-22	.11	.31***	.34***	.53**	1.00		
6. Past treatment experiences	61.74 (33.91)	0-100	-.04	-.12	.17	.31*	.01	1.00	
7. Internalized sexual stigma ^d	54.87 (14.27)	17-81	.53**	.46***	.46***	.43***	.26***	.10	1.00

Note. Intercorrelations were calculated separately for the past treatment experience variable to avoid losing cases through listwise deletion as $n = 60$. Only participants who had disclosed their sexual interest in children to a treatment provider were included in analyses that examine past treatment experience.

^aAs measured by the Brief COPE – maladaptive subscale; ^bAs measured by the SOCRATES ^cAs measured by the revised Specific Self-Efficacy for Modifying Sexual Interest in Children total score ^dAs measured by the adapted Internalized Sexual Stigma Scale
* $p < .05$. ** $p < .01$. *** $p < .001$

Table 4*Moderated Regressions for Maladaptive Coping and Treatment Motivation*

Model	B [95% CI]	<i>t</i>	<i>F</i>	<i>R</i> ²	ΔR^2
Recognition (<i>n</i> = 60)			6.58**	.26	.007
Maladaptive coping	0.41 [0.20, 0.62]	3.84***			
Past treatment experiences	-0.02 [-0.06, 0.02]	-1.11			
Maladaptive coping x Past treatment experiences	-0.002 [-0.008, 0.004]	-0.72			
Recognition (<i>n</i> = 199)			28.96***	.31	.003
Maladaptive coping	0.38 [0.25, 0.51]	5.79***			
Internalized sexual stigma	0.10 [0.04, 0.15]	3.35**			
Maladaptive coping x Internalized sexual stigma	-0.003 [-0.01, 0.004]	-0.85			
Ambivalence (<i>n</i> = 60)			3.70*	.17	.001
Maladaptive coping	0.36 [0.11, 0.60]	2.93**			
Past treatment experiences	0.03 [-0.02, 0.07]	1.21			
Maladaptive coping x Past treatment experiences	-0.001 [-0.01, 0.01]	-0.27			
Ambivalence (<i>n</i> = 200)			34.73***	.35	.03
Maladaptive coping	0.47 [0.33, 0.61]	6.74***			
Internalized sexual stigma	0.10 [0.04, 0.16]	3.13**			
Maladaptive coping x Internalized sexual stigma	-0.01 [-0.02, -0.004]	-3.05**			
Taking steps (<i>n</i> = 60)			5.21**	.22	.01
Maladaptive coping	0.27 [0.07, 0.47]	2.67*			
Past treatment experiences	0.04 [0.01, 0.08]	2.36*			
Maladaptive coping x Past treatment experiences	-0.003 [-0.01, 0.003]	-0.95			

Taking steps (<i>n</i> = 200)			24.38***	.27	.02
Maladaptive coping	0.31 [0.19, 0.43]	5.10***			
Internalized sexual stigma	0.09 [0.04, 0.14]	3.30**			
Maladaptive coping x Internalized sexual stigma	-0.01 [-0.02, -0.001]	-2.32*			
Self-efficacy (<i>n</i> = 60)			1.06	.05	.01
Maladaptive coping	0.16 [-0.02, 0.34]	1.78			
Past treatment experiences	0.001 [-0.03, 0.03]	0.04			
Maladaptive coping x Past treatment experiences	0.002 [-0.004, 0.007]	0.58			
Self-efficacy (<i>n</i> = 199)			5.05**	.07	.001
Maladaptive coping	-0.02 [-0.13, 0.08]	-0.41			
Internalized sexual stigma	0.08 [0.04, 0.13]	3.46***			
Maladaptive coping x Internalized sexual stigma	-0.001 [-0.01, 0.01]	-0.42			

Note. Results are grouped by indicator type with each bolded subheading row representing a regression.

Sample size is 60 because only participants who had disclosed their sexual interest in children to a treatment provider were included in analyses. R^2 change specifically in reference to interaction term.

* $p < .05$. ** $p < .01$. *** $p < .001$

Table 5*Study 2 Participant Characteristics, N = 290*

Variable	<i>M (SD) or %</i>
Age (<i>n</i> = 171)	39.30 (11.90)
Identified Gender ^a (<i>n</i> = 286)	
Female	72.4% (<i>n</i> = 210)
Male	24.8% (<i>n</i> = 72)
Transwoman	0.3% (<i>n</i> = 1)
Transman	0.7% (<i>n</i> = 2)
Other (e.g., queer woman)	0.3% (<i>n</i> = 1)
Ethnicity (<i>n</i> = 289)	
Asian – East (e.g., Chinese, Japanese, Korean)	3.5% (<i>n</i> = 10)
Asian – South (e.g., Indian, Pakistani, Sri Lankan)	2.4% (<i>n</i> = 7)
Asian – South East (e.g., Malaysian, Filipino, Vietnamese)	10.7% (<i>n</i> = 31)
Black – African (e.g., Ghanaian, Kenyan, Somali)	1.0% (<i>n</i> = 3)
Black – Caribbean (e.g., Barbadian, Jamaican)	1.0% (<i>n</i> = 3)
Black – North American (e.g., Canadian, American)	0.3% (<i>n</i> = 1)
First Nations	1.0% (<i>n</i> = 3)
Indian – Caribbean (e.g., Guyanese with origins in India)	0.7% (<i>n</i> = 2)
Latin American (e.g., Argentinean, Chilean, Salvadorian)	1.0% (<i>n</i> = 3)
Métis	0.7% (<i>n</i> = 2)
Middle Eastern (e.g., Egyptian, Iranian, Lebanese)	2.8% (<i>n</i> = 8)
White – European (e.g., English, Italian, Portuguese, Russian)	16.3% (<i>n</i> = 47)
White – North American (e.g., Canadian, American)	52.1% (<i>n</i> = 151)
Mixed heritage (e.g. Black-African and White-North American)	4.8% (<i>n</i> = 14)
Other (e.g., Ashkenazi Jewish, Lebanese Canadian, “Mixed,” “White”)	1.4% (<i>n</i> = 4)
Prefer not to say	0.3% (<i>n</i> = 1)
Provincial/territorial Registration ^b (<i>n</i> = 299)	
Alberta	7.6% (<i>n</i> = 22)

British Columbia	6.6% (<i>n</i> = 19)
Manitoba	2.8% (<i>n</i> = 8)
New Brunswick	0.3% (<i>n</i> = 1)
Newfoundland and Labrador	0.3% (<i>n</i> = 1)
Northwest Territories	---
Nova Scotia	3.8% (<i>n</i> = 11)
Nunavut	0.3% (<i>n</i> = 1)
Ontario	56.6% (<i>n</i> = 164)
Prince Edward Island	2.1% (<i>n</i> = 6)
Quebec	1.7% (<i>n</i> = 5)
Saskatchewan	6.9% (<i>n</i> = 20)
Yukon	0.3% (<i>n</i> = 1)
Student and not currently registered	13.8% (<i>n</i> = 40)
Highest degree professional designation based on ^c (<i>n</i> = 289)	
Student in a professional or graduate program	13.1% (<i>n</i> = 38)
Bachelor's degree/Bachelor's degree (honours)	13.5% (<i>n</i> = 39)
College degree	2.8% (<i>n</i> = 8)
Medical degree	5.5% (<i>n</i> = 16)
Postgraduate degree	1.4% (<i>n</i> = 4)
Master's degree	33.9% (<i>n</i> = 98)
Doctoral degree	29.8% (<i>n</i> = 86)
Health profession (including students/trainees) ^c (<i>n</i> = 270)	
Physician	3.8% (<i>n</i> = 11)
Psychiatrist	4.8% (<i>n</i> = 14)
Psychologist	38.6% (<i>n</i> = 112)
Social worker	21.4% (<i>n</i> = 62)
Counsellor/Psychotherapist	14.1% (<i>n</i> = 41)
Occupational Therapist	2.1% (<i>n</i> = 6)
Behaviour Therapist	1.7% (<i>n</i> = 5)
Other (e.g., Child and Youth Care Practitioner, Nurse)	18.3% (<i>n</i> = 53)
Number of years practicing as a regulated healthcare professional (<i>n</i> = 250)	11.41 (10.63)

Graduate/postdoctoral students – number of hours worked under a regulated health professional (<i>n</i> = 119)	763.64 (1580.41)
I provide mental health services to (check all that apply) ^c	
Children (under 12 years)	20.0% (<i>n</i> = 58)
Adolescents (12-17 years)	39.7% (<i>n</i> = 115)
Adults	88.3% (<i>n</i> = 256)
Older adults (65+ years)	32.8% (<i>n</i> = 95)
Families	21.0% (<i>n</i> = 61)
Couples	19.3% (<i>n</i> = 56)
Other (e.g., communities, front-line clinicians)	4.1% (<i>n</i> = 12)
I have competency to work with the following ^c (<i>n</i> = 932)	
Those with general mental health issues (e.g., depression, anxiety)	98.9% (<i>n</i> = 281)
Those who have been conflict with the law for reasons other than sexual offending/sexual behaviour problems (e.g., violent offending)	59.9% (<i>n</i> = 170)
Those who have committed sexual offenses	41.9% (<i>n</i> = 119)
Those with paraphilic interests (not including sexual interest in children)	33.5% (<i>n</i> = 95)
Those with a sexual interest in children	30.3% (<i>n</i> = 86)
Those with sexual health problems (e.g., sexual compulsivity) or sexual disorders (e.g., erectile dysfunction) other than paraphilias or sexual interest in children	29.2% (<i>n</i> = 83)
Those seeking sex therapy	9.9% (<i>n</i> = 28)
Those seeking couples' therapy	24.6% (<i>n</i> = 70)
Provided assessment and/or treatment to clients where the identified area of concern or focus of the work with the client was ^c ...(<i>n</i> = 926)	
General mental health issues (e.g., depression, anxiety)	97.9% (<i>n</i> = 279)
Being in conflict with the law for reasons other than sexual offending or sexual behaviour problems (e.g., violent offending)	58.6% (<i>n</i> = 167)
Problems related to committing sexual offenses	40.7% (<i>n</i> = 116)
Paraphilic interests (not including sexual interest in children)	31.6% (<i>n</i> = 90)
A sexual interest in children	32.3% (<i>n</i> = 92)
A sexual health problem (e.g., sexual compulsivity) or sexual disorder (e.g., erectile dysfunction) other than paraphilias or sexual interest in children	30.9% (<i>n</i> = 88)
General sex therapy	9.1% (<i>n</i> = 26)

Couples' therapy	23.9% (<i>n</i> = 68)
I have training and/or experience to provide assessment and/or treatment services to individuals with sexual interest in children (<i>n</i> = 290)	
Yes	28.3% (<i>n</i> = 82)
No	55.2% (<i>n</i> = 160)
Unsure	16.6% (<i>n</i> = 48)

Note. ^aPercentages do not total 100% as some participants did not answer this question;

^bPercentages total more than 100% as some participants endorsed registration in more than one province; ^cPercentages total more than 100% as participants were to check all applicable options

Table 6

Therapy Motivation Scale and Stigma Inventory Scores by Competency and Assessment/Treatment Provision Experience

Independent Variable	Dependent Variable	General Clinicians <i>M (SD)</i>	Clinicians with Forensic Specialization <i>M (SD)</i>	Clinicians with Sexology Specialization <i>M (SD)</i>
Competency	Total Therapy Motivation Scale score	5.68 (5.72)	9.99 (5.77)	5.79 (4.77)
	Total Stigma Inventory score	33.79 (14.61)	31.35 (14.34)	26.46 (9.27)
Assessment/treatment provision experience	Total Therapy Motivation Scale score	5.08 (5.47)	10.16 (5.67)	7.10 (5.30)
	Total Stigma Inventory score	34.37 (14.45)	31.42 (14.41)	26.20 (9.56)

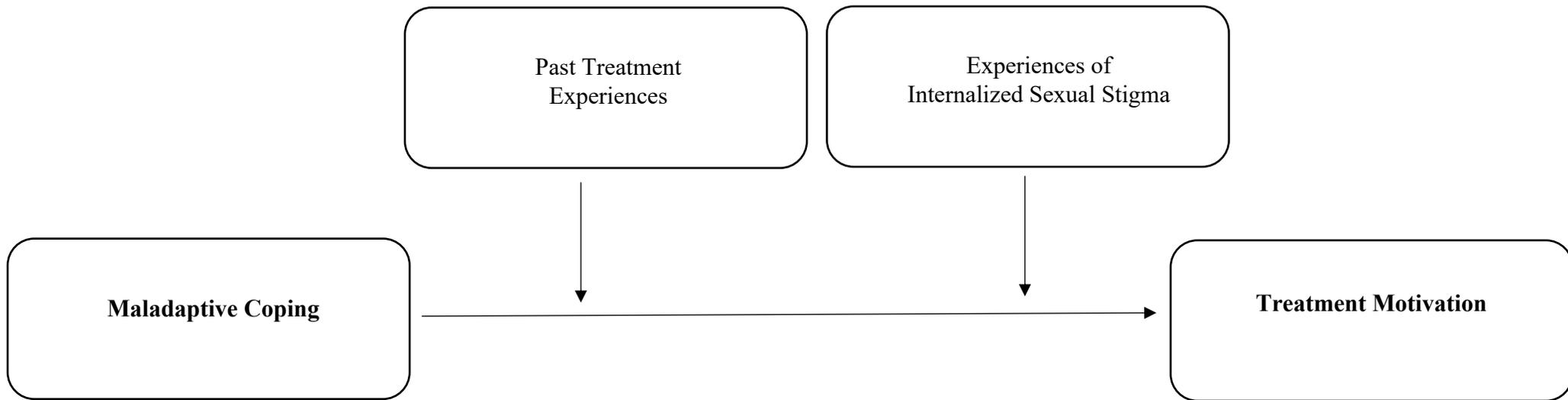


Figure 1. Proposed relationship between maladaptive coping strategies and treatment motivation, moderated by experiences of past treatment experiences and internalized sexual stigma

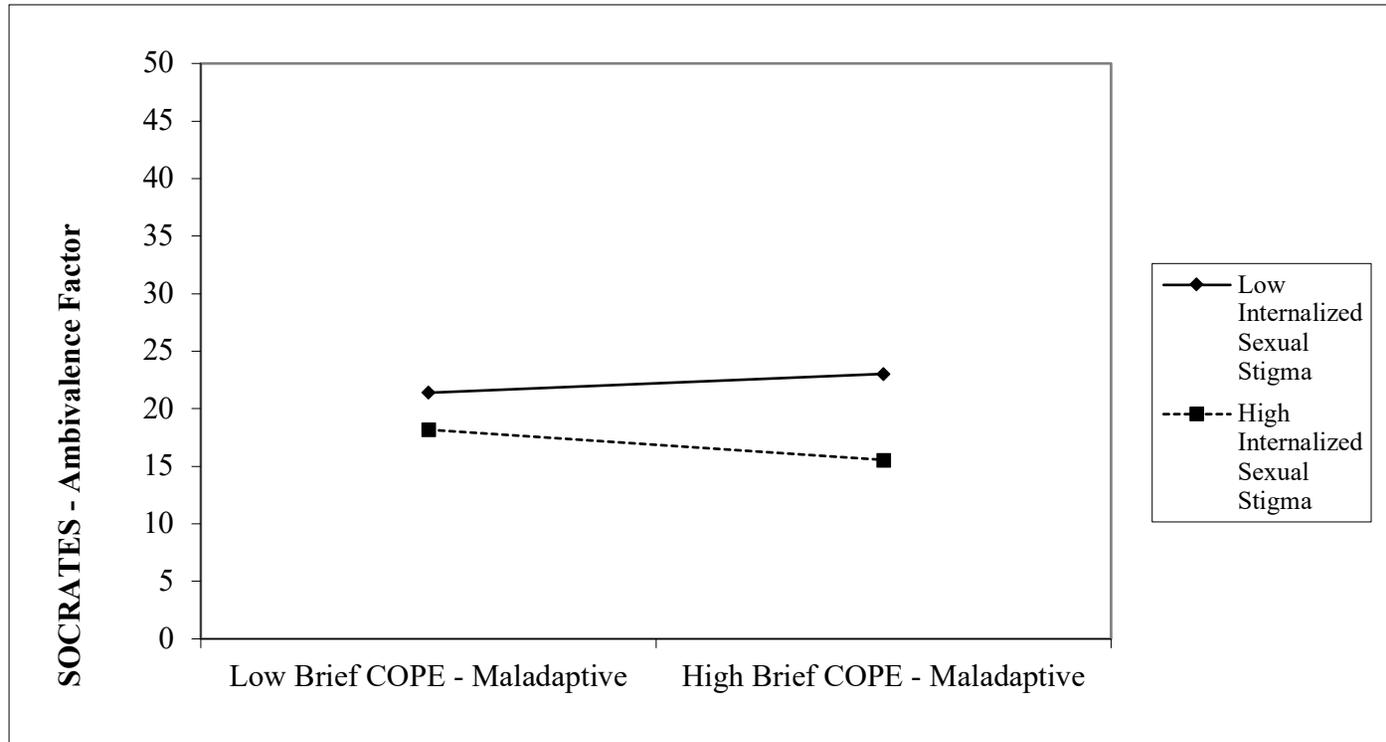


Figure 2. Plotted moderated regression displaying a significant interaction between the SOCRATES Ambivalence factor and maladaptive coping as measured by the Brief COPE. The Dawson website was used to depict moderation results and it divided the study sample into “low” versus “high” levels of maladaptive coping strategies. Greater maladaptive coping increased feelings of ambivalence (i.e., treatment motivation) and this was exacerbated by higher levels of internalized sexual stigma.

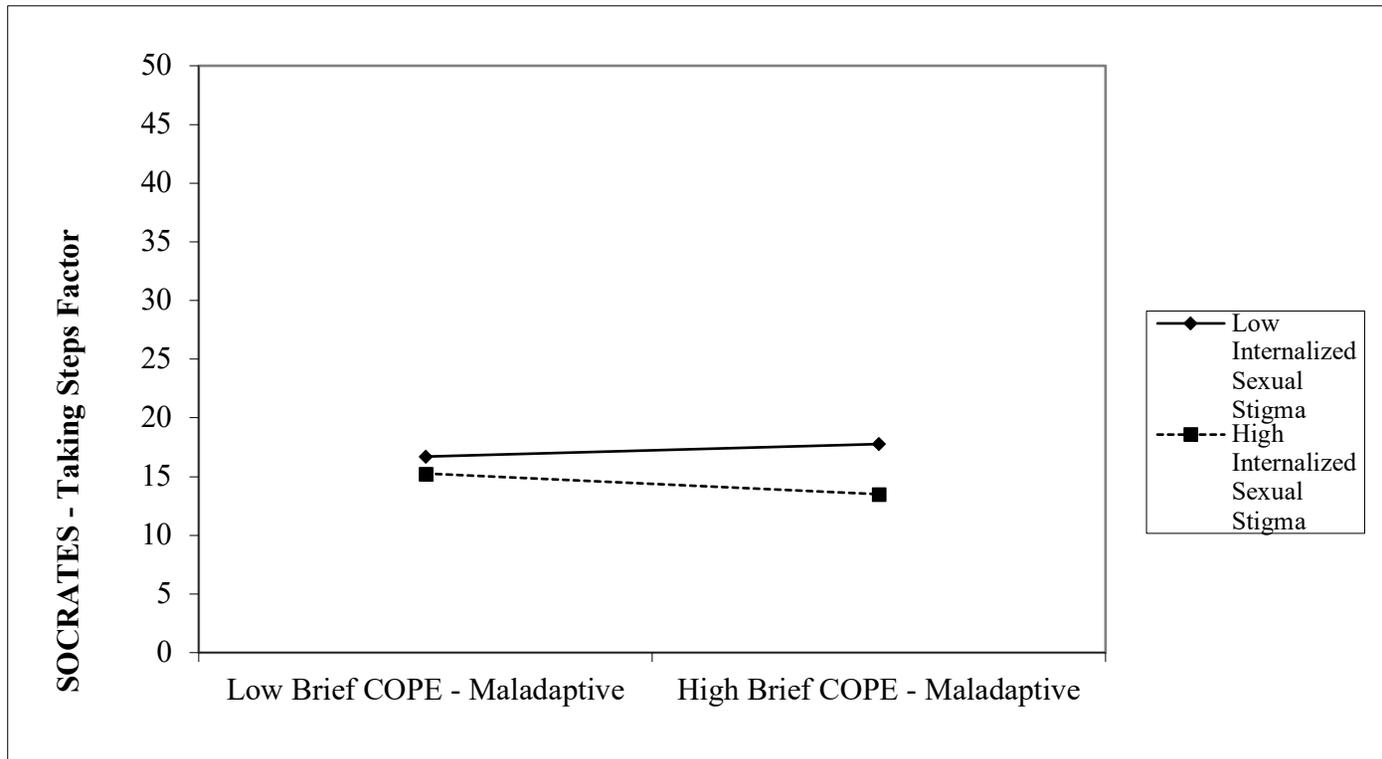


Figure 3. Plotted moderated regression displaying a significant interaction between the SOCRATES Taking Steps factor and maladaptive coping as measured by the Brief COPE. The Dawson website was used to depict moderation results and it divided the study sample into “low” versus “high” levels of maladaptive coping strategies. Higher levels of maladaptive coping were associated with lower ratings of taking steps to creating positive changes related to controlling one’s sexual interest in children and this was exacerbated by higher levels internalized sexual stigma.

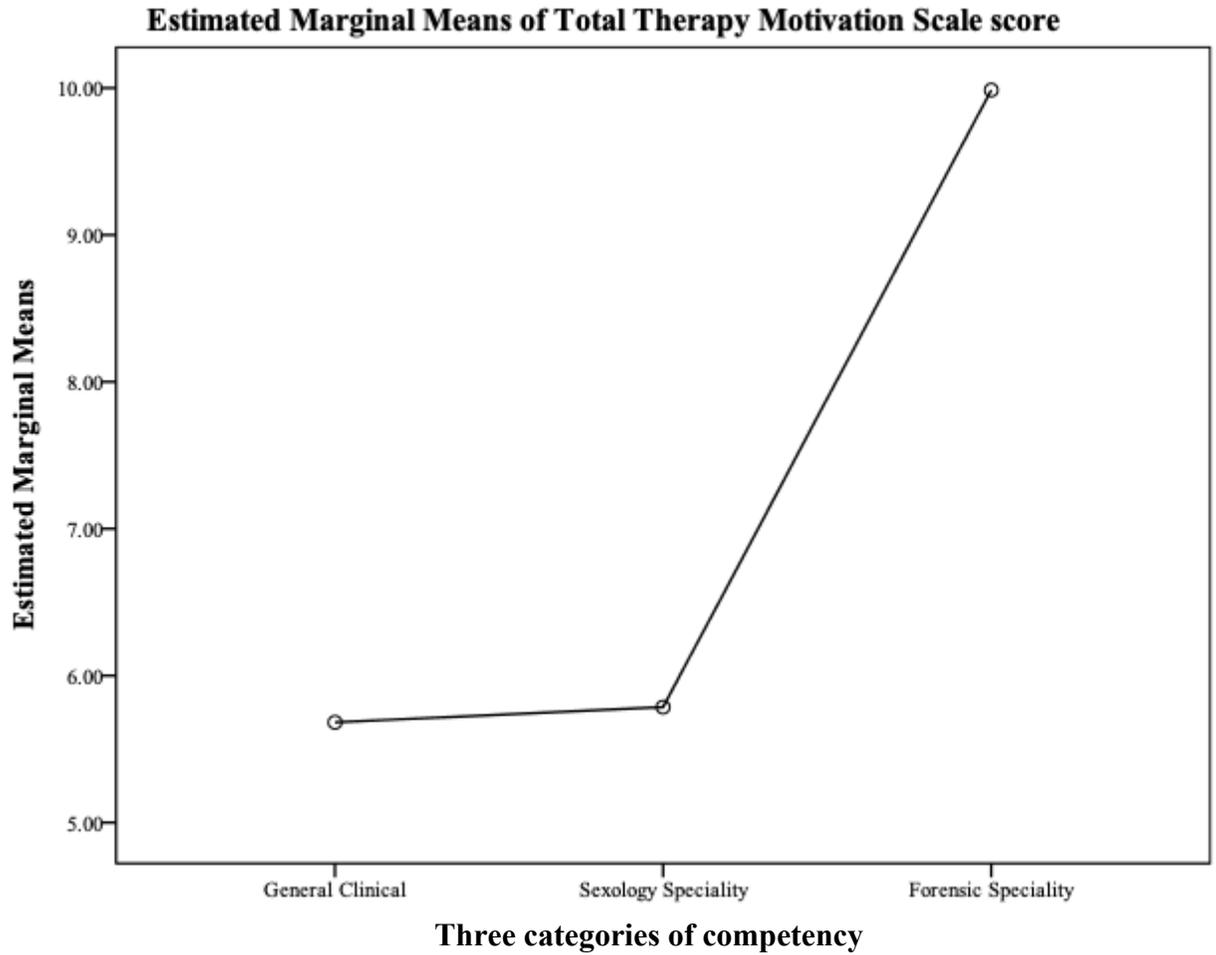


Figure 4. Plotted Bonferroni post-hoc displaying statistically significant differences in competency between general clinicians, and those with forensic and sexology specialization regarding motivation to treat MAPs.

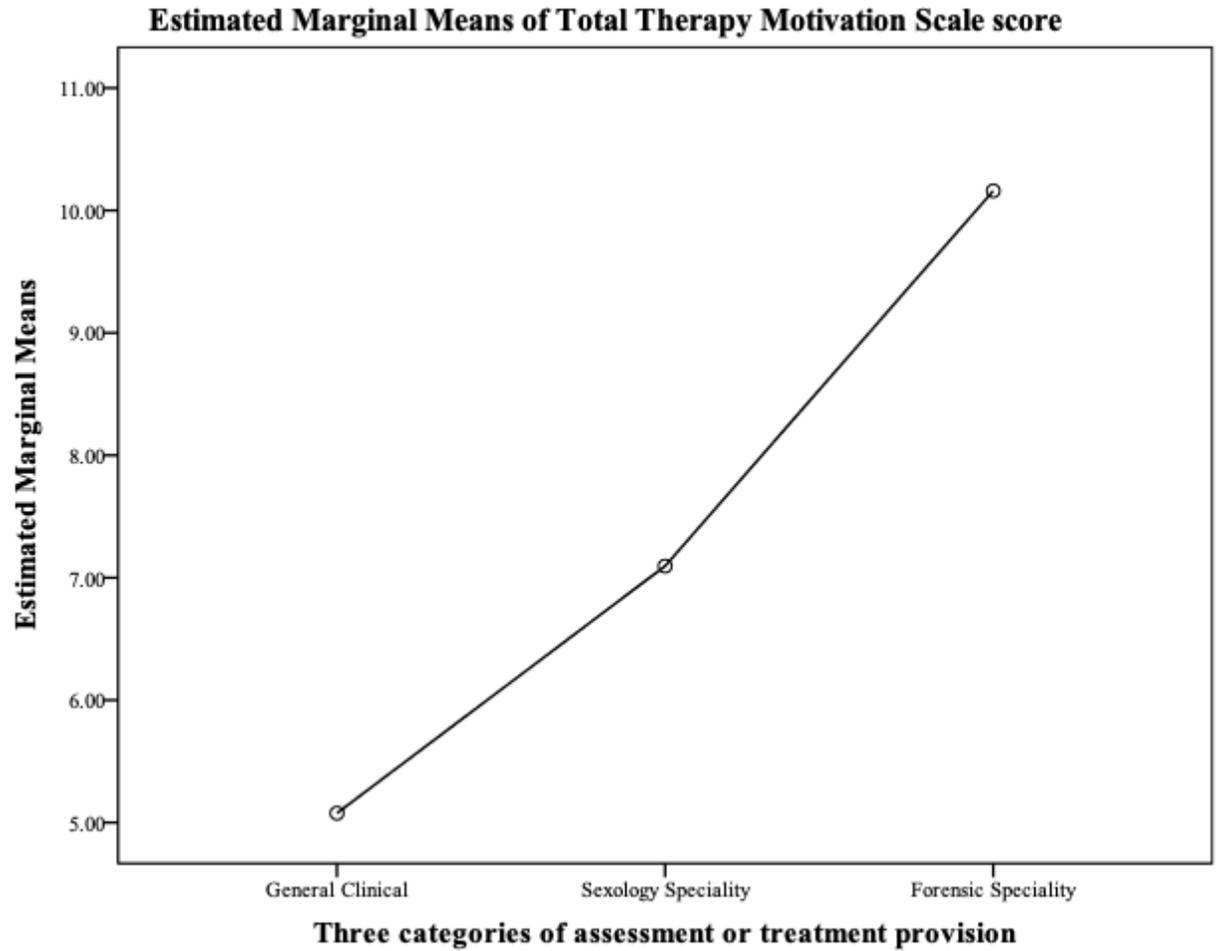


Figure 5. Plotted Bonferroni post-hoc displaying statistically significant differences in assessment/treatment provision experience between general clinicians, and those with forensic and sexology specialization regarding motivation to treat MAPs.

Appendix A

Background Questions for Clinicians

- How many years of experience do you have conducting clinical work? (open ended)
- What is your professional designation?
 - Physician
 - Psychiatrist
 - Psychologist
 - Social Worker
 - Counsellor/Psychotherapist
 - Occupational Therapist
 - Behaviour Therapist
 - Other, please specify
- I provide mental health services to (check all that apply)?
 - Children (under 12 years)
 - Adolescents (12-17 years)
 - Adults
 - Older adults (65+ years)
 - Families
 - Couples
 - Other, please specify:
- I have training and/or experience to provide assessment and/or treatment services to individuals with a sexual interest in children?
 - Yes
 - No
 - Unsure
- I have **competency** to work with the following client groups (check all that apply):
 - Those with general mental health issues (e.g., depression, anxiety)
 - Those who have been in conflict with the law for reasons other than sexual offending/sexual behaviour problems (e.g., violent offending)
 - Those who have committed sexual offences
 - Those with paraphilic interests (not including sexual interest in children)
 - Those with a sexual interest in children
 - Those with sexual health problems (e.g., sexual compulsivity) or sexual disorders (e.g., erectile dysfunction) other than paraphilias or sexual interest in children
 - Those seeking sex therapy
 - Those seeking couples' therapy

- I have **provided assessment and/or treatment** to clients where the identified area of concern or focus of the work with the client was (check all that apply):
 - General mental health issues (e.g., depression, anxiety)
 - Being in conflict with the law for reasons other than sexual offending or sexual behaviour problems (e.g., violent offending)
 - Problems related to committing sexual offences
 - Paraphilic interests (not including sexual interest in children)
 - A sexual interest in children
 - A sexual health problem (e.g., sexual compulsivity) or sexual disorder (e.g., erectile dysfunction) other than paraphilias or sexual interest in children
 - General sex therapy
 - Couples' therapy