

INFORMING THE DEVELOPMENT OF A CLINICIAN WORKSHOP

INFORMING THE DEVELOPMENT OF A WORKSHOP TO INCREASE CLINICIAN
COMPETENCY AND WILLINGNESS TO TREAT INDIVIDUALS WITH SEXUAL
INTEREST IN CHILDREN

By

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Abstract

Informing the development of a workshop to increase clinician competency and willingness to treat individuals with sexual interest in children.

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Abstract: This thesis represents the first step toward developing an educational workshop to increase clinician competency and willingness to treat those with sexual interest in children. In study 1, North American clinicians with lower stigma and competency to assess and/or treat this population were more likely to accept a referral for someone with a sexual interest in children, and more willing to attend a workshop. Both studies asked clinicians and those with sexual interest in children about what should be included the workshop. Clinicians were also asked about barriers to attendance. Clinicians focused on the inclusion of therapeutic models, risk assessment, and mandatory reporting, while those with sexual interest in children focused on increasing understanding, stigma reduction, and a positive therapeutic environment. According to clinicians, the greatest barrier to attendance would be accessibility (i.e., cost and location). The final chapter discusses key elements of a workshop and next steps for development.

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Chapter 1- Introduction

The present thesis is comprised of two studies that aim to develop an understanding of North American mental health clinicians' attitudes toward individuals with sexual interest in children and their willingness to participate in an educational anti-stigma workshop. The first study (Chapter 2) involved administering a survey to clinicians across North America. The goal of this study was twofold. First, the study aimed to gain an understanding of clinicians' stigma toward those with sexual interest in children and the relationship of this stigma with their willingness to participate in an educational anti-stigma workshop. This information is important to the development of such a workshop. The second study (Chapter 3) aimed to develop an understanding of what individuals with sexual interest in children believe clinicians should know about their interest and what they think should be included in an educational anti-stigma workshop. The thesis research is integral to the development of an anti-stigma and educational workshop for clinicians aimed at increasing competency to provide clinical services to people with sexual interest in children. Providing increased services to those with sexual interest in children is important for those who want treatment for mental health needs as well as for teaching strategies for managing sexual urges and abstaining from child sexual offending. Before describing the individual studies, a brief overview of relevant literature is provided.

Sexual Interest in Children

Sexual interest in children¹ is a broad term that is briefly operationalized before further discussion of the topic. Typically, the term “pedophilia” is attributed to the term sexual interest in children; however, pedophilia only represents sexual interest in prepubescent children, those who are in Tanner Stage 1 of sexual development and are typically between the ages of 3 and 10 (Seto, 2017). Another term that falls under the umbrella of sexual interest in children is “hebephilia,” which is the sexual interest in pubescent children who are in Tanner Stage 2 or 3 of sexual development, and who tend to be between the ages of 11 and 14 (e.g., Blanchard et al., 2009; Stephens & Seto, 2015). Lastly, “pedohebephilia” refers to the sexual interest in *both* prepubescent and pubescent children (e.g., Blanchard et al., 2009).

Given the definition of sexual interest in children, it is important to briefly consider the difference between sexual interest and sexual offending against children, as much of the research on this sexual interest has been conducted using clinical or correctional samples (Seto, 2009). Sexual interest in children is often equated with childhood sexual abuse (CSA). This inference is perhaps due to the belief that all individuals who commit CSA have sexual interest in children and that all individuals who have sexual interest in children will commit CSA (e.g., Bailey, Bernhard, & Hsu, 2016b; Kingston, Firestone, Moulden, & Bradford, 2007). Although sexual interest in children is a risk factor for reoffending in men who have committed sexual offences (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005; Mann, Hanson, & Thornton, 2010),

¹ For the duration of this paper, the term “pedophile” will be avoided for two reasons: first, labelling someone as a “pedophile” unnecessarily pathologizes the sexual interest; second, recent research has shown that labelling an individual as a “pedophile” results in an increase in stigmatizing and punitive attitudes toward the individual (Imhoff, 2015). Therefore, this population will be henceforth referred to as “individuals with sexual interest in children” and encompasses individuals attracted to prepubescent and/or pubescent children.

approximately 40% and 50% of offenders against children do not have a sexual interest in children (Marshall, 1997; Seto & Lalumière, 2001; Seto, 2018). Rather than a sexual interest in children, some offenders against children may commit CSA due to a myriad of other factors such as, opportunism, hypersexuality, sexualized coping, or disinhibition from substance use (Whitaker et al., 2008; Seto, 2019). While the literature on risk factors for sexual offending is extensive, it is beyond the scope of the present thesis (for a more fulsome discussion see Mann et al., 2010). It should also be acknowledged that while the research on risk factors for sexual recidivism is exhaustive, there is no current research that has pinpointed risk factors for the onset of sexual offending (i.e., factors possessed by those living in the community) in individuals with sexual interest in children.

Overall, there has been much less attention to individuals with sexual interest in children living in the community in general. Despite the belief that people with sexual interest in children are unable to abstain from CSA, various studies with non-clinical samples challenge that assumption. For example, Riegel (2004) found that 78% of a sample with pedophilic interest had no self-reported history of perpetrating CSA, and Beier and colleagues (2009) found that 25% of their sample self-reported that they had not committed CSA or viewed child sexual exploitation material (CSEM). Additionally, in a large-scale Internet survey, 72% of respondents with sexual interest in children indicated that they do not struggle to avoid committing CSA, while 87% reported that they had not been convicted of CSA nor viewing Child Sexual Exploitation Material (CSEM; Bailey, Bernhard, & Hsu, 2016b). In support of non-offending individuals with sexual interest in children, there are several popular online support groups, such as B4U-Act and Virtuous Pedophiles. Importantly, both online communities endorse non-

offending behaviour, which includes a strong stance against viewing CSEM (e.g. b4uact.org; virped.org). These groups provide a safe place for individuals with sexual interest in children to obtain peer support and available resources, such as information about mental health treatment. Ultimately, groups such as B4U-Act and Virtuous Pedophiles place an emphasis on reducing stigma so that individuals feel more comfortable reaching out for help.

Although literature has discussed the differences between offending and non-offending individuals with sexual interest in children, it is an unfortunate reality that there is still research that conflates these individuals with child sex offenders (Feelgood & Hoyer, 2008). For instance, Imhoff (2015) describes an example in which a recent study examined attitudes toward sex offender rehabilitation and used the label of “pedophile” across the items instead of “sex offender,” which promotes the stereotype that all individuals with this sexual interest commit CSA (Viki, Fullerton, Raggett, Tait, and Wiltshire, 2012). As a result, the erroneous assumption that all people with sexual interest in children commit acts of CSA if given the opportunity is perpetuated, resulting in anger and negative attitudes toward the group (Imhoff, 2015; Seto, 2009).

This misinterpretation can lead to a fundamental misunderstanding of individuals with sexual interest in children and result in inappropriate recommendations within the literature. For example, respondents to a B4U-Act survey (2011b) were asked to respond to a recent article in the Harvard Mental Health Letter (2010) on pedophilia. The main points of the article discussed limitations of research on pedophilia, management options for sexual urges, and a focus on prevention of CSA. Participants agreed that the article was a good representation of how clinicians viewed those with sexual interest in children

(i.e., as being at risk for committing sexual offenses), and argued that it promoted inadequate and unethical treatment practices. For instance, the article conflated sexual interest in children with those who have committed sexual offenses and promoted the use of medication to suppress sexual desire (Harvard Mental Health Letter, 2010). It should be noted that while some of those with sexual interest in children do not agree with the use of arousal dampening medications, this is one of the main pharmacological treatments for those looking to manage their sexual interest (e.g., McPhail and Olver, 2020). In addition, over 30% of B4U-Act (2011b) respondents indicated that when trying to seek mental health treatment, the clinician's treatment goals did not align with their own. The study also found that of the individuals who sought treatment, almost half encountered clinicians who made incorrect and unjustified assumptions about them, including that the individual had engaged in sexual offences against children (B4U-Act, 2011b). Individuals responding to this survey responded similarly to DSM-related literature about pedophilia; for example, participants reported that DSM-related literature made inaccurate assumptions, such as the client previously engaging or being at risk to engage in sexual contact with a child (B4U-Act, 2011b).

As much of the literature regarding individuals with sexual interest in children is restricted to clinical and forensic populations, the findings that have been established may not be representative of those living with the sexual interest in the community. In addition, focusing on forensic populations when studying individuals with sexual interest in children may compound the issues surrounding stereotypes and stigma. Therefore, to obtain a more accurate depiction of those with sexual interest in children, research should

direct more attention to studying those with sexual interest in children who are living in the community.

Conceptualizing Stigma

Prior to discussing stigma toward individuals with sexual interest in children, a brief overview of the conceptualization of stigma is required. Since it was first introduced as a social phenomenon by Emile Durkheim in the late 1800s, the term ‘stigma’ has been operationalized in several different ways in the literature. Perhaps the most common operationalization of the term is from sociologist Erving Goffman (1963), who described stigma as an attribute that discredits an individual. Since Goffman, there has been an abundance of stigma-centred research in countless different areas, including mental health (Clement et al., 2014; Thornicroft et al., 2015) and sexual orientation (Bockting, 2014; Cochran, 2001; Saewyc et al., 2006); this research has led to the evolution of the stigma definition. In their paper on the conceptualization of stigma, Link and Phelan (2001) offer a comprehensive definition of stigma, explaining that it occurs, “...when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold” (p. 367). In other words, for a group to be stigmatized, there must be a difference in social, economic, and/or political power between the non-stigmatized and stigmatized groups.

To understand the concept of stigma, it is important to briefly consider how it develops. According to their definition of stigma Link and Phelan (2001) stated that groups must first be distinguished and labeled in an oversimplified manner. The most common assignment of categories would be those associated with race such as “black” and “white.” In the case of individuals considered in the present thesis, they would most

likely be placed in a category labeled “pedophiles” or “child molesters.” These labels are typically generated from lay theories (theories that people believe are true about the world) that the public frequently uses (Jahnke & Hoyer, 2013); lay theories can quickly develop into public stigma (Corrigan, Morris, Michaels, Rafacz, and Rüsç, 2012). Public stigma is expressed through stereotypes, prejudice, and discrimination (Rüsç et al., 2005; Thornicroft et al., 2016). Stereotypes are the negative beliefs about a group (Thornicroft et al., 2016) such as the idea that those with sexual interest in children are dangerous and sex obsessed. When individuals begin to agree with these stereotypes and develop negative emotional reactions toward a group, this becomes prejudice (Rüsç et al., 2005). This prejudice results in discrimination which is the behavioural response to the presence of the stigmatized group; behaviours can range from social exclusion to acts of violence.

Sexual Minorities, Stigma, and the Minority Stress Model

There are countless groups throughout history who have experienced stigma; one group that has been the focus of stigma research is those who identify as sexual minorities (i.e., Lesbian, Gay, Bisexual, Transsexual, Queer/Questioning, Two-Spirited, Plus; [LGBTQ2S+]). Sexual stigma is the negative view and inferior status that society imparts upon individuals who deviate from normative sexual behaviour, identity, relationships, and/or community (Herek, 2000). The negative impact of sexual stigma has been extensively documented for individuals who identify as LGBTQ2S+ (Botswick, 2012; Clements-Nolle, 2006; Cochran, 2001; Meyer, 2013; Saewyc et al., 2006). Research has shown that people who identify as gay and lesbian present with higher rates of mental illness than those who identify as heterosexual, including having higher rates of substance

abuse (Gilman et al., 2001) and suicide (King et al., 2008). Furthermore, the literature on mental health indicates that individuals who identify as bisexual present with higher rates of depression and anxiety compared to all other groups, including other sexual minority populations (Cochran & Mays, 2007; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002). This disproportionately high level of mental illness present in the LGBTQ2S+ community has been suggested to be a result of stigma, prejudice, and discrimination creating a stressful social environment, which in turn fosters the development of mental health problems (Friedman, 1999).

Based on this idea, Meyer (2003) developed the minority stress theory, which states that perceived (expected) stigma, internalized stigma (believing negative stereotypes about oneself), and the concealment of a stigmatized attribute, such as one's sexual orientation, can result in detrimental mental health effects. Within the sexual minority stigma literature, Meyer's minority stress theory appears to be the most dominant theory and has been further extended to those with sexual interest in children (Jahnke, Schmidt, Geradt, & Hoyer, 2015c; see below). Given the centrality of this theory in the literature, the minority stress model is explicitly discussed.

As part of minority stress, individuals within the LGBTQ2S+ community maintain high levels of perceived stigma. In turn, the greater the perceived stigma, the more energy the individual invests in maintaining vigilance when interacting with the public, resulting in increased stress (Meyer, 2003). In addition, sexual minorities may internalize negative attitudes and live with the fear of rejection which cultivates feelings of alienation, and a lack of community integration and self-acceptance (Baams, Grossman, & Russell, 2015). Both Kelleher (2009) and Pachankis (2007) found that these

stressors were correlated with mental health problems such as depression, anxiety, and suicidal ideation. Therefore, given the negative impact that stigma-related stress has on their mental well-being and social functioning, there is overall support in the literature for the minority stress model as it applies to the LGBTQ2S+ population.

Sexual Interest in Children, Minority Stress, and Public Stigma

Although the minority stress model has been extensively examined in the LGBTQ2S+ community, it has been less frequently utilized when considering other sexual minority groups. Recently, researchers have applied the minority stress model to individuals with sexual interest in children to explore the consequences of stigma within this group (Jahnke & Hoyer, 2013; Jahnke, et al., 2015c). As with those within the LGBTQ2S+ community, individuals with sexual interest in children face issues that are presented in the minority stress model (Meyer, 2003), such as perceived stigma, internalization of negative attitudes, and having to conceal their sexual interest.

The minority stress that individuals with sexual interest in children experience is, in part, a result of stigmatizing attitudes from the public. It is no secret that individuals with this interest are stigmatized and there has been ample research conducted to support this. For example, Furnham and Haraldsen (1998) found that while participants reported they were generally tolerable of people with paraphilias (i.e., fetishism, sadism, and voyeurism), this did not extend to individuals with sexual interest in children. Further, Feldman and Crandall (2007) measured participants' social distance ratings on forty vignettes which depicted different mental health disorders (e.g., schizophrenia, antisocial personality, substance abuse disorders) and included a vignette on sexual interest in children. Participants reported they were most unwilling to associate with people with

sexual interest in children than all other disorders, except antisocial personality disorder.

These findings indicate that individuals with a sexual interest in children may be at an increased risk for social isolation compared to those with mental health disorders.

As with those who have committed sexual offenses (see Harper, Hogue, & Bartels, 2017), people generally have negative views regarding the character of individuals with sexual interest in children. McCartan (2004) found that 90% of participants believed that individuals with sexual interest in children actively fondled children and nearly 60% indicated that individuals with this sexual interest are evil. Relatedly, both Imhoff (2015) and Jahnke et al. (2015a) found that people held extreme punitive attitudes toward those with sexual interest in children, even if there was no offending behaviour present. In fact, participants responded with extreme views, with 28% of participants agreeing that people with sexual interest in children should be dead, regardless of their offense status (Jahnke et al., 2015b). Further, Jahnke (2018b) found that participants expressed feelings of disgust, hatred, and fear toward individuals with a sexual interest in children, which was associated with feeling that these individuals are dangerous, abnormal, and amoral. Interestingly – but perhaps not surprisingly – Imhoff (2015) found that punitive attitudes were positively associated with social desirability which suggests that people find it socially desirable to hold negative attitudes toward individuals with sexual interest in children. As the general public often conflates sexual interest in children with child sexual abuse (e.g., Harper & Hogue, 2015), it follows that people would also find it desirable to hold negative attitudes toward those that they believe to be actively causing harm to children.

Given the intense public stigma people with sexual interest in children face, it is reasonable to assume that this group would experience similar minority stress-related consequences as those within the LGBTQ2S+ community. In their article on stigma-related stress among men with sexual interest in children, Jahnke et al. (2015c) were the first to develop a framework based on the work of Meyer (2003) that provided an overview of stigma-related stress and its impact on people with sexual interest in children. According to the framework, stigma-related stress negatively impacts emotional functioning (e.g., exacerbation of mood, anxiety, and substance abuse disorders and subclinical emotional problems), social functioning (social avoidance, withdrawal, lack of support, joining pro-offense groups), cognitive distortions (low self-efficacy related to control of sexual urges; distorted beliefs about sex with children), and help-seeking motivation (not seeking mental health services even when desired) (Jahnke et al., 2015c).

These stress-induced impairments are illustrated throughout the literature on individuals with sexual interest in children. For example, in a study conducted by B4U-Act (2011a), 45% of participants indicated that they seriously considered suicide due to their sexual interest, while 32% admitted to having a plan for ending their life. Studies conducted by Levenson and Grady (2018) and Cohen et al. (2019) found similar results. While both studies found that approximately 30% of participants experienced suicidal ideation, Cohen et al. (2019) also found that suicidal ideation was positively correlated with perceived stigma. In addition to suicidal ideation, respondents in Levenson and Grady (2018) self-reported high rates of mental health symptomatology coinciding with depression, anxiety, and substance abuse. Apart from mental health symptoms, individuals with sexual interest in children also experience other stressors as a result of

stigma-related stress, such as low-self esteem (Whitaker et al., 2008), and fear of being negatively judged (Jahnke et al., 2015a). For example, Levenson and Grady (2018) found that 50% of their community sample reported having previously sought counseling services for personal and emotional issues besides their sexual interest. The same study found that just over 60% of participants indicated that they were struggling with self-hatred and low self-esteem. In addition, individuals with sexual interest in children internalize the negative attitudes and stereotypes that are promoted throughout society which negatively impacts their self-concept (Buckman et al., 2016; Jahnke, 2018b). Finally, individuals with sexual interest in children tend to have issues with emotion regulation which is concerning when considering that those who go on to perpetrate CSA tend to have less functional coping strategies than those who do not offend (Whitaker et al., 2008).

Individuals with sexual interest in children also suffer from diminished social functioning as a result of their stigma-related stress (Jahnke et al., 2015b). According to Link, Struening, Rahav, Phelan, and Nuttbrock (1997), those who are diagnosed with mental health disorders have higher perceived stigma and as a result suffer more from problems related to social functioning and withdrawal. For example, Jahnke et al. (2015c) examined self-reported stigma-related stress among men with sexual interest in children and found that participants overestimated perceived stigma; participants magnified the negative feelings that the public held toward them. Due to this high perceived stigma, individuals with sexual interest in children face the challenge of concealing their interest (Jahnke & Hoyer, 2013). Jahnke et al. (2015c) found that individuals with sexual interest in children feared others discovering their sexual interest, resulting in participants feeling

distressed and experiencing an increase in emotional and social problems such as loneliness and withdrawal. Jahnke et al (2015c) suggest that some individuals with sexual interest in children may seek out other people with their sexual interest online. While some of these online forums support non-offending behaviour and promote counselling for mental health concerns (e.g. b4uact.org; virped.org), others may promote problematic behaviours, such as seeking inappropriate relationships with children.

In their framework, Jahnke et al. (2015c) include cognitive distortions as a factor that is influenced by stigma-related stress. Common cognitive distortions for individuals with sexual interest in children seem to stem from their tendency to hide their interest. According to West (2000), because they tend to be isolated, some individuals with sexual interest in children may not learn healthy ways to cope with their sexuality and instead develop distorted beliefs about CSA, such as the belief that children benefit from sexual activity. In addition, people with sexual interest in children may internalize the stereotypes that the public believe about them, such as not being able to control themselves around children (Jahnke et al., 2015c). These pervasive stereotypes, if internalized, may reduce feelings of responsibility for their actions. For example, internalizing the belief that all of those with sexual interest in children are destined to offend may result in low self-efficacy related to the control of sexual urges, thereby increasing the risk of committing CSA.

Finally, the stigma-related stress framework includes stigma's effects on help-seeking behaviour (Jahnke et al., 2015c). Survey results published by B4U-Act (2011a) showed that 82% of respondents with a sexual interest in children agreed that they would benefit from receiving mental health services to cope with the stress related to their

interest. Unfortunately, literature suggests that stigma-related stress impacts help-seeking behaviour (Clement et al., 2014). Although they may realize their need for mental health interventions, empirical studies have found that individuals with sexual interest in children may avoid seeking out help due to the fear of clinicians having a negative reaction (Levenson & Grady, 2018; Jahnke & Hoyer, 2013). Stigma from clinicians is arguably more detrimental than public stigma to the well-being of individuals with sexual interest in children; if clinicians do not fully understand their client's sexual interest, this may lead to negative reactions and even reporting the individual to the authorities when CSA is absent (Jahnke et al., 2015c). As suggested by Link et al. (1997), to successfully offer treatment for mental health issues, clinicians must address stigma as its own separate issue. Extending this to the present population, if the overarching goal of offering treatment to individuals with sexual interest in children is to treat mental health issues and reduce the likelihood of offending behaviour, then clinicians must first address stigma.

Clinician Stigma

Clement et al. (2014) found that stigma placed fourth out of ten barriers to mental-health help-seeking with both disclosure of mental health issues and confidentiality causing apprehension among clients. Of course, the stigma associated with being an individual with a sexual interest in children can result in difficulties when seeking professional help; as with the public, research has indicated that individuals with sexual interest in children are at risk of being stigmatized by clinicians (Levenson & Grady, 2018; Steils-Glenn, 2010). Although some individuals with sexual interest in children have indicated a desire to seek professional help (B4U-Act, 2011a; Beier et al., 2009),

fear of judgement and stigmatization may be a significant barrier to help-seeking behaviour.

One B4U-Act survey (2011a) found that 58% of respondents felt that they would benefit from mental health services for an issue related to their sexual interest in children but would not actively seek help from a clinician. In subsequent responses, the majority of respondents cited doubt about the understanding that clinicians have regarding their sexual interest, as well as concerns about receiving respect, being judged, being treated ethically, and concerns related to confidentiality (B4U-Act, 2011a). Similar results were found by Levenson and Grady (2018); almost 70% of respondents were concerned about receiving a negative reaction from the clinician while another 70% expressed concern regarding confidentiality. In both studies, the largest concern was that the clinician would report them to law enforcement even if they had not committed a crime or there was no risk of a crime occurring (B4U-Act, 2011b; Levenson & Grady, 2018). When asked whether there were any negative consequences resulting from not receiving professional help, 48% of participants reported that they suffered from issues such as depression, low self-esteem, suicidal ideation and/or attempts, feelings of isolation, etc. (B4U-Act, 2011b).

Given the anticipated stigma from clinicians, it is worth investigating whether clinicians hold stigmatizing attitudes toward individuals with sexual interest in children. There is currently a lack of literature in North America on clinician stigma toward this group, however, it is a topic that has been researched in a limited number of European studies. The results of these studies are mixed; while some clinicians seem to be open to working with individuals with sexual interest in children, many are reluctant (Alanko,

Haikio, Laiho, Jahnke, & Santtila, 2014; Jahnke, Philipp, & Hoyer, 2015b; Koops, Turner, Jahnke, Märker, & Briken, 2016; Stiels-Glenn, 2010). For example, Stiels-Glenn (2010) found that 95% of participating German psychotherapists were unwilling to work with individuals who self-reported as having sexual interest in children and even fewer were willing to work with individuals who had committed CSA. In addition, Alanko et al. (2014) surveyed Finnish psychotherapists on their willingness to treat individuals with sexual interest in children. As with the results obtained by Stiels-Glenn (2010), many (38%) were unwilling to treat this population due to their personal attitudes (e.g., holding negative attitudes toward those with sexual interest in children such as their lack of motivation for treatment). Further, Koops et al. (2016) reported on a sample of Russian sexologists who indicated feeling less empathy and more anger toward people with a sexual interest in children; over one quarter of respondents believed that people with sexual interest in children should be incarcerated, regardless of whether they have offended.

Despite these concerning results, other studies have been more promising. For example, a pre-test survey from a stigma reduction study conducted by Jahnke et al. (2015b) found that 80% of psychotherapists in training were willing to treat non-offending individuals with a sexual interest in children even prior to the anti-stigma intervention. Overall, the clinicians in this study held more positive attitudes toward this group compared with previous studies.

From the literature it appears that many clinicians are hesitant to treat individuals with sexual interest in children. When examining the reasons that clinicians provided for not wanting to provide treatment to this population, Stiels-Glenn (2010) found that 38%

responded that it was due to negative attitudes, negative prior experiences, or doubts regarding motivation for treatment. Similarly, 38% of psychotherapists in Alanko et al. (2014) said that their negative perceptions resulted in a lack of willingness to treat individuals with sexual interest in children. Although these responses are consistent with potential stigma, it was not only stigma that created a barrier to treatment. In addition to negative attitudes, the psychotherapists also cited their lack of training and experience with this population as a reason for their unwillingness to treat (Alanko et al., 2014; Stiels-Glenn, 2010). For example, 20% of psychotherapists in the Stiels-Glenn (2010) study and 64% in Alanko et al. (2014), referred to their lack of training and expertise in this area as a reason for why they did not want to treat individuals with sexual interest in children. As a result, the decision to not offer treatment to this client population may in part be due to limited competency regarding sexual interest in children.

Consistent with these findings, recent research has shown that many clinicians lack training even in the domain of general sexual health. A survey administered by Reissing and Giulio (2010) to practicing psychologists in Canada found that although 78% of respondents had worked with patients who identified sexual health concerns in the preceding 12 months, 54% of psychologists had not received any sexual health training at the graduate or post-graduate level and 52% had not received any training at the undergraduate level. This is concerning because, as Widerman and Sansone (1999) discuss, a lack of sex-related knowledge when dealing with sexual health issues may result in inadequate treatment and even harm. Therefore, not only is it important to address clinician stigma toward individuals with sexual interest in children, but also for

clinicians to obtain comprehensive training in sexual health and the treatment of sexual minority groups.

Addressing Mental Health Professional Stigma and Competency

Research on mental health has begun to make a shift toward effective stigma-reducing interventions using contact with stigmatized groups, education, and personal narratives. Research supports that both contact and personal narratives result in greater attitudinal changes compared to strictly knowledge-based approaches (Clement et al., 2013; Corrigan et al., 2012; Thornicroft et al., 2016; Yamaguchi et al., 2013). For example, Yamaguchi et al. (2013) found that social contact and videos of people from stigmatized populations were the most impactful in terms of increasing self-reported positive attitudes and reducing social distance scores. Additionally, Corrigan et al. (2012) found that interventions incorporating both education and social contact improved self-reported attitudes and subsequent behaviour intentions (measured by level of avoidance) when compared to strictly knowledge-based interventions. Therefore, while effective educational anti-stigma workshop should involve improving knowledge of those with sexual interest in children, according to past research, (Corrigan et al., 2012; Yamaguchi et al., 2013), it should also initiate social contact with these individuals.

Recently, researchers have attempted to apply these strategies to reduce stigma toward individuals with sexual interest in children; however, the literature in this area is not as extensive as the research on mental health stigma reduction. Using a mix of self-report and implicit stigma measures, Harper, Bartels, and Hogue (2016) examined whether stigma toward individuals with interest in children could be reduced via narrative humanization in a community sample. Harper et al. (2016) presented participants with

either a first-person narrative featuring an individual with sexual interest in children or an expert opinion about sexual interest in children. The results demonstrated that although both strategies led to a decrease in stigmatizing attitudes, the first-person narrative also led to a decrease in implicit (unconscious) stigmatizing attitudes. A short-term longitudinal follow-up study by Harper, Lievesley, Carpenter, Blagden, and Hocken (2019) found that these effects were present four months later. This supports previous findings from Yamaguchi et al. (2013) suggesting that social contact via video plays a role in stigma reduction by presenting participants with personal narrative information.

A more recent pretest-posttest study examined whether a course on child sexual offenders would affect university students' attitudes and knowledge toward child sex offenders; in addition to factual knowledge, students were also presented with different forms of personal narrative (Wurtele, 2018). The student participants were exposed to modules that covered CSA and exploitation that were taught by both psychology and criminal justice professors. Additionally, the students watched a documentary that featured a non-offending individual with sexual interest in children discussing their experiences with stigmatization, and read material posted on the Virtuous Pedophile website (Wurtele, 2018). The results showed that after completing the course, students endorsed fewer negative stereotypes and harsh punitive sentencing and participants reported more positive attitudes toward offender rehabilitation.

Only two studies to date have focused on administering anti-stigma strategies to clinicians to reduce stigma toward individuals with sexual interest in children (Jahnke et al., 2015b; Levenson & Grady, 2019). Most recently, Levenson and Grady (2019) implemented a short training workshop across four conferences (two social worker

conferences and two Association for the Treatment of Sexual Abusers conferences) to help clinicians provide ethical and effective treatment to those with sexual interest in children. The workshop was knowledge-based and delivered in either a 3-hour or 90-minute format and a pretest-posttest survey developed by the authors was utilized to measure knowledge and attitudes toward those with sexual interest in children. Their results showed that there were no significant differences in scores between the two different workshop lengths. Further, they found that while the workshop was effective in increasing knowledge of those with sexual interest in children, it was not successful in changing clinicians' attitudes (Levenson & Grady, 2019). However, it is worth noting that attitudes were not particularly negative prior to the workshop. This makes sense given the fact that participants at the conferences were likely to have previously provided assessment and/or treatment to those with sexual interest in children and therefore be more comfortable working with these clients. Based on the previous research on social contact and humanizing narratives, it is possible that these attitudes were not affected due to the purely knowledge-based nature of the workshop. More likely, participants had previous experience working with this group and therefore fewer stigmatizing attitudes, resulting in less attitudinal change. It is possible that the same workshop presented to general mental health clinicians may have resulted in significant changes in stigma due to a lack of competency in treating those with those with sexual interest in children. Moreover, the study lacked a true control group, which prevented more sophisticated analyses of the workshops' efficacy.

Jahnke et al. (2015b) administered a ten-minute online program to a group of psychotherapists in training while a control group received a ten-minute online program

on child welfare and therapy. The anti-stigma intervention comprised a series of texts that addressed myths related to sexual interest in children. Similar to the Wuertle (2018) study, Jahnke et al (2015b) incorporated excerpts from a documentary featuring a non-offending individual with sexual interest in children discussing his sexual interest, stigmatization, and experiences with therapy. Participants who were assigned to the anti-stigma program subsequently self-reported reduced stereotype endorsement and reduced social distance scores compared with the control group who received the child welfare program. In addition to stigma reduction, the program served to increase psychotherapists' self-reported knowledge of the population; for example, the psychotherapists in the anti-stigma group were less likely to believe in the controllability of sexual interest in children (Jahnke et al., 2015b); however, the effects were only short-term (i.e. between one week and 64 days), which could be due to the brevity of the program.

Based on their results, Jahnke et al. (2015b) made several suggestions for future workshops. They suggested that in the future, programs or workshops should be longer and more varied in their approach. For example, based on research on stigma and narrative humanization (e.g., Harper et al., 2016), not only should a workshop incorporate education, but it should also include contact with individuals with sexual interest in children, and with clinicians who have experience treating this population. Despite not having a long-term impact, these results are promising in that they suggest the ability for educational anti-stigma workshops to positively influence clinicians' attitudes and knowledge surrounding individuals with sexual interest in children, and potentially increase willingness to treat the population. In addition to reducing stigma, future

workshops should also aim to increase competency to treat general mental health issues within this population. As discussed above, individuals with sexual interest in children are at a high risk of suffering from emotional irregularities and mental health issues such as depression, anxiety, and suicidal ideation (B4U-Act, 2011b; Cohen et al., 2019; Levenson & Grady, 2018). Therefore, it is optimal for individuals with general mental health concerns to receive effective treatment, which could be offered by clinicians in general mental health settings who have competency to treat these issues but may be less comfortable working with people with sexual interest in children.

Currently, it appears that many clinicians are averse to treating individuals with sexual interest in children either because of their personal stigmatizing attitudes or because of their lack of training (Alanko et al., 2014; Stiels-Glenn, 2010). In other words, both a lack of competency and stigmatizing attitudes impact clinician decision making. Indeed, Stephens, McPhail, Heasman, and Moss (2020b) found that clinicians with higher stigmatizing attitudes toward those with sexual interest in children were more likely to indicate that they would make a mandated report relating to a client who disclosed their sexual interest in children. While not directly measured, it is possible that clinicians with a lack of competency in working with this population may also report more frequently based on a misunderstanding of risk and mandatory reporting laws. For these reasons, asking clinicians the type of education they would require to increase competency with this population would be integral to creating an effective educational and anti-stigma workshop. Consequently, the goal of an educational and anti-stigma workshop would be to increase the ability for clinicians to treat individuals with sexual interest in children by targeting stigmatizing attitudes and increasing knowledge about the population.

The subsequent chapters represent the early stages of developing an educational and anti-stigma workshop for clinicians that aims to reduce stigma and increase competency to provide treatment to individuals with sexual interest in children. Chapter 2 contains study 1 which examined clinicians' stigma toward individuals with sexual interest in children and whether this stigma impacts their willingness to participate in an educational anti-stigma workshop. Study 1 also asked clinicians what should be included in a workshop in terms of content and about potential barriers to workshop attendance. Chapter 3 contains study 2 which recruited individuals with sexual interest in children who reside in the community and surveyed them about what they believe clinicians should receive training on to provide effective mental health treatment to this population. Chapter 4 provides an overarching discussion that considers the results of these studies and their impact on the development of a comprehensive clinician educational anti-stigma workshop.

Chapter 2 – Study 1

Present Study

Although some clinicians are open to treating individuals with sexual interest in children, others are unwilling to provide treatment (Alanko et al., 2014; Koops et al., 2016; Stiels-Glenn, 2010). This is noteworthy as it is possible that clinicians who participated in surveys of stigma and willingness to treat those with sexual interest in children may have had more accepting views of this group than those who did not participate by virtue of their participation. In addition, almost 60% of the B4U-ACT (2011a; 2011b) participants were from North America, while nearly all studies examining clinician stigma toward people with sexual interest in children were completed in European countries. As acceptance of those with sexual interest in children varies across culture (e.g., Green, 2002), it is reasonable to assume that different results may be found when examining North American clinicians' attitudes toward individuals with sexual interest in children. Indeed, Imhoff (2015) ran a comparison study of the public's self-reported stigma and attitudes toward those with sexual interest in children. The results showed that the North American sample had more pronounced negative associations toward those with sexual interest in children than did the German sample. Furthermore, programming for individuals with sexual interest in children is widespread in Germany (e.g., Prevention Project Dunkelfeld; Beier et al., 2009), which may have resulted in clinicians being more open to treating individuals with sexual interest in children simply due to exposure.

To date, there has not been an examination of clinician stigma toward individuals with sexual interest in children in North America and its impact on willingness to

participate in an educational anti-stigma workshop or to accept treatment referrals for people with sexual interest in children. While Levenson and Grady (2019) addressed knowledge, stigma, and willingness to treat in North American clinicians, they did not look at willingness to attend further training in the area. Further, their sample was pre-selected as these clinicians had signed up to complete the workshop and are unlikely to be representative of the average general mental health clinician. The current study aimed to gauge stigma and willingness of clinicians in North America to participate in an educational anti-stigma workshop that would aim to reduce stigma and increase competency to treat individuals with sexual interest in children. Further, it examined the impact of stigma on willingness to participate in such a workshop and to accept treatment referrals from this population.

The proposed study had several hypotheses. First, it was hypothesized that general clinicians with no background in providing assessment or treatment of atypical sexual interest (including sexual interest in children) would hold a greater degree of stigmatizing attitudes toward individuals with sexual interest in children compared with those who had this previous experience. Second, clinicians with high levels of stigmatizing attitudes would be less likely to accept a referral to treat clients with sexual interest in children, regardless of their presenting issue, when compared to clinicians with low levels of stigmatizing attitudes. Finally, when controlling for competency, clinicians with high levels of stigmatizing attitudes would be less likely to participate in an educational anti-stigma workshop than clinicians with low levels of stigmatizing attitudes. In addition to these three hypotheses, the current study conducted an exploratory analysis regarding the

type of education clinicians would be interested in receiving which will be integral to the development of future programming.

Method

Power Analysis

Prior to data collection, an a-priori power analysis was conducted using the G-Power software package (Faul & Erdfelder, 1992). First, an effect size of $d = .73$ was derived from the difference in stigma scores between forensic and non-forensic clinicians from a separate thesis study (Moss, 2019). The effect size was then converted into an odds ratio of 3.76 using an online calculator (https://www.psychometrica.de/effect_size.html) and inputted into G-Power with a β of .80, resulting in a suggested sample size of 41. As the present study aimed to collect an equal number of clinicians across four vignettes, the calculated sample size was multiplied by four for a final recommended sample size of 164.

Participants

Clinicians² across North America who provide mental health treatment or who were in professional training programs to provide mental health treatment were recruited for the present study. To participate, individuals must have provided mental health treatment within the last 12 months prior to taking the survey and understand the English language. Students in a professional program to provide mental health treatment and/or assessment were also encouraged to participate. Over a five-month period, a total of 132

² Note that for this study, the term ‘clinician’ refers to two groups a) any person who provides mental health treatment and/or assessment and b) students in a professional program designed to train them to provide mental health treatment and/or assessment. Therefore, the term ‘clinician’ is broad and refers to students, and different allied health professionals.

clinicians responded to the survey. Clinicians were excluded if they did not complete the survey ($n = 30$) and if they were not from North America ($n = 6$). This resulted in a total of 101 clinicians. Clinicians' demographic information is presented in Table 1. As the initial power analysis indicated that a sample size of 164 was required to achieve 80% power, a sample size of 101 (a sample size 38% smaller than required) suggests an overall power of 42%.

Measures

Background questions. Clinicians were invited to answer a series of background questions to determine clinicians' professional title, years of experience, competency to treat different types of presenting issues, and area of speciality (e.g., forensic, general mental health). Clinicians were also asked whether they had experience working with individuals with atypical sexual interests, including sexual interest in children. A series of more general demographic questions were also asked, including age, gender, ethnicity, country, highest level of education, and political orientation. All questions (including survey questions) can be found in Appendix A.

Attitudes Toward Persons with Sexual Interest in Children (APSIC). The APSIC is a 21-item scale developed by the author and thesis supervisor in collaboration with B4U-Act for the purposes of this study. The APSIC is based off the Attitudes Towards Sex Offenders – 21 (ATS-21) scale developed by Hogue and Harper (2019). While the ATS-21 assesses participants' attitudes toward individuals who have committed sex offenses, the APSIC was created to assess attitudes toward individuals with sexual interest in children. For the first draft of the APSIC, the author and thesis supervisor changed the ATS-21 descriptor from "sex offender(s)" to "individuals with

sexual interest in children.” Afterwards, the author and supervisor had a phone meeting with the research coordinators of B4U-Act to discuss the content of the scales’ items and how to best incorporate a range of negative attitudes specific to those with sexual interest in children. Subsequently, eight items from the original ATS-21 were altered to better encapsulate common stigmatizing ideas of those with sexual interest in children (see Appendix B for all changes made to the ATS-21). For example, item six of the ATS-21 originally read, “Give a sex offender an inch and they take a mile.” After collaborating with B4U-Act, the item was changed to “Individuals with sexual interest in children are emotionally immature.”

The APSIC items were scored on a 7-point Likert scale from *strongly disagree* to *strongly agree*. Ten items are reverse-scored, and scores could range between 0-126, with higher scores indicative of greater stigmatizing attitudes toward those with sexual interest in children. Within the present study, the APSIC demonstrated very good internal consistency ($\alpha = .87$).

Vignettes. Clinicians were randomly assigned to one of four vignettes that provided a description of a hypothetical client that the clinician received as a referral from a family physician. While all vignettes portrayed an individual with sexual interest in children, they varied in terms of offence history (no offence history or sexual contact offence history) and the issue that the client was seeking treatment for (low mood unrelated to their sexual interest or because they are struggling with their sexual interest). The vignettes were developed by the author and the thesis supervisor and were approximately 120 words in length. All four vignettes can be found in Appendix A (p. 139 of this thesis).

Following the vignette, clinicians were asked whether they would be willing to accept the referral and provide treatment to the client. If clinicians indicated that they would *not* be willing to provide treatment to the client, they were redirected to a question that asked the reason for their unwillingness to treat; four options were available for selection: “I would not treat this client due to my own beliefs toward individuals with sexual interest in children”; “I would not treat this client due to my lack of competency in treating individuals with sexual interest in children”; “Both”; or “Other.” All clinicians were then directed to a separate question that asked whether they would be willing to participate in a workshop that would expand their knowledge of treating this population. Regardless of their response, clinicians were presented with an open answer question that asked them about the types of information they believe would be important to include in a workshop on working with people with sexual interest in children. All vignettes and questions presented to clinicians are listed in Appendix A.

Procedure

Clinicians were recruited through several different approaches. First, clinicians were recruited through professional listservs for mental health professionals in North America, as well as through social media, such as Twitter and the supervisor’s website. In addition, the survey was posted by the Association for Treatment of Sexual Abusers (ATSA), the Association of Psychologists of Nova Scotia (APNS) and the Canadian Association of Occupational Therapists (CAOT) on their respective websites. Further, clinicians were recruited using snowball sampling as the thesis supervisor sent the survey to colleagues who were also asked to distribute it.

After receiving information about the study, clinicians could click a link to read the informed consent form. If they agreed to participate in the study, clinicians were invited to fill out the background questions. After completing the background questions, clinicians were randomly assigned to one of four vignettes that provided a description of a hypothetical client that they received as a referral. After reading the vignette, they were asked a series of questions about their willingness to treat the hypothetical client, as well as their willingness to participate in an educational workshop aimed at increasing competency to treat those with sexual interest in children. Regardless of their response, clinicians were invited to fill out an open-ended question regarding what they believe should be included in such a workshop as well as an open-ended question on potential barriers to attendance. Finally, clinicians were invited to complete the APSIC scale. At the end of the study, interested clinicians were directed to a link where they were able to enter for a chance to win one of two \$250 CAD Amazon gift cards.

Data Analysis

Quantitative Data. The first hypothesis for the current study was that clinicians with no background in providing assessment and/or treatment to individuals with atypical sexual interests, including sexual interest in children, would have more stigmatizing attitudes towards individuals with sexual interest in children than those who have previous experience. To test this hypothesis, a new dichotomous variable was created to indicate whether participants had a background in treating and/or assessing people with atypical sexual interests (dichotomous variable yes or no). The total APSIC scores for these two groups were compared using an independent samples t-test and the corresponding effect size (Cohen's D) was calculated.

The second hypothesis was that clinicians with higher levels of stigmatizing attitudes would be less likely to treat clients with sexual interest in children when compared with clinicians with lower levels of stigmatizing attitudes, regardless of the client's presenting issue in the vignette. A hierarchical logistic regression was utilized to address the second hypothesis. The vignette condition was entered into step one and APSIC score was entered into step 2.

Lastly, it was hypothesized that when controlling for competency, clinicians with high levels of stigmatizing attitudes would be less likely to participate in an educational anti-stigma workshop compared to clinicians with low levels of stigmatizing attitudes. This hypothesis was addressed by using a hierarchical logistic regression. In the survey, when asked whether they would be willing to participate in an educational anti-stigma intervention, clinicians were given the options of yes, no, or maybe. To run a logistic regression, and in consideration of sample size, clinicians who answered maybe (13.9%, $n = 14$) were grouped in with those who answered no, thereby creating a dichotomous outcome variable. To control for competency, the competency variable was placed in the first block, while the APSIC total score was placed into the second block.

Qualitative. For the two open-ended questions, responses were analyzed through thematic analysis using the NVivo software. Inductive thematic analysis was used to extract patterns from within the data across the two questions (Braun & Clarke, 2006). In inductive thematic analysis, the emerging themes are linked to the data themselves and not a pre-existing coding manual. Codes are terms or phrases that identify an element within the data that may be of interest to the researcher and assist in organizing data into groups. Themes, which are made up of codes, are much broader and allow for the

interpretation of the data. Thematic analysis was used as it is more flexible and can be used across different theoretical frameworks.

During phase 1 of the thematic analysis, the author became familiar with the data by reading the interview transcripts. Throughout this initial phase, responses that were considered too vague (e.g. one or two-word responses; $n = 7$) or nonsensical ($n = 1$) were not considered in the analysis. As per Braun and Clarke (2006), the author engaged in active reading during which they searched for emerging patterns within the data. Additionally, the author took notes regarding ideas for potential codes or points of interest. In phase 2, the author carefully combed through the entire dataset and developed codes for elements of interest. Subsequently, phase 3 involved collating codes into comprehensive themes. In phase 4, themes were refined to include only those which were made up of coherent data and were distinctive from other themes (i.e., themes can stand alone and cannot be integrated into another theme; Bazeley & Jackson, 2013). Lastly, in phase 5, themes were defined and the data within analysed.

Due to the subjective nature of the coding process, criteria such as internal validity and reliability cannot be established in thematic analysis. In absence of validity and reliability, qualitative researchers have recommended the use of credibility, transferability, and confirmability (Livingston et al., 2016). Credibility, similar to internal validity, involves ensuring that the qualitative findings are believable from the viewpoint of the participants. This was achieved in the present thesis by sharing qualitative results with those in similar roles to the clinicians. Transferability, as with external validity, refers to the ability of the researcher to generalize the findings to other contexts. Finally, confirmability (i.e. objectivity) is the degree to which the findings may be confirmed by

others (Trochim et al., 2016). Confirmability was obtained by openly sharing themes, codes, and a raw data set with the thesis supervisor.

Results

The average total APSIC score was 48.56 ($SD = 15.24$) with the highest and lowest scores being 25 and 98, respectively. This means that, on average, clinicians were in the low to mid-range in terms of endorsing stigmatizing attitudes toward those with sexual interest in children. Accordingly, most clinicians (77.2%, $n = 78$) indicated that they would agree to provide mental health treatment to the client described in the assigned vignette. Of those who said they would not treat the client the majority indicated it was due to their lack of competency in the area (60.9%, $n = 14$) while fewer clinicians indicated that it was due to their personal beliefs (4.3%, $n = 1$), both (17.4%, $n = 4$), or other reasons (17.4%, $n = 4$) which mostly included that the clinicians primarily worked with children. Finally, while 77.2% ($n = 78$) stated that they would be willing to participate in a workshop, 13.9% said maybe, and 8.9% indicated they would *not* be willing to participate in a workshop.

Competency and Stigma

An independent samples t-test was conducted to test the first hypothesis. Results of the t-test indicated that those with competency to treat clients with atypical sexual interests including sexual interest in children had a significantly lower APSIC score ($M = 44.05$, $SD = 12.72$) than those with no competency ($M = 54.53$, $SD = 16.36$) in this area, $t(98) = 3.61$, $p < .001$, and the effect size was medium in size $d = 0.71$.

Willingness to Treat

A hierarchical binary logistic regression was used to test hypothesis two. Detailed results can be found in Table 2. Results revealed that the first step of the model was significant; willingness to treat was significantly associated with vignette condition, $\chi^2(3) = 12.75, p = .005$, and explained 18.1% of the variance. Classification accuracy was moderately high (77%) with correct prediction rates of 100% for clinicians who indicated that they would treat the client and 0% for clinicians who indicated that they would not treat the client. Relative to the baseline condition of a client who requested treatment for their sexual interest and had a history of a contact sexual offense, clinicians were significantly more likely to indicate willingness to treat the client for the other three vignette conditions (low mood, no sexual offense; low mood, contact sexual offense; sexual interest, no sexual offense).

Results revealed that the second step was also significant; willingness to treat was significantly associated with APSIC score when controlling for vignette condition, $\chi^2(4) = 23.63, p < .001$. Adding in APSIC score improved the model, and Nagelkerke's R^2 detected that, in total, 31.9% of the variance was explained. Classification accuracy was moderately high (78%) with correct prediction rates of 92.2% for clinicians who indicated that they would treat the client and 30.4% for clinicians who indicated that they would not treat the client. The results suggested that, relative to the baseline condition, clinicians were more willing to accept referrals from the other three vignette conditions (i.e., low mood and no offense history; low mood and offense history; and sexual interest and no offense history). Further, when controlling for vignette condition, lower stigma scores were associated with an increased willingness to treat the client in the vignette.

Willingness to Attend a Workshop

A hierarchical binary logistic regression was used to test hypothesis three. Detailed results are presented in Table 3. The results indicated that the first step of the model was significant; competency to treat and/or assess those with sexual interest in children was significantly associated with willingness to attend a workshop, $\chi^2(1) = 3.87$, $p = .049$, and explained 5.7% of the variance. Classification accuracy was moderately high (77%) with correct prediction rates of 100% for clinicians who indicated that they would attend a workshop and 0% for clinicians who indicated that they would not attend a workshop. Those who indicated that they had competency to treat and/or assess those with sexual interest in children were 2.58 times more likely to indicate that they would attend a workshop than those without competency.

The results for the second step indicated that the overall model was significant; workshop attendance was significantly associated with APSIC score when controlling for competency, $\chi^2(1) = 8.42$, $p = .004$. Nagelkerke's R^2 detected that, in total, 17.5% of the variance was explained by the model. Classification accuracy was moderately high (78%) with correct prediction rates of 96.1% for clinicians who indicated that they would attend a workshop and 17.4% for clinicians who indicated that they would not attend a workshop. Competency was no longer significant in the second step and only the total APSIC score was a significant predictor of workshop attendance. Controlling for competency, clinicians with lower APSIC scores were 0.95 times more likely to indicate that they would attend a workshop.

Qualitative Analyses: Themes

For the second objective of the study, an inductive thematic analysis was conducted on the clinicians' responses to the two open-ended questions. Eight themes

were found for the question that asked about the content of an educational anti-stigma workshop that would provide training to clinicians to increase effectiveness. There were three themes for the second question that asked about barriers to attending a workshop. A discussion of each theme is presented alongside direct quotes from participants; themes are presented from those that appeared most frequently to least frequently. Please note that n does not represent the number of participants who endorsed a particular theme, but the number of times that the theme was endorsed throughout responses overall. A list of all themes and sample narrative excerpts is presented in Table 4.

Question 1

If a workshop were to be developed that increased competency to treat individuals with sexual interest in children, what do you think should be included for it to be effective?

Therapeutic strategies ($n = 77$). Most responses to this question centered on the theme of therapeutic strategies to use when working with individuals with sexual interest in children. Specifically, most clinicians wanted to know which therapeutic strategies were most effective for this population. As one respondent stated, the workshop should discuss “which forms/theories of treatment are most used with this population (e.g., group therapy, CBT) and an explanation of the benefits of these treatments.” Clinicians emphasized that these therapeutic strategies should be “evidence-based” in that they “have demonstrated efficacy in helping a treated individual gain skills to address their sexual urges.” While some clinicians wanted to learn more about addressing issues such as shame and depression, others wanted more information on how to help a client “successfully manage [their] sexual interests” and “manage inappropriate sexual fantasies and urges.”

Risk ($n = 32$). Risk was also a prominent theme in the responses. Clinicians were particularly interested in learning more about assessing risk for a client to sexually offend against a child. As one clinician stated, they were interested in learning how “to assess risk of offending sexually against children, behaviours or situations where children can be vulnerable.” One clinician discussed the importance of learning more about assessing risk “in order to balance appropriate duty of care to society with not [sic] overreacting to things that don’t actually represent elevated risk.” Accordingly, clinicians also indicated that a workshop should discuss common factors that elevate one’s risk, “potentially leading individuals to acting on sexual impulses.” Clinicians further recommended that a workshop educate mental health professionals on how to manage a client’s risk and how to develop “safety planning for clients” who may be struggling to manage their sexual interest.

Sexual health ($n = 30$). The third most frequently endorsed theme was sexual health. Some clinicians indicated the need for a workshop to include more general sexual health information. For example, one clinician recommended the workshop discuss “basic to advanced education about sex, sexuality, and gender in general.” Still others stated that there should be information dedicated to “understanding the range of sexual interests” and “normative sexual development.” More clinicians, however, focused on the need for information on atypical sexual interests, including sexual interest in children. Above all, clinicians reiterated the importance of understanding the difference between sexual interest and behaviour. As one clinician stated, the workshop should “clarify the venn diagram that is sexual interest in children and sexual offending against children.” Further, some respondents recommended that a workshop educate mental health professionals on

the difference between having a paraphilia and having a paraphilic disorder. Some respondents also felt it important to have more general information pertaining to paraphilias; “It should involve an analysis of paraphilias, their origin, treatment, etc.”

Understanding minor attraction ($n = 28$). Gaining a better understanding of those with sexual interest in children was also important to clinicians. Most wanted to develop an understanding of how and why someone becomes sexually interested in children (e.g., “I would like to learn more about possible causes for sexual interest in children.”). Some also wanted to know more about the experiences of those living with sexual interest in children. As one clinician said, “Humanize the problem – how do you live with desires that, if acted out, hurt someone?” Another stated that “there should be a discussion differentiating between minor attracted and offenders, including the societal pressures and restrictions that some may have to contend with.” In addition, clinicians indicated that they wanted a better understanding of sexual interest in children and its “association with sexual offending.” For example, “statistics on the likelihood of offending or re-offending.”

Ethics and liability ($n = 25$). Another important theme was that of ethics and liability. Respondents opined that a workshop should include detailed information on “legal duty to warn requirements and issues of confidentiality.” For example, some clinicians wanted a better understanding of “mandated reporting laws around sexual interest with children” including “when or how and who to report to if a threat should occur – and when we are allowed to report if at all.” Some also wanted more information on “limits of confidentiality.” One clinician also wanted details on how to maintain “client-centered practice when you are afraid of liability or client risk”.

Stigma ($n = 20$). Clinicians recognized that a workshop aimed at increasing competency to work with those with sexual interest in children should also focus on the issue of stigma. Respondents expressed the need to address biases and assumptions that mental health professionals hold toward those with sexual interest in children (e.g. “Information to dispel myths about such individuals”). One respondent stated that “the workshop should discuss methods in which therapists or providers can focus on the client as a person with a mental health problem instead of identifying them with the stigma they perceive based on their personal beliefs.” In addition to identifying these beliefs, some clinicians recommended that the workshop should also discuss ways to decrease negative attitudes toward those with sexual interest in children. As one clinician stated, the workshop should consider “how we as clinicians can help reduce stigma or increase likelihood that our services are offered in a safe environment.”

Therapeutic relationship ($n = 17$). Clinicians wanted to know more about developing a positive therapeutic relationship with clients who have sexual interest in children. Respondents endorsed the idea of “client-focused treatment” in which the mental health professional considers the client’s goals for therapy. Moreover, respondents wanted to learn about how to balance attention to risk with client-focused therapy “in a way that will allow [clients] to open up and share their thoughts and feelings without fear of legal involvement/being reported.” To further build upon trust within the clinician-client relationship, respondents suggested a workshop discuss “what questions to ask” clients, “preferred language/terms to use” and “the importance of no judgement.”

Clinician characteristics ($n = 16$). The final theme that emerged was the theme of clinician characteristics. Clinicians felt that a workshop should address topics directly

related to the mental health professionals themselves. For example, one topic that was recommended was countertransference, or the mental health professional's projection of their feelings onto the client. As one respondent stated, a workshop should examine "how to manage and address countertransference that comes up during the counselling session." Relatedly, some clinicians raised the issue of the mental health of clinicians working with this population and suggested that there be "discussion of how to work with therapist feelings that might arise as a result of this work." As an example, some clinicians encouraged discussion around "personal resiliency" and "compassion fatigue and coping strategies for therapists." Another topic was related to empathy and "strategies for fostering empathy toward client's [sic] with this sexual interest."

Question 2

What barriers might interfere with participation in such a workshop?

Accessibility (n = 92). Most responses indicated that accessibility would be the greatest barrier to participation in a workshop. One potential issue that respondents pointed out was the cost of attending a workshop (e.g., costs of workshop and funding available to attend workshop). One clinician indicated that cost may be a particular issue for students; "Cost – I would likely pay for this kind of workshop but I couldn't afford to may [sic] more than \$20 as a student." Clinicians also indicated that time would be a significant barrier to attending; "The timing, i.e., the time of the week or weekend and the length of training." Some respondents mentioned that having a workshop on a weekday, although optimal, would cause other issues such as "needing time off from work." Again, students would also be affected by scheduling conflicts; "As a full-time graduate student, I am required to complete up to 12 hours of coursework plus 24 hours at a field placement

each week so my schedule is not set in stone.” Accordingly, location was also presented as a barrier as attendees may have to incur additional costs related to travel, accommodations, and missed time at work if the workshop were to be located outside of their area.

Stigma ($n = 40$). Clinicians also saw stigma as a barrier to attendance.

Specifically, respondents stated that people’s personal views and preconceived notions of those with sexual interest in children could prevent them from attending. One respondent stated that “people do not like this population and do not want to help people who have ‘immoral behavior or thoughts.’” Another clinician explained that some clinicians might not attend due to “stigma toward MAPs³, misunderstanding of MAPs (i.e., believing that they will all offend or have offended), discomfort with the topic, having young children and personalizing things too much.” Overall, it was expressed that “for some clinicians it might be that they do not feel comfortable working with clients with these sorts of sexual desires and may therefore not be interested in learning the techniques for properly treating them.” Some clinicians also opined that it would be “easier to stay away” from treating those with sexual interest in children due to the “risk of litigation if working with these groups and you assess something incorrectly.” Interestingly, some clinicians saw the “lack of evidence for effective treatment” and the “belief that [sexual interest in children] is not treatable” as a barrier to attendance. One clinician felt that “providing this treatment is difficult” and that “clients usually present as not very good clients” which could further

³ MAP(s) stands for Minor Attracted Person(s). MAP is a broad term that includes those with sexual interest in older adolescents which, although taboo, is not considered a paraphilia.

deter potential attendees as they might not want to become competent in providing treatment for this group.

Relevance ($n = 14$). The final barrier to attendance was the topic's relevance to clinicians. Some clinicians felt as though information regarding sexual interest in children would not be relevant to the population they currently treat; "For me personally due to the area that I work in with women, which means that to my knowledge this is not a predominant issue in my client population which means that I might personally not be inclined to attend such a workshop." Another clinician stated that "as I work mainly with children it is unlikely that I would attend a workshop about working with adults." One individual responded that "some general clinicians have expressed that ... being competent in this area may impact their ability to treat children in the same practice." Others cited a lack of interest in this topic or stated that due to the "small treatment population", working with those with sexual interest in children "wouldn't be a priority."

Discussion

Willingness to Treat People with Sexual Interest in Children

Consistent with expectation, clinicians with competency to assess and/or treat those with atypical sexual interests, including sexual interest in children, had significantly lower stigma scores than those without competency. It is not unusual to find that clinicians with lower stigma toward those with atypical sexual interests were more willing to provide treatment to referrals with sexual interest in children. Those with competency have most likely had more exposure to this population than those without competency. According to stigma literature (e.g., Corrigan et al., 2012; Harper et al., 2016, 2019;

Yamaguchi et al., 2013), social contact and humanizing narratives are impactful in increasing positive attitudes and reducing social distance toward the stigmatized group.

The present study also found that when controlling for vignette condition, clinicians were less likely to indicate they would provide treatment if the client referred wanted treatment for managing their sexual interest in children and had committed a sexual offense compared to the other three vignette conditions. In one of the only other studies to examine clinician willingness to treat those with sexual interest in children, Jahnke et al. (2015b) found that 80% of psychotherapists in training indicated a willingness to provide treatment to those with a sexual interest in children who had never committed a sexual offense. In contrast, only 38% were willing to offer treatment to those with a sexual interest in children who had committed a sexual offense. These results coincide with the present finding that fewer clinicians were willing to accept a referral for a client who wanted to focus on treatment for their sexual interest and had also committed a sexual offense in the past. This makes sense as clinicians working outside of a forensic context are not typically trained to work with those who have committed offenses and therefore may feel that accepting such a referral would be outside of their scope.

In addition to the presenting problem in the vignette, lower stigma scores were associated with an increased willingness to treat the hypothetical client, regardless of the vignette condition. Thus, it is evident that stigma plays a large role not only in clinician's personal attitudes toward those with sexual interest in children, but also their clinical decision making (i.e., whether to accept a referral). This is in line with other research that has shown the impact of stigma on clinical decision making (e.g., Stephens et al., 2019). Stephens et al. (2019) found that clinicians with higher stigma toward those with sexual

interest in children were more likely to report an individual who disclosed their sexual interest to the authorities. Therefore, stigma is clearly an important target in the development of an educational workshop and workshops containing knowledge translation, social contact, and humanizing narratives, have been most efficacious in reducing stigmatizing attitudes (see Corrigan et al., 2012).

Stigma is not the only reason that a clinician would refuse to provide treatment to the hypothetical client in the vignette. Of those who indicated that they would not treat the client, 60% stated that it was due to a lack of competency to treat those with sexual interest in children. Similarly, 64% of psychotherapists in the study by Alanko et al. (2014) stated that they were unwilling to treat this population due to a lack of training in the area. The same sentiment was expressed by 20% of psychotherapists who indicated they were unwilling to treat those with sexual interest in children in a study by Steils-Glenn (2010). This is not to say that clinicians refusing referrals outside of their competency is improper. Many clinicians do not receive training in general sexual health (Reissing & Giulio, 2010), let alone training in the assessment and treatment for those with more atypical sexualities such as sexual interest in children. It is understandable that unless they have experience with this population, many clinicians would not feel comfortable accepting a referral for a client who presents with difficulties managing their sexual interest toward children, especially if they have a history of offending. What this does mean is that clinicians should be given more training in general sexual health so that they have better competency to treat clients who present with atypical sexual interests (e.g., sexual interest in children) but want treatment for more general issues, such as depression.

Willingness to Attend a Workshop

Overall, 77% of the present sample indicated that they would be willing to participate in a workshop that would increase competency to treat those with sexual interest in children. This is in line with the 79% of participants in the Jahnke et al. (2015b) study who stated that they were willing to attend educational courses to increase their ability to treat the same population. The present study also found that although willingness to attend a workshop was significantly predicted by competency, the effect of stigma was a stronger predictor in that those with lower stigma were more willing to attend. Therefore, when considering both predictors, the effect of stigma overshadowed the effect of competency.

Although it is encouraging to see that most clinicians indicated they would be willing to attend an educational workshop, it is considerably less promising when considering that willingness to attend is dependent upon competency, but more largely determined by stigma. In other words, those clinicians who the workshop would target (i.e., general clinicians with stigmatizing attitudes toward those with sexual interest in children) are the least likely to attend. Therefore, when creating an educational workshop, developers should consider how the workshop can be advertised in a way that will draw the interest of those statistically least likely to attend. For example, developers could focus on advertising the workshop to non-forensic oriented groups such as general clinician listservs. Developers could also consider hosting the workshop at a conference focused on general mental health topics, as clinicians who are generalists may be more likely to attend the workshop if it is easier to access. Prior to examining where best to host a workshop or how best to advertise, however, it is important to first gauge what

clinicians feel should be included for the workshop to be effective in increasing competency to treat those with sexual interest in children.

Workshop Content and Barriers to Attendance

Therapeutic strategies. Overall, clinicians wanted an educational workshop to include information on effective therapeutic strategies to use when treating those with sexual interest in children. While respondents varied in terms of therapeutic targets (i.e. managing low mood and shame or managing sexual interests), the majority emphasized that strategies should be evidence-based.

Despite the desire for evidence-based treatment techniques and strategies for sexual interest in children, there is currently no “one size fits all” therapeutic strategy for this population. Some have suggested that it is possible to change one’s sexual interest in children through treatment (e.g., Fedoroff, 2018; Müller et al., 2014). For example, Müller et al. (2014) looked at pre- and post-treatment penile plethysmography results of 43 men with sexual interest in children. Their results showed a significant decrease in response to pedophilic stimuli in half of the men after “various treatments” and they concluded that sexual interest in children is indeed changeable. However, many others in the field (e.g., Bailey, 2015; Cantor, 2015; Lalumière, 2015) expressed concern around methodological issues present in the Müller et al. (2014) study and this conclusion seems to not be generally accepted. Furthermore, there are no evidence-based treatments for sexual interest in children specifically, nor are there evidence-based treatments for the modification of sexual interest in children. Instead, existing interventions may focus on self-management of sexual interest as well as pharmacological methods to both prevent sexual offending and increase client well-being (Seto, 2018; Winder et al., 2019).

Recently, McPhail and Olver (2020) conducted a meta-analysis of interventions for managing sexual interest in children. While they found little evidence for the efficacy of increasing sexual interest in adults, their results showed that both behavioural (e.g., arousal reconditioning) and pharmacological interventions significantly decreased sexual interest in children.

Another form of treatment modality that can be used when working with those with sexual interest in children is cognitive behavioural therapy (CBT). CBT is arguably one of the most empirically tested intervention models and has been found to be effective for a wide range of mental health problems, including depression (Gartlehner et al., 2017), anxiety (DiMauro et al., 2013), and substance use disorders (McHugh et al., 2010).

An example of a CBT-based intervention program for sexual interest in children is Prevention Project Dunkelfeld. Beier et al. (2015) used a nonrandomized waiting-list control design to provide preliminary results from the program. When examining within-subject change they found that the program was successful in reducing dynamic risk in participants with sexual interest in children. Specifically, after one year, participants exhibited a decrease in emotional deficits with an increase in sexual regulation (Beier et al., 2015). A recent reappraisal of the program, however, found a flaw in the initial study's data analysis. When considering the interaction between time and treatment group, Mokros and Banse (2019) found that there was a non-significant effect between the treatment and dynamic risk factors. This is important because while people were initially hopeful about the impact of the program, the follow-up by Mokros and Banse (2019) contradicted the initial findings. Nonetheless, the Mokros and Banse re-analysis produced effect sizes that were small and future research with more advanced program

data may prove more fruitful. It is also worth noting that the Prevention Project Dunkelfeld was developed for those with sexual interest in children who struggle with managing their sexual behaviour. It should be acknowledged that many with sexual interest in children do not struggle with managing their sexual interest and instead desire to focus on managing their general mental health (Levenson & Grady, 2018; B4U-Act, 2011b). For these individuals, intensive programs such as Prevention Project Dunkelfeld may be inappropriate.

Nonetheless, CBT may be an efficacious method of addressing the more general mental health issues (e.g. depression and anxiety), especially when considering that those with sexual interest in children report struggling with many of the same issues that a “typical” client would present with. For example, those with sexual interest in children living in the community have self-reported symptoms associated with depression, anxiety, substance abuse, and suicidal ideation (Cohen et al., 2019; Levenson & Grady, 2018). Not unlike other sexual minorities, those with sexual interest in children have also reported feelings of self-hatred, shame, and low self-esteem, perhaps due to internalizing stigma imparted by society (Buckman et al., 2016; Jahnke 2018b; Levenson & Grady, 2018). These issues may be the focus of potential treatment and there are well established treatment programs for these issues that could be delivered to people with sexual interest in children.

Therapeutic models that target stigma and shame, such as Acceptance and Commitment Therapy (ACT) may also be beneficial when working with those with sexual interest in children. The core principles of ACT center around acceptance, mindfulness, considering values, and setting and achieving goals (Harris, 2006). A 2015

meta-analysis by A-Tjak et al. found that ACT was more effective than placebo and could be just as effective in treating depression, anxiety, and substance abuse disorders as other therapies such as CBT. While the efficacy of ACT has not been studied specifically in those with sexual interest in children, Yadavaia and Hayes (2012) evaluated its usefulness in addressing self-stigma in those with same-sex attraction. While this study lacked a control group and had a small sample size (i.e., $n = 5$), the results demonstrated significant reductions in sexual orientation-related distress, internalized homophobia, depression, anxiety, and stress after a 12-week post-treatment follow-up. Similar reductions in shame and self-stigma were found in a study that applied ACT and compassion-focused therapy in a group of five HIV-positive men (Skinta, Lezama, Wells, & Dilley, 2015). Although ACT is clearly in its infancy with regard to its efficacy in treating sexual minority groups, it is still worth considering for addressing the internalized stigma and self-hate plaguing many of those with sexual interest in children.

Risk, Ethics, and Liability. Another significant theme highlighted by clinicians suggested that a workshop should include information regarding the assessment and management of risk for a client to commit a sexual offense against children. Typically, an individual's risk to commit a sexual offense is assessed by a Clinical-Forensic Psychologist and would include the explicit use of risk assessment instruments (Hanson, 2009). Of course, it would be unreasonable to expect clinicians to attend training for every single risk instrument, especially if those with sexual interest in children make up the minority of their client population. In addition, these instruments are meant to be used with individuals who have either been charged or convicted of a sexual offense, not with those who have indicated a sexual interest in children and have no known offence history.

While one study was conducted on the use of the Risk for Sexual Violence Protocol (RSVP) with clients with no offense history (Darjee et al., 2016), there was little support for predictive validity. Essentially then, there are no validated risk assessment tools that can be used with this population.

It is possible that the high frequency of comments regarding risk assessment in this study were due to the large proportion of participants with a forensic background. Understandably, these clinicians would most likely benefit from a workshop with forensic-oriented topics rather than a focus on general mental health. As the proposed educational anti-stigma workshop would be aimed to general clinicians as well, it may be more beneficial to incorporate information about risk factors for sexual abuse against children in general rather than discussing risk instruments which they may not be able to use with their clients. For example, Bailey et al. (2016a) found that in those who self-reported detected offending behaviour, preferential sexual interest in male children, a history of falling in love with children, a history of child-oriented employment, being the victim of childhood sexual abuse, and struggling to manage sexual interests were associated with the commission of a detected sexual offense. Further, antisociality and hypersexuality are also risk factors for the commission of childhood sexual abuse in general community samples (Klein, Schmidt, Turner, & Briken, 2015; Seto, 2018). As general clinicians likely have no background in risk assessment, bringing their attention to common risk factors may be sufficient for them to determine whether someone is at risk of committing an offense. Nonetheless, there is a need for future research that examines risk factors for sexual offending against children in individuals who have sexual interest in children but no offence history.

Related to risk was clinicians' desire to know more about the ethics and liability associated with providing treatment to those with sexual interest in children. Specifically, clinicians wanted a workshop to include discussion around the balance between maintaining confidentiality and knowing when and how to report a client they feel is at risk of committing a sexual offense. According to the Canadian Psychological Association, clinicians may share private information about a client under the following circumstances: if the client poses a danger to themselves and/or the public; in cases of abuse and/or neglect of children, individuals with disabilities, or the elderly; and in response to a court order (CPA, 2017). Equipping clinicians with the knowledge of common risk factors is one way of helping clinicians to interpret whether a client is at risk of committing a child sexual offense. However, clinicians must also be aware of the reporting legislation in their province/state. For example, in some areas of the United States, clinicians are required to report an individual who admits to viewing CSEM while clinicians in Canada are not required to report use of CSEM, although many Canadian clinicians are unaware of this fact (Stephens et al., 2020). Therefore, an educational anti-stigma workshop would have to adapt mandatory reporting information based on the location in which it is provided.

Barriers to Attendance

Overall, clinicians expressed that the greatest barrier to attending a workshop was accessibility. Issues raised included location, timing of the workshop, and cost. As this was a large concern for many clinicians, when developing the workshop, thought should be given as to how some of the obstacles to accessibility can be overcome. One solution would be to offer the workshop in an online format as well as in-person, with the online

option being offered at a cheaper rate. The online workshop could be held live, and a recorded version could be available to participants who were unable to attend. While the live session could allow participants to be more interactive, such as asking questions via textbox, the recorded session would allow people to attend the workshop at a time most convenient for them. While some may prefer in-person workshops, online options for professional development have also received praise, especially with students who may have limited funds and availability (e.g., Gauvreau, Hurst, Cleveland-Innes, & Hawranik, 2016). Furthermore, information discussed in the workshop could be presented permanently on a website for clinicians to easily access when required.

In addition to accessibility, clinicians also cited stigma and relevance as potential barriers to attending the workshop. With regard to stigma, clinicians specified that negative attitudes toward those with sexual interest in children, such as the idea that they are immoral or that they have all committed a sexual offense, may deter potential attendees. This barrier to attendance is supported by the present study which found that stigma was significantly associated with willingness to attend a workshop. As discussed in more detail above, this is a difficult issue as clinicians who have stigmatizing attitudes toward those with sexual interest in children are an important target audience for this workshop. If stigma is impacting attendance, then this would need to be taken into consideration when advertising for a workshop.

Clinicians also indicated that perceived relevance could pose a barrier to attendance. Some stated that as they worked with children, knowledge on how to provide treatment to those with sexual interest in children would not be of interest to them. Still others cited the small population of those with sexual interest in children and therefore

obtaining competency in this area would not be a priority. It is true that there are fewer individuals with sexual interest in children compared to those with sexual interest in adults living in the community; most recent estimates of prevalence among men is approximately 1% (Seto, 2018). Regardless of the prevalence in the community, clinicians should at least be aware of best practices in working with these clients, if not to provide assessment and/or treatment, then to respond in a sensitive manner and help refer them to someone more suitable. Clinician response is particularly important when considering studies that have shown an association between clinician reaction and help-seeking behaviour. For example, Moss (2019) found that positive treatment experiences were associated with increased treatment motivation, although the sample size was small. In addition, B4U-Act (2011b) found that over half of their respondents wanted to seek mental health treatment but avoided doing so due to fear of a negative reaction.

Furthermore, as the literature indicates that those with sexual interest in children first become aware of their sexual interest during puberty (i.e. between ages 12 and 14; Bailey et al., 2016b), clinicians working with younger individuals should not write off the possibility of being faced with a client presenting with a sexual interest in children. In fact, it may be even more important in terms of prevention and client well-being for a clinician to respond to an adolescent's disclosure of sexual interest in children in a more delicate and thoughtful manner. As youth may be more sensitive to judgement, it is possible that a negative response from a clinician may result in seeking out unguided support from other mediums (e.g., online) which may or may not promote antisocial views.

Limitations

The present study is not without its limitations. Firstly, the study was based on self-report cohort data and convenience sampling (i.e. snowball sampling). Additionally, as the study made use of an explicit stigma scale, clinicians may have been more inclined to respond in a socially desirable manner. Furthermore, the APSIC has only been subjected to preliminary psychometric analysis by way of an honours thesis (Robichaud, 2020) and further research is required before it is established as a valid measure of clinician stigma.

Second, due to the cohort data and snowball sampling, more than half of the sample were clinicians who had competency to treat those who had committed sexual offenses and/or had paraphilias. Conversely, very few clinicians endorsed competency in sexology. While there was an attempt on the part of the author to recruit from different organizations and institutions of different professional backgrounds (e.g., physicians, social workers, nurses) and competencies (e.g., sexology, couples' therapy, occupational therapy), most of the invitations to advertise the study were not responded to. The limited diversity in the sample may have therefore impacted results as clinicians already working in a forensic capacity were shown to have a greater willingness to treat those with sexual interest in children and an increased willingness to attend a workshop aimed at this population. It is possible that having a sample containing a greater number of general clinicians would have resulted in different outcomes. For example, in the present study the overall stigma scores were relatively low. While it is true this may have been due to social desirability, it is also possible that a sample containing a greater number of general clinicians would have resulted in higher overall stigma scores. Indeed, the present study found that those with no competency to treat those with sexual interest in children had

significantly higher stigma scores than clinicians with competency. The lack of diversity in the sample may have also impacted the themes that emerged in the qualitative analyses in that general clinicians may have expressed different needs in terms of workshop content when compared to the present forensic-leaning sample. For example, anecdotally general clinicians have expressed more concern around legal and ethical obligations (i.e., mandatory reporting and breaching confidentiality) than did the present sample.

In addition to the above, there are other also limitations inherent to conducting qualitative research, including potential bias from the author when interpreting the data, a lack of inter-rater reliability given one coder, and the inability to establish causality.

Finally, the last major limitation present in this study is the small sample size. While an initial power analysis suggested a sample size of 164, after exclusionary criteria, the present study was left with a total sample of 101. While the sample size does not impact the qualitative data, it is likely to have affected the quantitative analyses. This is demonstrated by the presence of wide confidence intervals in hypothesis two, suggesting that the present sample was limited in size and that the effects are not stable. Future research should seek to replicate these analyses with a larger and more diverse sample of clinicians by recruiting for a longer period of time and promoting the study across a number of various venues.

Conclusion

Despite these limitations, the present study offers a promising first look at North American clinicians' willingness to treat those with sexual interest in children as well as their willingness to attend an educational anti-stigma workshop. Furthermore, these findings are novel in terms of informing the development of such a workshop; while

previous literature has examined the mental health needs of those with sexual interest in children, no study to date has asked clinicians what they would like to know in order to provide treatment to this group. Based on the information gathered as well as in consideration of willingness to attend and low levels of explicit stigma, it seems promising that should an educational anti-stigma workshop be developed, there would be a high level of interest in attending.

Chapter 3 – Study 2

Present Study

When considering the development of an educational anti-stigma workshop for clinicians to gain competency working with those with sexual interest in children, it is obvious that these same clinicians should be consulted on what content to include. However, clinicians are not the only stakeholders in the development of such a workshop, and those with sexual interest in children should also be considered when formulating the program. The perception of individuals with sexual interest in children is important in the development of the educational anti-stigma workshop, as they would be directly impacted by such a program and are key stakeholders in program outcomes. Further, they have previously expressed their concerns regarding clinicians' knowledge of their sexual interest as well as appropriateness and effectiveness of treatment and treatment goals (B4U-Act, 2011a; 2011b; Levenson & Grady, 2018). As such, the present study examined the content individuals with sexual interest in children believe should be part of an educational anti-stigma workshop for clinicians to decrease stigma and increase competency to work with people with sexual interest in children.

The current study used an exploratory approach and recruited individuals with sexual interest in children in the community with the goal of obtaining knowledge as to what they believe would be conducive to an educational anti-stigma workshop aimed at clinicians. Specifically, the study asked participants about their previous experiences with clinicians, what they thought clinicians should be better educated on to provide treatment to people with sexual interest in children, and the types of positive therapeutic strategies that could be used to provide effective treatment to those with sexual interest in children.

As the present study involved data collection from individuals from a marginalized group, a community-based participatory action research (CBPAR; McTaggart, 1989) approach was used to ensure that the study was representative of the needs of the community. CBPAR is a research orientation that involves an egalitarian relationship between community members and researchers who are studying an issue to create positive change (Baum, MacDougall, & Smith, 2006). CBPAR is thought to have originated with social psychologist, Kurt Lewin, who, in the 1940s, developed the term “action research”. Lewin (1946) described action research as a system that includes a marginalized community in the cyclical process of planning, action, and reflection. Stemming from its early roots, participatory action research (PAR; later classified as CBPAR) was formed and is most commonly associated with Brazilian philosopher and educator, Paulo Freire (Freire, 1970), as well as Columbian sociologist, Orlando Fals Borda (Fals Borda, 1987). Both scholars developed their approaches in response to the colonizing characteristics of research that most often negatively impacts marginalized communities. Freire and Fals Borda believed that educated underprivileged communities would result in these groups freeing themselves from oppression. To teach the communities, Freire discussed the importance of engaging in community research that emphasizes both solidarity and support. Moreover, Fals Borda insisted that researchers integrate community participation and action into their research. He believed in the importance of taking on community members as co-researchers and disseminating results in a way that community members would be able to both access and understand (Fals Borda, 1995).

Recently, researchers have argued that this approach may be valuable to participant-based studies on paraphilias (Stephens, Roche, & McPhail, 2020). While CBPAR can consist of up to seventeen principles and tenets (see McTaggart, 1989), including every principle in research may prove to be difficult or inappropriate given the nature of the study. Utilizing the CBPAR approach, the present study included the following principles: recognizing the community as a unit of identity; facilitating collaborative, equitable partnerships in all research phases; disseminating findings to all partners and involving partners in the dissemination process; and long-term process and commitment (see Table 5 for further detail).

Method

Participants

An *a priori* power analysis was not conducted for the present study due to its exploratory nature and the use of thematic analysis. Individuals were eligible to participate in an anonymous online survey informing the development of an educational workshop for clinicians if they were over the age of 18, identified as having a sexual interest in children, and understood the English language. For the purposes of the present study, sexual interest in children was defined as having a sexual interest in those under the age of 15. Over a three-month period, 253 responses were collected. Participants were excluded if they did not complete the survey ($n = 65$) or if they indicated that they were younger than 18 years ($n = 4$). In addition, one participant was removed for providing nonsensical responses for the entirety of the survey, resulting in a total of 183 participants.

Participants' demographic information is presented in Table 6. Participants ranged in age from 18-70 years old ($M = 32.00$, $SD = 12.95$) and the majority were Caucasian (82%, $n = 145$). Participant sex was mostly male (84.4%, $n = 152$) and in terms of relationship status, most of the sample indicated that they were single (62.1%).

Measures

Demographics. Participants were invited to answer a series of questions on background demographic characteristics. Demographic variables included age, sex assumed at birth, the gender they identified with, ethnicity, relationship status, and level of sexual interest in males and females of various age groups on a scale from 0 (not at all interested) to 100 (extremely interested).

Mental Health Experiences and Educational Intervention Questions. A series of questions was developed by the author and thesis supervisor in collaboration with B4U-Act for the purpose of understanding previous experience with clinicians and areas of focus for an educational anti-stigma workshop. All survey questions can be found in Appendix C. Participants were asked about their experiences with mental health programs, including whether participants had ever wanted help from a clinician for reasons related and/or unrelated to their sexual interest in children; whether they sought help; how many times they sought help; what they sought help for; and whether they disclosed their sexual interest to a clinician. Participants who sought mental health help were asked how positive they found their experience(s) on a 7-point Likert scale from extremely positive to extremely negative. Similarly, participants who indicated that they had disclosed their sexual interest to a clinician were asked to rate their experience on a 7-point Likert scale from extremely positive to extremely negative. Participants who

indicated that they wanted mental health treatment but had not sought help from a clinician were asked what they would have sought help for.

Participants were also asked open-ended questions regarding clinicians' treatment of individuals with sexual interest in children. Questions for thematic analysis included: what they believe clinicians should be educated on in order to provide effective mental health treatment to individuals with sexual interest in children; and positive strategies they believe could be used by clinicians when treating those with sexual interest in children.

Procedure

Given the use of CBPAR in the present study, steps were taken by the author to work collaboratively with B4U-Act after the project goals were conceptualized. Briefly, after contacting B4U-Act through email, the author initially met with the assistant B4U-Act research coordinator via web-conference to discuss the potential for collaboration on a survey that would be distributed to the community via the B4U-Act website. During this meeting, the author described the thesis in its entirety, with an emphasis on the present study. A second meeting occurred shortly after and included the author, the B4U-Act research coordinator, and the assistant research coordinator. Again, the synopsis for the thesis was discussed, with a focus on B4U-Act's potential role in the development of the present study. The research coordinator laid out the expectations and research ethos of B4U-Act which included that research should be dedicated to the betterment of the community and the education of the public as well as mental health practitioners. After finding that the author's project aligned with their mandate, the research coordinator

agreed to work with the author. A tentative timeline was established for the development of the survey and data collection.

Shortly after, the author attended a B4U-Act web-conference that focused on the development of a manual that would educate clinicians on how to offer treatment to individuals with sexual interest in children. Also present in the web-conference were the research coordinator, research assistant, several researchers, and several members of B4U-Act who identified as having sexual interest in children. This web-conference allowed the author to gain insight into some of the concerns that individuals with sexual interest in children have with regard to treatment and steps that can be taken to remedy these concerns.

After completing the initial thesis proposal, the author sent the proposal to the coordinator and assistant coordinator. There was then a telephone meeting between the author, thesis supervisor, and the coordinators to discuss next steps. During the meeting, the coordinators gave helpful feedback on the survey (e.g., the coordinators made suggestions regarding questions). Once the author had finalized the survey, it was sent back to the coordinators for final approval prior to transferring the survey to SoSci – a data collection platform. Due to the social risk associated with being identified as an individual with sexual interest in children, extra precautions were taken to ensure anonymity. SoSci was chosen as it does not store IP addresses; is secured against unauthorized access; access to the server is SSH-encrypted; and the questionnaires do not use any cookies. In addition, SoSci is TOR compatible, allowing participants to further mask their location. University ethics approval was also granted for the study.

Participants were recruited via forums for individuals with sexual interest in children: B4U-Act, Virtuous Pedophiles, and Visions of Alice. Participants were also recruited through social media, most notably Twitter and the supervisor's website. After reading information about the study, participants could click on the link to review the informed consent form that described the survey in further detail. If they agreed to participate in the study, participants were invited to fill out the background characteristics followed by questions regarding their experiences with clinicians. Participants were also invited to fill out open-ended questions regarding what they believed clinicians should be educated on to provide effective treatment to their population and positive techniques that clinicians should utilize.

Data Analysis

As the present study was exploratory in nature, the author examined frequencies for the quantitative data that looked at responses to questions about previous experiences with clinicians. For the open-ended questions, responses were analyzed through thematic analysis using the NVivo software. For a detailed explanation of the thematic analysis process, please see Chapter 2.

Results

Quantitative Analysis: Descriptive Information

Descriptive statistics for the information about treatment experiences are presented in Table 7. Nearly half of the participants indicated that they did not believe clinicians have the necessary skills to provide effective counselling to persons with sexual interest in children. Others responded that they felt clinicians *may* have the required skills to treat this population. Overall, only a small percentage of participants (3.9%, $n = 7$)

believed that clinicians have the necessary skills to provide effective counselling to those with sexual interest in children. A post-hoc analysis showed that of those who indicated that they did not believe clinicians to have the necessary skills, 80.8% ($n = 59$) had actively sought treatment for reasons unrelated to their sexual interest and 50% ($n = 32$) had sought treatment for reasons directly related to their sexual interest.

Most participants (82.1%, $n = 147$) indicated that they had previously wanted counselling for reasons unrelated to their sexual interest in children. Most participants (80.1%, $n = 117$) also reported that they had previously sought counselling unrelated to their sexual interest, and on average, sought counselling around six times. Most respondents (38.5%, $n = 45$) endorsed that their counselling experience was “moderately positive.”

Similarly, most (68.3%, $n = 123$) reported that they had previously wanted counselling for reasons directly related to their sexual interest in children; however, over half (52.8%, $n = 65$) indicated that they had not previously sought counselling for these issues. On average, those who indicated that they *had* sought counselling for issues related to their sexual interest actively sought counselling approximately twice. Overall, most participants rated their counselling experience as being extremely positive (23.6%, $n = 13$), moderately positive (14.5%, $n = 8$), or slightly positive (14.4%, $n = 8$).

Of those who sought counselling, the most prominent reasons indicated were for managing general mental health concerns in relation to their sexual interest in children, coping with their sexual interest, dealing with stigma related to their sexual interest, improving self esteem, and improving general mental health concerns. Fewer participants indicated seeking help for managing intensity of their sexual interest, learning strategies

to prevent offending, managing/establishing romantic relationships with adults, and how to disclose their sexual interest to others. Further, 25% ($n = 14$) indicated that they wanted help with “other” issues which mostly consisted of general mental health concerns such as dealing with loneliness and sadness, as well as those looking for diagnostic assessments for issues such as obsessive-compulsive disorder and autism. Of note, a small number of participants who had *not* sought counselling indicated that they wanted help for learning strategies to prevent offending and most indicating that they were interested in seeking treatment for general mental health concerns.

Lastly, most participants indicated that they had not previously disclosed their sexual interest in children to a clinician. Of those who indicated that they had or *may have* disclosed their sexual interest to a clinician, the majority indicated that it had been a positive experience.

Qualitative Analyses: Themes

Nine themes were identified for a question that asked about the content of an educational workshop that would provide training to clinicians to increase effectiveness. There were 11 themes for the second question that asked about strategies clinicians could use that participants would find helpful when seeking help. A discussion of each theme is presented alongside direct quotes from participants; themes are presented from those that appeared most frequently to least frequently. A list of all themes and sample excerpts can be found in Table 8.

Question 1

If an educational workshop were to be developed, what are some things that you feel mental health professionals should be educated on in order to provide effective counselling to MAPs?

Understanding ($n = 134$)⁴. Most responses to this question centered on the theme of understanding. In general, respondents perceived that clinicians lack an understanding of those with sexual interest in children, including the attributes of those who comprise this population. Participants felt that clinicians often “fall into stereotypes” when considering individuals with sexual interest in children and should therefore be educated on the heterogeneity of this population. As one participant wrote, “minor attraction is a spectrum. There are exclusives, non-exclusives, attraction to boys, girls... and not only men can be minor attracted.” Another respondent stated “not all MAPs are the same! Some MAPs have high self-esteem and no hatred of their sexuality, while others have reverse.” Respondents stressed that, as with “typical” clients, clinicians should place “emphasis on the individual” rather than focusing on the group to avoid perpetuating stereotypes.

Participants also felt that clinicians display a lack of understanding regarding the more basic concepts of sexual interest in children– the difference between interest and behaviour. Specifically, participants felt that many clinicians conflate sexual interest in children with child sexual abuse; therefore, a workshop should inform clinicians on “the difference between child molestation and paedophilia.” Accordingly, participants expressed that clinicians fail to understand that many individuals with sexual interest in

⁴ Please note that n does not represent the number of participants who endorsed a particular theme, but the number of times that the theme was endorsed throughout responses overall.

children do not struggle to abstain from offending behaviour. As one participant states, “attraction does not equal action. Although I may be attracted to minors, I have never (not even once), ever even remotely considered the possibility of acting on my attraction.” As a result of this assumption, some participants resented the tendency for clinicians to immediately focus on an individual’s sexual interest in children, rather than the individual’s own therapeutic goals. One individual advised that clinicians “need to learn that we have struggles other than just trying to refrain from engaging in abusive or illegal sexual acts, and that for most of us that isn’t even one of our major struggles.” It was further advised that “unless the client says otherwise the professional needs to not focus primarily on the attraction.”

Furthermore, respondents felt as though clinicians lacked a critical understanding of the lived experiences of those with sexual interest in children. As one participant stated, “I imagine that some mental health professionals might be surprised by the sorts of issues that a MAP might have.” Some participants went into further detail, explaining some of the experiences that those with sexual interest in children must face. For example, one participant stated that clinicians “need to know what it means to have to lie every day to every person we meet in order to get by.” Other respondents referenced the “strong isolation” that they feel due to “not being able to talk” with others about their sexual interest.

To increase their understanding of persons with sexual interest in children, participants encouraged clinicians to take initiative in educating themselves. One participant wrote that “they need to be aware of the non-forensic sexological research on MAPs.” Another encouraged clinicians to “respect and endeavor to learn from other

professionals who advocate, either within the professions or out in society, on behalf of their MAP clients.”

Stigma ($n = 94$). Stigma was a prominent theme in response to the above question. Above all, participants felt that an educational workshop for clinicians should work to dispel the notion that all individuals with sexual interest in children are offenders or are destined to offend; “People tend to believe that we’re ticking time bombs that could molest a child at any moment when that’s not true.” Further, respondents stated that clinicians should be taught that those with sexual interest in children are not “inherently a risk” toward children. Participants expressed that clinicians “need to stop perceiving us as potential offenders or sources of suffering.” Participants felt as though clinicians viewed them as “subhuman monsters” and treated them “like broken or sick things.” They therefore expressed their desire to be viewed as “ordinary human beings with interests, desires, and a psychological profile little or no different than any random person.”

To decrease stigma toward those with sexual interest in children, participants suggested that an educational workshop should aim to “humanize MAPs,” using strategies such as “first-person narratives” and exposure to those with the sexual interest. Further, participants felt that clinicians should learn about the impact of stigma on individuals with sexual interest in children, including the “shame, guilt, and fear involved in internalized stigma and how that affects seeking help.”

Minor attraction as an orientation ($n = 60$). Another topic of importance was the idea of sexual interest in children as a sexual orientation, and the difference between orientation and disorder. Indeed, many participants resented the conflation of their sexual interest with a mental disorder. Respondents generally felt that clinicians should be

educated on “the difference between pedophilia and pedophiliac [sic] disorder” so that clinicians “do not become mistakenly preoccupied with attempting to treat a sexual orientation that cannot be changed.” Furthermore, participants wanted clinicians to realize that, as with more ‘typical’ sexual orientations, “being a MAP is not a choice,” but rather a “natural and inborn sexual orientation.” Respondents drew further parallels between sexual interest in children and other sexual orientations. Participants commented that, as with other sexual orientations, sexual interest in children is often “first recognized in puberty,” can involve a “wide spectrum” of attraction and involves “emotional attraction” in addition to sexual attraction. Perhaps most importantly, participants emphasized that sexual interest in children is static and cannot be changed or “cured.” Further, while some suggested that they were unhappy with their sexuality, most others rejected the attempts of clinicians to change their sexual interest in children, likening these efforts to “conversion therapy” that has been used with those in the LGBTQ2S+ community. As one participant articulated, “I have no interest in being changed. For better or worse, this is how I am and I wouldnt [sic] change it.”

Clinician-Client Relationship ($n = 58$). The clinician-client relationship is a fundamental aspect of effective therapeutic intervention; many responses to the above question suggested that clinicians would benefit from learning more about how to build trust with clients who present with sexual interest in children. Most responses within this theme emphasized the importance of respect, compassion, empathy, and non-judgement in building a trusting clinician-client relationship. One individual opined that “as long as there’s a sense of empathy and understanding from the therapist, things should be fine.” Participants considered it particularly important for the clinicians to provide their client

with a “safe place” to be able to openly discuss their thoughts, given that they are largely unable to talk freely with family or friends. Indeed, one respondent commented that “they have to provide a safe space for a pedophile to talk about anything, because we often feel we cannot talk to anyone about our feelings.” One participant suggested that clinicians work to create a sense of safety even before meeting their client. Specifically, they stated that clinicians should openly advertise that they work with persons with sexual interest in children; “MAPs, when they view therapists’ or services’ websites, are looking for some sort of explicit acknowledgement that the therapist or the organization works with MAPs.”

Respondents added that to create a safe space, clinicians should pay careful attention to confidentiality given the social ramifications should the client be “outed.” In addition, participants expressed that they were more trusting of clinicians who prioritized the well-being of the client rather than focusing on prevention. This is not to say that participants did not see the importance of preventing child sexual abuse, but rather they believed that prioritizing well-being would in turn reduce the risk of offending behaviour; “the goal of therapy should be to help the person be happier and healthier, any prevention of CSA this has should be seen as a side effect, not the goal itself.”

General mental health ($n = 54$). While most clinicians should be well-versed in the area of general mental health, participants who responded to this question felt that clinicians could be better educated on the mental health concerns common within those with sexual interest in children. Depression, suicidal ideation, anxiety, low self-esteem, and isolation were among some of the most common mental health concerns cited by respondents. Also prevalent were feelings of shame and “self disgust” which impacted

their daily lives. As one respondent stated, “As much as I’m able to tell myself that I didn’t choose to be this way, I still feel like I’m the lowest of the low. Knowing that my wife, my family, and my friends would all wish me dead if they knew fills me with such a deep sense of shame that it affects every aspect of my life.” As a result, many participants requested that more focus be placed on coping with the negative impacts of their sexual interest while also accepting themselves for who they are. Participants also emphasised the need for mental health help unrelated to their sexual interest; “some need help dealing with their attractions while others just need help dealing with stigma and everyday stuff.”

Sex and Sexuality ($n = 39$). Participants identified that clinicians lack training in general human sexuality and sexual health. It was therefore recommended that clinicians should be educated on more ‘typical’ subjects such as etiology of attraction, knowledge of the LGBTQS+ community, exclusivity of interest (i.e. exclusive vs unexclusive), healthy sexual coping, the development of healthy sexual relationships, and “basic knowledge of paraphilias.” In addition, respondents indicated that they felt that clinicians should be educated on the “difference between fantasy and genuine sexual interest”, in that one’s sexual fantasies do not always translate to a sexual preference or orientation.

Outside of general sex education, many participants expressed the desire for clinicians to be educated on alternative strategies for those with a sexual interest in children. These alternative strategies were specific to obtaining sexual release and included: use of fantasy, use of drawings of fictional children, masturbating to legal images of children, and the use of child sex dolls. As one participant commented, “please don’t automatically discourage legal outlets like looking at legal images online. We need some outlet.”

Reporting ($n = 19$). A major concern that many participants expressed was that clinicians are unaware of proper mandatory reporting protocol. Specifically, respondents opined that some clinicians erroneously report clients “who merely expresses attractions or fantasies about children” when there is no immediate risk to a child. As one individual stated, “I think the main concern for MAPs is mandatory reporting for those of us who are not breaking the law.” Another participant also called into question “the ethics of reporting use of CSEM.” This unease around reporting appears to have led to some individuals being “scared to come out even to professionals” and less likely to seek mental health treatment; “Why would anyone approach you when they are likely to fear that even revealing an attraction that they haven’t acted upon, or having viewed child porn, would result in them being turned in to police?” Participants therefore stated that clinicians should be properly educated on the mandatory reporting laws in their area of practice. Further, some stated that clinicians should be better educated on how to explain mandatory reporting protocol to their clients lest their clients reveal “self-incriminating” information. As one participant explained, “professionals should know to be immediately up front and clear with new patients about mandatory reporting laws and examples of things that would or would not need to be reported.”

Sexual offending ($n = 16$). While for the most part, participants rejected prioritizing prevention over client well-being, some still believed that clinicians should have some knowledge on sexual offending. Firstly, participants opined that clinicians should be aware of information such as “low recidivism rates” associated with sexual offending and the difference between “situational versus preferential offending.” Furthermore, respondents stated that clinicians should be trained to assess and reduce risk

for sexual offending, especially when working with clients who have previously committed a sexual offense. One participant in particular responded that clinicians should be educated on “what risks exist, the degree of risk, and whether someone is a risk or not.” In terms of risk reduction, respondents suggested that clinicians learn about “realistic strategies to help pedophiles stay away from offending” and to identify “when a safety plan is needed to help the MAP not offend.”

Question 2

What are some strategies that the mental health professional could use that you would find to be helpful when seeking help for sexual interest in children?

It should be noted that several of the themes that emerged from this question were similar to those that emerged from question 1 (i.e., clinician-client relationship, sex and sexuality, understanding, minor attraction as an orientation, and general mental health) and are therefore not discussed below. Readers may refer to Table 7 for a full list of themes pertaining to question 2.

Promoting positive identity ($n = 74$). Many responses to the above question centered on the theme of promoting positive identity. As participants frequently reported experiencing feelings of shame, self-hatred, and disgust, it follows that one of the most desired therapeutic outcomes appears to be “reframing” their self concept to “increase self-acceptance” and “build self-esteem.” A common sentiment from respondents was that they wanted the clinicians to reassure them they were “not a monster” and that, being fully in control of their own actions, were not “destined to offend.” Participants appreciated when the clinician emphasized that their attraction to children is only one aspect of themselves; it “is something they didn’t chose [sic]” and “they aren’t defined by

their attraction.” Moreover, respondents benefited from the knowledge that they were not alone in their attraction toward children and knowing that “someone can be a MAP and be a good person with a healthy, functional life”.

Safety ($n = 31$). Participants indicated that helpful therapeutic strategies included those that ensured the safety of both themselves and children they may come into contact with. Firstly, respondents felt that clinicians should acknowledge and support their clients’ “non-offending stance.” Some conceded, however, that not all persons with sexual interest in children are anti-contact; therefore, clinicians should be able to address and “dismantle cognitive distortions.” One recommended strategy included “talking through issues of consent” with a client and explaining the “consequences of child sexual abuse.” For example, one participant found it helpful that a clinician “describ[ed] why child porn is bad in a way that isn’t ‘it’s illegal’.” Some responses indicated that they found it helpful for the clinician to directly ask the client about their use of child sexual exploitation material and to encourage abstinence if it were something they had been accessing. In order to be successful in this endeavor, participants stated that it would be beneficial to work on coping mechanisms “for resisting temptation when given the opportunity to offend” as well as learning “how to redirect any intrusive thoughts about minors.” While some were interested in “how to feel comfortable around minors”, others were more focused how to avoid “situations that might lead to offensive behaviour (like physical proximity or private moment of intimacy)” and “steps that could be taken to avoid becoming too attracted/obsessed with a child.”

Fostering pro-social relationships ($n = 12$). Respondents expressed a desire for clinicians to assist them in developing healthy relationships. Many stated that they

believed it would be helpful for clinicians to direct them to pro-social online communities such as VirPed and B4U-Act. One participant found that these types of groups “can provide a certain sense of belonging which alleviates some of the psychological burden.” Others were interested in meeting others with sexual interest in children in person and suggested that a group-therapy model would be beneficial; “I think group therapy would be ideal. They can come to see that there are others like themselves. Older pedos can be role-models for younger ones.”

Stigma ($n = 14$). The theme of stigma emerged when participants expressed the need for strategies to help cope with negative attitudes and hate from society. One participant recommended that clinicians “make sure to address the problems that MAPs face outside of there [sic] sexual preference, for example: the damage caused by frequently hearing people call for the murder, castration, rape, sterilization, or otherwise general violence against MAPs.” Another suggested helping clients with “desensitization to discussions of children and buzzwords like pedophile and sex offender.”

Discussion

Improving Knowledge and Dispelling Stereotypes

Overall, participants recommended that clinicians gain a better understanding of individuals with sexual interest in children. In fact, only approximately four percent of participants in this study believed that clinicians have the necessary skills in order to provide treatment to this group. A post-hoc analysis showed that most participants who indicated that clinicians did not have the required skills *had* in fact sought treatment in the past. Among other issues, respondents cited the conflation between sexual interest in children and sexual offending, the assumption of homogeneity among people with sexual

interest in children, and the focus clinicians place on prevention at the exclusion of client well-being. Similar sentiments were expressed in a study by Grady et al., (2018) which explored barriers to preventative services for those with sexual interest in children.

Participants in the study found that clinicians made incorrect assumptions of their sexual interest and their experience which further complicated the therapeutic relationship (Grady et al., 2018). The present results also support those reported by B4U-Act (2011b) in which 50% of respondents claimed that the clinicians made inaccurate and unjustified assumptions. For example, one third of the sample stated that their clinicians assumed that all their interactions with a child were for a sexual purpose. Further, participants reported that these assumptions interfered with their therapeutic goals (67%) and made them less likely to return for further sessions (63%; B4U-Act, 2011b). This coincides with the present participants' feelings that clinicians place too much focus on the client's sexual interest, thereby overlooking important underlying issues such as social isolation, shame, self-hate, and hypervigilance to being outed.

Interestingly, despite feeling that clinicians lack the necessary knowledge to treat those with sexual interest in children, most participants who sought therapy indicated that they had had a positive experience. Similarly, the majority of those who had disclosed their sexual interest to their clinicians reported that the response had been positive. These findings are promising because they may indicate a discrepancy between the fears those with sexual interest in children have around therapy and their actual experiences with clinicians. Indeed, a study of stigma-related stress among those with sexual interest in children conducted by Jahnke et al. (2015c) found that most participants significantly overestimated the level of discrimination from the public toward their group than was

self-reported by the public itself. Jahnke et al. (2015c) suggest that assumptions of how the public (including clinicians) view those with sexual interest in children may be based on experiences with small groups of vocal individuals and the media, rather than an accurate portrayal of how all members of the public feel. Therefore, due to their perceived stigma, some individuals with sexual interest in children may adopt hostile attribution biases (Dodge, 1980) where they erroneously interpret clinicians' to be callous and judgemental of their sexual interest. This may be particularly true in situations of high arousal (Crick & Dodge, 1996), such as when disclosing one's sexual interest in children to a clinician for the first time. Nonetheless, this does not discount those who reported negative experiences with clinicians or that there is a need for further training for clinicians who may encounter this client group.

Stigma and Client-Clinician Relationship

Consistent with the emphasis in open-ended responses on improved knowledge to dispel stereotypes, it is unsurprising that stigma emerged in the present study as a key theme. As discussed in Chapter 1, those with sexual interest in children are highly stigmatized and there is an abundance of literature to support this. Many of the same sentiments as in Grady et al. (2018) were echoed by the present participants. Participants in Grady et al. (2018) indicated that they felt as though clinicians believed them to have already offended or be destined to offend. The same opinion was expressed by participants in a study by B4U-Act (2011b); nearly 40% of participants who voluntarily sought mental health treatment stated that the clinician assumed they had or would engage in sexual activity with a child. Participants in the present study also feared being judged as morally reprehensible by the clinician. Indeed, a study by Koops et al. (2016)

reported on a sample of Russian sexologists of whom 36% expressed anger toward those with sexual interest in children, and over one quarter indicated that they should be incarcerated regardless of whether they had offended.

In the present study, respondents suggested that stigmatizing attitudes could be diminished by combating stereotypes and assumptions using education and social contact. As discussed in Chapter 1, recent studies have shown the efficacy of interventions to reduce stigma toward those with sexual interest in children (Harper et al., 2016; Jahnke et al., 2015b; Kleban & Jeglic, 2012; Levenson & Grady, 2019; Wuertele, 2018); however, only two have specifically looked at such an intervention in relation to clinicians. Jahnke et al. (2015b) administered an anti-stigma education and contact-based intervention to a group of psychotherapists in training. The intervention presented participants with textual information that addressed misconceptions of those with sexual interest in children as well as part of a documentary featuring a non-offending individual with a sexual interest in children. While the intervention resulted in increased knowledge and positive attitudes toward those with sexual interest in children, the results were only short-term, perhaps due to the program's brevity (10 minutes). More recently, Levenson and Grady (2019) developed two longer educational interventions (one 90-minute intervention and one 3-hour intervention) which were presented to clinicians across four separate conference workshops. Results showed significant changes occurred in terms of knowledge of mandatory reporting, counselling goals for those with sexual interest in children, *DSM-5* criteria for pedophilic disorder, and risk of committing CSA. Changes in attitude, however, were not significant, perhaps because attitudes were not particularly negative prior to the workshop. Based on these findings, expanding to create a longer, more

comprehensive workshop with multiple modes of anti-stigma approaches (i.e. education *and* social contact) may prove to create lasting changes in clinicians' attitudes toward those with sexual interest in children. Improving attitudes toward this group could in turn create a more favourable therapeutic environment for those with sexual interest in children – one where they are less likely to feel stigmatized.

As stigma has been correlated with reduced emotional and social functioning (Jahnke et al., 2015c), as well as an increase in suicidal ideation in this group (Cohen et al., 2019), it is important that a workshop aim to reduce stigma among clinicians to provide more effective counselling to those with sexual interest in children. While it may not be realistic to expect general clinicians to become experts in treating those with sexual interest in children, it is a realistic expectation for clinicians to improve their initial responses toward this group. Relatedly, another prominent theme communicated by participants was the importance of the clinician-client relationship. Participants frequently endorsed the need for clinicians to be compassionate, empathetic, and non-judgemental. Additionally, respondents emphasized the need for clinicians to provide a safe environment where clients feel that they are free to openly discuss their thoughts and feelings without fear of having their confidentiality breached. These requests are in line with the proposition that specific qualities of clinicians (i.e. warmth, empathy, acceptance, non-judgemental) are important factors related to positive outcomes for clients (Laughton-Brown, 2010).

While the clinician-client relationship is paramount in the effectiveness of therapeutic intervention, previous research has suggested that some individuals with sexual interest in children do not have high expectations for clinicians to be able to form

such a relationship. In the qualitative study by Grady et al. (2018), one participant indicated that they felt as though the clinician could not empathize with them. In a separate study 69% of respondents reported that they feared being judged by a clinician and 67% feared that a clinician would breach confidentiality (Levenson & Grady, 2018).

While respondents call for increasing clinician empathy toward those with sexual interest in children, it is important to consider whether these attributes can be taught in a workshop setting. A systematic review of the literature on increasing empathy in medical school students found that educational interventions may be effective in both maintaining and enhancing empathy in this group (Batt-Rawden et al., 2013). Rather than trying to teach empathy, perhaps an arguably easier solution would be for professional programs (e.g. clinical psychology and social work programs) to develop more effective strategies to screen for empathy and interpersonal skills during student interviews. For example, some programs require an in-person interview with the applicant as well as references from other clinicians who can speak to the applicant's suitability for clinical training. Less commonly, programs request a video of a mock-therapy session be included in the application package. Screening interviews could involve presenting potential trainees with situations that might challenge them to respond with some of these core clinician characteristics. Even if clinicians do not have the competency to provide treatment to those with sexual interest in children, referring the client to someone who does, all the while responding with compassion and empathy would ensure that the experience remains positive and hopefully promote future help-seeking behaviour. Indeed, in a book on strengths-based treatment of those who have committed sexual offenses, Marshall (2011) describes how a clinician's body language, as well as how they respond to client,

will in turn shape that client's behavioural response. Therefore, treating the client with respect and with compassion can model positive behaviour in the client going forward.

Positive Self Image and General Mental Health

Respondents expressed that it was important for clinicians to foster a positive self-image in their clients as well as address general mental health concerns. Indeed, in the present study, 56% of participants indicated that they had sought help for general mental health concerns unrelated to their sexual interest. Of those who had *not* sought help, 64% expressed an interest in seeking help for dealing with their general mental health concerns unrelated to their sexual interest. Similarly, 50% of participants in a study by Levenson and Grady (2018) reported previously seeking counselling for personal or emotional problems unrelated to their sexual interest in children (e.g. depression and anxiety). Another similarity was respondents' indication that they wanted clinicians to help them improve their self-concept by improving self-esteem, addressing shame, and thinking of their sexual interest in a positive light. Of particular concern, many participants in the present study mentioned the need for suicide prevention. This coincides with a previous study which found that 45% of the sample had seriously considered suicide due to their sexual interest in children (Cohen et al., 2019). It is therefore evident that treatment for those with sexual interest in children should have a larger focus on general mental health issues including depression, anxiety, shame, and suicidal ideation and not just a narrow focus on the prevention of childhood sexual abuse. As participants noted, improving general well-being and quality of life is not incompatible with prevention efforts. Indeed, even when working with legally involved clients, Clinical-Forensic psychologists may make use of the Good Lives Model (GLM; e.g., Ward & Gannon, 2006; Ward &

Marshall, 2004; Ward & Stewart, 2003) which focuses equally on risk and an individual's strengths in living an offence free life. Specifically, the GLM teaches individuals about obtaining "primary goods" (e.g., excellence in play and work, inner peace, friendship, community, etc.) that will ideally result in increased emotional, mental, and physical well-being that is incompatible with offending behaviour (Ward & Gannon, 2006; Willis, Prescott, & Yates, 2013). Rather than narrowing in only on risk, the GLM helps the client meet values that they feel are most important to them with regards to living a healthy and fulfilling life (Willis & Ward, 2011).

The desire to focus on ones' self-image and general mental health concerns is not unique to those with sexual interest in children. In fact, these are two very common treatment goals that can be addressed through different therapeutic modalities, such as cognitive behavioural therapy (CBT). The goal of CBT is to modify maladaptive cognitions and problematic behaviour to address different clinical issues (Beck, 1970). CBT is one of the more commonly taught forms of psychotherapy, perhaps because it has been extensively researched and adapted for a wide range of disorders (Butler et al., 2006). The delivery of treatment for general mental health concerns in those with sexual interest in children is likely within the realm of clinicians' abilities. Despite having the competency to treat general mental health concerns, it may be that some clinicians have little to no experience with those with sexual interest in children, leading them to overlook the general mental health issues and focus on the sexual interest. This, along with a lack of understanding of what sexual interest in children entails, and potential stigmatizing attitudes, may lead a clinician to either turn the therapeutic focus to the individuals' sexuality, or refuse to accept the client entirely. Improved education on the

therapeutic needs of those with sexual interest in children may therefore result in an increased willingness to treat this population for general mental health issues.

Sexual Health and Alternative Strategies

The last theme that will be highlighted as an important component of an educational workshop is the inclusion of information on the promotion of sexual health and alternative strategies. Participants stated that clinicians should be better educated in the area of human sexual health and behaviour. Within Canada, research has shown that clinicians are unlikely to receive general sexual health training at any level of their education (Reissing & Giulio, 2010). Outside of psychology, sexuality and sexual health education are not required at any level of social work training, either BSW or MSW (Winter, O'Neill, Begun, Kattari, & McKay, 2016). Further, an exploratory study in the United States found that only 16% of nurse educators believed that their students were prepared to work with clients reporting sexuality issues and one-third reported that content on sexuality is not a part of the nursing curriculum (Aaberg, 2016). It is likely, then, that some clinicians may feel unqualified to work with those with sexual interest in children when they lack even basic sexual health training. Therefore, future programming should strive to incorporate information regarding treatment for those with sexual interest in children in the context of what is known about human sexuality.

Further, participants recommended that clinicians be better educated in “alternative strategies.” Alternative strategies involved exploring outlets for sexual urges such as fantasizing about children, the use of fictional drawings and/or stories involving children, and masturbating to legal images of children online (i.e. pictures of children uploaded to the Internet without sexual intent). These responses alongside others implied

that encouraging those with sexual interest in children to repress their sexual urges, rather than expressing them, could potentially lead to offending behaviour. It was clear from some participant responses that they would like alternative strategies to be considered by clinicians.

Although one's sexual satisfaction is certainly important to consider in terms of overall well-being, there is some contention over whether it would be appropriate for a clinician to recommend or encourage those with sexual interest in children to engage in self-stimulation using fantasies or depictions of children. The debate is further complicated by a lack of literature in the area of alternative strategies; specifically, there is no research to suggest that encouraging the use of alternative strategies will increase *or* decrease risk for committing CSA. For example, while Dombert et al. (2016) and Klein et al. (2015) found a positive association between fantasizing about children and increased sexual offending, Bailey et al. (2016a) did not find the same results. Still, some researchers worry about the role of fantasies in increasing sexual preoccupation in those with sexual interest in children (Klein et al., 2015; Santilla et al., 2015) as sexual preoccupation is a risk factor for sexual offending among those who have offended (Hanson & Harris, 2000).. However, if future research were to suggest that engaging in alternative strategies decreases risk of engaging in offending behaviour, then, from a harm reduction standpoint, clinicians should consider the benefits not only for the client but for potential victims of CSA (Heasman & Foreman, 2019). For example, alternative strategies, if practiced in a way that is balanced (and not encouraging preoccupation), may work to improve well-being and decrease risk of offending by managing sexual frustration. Of course, the use of alternative strategies would certainly not be appropriate

for all individuals, and clinicians should strongly consider whether making such a recommendation would help or hinder client well-being, as well as whether it would increase risk and/or sexual preoccupation.

In addition to the unknown association between alternative strategies and risk, clinicians would need to be very careful about recommending that clients engage in alternative strategies, since some of these strategies might bring them into conflict with the law. In Canada for example, child pornography laws include “any written material, visual representation, or audio recording that advocates or counsels sexual activity with a person under the age of 18 years” [*Criminal Code*, RSC 1985, c. C-46, s 163.1 (c)]. Therefore, suggestions surrounding written stories about sexual contact with children as a means of alternative expression of sexual interests could bring clients into contact with the law. Further, these laws can be extended. For example, one respondent suggested that clinicians recommend the use of child sex dolls. In Canada, possession of a child sex doll would be considered a violation of s. 163.1 (4) C.C.C., or possession of child pornography. This was recently confirmed in Canada’s only child pornography case involving a child sex doll (CBC, 2019). In addition, there may be legal repercussions to an individual accessing and masturbating to “legal” images of children (e.g., pictures of children in bathing suits uploaded to the internet with a non-sexual purpose) as it is possible for authorities to regard them as being child sexual exploitation material. Therefore, alternative strategies need to be carefully considered within the context of the current legal climate, as well as the individual characteristics of the client. Additionally, future research is needed on the impact of such strategies and for whom such strategies might be important.

Limitations

As with all studies, the present study is not without limitations. The most evident limitation is that the present study relies exclusively on self-report data. Self-report data, especially from those of marginalized groups, is often vulnerable to impression management; therefore, it is possible that participants responded in a way that they believed would be more “desirable” to the researchers. In addition, the quantitative portion of this study was vulnerable to selection bias, in that the individuals who participated in the study may not be representative of all individuals with sexual interest in children. The present study used the same recruitment strategy as past studies that aimed to gain an understanding of this community (e.g., Bailey et al., 2016 a, b; Grady et al., 2018; Levenson & Grady, 2018). Participants were recruited through online communities dedicated to those with sexual interest in children, as well as through the authors’ social media platforms. In addition, the online communities that were used for recruitment are known to share more pro-social, anti-contact views than some other alternative communities. Further, it was noted by the author that all of these groups were generally in support of new research being conducted on those with sexual interest in children. It is possible that those who participated in the present study were more interested in pursuing mental health treatment as well as assisting in research than those who did not participate or who are not part of these specific communities. As well, because the recruitment strategy was so similar to the previously mentioned studies, it is possible that the present sample is not distinct from previous samples collected by past researchers. While generalizability is not much of a concern for qualitative research (Carminati, 2018), it could be that some of the responses to the quantitative data were

affected by recruiting from these specific online communities. Although it could be more difficult to get these groups to participate, future research should aim to extend invitation to complete studies of this nature to groups who are considered to have more pro-contact discourse.

Finally, there is potential for the themes to have been influenced by the views and biases of the coder; however, the first author attempted to reduce their influence on the themes through transparency (e.g., offering up examples of the codes and data used to construct each theme as demonstrated in Table 7). Further limitations include a lack of interrater reliability due to having only one coder, and the fact that qualitative coding does not allow for the determination of causation.

Conclusion

Despite the limitations, the present study provides relevant information to the extant literature on the mental health experiences of those with sexual interest in children. Moreover, the present findings contribute novel information regarding what those with sexual interest in children believe should be included in an educational anti-stigma workshop to increase clinician competency to work with their population. Based on the information collected, an educational anti-stigma workshop should focus on improving general knowledge and dispelling stereotypes, developing strategies to build strong therapeutic relationships, promoting positive self image and the improvement of general mental health, and increasing knowledge of sexuality and sexual health.

Chapter 4 – General Discussion

The present thesis contributes to the development of a workshop for clinicians that will aim to decrease stigma and increase competency to treat those with sexual interest in children. Study 1 had two aims: to assess clinicians' willingness to treat those with sexual interest in children and willingness to attend an educational anti-stigma workshop; and to inform the development of said workshop by asking clinicians about what content should be included and potential barriers to attendance. For the first aim, clinicians with previous experience in providing assessment and/or treatment to those with sexual interest in children demonstrated less stigma than those with no previous experience. Further, clinicians who scored higher on a measure of stigma were less likely to accept a hypothetical treatment referral for a client with sexual interest in children and to indicate that they would attend a workshop to improve competency. The effects of stigma were present when controlling for other factors (e.g., client's presenting problem). For the second aim, clinicians reported that it would be most helpful for a workshop to include discussion of effective therapeutic strategies, risk assessment, sexual health, general information about those with sexual interest in children, ethics and liability, stigma, forming a therapeutic relationship, and clinician characteristics. Regarding potential barriers to workshop attendance, clinicians discussed accessibility (e.g., cost, time, and geographic location), stigma, and relevance to their own area of treatment.

Study 2 surveyed people with sexual interest in children about their past treatment experiences and, critically, what they believed was important in developing a clinician educational anti-stigma workshop. While similar to clinicians, those with sexual interest in children also mentioned that a workshop should consider the general understanding of

those with sexual interest in children and their lived experiences, stigma, the therapeutic relationship, and sexual health. Different themes were also emphasized as participants thought it would be beneficial for a workshop to incorporate topics such as minor attraction as an orientation, and knowledge and treatment of general mental health issues that frequently present in people with sexual interest in children. Those with sexual interest in children also described positive strategies that clinicians could use when providing treatment such as promoting positive self identity and safety, fostering pro-social relationships, and addressing stigma, which may also be important areas to discuss in a clinician educational workshop.

Implications

The results of these two studies have several implications for the development of a workshop and two of the most significant implications are discussed. First, stigma reduction should be a target in the development of a workshop for mental health clinicians. As shown in study 1, clinicians with no prior experience with this population hold greater stigmatizing attitudes toward those with sexual interest in children. A possible clinical implication (as supported in the thesis) is that clinicians with increased stigma may be less likely to accept clients with sexual interest in children, regardless of their presenting characteristics. Furthermore, clinicians with higher levels of stigma toward those with sexual interest in children were less likely to express willingness to attend an educational workshop. Stigma was also highlighted as an important component of a workshop as demonstrated in qualitative data from both clinicians and those with sexual interest in children. Overall then, stigma not only impacts clinicians' personal attitudes toward clients but also effects clinical decision making. Indeed, a recent study

on mandatory reporting decision making found that clinicians with high levels of stigma toward those with sexual interest in children were more likely to report individuals who disclosed their sexual interest to authorities (Stephens et al., 2019). Outside of psychology, Covarrubias and Han (2011) found a positive association between stigma toward those with major mental illness and endorsement of restrictions (e.g., revoking driver's licenses and mandatory admission into psychiatric hospitals) in graduate-level social work students.

When developing a workshop for clinicians then, it will be important to address stigma. While education itself has been shown to decrease stigma across several studies (e.g., Clement et al., 2013; Wurtele, 2018), developers of such a workshop should consider integrating other elements to further combat stigmatizing attitudes. For instance, studies have shown that having contact with individuals from a stigmatized group is effective in decreasing stigmatizing attitudes (e.g., Corrigan et al., 2012; Yamaguchi et al., 2013). It may therefore be beneficial for a clinician workshop to include contact with those with sexual interest in children. Having an individual with sexual interest in children present at the workshop would not only provide contact but allow for the individual to describe their experience and answer any questions from the viewpoint of someone with sexual interest in children. Indeed, recent research has shown that personal narratives are effective in reducing stigma toward those with sexual interest in children (Harper et al., 2016; Harper et al., 2019).

Nonetheless, in inviting someone with sexual interest in children to attend the workshop, several other factors must be considered. First, the way in which the individual attended (i.e. in person versus video or audio call) would need to be contemplated. While

attending in person would be ideal, it may not be practical in terms of safety for the individual. Second, workshop coordinators should work with the guest speaker to prevent presenting them as a case study and further pathologizing their sexual interest. The guest speaker and their experience should be presented holistically to avoid further “othering” and potentially leading to increases in stigma. Suggestions on how to effectively and appropriately integrate an individual with sexual interest in children into the workshop may include: having the speaker involved with the development and organization of the workshop; having the speaker conduct their own presentation (i.e., without the mediation of a clinician); include time for questions and answers at the end of the speaker’s presentation; and have more than one guest speaker with sexual interest in children.

The second implication of the results is that an educational anti-stigma workshop should include information that both key stakeholders (i.e. clinicians and those with sexual interest in children) think is important for increasing competency to treat people with sexual interest in children. Overall, those with sexual interest in children expressed the importance of a workshop working to improve understanding of people with sexual interest in children (e.g., lived experiences, stigma, sexual health), teaching clinicians how to promote positive self-identity, and viewing their interest as a sexual orientation. Clinicians wanted more education on effective therapeutic models, risk assessment, and legal obligations such as mandatory reporting. Incorporating the needs of both groups would result in a comprehensive workshop that would serve to effectively increase competency of clinicians to treat those with sexual interest in children. Table 9 contains proposed topics based on their importance as well as key points that should be considered.

As stated above, to increase competency to treat people with sexual interest in children, many clinicians wanted to know more about evidence-based therapeutic models. Up until recently, most prevention literature has focused on sexual interest in children as a risk factor for committing child sexual abuse (e.g., Hanson & Morton-Bourgon, 2005; Seto & Lalumière, 2001) and indeed, many of those with sexual interest in children have reported wanting help for controlling their sexual interest (e.g., Beier et al., 2009; Levenson & Grady, 2018). Within recent literature, however, it has become clear that those with sexual interest in children also suffer from high rates of mental health problems (B4U-Act 2011a; Cohen et al., 2018; Levenson & Grady, 2018) and would therefore benefit from treatment focusing on general mental health concerns as well. Indeed, within the present thesis, participants with sexual interest in children emphasized the need for increased understanding of sexual interest in children and a focus on positive self-image and general mental health concerns. While there were certainly some overlapping themes, it is clear that clinicians were more focused on risk and ethical responsibility while those with sexual interest in children were more concerned about clinician response and treatment focus. Evidently, when developing a workshop there should be some consideration as how to best balance the needs of both clinicians and those with sexual interest in children. As the goal of a workshop is to increase clinician competency and willingness to treat those with sexual interest in children, then addressing their concerns of risk and ethical obligations is important. Arguably, clinicians who have a better understanding of risk factors and reporting would be more competent and therefore more willing to take on clients with sexual interest in children. Focusing on these topics would also be beneficial for the clients, as one of the concerns expressed by

those with sexual interest in children in previous research was that clinicians would report them to the authorities simply for disclosing their sexual interest (e.g., Levenson & Grady, 2018). Therefore, a workshop should seek to educate clinicians on the basics of assessing risk factors for clients who disclose a sexual interest in children, as well as when and how they should go about reporting an individual they feel is at risk to commit an offense.

Nevertheless, increasing competency to treat those with sexual interest in children should also involve addressing some of the key issues raised by this population. In terms of providing effective client-centered treatment, a workshop could incorporate further CBT training as well as ACT training to help deal with those struggling with the effects of stigma. Therapeutic training should also encourage clinicians to make their office a place of refuge for those with sexual interest in children. A client's disclosure of their sexual interest in children should be met with warmth and understanding. Clinicians should realize that sexual orientation toward children is stable (Bailey et al., 2016b; Seto, 2017), and treatment should focus on the client's goals rather than just their sexuality.

In addition to workshop content, most clinicians in the present thesis cited accessibility as the main barrier to attending the workshop. Specifically, participants were concerned about location, cost, and the date/time that the workshop would be held. Therefore, in order to maximize attendance, each of these factors should be carefully considered when developing the workshop. To address these issues, some participants suggested that the workshop be held as a pre-conference workshop at conferences such as the Association for the Treatment of Sexual Abusers (ATSA). While this is one option, holding the workshop at conferences such as ATSA would result in attendance of those

mostly in the forensic area and therefore most likely have experience treating those with sexual interest in children. Another solution would be to offer an online streaming option to those unable to attend in-person; unfortunately, while participants would still be able to gain useful information, this would limit their ability to actively participate in the workshop. Further, a website could be developed to provide clinicians with key information and resources that would otherwise be discussed more in-depth in a workshop. This would give clinicians multiple avenues to access information that would increase competency to treat those with sexual interest in children.

Regardless of the content and the format of the workshop, developers should seek to incorporate program evaluation measures that will not only assist with understanding the desired outcomes of the workshop, but also help with evaluating the usefulness of the program later on. One way to build in program evaluation is to create a logic model of the workshop. A logic model is an organized visualization of the relationships among the program's resources, activities, and intended results (Kellogg, 2004). Readers are directed to Figure 1 for a sample logic model of the proposed educational anti-stigma workshop.

Briefly, program goals are the results that stakeholders hope to achieve through the implementation of the program. As stated throughout this thesis, the aim of a workshop would be to increase competency for clinicians to work with those with sexual interest in children, as well as decrease stigma and increase clinician willingness to work with this group. Inputs are the resources that the program has available; these can include human, financial, organizational, and community resources (Kellogg, 2004). For the proposed workshop, some resources would include funding, clinicians and guest speakers, web-developers, advertising, and relevant tools such as a location to host the

workshop. Following this, activities are what the program does with the resources. This would not only include the facilitation of the workshop itself, but the activities behind the scenes such as interviewing and training clinicians and guest speakers, creating training materials, creating workshop materials and pre-posttest measures, and advertisement and recruitment. Outputs are the products that result from the activities and may include the number of workshop attendees, preliminary data, and connections with outside organizations. Finally, outcomes are specific changes that occur as a result of the program. Short-term outcomes may include sustainable funding, increased knowledge of the workshop, and increased attendance. Long-term outcomes would ideally reflect the initial program goals with an added positive impact on help-seeking behaviour and mental well-being in those with sexual interest in children.

Taken together, having a better understanding of those with sexual interest in children, an idea of effective treatment options, and a grasp on risk factors and reporting standards may result in mental health clinicians feeling more competent and willing to provide treatment to those with sexual interest in children. Further, having clinicians who are qualified and more secure in their ability to treat this population may lead to more individuals with sexual interest in children accessing mental health services. Developers of a workshop should aim to incorporate program evaluation measures to determine the effectiveness of the program in the future.

Future Directions

Future research in this area should devote increased resources to engaging in research with general mental health clinicians. In the present thesis, the author was limited in terms of the amount of time that could be dedicated to reaching out to

organizations representing general mental health research and clinical work. Further, many organizations that were contacted either did not reply or stated that they were unable to share Study 1 with their audience. Methods to circumvent barriers to engaging general clinicians in research may include paying for advertising on general mental health listservs and websites, advertising at general mental health conferences, offering more incentive to participate (e.g., increasing the amount of potential prizes), or simply dedicating more time reaching out to mental health organizations.

In terms of workshop development, future research is needed in two main areas. First, additional studies could consider the content of such a workshop. For instance, future research could interview clinicians with experience working with those with sexual interest in children to inform best practice therapeutic strategies that could be included in a workshop. Further, as briefly discussed above, elements of program evaluation should be built into the workshop to determine its effectiveness in reducing stigma and increasing competency of the attendees. In preparation for a program evaluation, developers of the workshop should: outline the goals and sub-goals of the workshop, consider inputs (i.e. resources needed to run the workshop), and detail activities (e.g., activities of workshop coordinators and workshop attendees), outputs (i.e. the products of activities) and expected outcomes.

Similarly, developers should consider evaluation questions that would explore the degree to which the workshop meets expected outputs, outcomes, and objectives. For example, program developers should consider the best indicators that clinicians' competency to assess/treat those with sexual interest in children is increasing. For instance, indicators may be related to an increase in knowledge of basic human sexuality

or mandatory reporting. Developers should think how best to measure these constructs. As this is a large undertaking, it is recommended that an initial workshop be limited to a smaller geographic location (Peerman, 2014) such as Nova Scotia. Not only would it be easier to fine-tune and perfect the inner workings, but evaluation of the workshop would be more manageable if the workshop were initially limited in size.

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Table 1*Study 1 Participant Demographic Information (N = 101)*

Variable	<i>M (SD) or %</i>
Age (<i>n</i> = 101)	40.56 (12.49)
Sex (<i>n</i> = 101)	
Female	67.3% (<i>n</i> = 68)
Male	32.7% (<i>n</i> = 33)
Other	-
Gender (<i>n</i> = 101)	
Woman	66.3% (<i>n</i> = 67)
Man	31.7% (<i>n</i> = 32)
Transwoman	-
Transman	-
Gender fluid/gender queer	2.0% (<i>n</i> = 2)
Other	-
Ethnicity (<i>n</i> = 100)	
Asian – East	-
Asian – South East	-
Black – African	-
Black – North American	2.0% (<i>n</i> = 2)
Indigenous/Aboriginal	1.0% (<i>n</i> = 1)
Latin American	-
Métis	-
Middle Eastern	-
White – European	13.0% (<i>n</i> = 13)
White – North American	77.0% (<i>n</i> = 77)
Mixed Heritage	3.0% (<i>n</i> = 3)
None of these apply (other)	4.0% (<i>n</i> = 4)
Political Orientation (<i>n</i> = 99)	
Very Liberal	27.3% (<i>n</i> = 27)
Liberal	35.4% (<i>n</i> = 35)
Slightly Liberal	9.1% (<i>n</i> = 9)
Moderate/Middle of the Road	11.1% (<i>n</i> = 11)
Slightly Conservative	4.0% (<i>n</i> = 4)
Conservative	5.1% (<i>n</i> = 5)
Very Conservative	2.0% (<i>n</i> = 2)
Libertarian	2.0% (<i>n</i> = 2)
Other	4.0% (<i>n</i> = 4)
Country (<i>n</i> = 101)	
Canada	44.6% (<i>n</i> = 45)
United States	55.4% (<i>n</i> = 56)
Profession (<i>n</i> = 101)	
Physician	2.0% (<i>n</i> = 2)
Psychologist	36.6% (<i>n</i> = 37)

Counsellor/Psychotherapist	9.9% (<i>n</i> = 10)
Occupational Therapist	2.0% (<i>n</i> = 2)
Social Worker	23.8% (<i>n</i> = 24)
Mental Health Nurse	1.0% (<i>n</i> = 1)
Behavioural Therapist	2.0% (<i>n</i> = 2)
Student	18.8% (<i>n</i> = 19)
Other	4.0% (<i>n</i> = 4)
Highest Degree Obtained (<i>n</i> = 101)	
Student in professional/graduate program	19.8% (<i>n</i> = 20)
Bachelor's Degree	4.0% (<i>n</i> = 4)
College Degree	1.0% (<i>n</i> = 1)
Medical Degree	2.0% (<i>n</i> = 2)
Master's Degree	35.6% (<i>n</i> = 36)
Doctoral Degree	37.6% (<i>n</i> = 38)
Competency ^a	
General mental health	92.1% (<i>n</i> = 93)
Those in conflict with the law	59.4% (<i>n</i> = 60)
Those who have committed sex offenses	55.4% (<i>n</i> = 56)
Those with paraphilic interest	56.4% (<i>n</i> = 57)
Those with sexual interest in children	49.5% (<i>n</i> = 50)
Those with sexual health problems	45.5% (<i>n</i> = 46)
Those seeking sex therapy	18.8% (<i>n</i> = 19)
Those seeking couples therapy	20.8% (<i>n</i> = 21)
Other	11.9% (<i>n</i> = 12)

Note. Dashes designate no data for the specific category.

^a Clinicians could select multiple options for the question of competency.

Table 2

Results of Hierarchical Binary Logistic Regression Analysis for Vignette Condition and APSIC Scores Predicting Willingness to Treat (N = 101)

Variable	B	SE	Wald	p	Exp(B)	95% CI
Step 1						
Constant	0.07	0.39	0.04	0.85	1.08	--
Vignettes (1)	2.23	0.84	7.11	0.01	9.29	[1.80, 47.77]
Vignettes (2)	1.63	0.67	5.99	0.01	5.11	[1.38, 18.85]
Vignettes (3)	1.58	0.67	5.63	0.01	4.88	[1.32, 18.05]
Step 2						
Constant	2.98	1.02	8.53	.004	19.77	--
Vignettes (1)	2.82	0.94	8.94	.003	16.74	[2.64,
Vignettes (2)	1.46	0.70	4.34	.037	4.32	106.20]
Vignettes (3)	1.87	0.75	6.20	.013	6.46	[1.09, 17.15]
APSIC	-0.06	0.02	9.33	.002	0.94	[1.49, 28.06]
						[0.91, 0.98]

Note. Vignette 1 = general mental health, no offense; Vignette 2 = general mental health,

previous sexual offense; Vignette 3 = managing sexual interest in children, no offense;

The reference category for the analyses was the vignette where the client wanted

treatment to focus on managing sexual interest in children and had a previous sexual

offense.

Table 3

Results of Hierarchical Binary Logistic Regression Analysis for Competency and APSIC Scores Predicting Willingness to Attend a Workshop (N = 100)

Variable	B	SE	Wald	p	Exp(B)	95% CI
Step 1						
Constant	0.73	0.33	5.01	0.25	2.07	--
Competency	0.95	0.49	3.76	0.05	2.58	[0.99, 6.70]
Step 2						
Constant	3.43	1.05	10.65	.001	30.94	--
Competency	0.49	0.53	0.86	0.36	1.63	[0.58, 4.61]
APSIC	-.05	0.02	7.66	0.01	0.95	[0.92, 0.99]

Note. Competency indicates clinicians' competency to assess/treat those with atypical sexual interests including those with sexual interest in children. Responses of "maybe" to willingness to attend were combined with responses of "no" in consideration of sample size.

Table 4*Themes and Sample Excerpts for Open-Ended Questions – Study 1*

Question	Theme	Sample narrative excerpts
1.	Therapeutic strategies (<i>n</i> = 77)	<p>“Information about common treatment presentations in this population. A review of the treatment outcome literature.”</p> <p>“Intervention strategies and approaches, I feel that I don’t know enough about how to treat or what to focus on.”</p>
	Risk (<i>n</i> = 32)	<p>“Ability to assess risk of offending sexually against children, behaviors or situations where children can be vulnerable.”</p> <p>“Any way to assess risk of hands-on offending risk if has not previously committed offenses against children. How to assess risk to reoffend.”</p>
	Sexual health (<i>n</i> = 30)	<p>“Statistics regarding ‘interest’ vs ‘action’ to highlight this important distinction.”</p> <p>“Sex positive intimacy skills.”</p>
	Understanding minor attraction (<i>n</i> = 28)	<p>“Interesting new information on etiology of pedophilia (possibly as an ‘orientation’).”</p> <p>“There should be a discussion differentiating between minor attracted and offenders including the societal pressures and restrictions that some may have to contend with.”</p>
	Ethics and liability (<i>n</i> = 25)	<p>“How to address ethical concerns (e.g., duty to report potential harm to children) in context of this type of treatment.”</p> <p>“Mandated reporting laws around sexual interest with children.”</p>
	Stigma (<i>n</i> = 20)	<p>“Exploring clinicians’ own biases and how they could affect treatment.”</p> <p>“Reducing the stigma and focusing on the individual.”</p>
	Therapeutic relationship (<i>n</i> = 17)	<p>“What does the client view as his treatment goals?”</p> <p>“How we as clinicians can help reduce stigma or increase likelihood that our services are offered in a safe environment.”</p>

	Clinician characteristics ($n = 16$)	“Recognition and management of countertransference in the clinical relationship.” “Strategies to help the clinician cope with the emotional impact of the work.”
2.	Accessibility ($n = 92$)	“Time, cost and if it would be worth my resources to invest in this treatment skill.” “Location, time, financial considerations.”
	Stigma ($n = 40$)	“People do not like this population and do not want to help people who have ‘immoral behavior or thoughts’ – it may be difficult to get funding for projects.” “Stigma towards MAPs, misunderstanding of MAPs (i.e., believing that they will all offend or have offended), discomfort with the topic, having young children and personalizing things too much.”
	Relevance ($n = 14$)	“Current area of work – as I work mainly with children it is unlikely that I would attend a workshop about working with adults.” “There is a relatively small treatment population so it wouldn’t be a priority.”

Note. 1 = “If a workshop were to be developed that increased competency to treat

individuals with sexual interest in children, what do you think should be included for it to

be effective?”; 2 = “What barriers might interfere with participation in such a workshop?”

Table 5*CBPAR Principles as they are Applied in Study 2*

Tenet/Principle	Definition	Application with B4U-Act
Recognizing the community as a unit of identity.	Conceptualizing the group as a community with shared interest and goals.	<ul style="list-style-type: none"> Identified specific shared interest, goals, concerns, and expectations by communicating with members of the organization through webchat and teleconference.
Facilitating collaborative, equitable partnerships in all research phases.	Researchers take steps to include community members in all aspects of research (e.g. literature review, creation of measurements, participant recruitment, etc.)	<ul style="list-style-type: none"> Invited to read proposal Involved in creation of survey Survey disseminated through their website Will be invited to read over results and discussion
Disseminating findings to all partners and involving partners in dissemination process.	Researchers ensure that results are not limited to other academics but are also accessible to the community in question and the community is involved in the communication of the findings.	<ul style="list-style-type: none"> Results will be shared with organization Findings of study will be available through the B4U-Act website.
Long-term process and commitment.	Involvement with the community does not end once the research is completed; partners intend to continue to work with one another to build on the current project or to assist in another area.	<ul style="list-style-type: none"> Preliminary discussion about working with B4U-Act to formulate future programming. First author to continue volunteering with B4U-Act in an organizational and research capacity.

Table 6*Study 2 Participant Demographic Information (N = 183)*

Variable	<i>M (SD) or %</i>
Age (<i>n</i> = 183)	32 (12.95)
Sex (<i>n</i> = 180)	
Female	15.0% (<i>n</i> = 27)
Male	84.4% (<i>n</i> = 152)
Other	0.6% (<i>n</i> = 1)
Gender (<i>n</i> = 178)	
Woman	5.6% (<i>n</i> = 10)
Man	75.3% (<i>n</i> = 134)
Transwoman	2.8% (<i>n</i> = 5)
Transman	5.6% (<i>n</i> = 10)
Gender fluid/gender queer	6.7% (<i>n</i> = 12)
Other	3.9% (<i>n</i> = 7)
Ethnicity (<i>n</i> = 177)	
Asian – East	1.1% (<i>n</i> = 2)
Asian – South East	0.6% (<i>n</i> = 1)
Black – African	1.1% (<i>n</i> = 2)
Black – North American	2.3% (<i>n</i> = 4)
Indigenous/Aboriginal	1.1% (<i>n</i> = 2)
Latin American	7.9% (<i>n</i> = 14)
Métis	0.6% (<i>n</i> = 1)
Middle Eastern	0.6% (<i>n</i> = 1)
White – European	32.8% (<i>n</i> = 58)
White – North American	49.2% (<i>n</i> = 87)
Mixed Heritage	2.3% (<i>n</i> = 4)
None of these apply (other)	0.6% (<i>n</i> = 1)
Relationship Status (<i>n</i> = 182)	
Single	62.1% (<i>n</i> = 113)
Dating	4.4% (<i>n</i> = 8)
Committed Relationship	10.4% (<i>n</i> = 19)
Common Law or Living Together	3.3% (<i>n</i> = 6)
Engaged	1.6% (<i>n</i> = 3)
Married	12.6% (<i>n</i> = 23)
Divorced	3.8% (<i>n</i> = 7)
Other	1.6% (<i>n</i> = 3)
Sexual Interest in...	
Males aged 0-5	22.77 (31.41) (<i>n</i> = 177)
Females aged 0-5	33.84 (37.23) (<i>n</i> = 178)
Males aged 6-10	40.81 (40.15) (<i>n</i> = 176)
Females aged 6-10	55.64 (40.39) (<i>n</i> = 180)

Males aged 11-14	41.44 (41.62) (<i>n</i> = 172)
Females aged 11-14	51.89 (37.44) (<i>n</i> = 179)
Males aged 15-16	29.54 (36.27) (<i>n</i> = 171)
Females aged 15-16	39.01 (36.01) (<i>n</i> = 177)
Males aged 17+	26.65 (34.07) (<i>n</i> = 171)
Females aged 17+	40.65 (38.17) (<i>n</i> = 176)

Table 7*Study 2 Descriptive Statistics (N = 183)*

Variable	<i>M (SD) or %</i>
Presence of mental health professional skills ^a (<i>n</i> = 180)	
Yes	3.9% (<i>n</i> = 7)
No	49.4% (<i>n</i> = 89)
Maybe	46.7% (<i>n</i> = 84)
Wanted counselling <i>unrelated</i> to sexual interest (<i>n</i> = 179)	
Yes	82.1% (<i>n</i> = 147)
No	17.9% (<i>n</i> = 32)
Sought counselling for reasons <i>unrelated</i> to sexual interest (<i>n</i> = 146)	
Yes	80.1% (<i>n</i> = 117)
No	19.9% (<i>n</i> = 29)
# of times counselling for reasons <i>unrelated</i> to sexual interest was sought (<i>n</i> = 117) ^b	5.94 (3.63)
Positivity of counselling experience for reasons <i>unrelated</i> to sexual interest (<i>n</i> = 117)	
Extremely positive	11.1% (<i>n</i> = 13)
Moderately positive	38.5% (<i>n</i> = 45)
Slightly positive	15.4% (<i>n</i> = 18)
Neither positive nor negative	14.5% (<i>n</i> = 17)
Slightly negative	7.7% (<i>n</i> = 9)
Moderately negative	9.4% (<i>n</i> = 11)
Extremely negative	3.4% (<i>n</i> = 4)
Wanted counselling <i>related</i> to sexual interest (<i>n</i> = 180)	
Yes	68.3% (<i>n</i> = 123)
No	31.7% (<i>n</i> = 57)
Sought counselling for reasons <i>related</i> to sexual interest (<i>n</i> = 123)	
Yes	47.2% (<i>n</i> = 58)
No	52.8% (<i>n</i> = 65)
# of times counselling for reasons <i>related</i> to sexual interest was sought (<i>n</i> = 60) ^b	1.53 (.50)
Positivity of counselling experience for reasons <i>related</i> to sexual interest (<i>n</i> = 55)	
Extremely positive	23.6% (<i>n</i> = 13)
Moderately positive	14.5% (<i>n</i> = 8)
Slightly positive	14.4% (<i>n</i> = 8)
Neither positive nor negative	9.1% (<i>n</i> = 5)

Slightly negative	14.5% (<i>n</i> = 8)
Moderately negative	12.7% (<i>n</i> = 7)
Extremely negative	10.9% (<i>n</i> = 6)
Help-seeking purpose (for those who sought help) (<i>n</i> = 57)	
How to disclose sexual interest to others	15.8% (<i>n</i> = 9)
Managing general mental health concerns related to sexual interest in children	77.2% (<i>n</i> = 44)
Managing general mental health concerns unrelated to sexual interest in children	56.1% (<i>n</i> = 32)
Coping with sexual interest	64.9% (<i>n</i> = 37)
Managing/establishing romantic relationships with adults	21.1% (<i>n</i> = 12)
Improving self esteem	63.2% (<i>n</i> = 36)
Dealing with stigma related to sexual interest	64.9% (<i>n</i> = 37)
Managing intensity of sexual interest	28.1% (<i>n</i> = 16)
Learning strategies to prevent offending	26.3% (<i>n</i> = 15)
Not in need of help from mental health professional	-
Other	25.0% (<i>n</i> = 14)
Help-seeking purpose (for those who did not seek help) (<i>n</i> = 125)	
How to disclose sexual interest to others	29.6% (<i>n</i> = 37)
Managing general mental health concerns related to sexual interest in children	45.6% (<i>n</i> = 57)
Managing general mental health concerns unrelated to sexual interest in children	64.0% (<i>n</i> = 80)
Coping with sexual interest	42.4% (<i>n</i> = 53)
Managing/establishing romantic relationships with adults	27.2% (<i>n</i> = 34)
Improving self esteem	54.4% (<i>n</i> = 68)
Dealing with stigma related to sexual interest	47.2% (<i>n</i> = 59)
Managing intensity of sexual interest	23.2% (<i>n</i> = 29)
Learning strategies to prevent offending	24.0% (<i>n</i> = 30)
Not in need of help from mental health professional	12.0% (<i>n</i> = 15)
Other	13.6% (<i>n</i> = 17)
Previous disclosure of sexual interest to mental health professional (<i>n</i> = 182)	
Yes	37.4% (<i>n</i> = 68)
No	57.7% (<i>n</i> = 105)
Somewhat	4.9% (<i>n</i> = 9)
Positivity of disclosing sexual interest to mental health professional (<i>n</i> = 54)	

Extremely positive	25.9% (<i>n</i> = 14)
Moderately positive	22.2% (<i>n</i> = 12)
Slightly positive	9.3% (<i>n</i> = 5)
Neither positive nor negative	11.1% (<i>n</i> = 6)
Slightly negative	5.6% (<i>n</i> = 3)
Moderately negative	14.8% (<i>n</i> = 8)
Extremely negative	11.1% (<i>n</i> = 6)

Note. ^a Indicates whether participants believed clinicians have the skills necessary to provide effective assessment and/or treatment to those with sexual interest in children.

^bThe number of times individuals sought counselling for reasons unrelated or related to their sexual interest was capped at 10.

Table 8*Themes and Sample Excerpts for Open-Ended Questions – Study 2*

Question	Theme	Sample narrative excerpts
1.	Understanding (<i>n</i> = 134)	<p>“They should learn that different MAPs have different genders, ages, skin colors, professions, favorite colors, favorite video games, and social environments”.</p> <p>“Attraction does not equal action. Although I may be attracted to minors, I have never (not even once), ever even remotely considered the possibility of acting on my attraction”.</p>
	Stigma (<i>n</i> = 94)	<p>“MAPs suffer similarly to other groups which receive great stigma. Professionals should understand how that stigma affects MAPs”.</p> <p>“Health practitioners are people, and have bias, therefore driving a wedge between the idea of a paedophile and child molester is CRUCIAL”.</p>
	Minor attraction as orientation (<i>n</i> = 60)	<p>“That being minor attracted is not a choice and feels as natural as any other sexuality”.</p> <p>“Minor attraction is a spectrum. There are exclusives, non-exclusives, attraction to boys, girls, and other, and not only men can be minor attracted. Also, the attraction cannot change, only the actions”.</p>
	Clinician-client relationship (<i>n</i> = 58)	<p>“How to reassure the patient that therapy will be non-judgemental and supportive, as well as on procedures taken to remain 100% confidential”.</p> <p>“How to offer MAPs something many of [us] do not have: Ability to talk about feelings and crushes face to face with a real person without being judged”.</p>
	General mental health (<i>n</i> = 54)	<p>“Therapy must include how to deal with the collaterals of the attractions: Low self esteem, depression, anxiety, suicide thinking in some cases, differentiation between fiction and reality”.</p> <p>“Strategies to cope with loneliness and shame”.</p>
	Sex and sexuality (<i>n</i> = 39)	<p>“They need an extensive education in human sexuality in general, as well as in MAP and youth/child sexuality in particular”.</p>

		“Helping the MAP to minimize harm and potential harm stemming from their behaviour while finding healthy ways to fulfil their own needs”.
	Reporting (<i>n</i> = 19)	“Professionals needs to be educated on mandatory reporting laws. Many believe they are obligated to break confidentiality with a patient who merely expresses attractions or fantasies about children when this is not actually the case”. ‘The risk of reporting a non offender, and when it’s appropriate to report someone”.
	Sexual offending (<i>n</i> = 16)	“Identifying when a safety plan is needed to help the MAP not offend”. “The lure of child porn and why people consume it/come back to it, different triggers for reproachable behaviour”.
2.	Clinician-client relationship (<i>n</i> = 93)	“Listening with an open mind about our issues without passing judgement.” “Listening. Allowing me to talk, while asking appropriate questions or challenging beliefs, but always in a calm and respectful way.”
	Promoting positive identity (<i>n</i> = 74)	“They gave me another perspective on the matter, seeing pedophilia not as a problem to be solved, but as a characteristic I had to (and could) manage and live with.” “Make them understand that part of themselves doesn’t make them monsters, and doesn’t completely define them.”
	Sexual and sexuality (<i>n</i> = 44)	“Teaching ways to realistically cope with urges and feelings without expecting the MAP to convert in to [sic] a perfect celibate with no sexual desires.” “Finding healthy and non-harmful ways to express those feelings are also helpful.”
	Safety (<i>n</i> = 31)	“Learn coping mechanisms when aroused to [sic] practices for resisting temptation when given the opportunity to offend.” “Strategies for avoiding situations that might lead to offensive behaviour (like physical proximity or private moment of intimacy).”

Understanding (<i>n</i> = 18)	<p>“Acknowledging how difficult it can be to carry around secret desires that could ruin your life should anyone find out.”</p> <p>“Get a clear idea of what their experience of minor attraction is really like before attempting to apply a preconceived strategy as how to treat us.”</p>
Minor attraction as orientation (<i>n</i> = 17)	<p>“Helping them understand that attraction to children is not a character flaw and instead a sexual orientation.”</p> <p>“But please realize, being MAP is like being gay or straight, it can never be changed no matter what anyone does. It’s just who you are. One doesn’t choose to be this way.”</p>
General mental health (<i>n</i> = 17)	<p>“Work on an integrative approach that involves not just the minor-attraction, but other issues that might be adding anguish, anxiety, fear or pain for the patient.”</p> <p>“Address suicidal thoughts, from what ive [sic] seen MAP are particularly likely to suffer from suicidal thoughts and tendencies.”</p>
Fostering relationships (<i>n</i> = 12)	<p>“My therapist affirmed that seeking support from others who struggle with my condition was positive.”</p> <p>“As I mentioned earlier, there are communities online which are both pro-MAP and anti-child-abuse [sic]. Those can provide a certain sense of belonging which alleviates some of the psychological burden.”</p>
Stigma (<i>n</i> = 14)	<p>“Many MAPs suffer from a disorder relating to distress, anxiety, and self hatred due to the stigma of having a sexual attraction to minors.”</p> <p>“As long as the therapist is empathetic towards the patient, things should be okay. The last thing someone in need wants is to be treated like a potential rapist.”</p>

Note. 1 = “If an educational workshop were to be developed, what are some things that you feel mental health professionals should be educated on in order to provide effective counselling to MAPs?” 2 = “What are some strategies that the mental health professional

could use that you would find to be helpful when seeking help for sexual interest in children?"

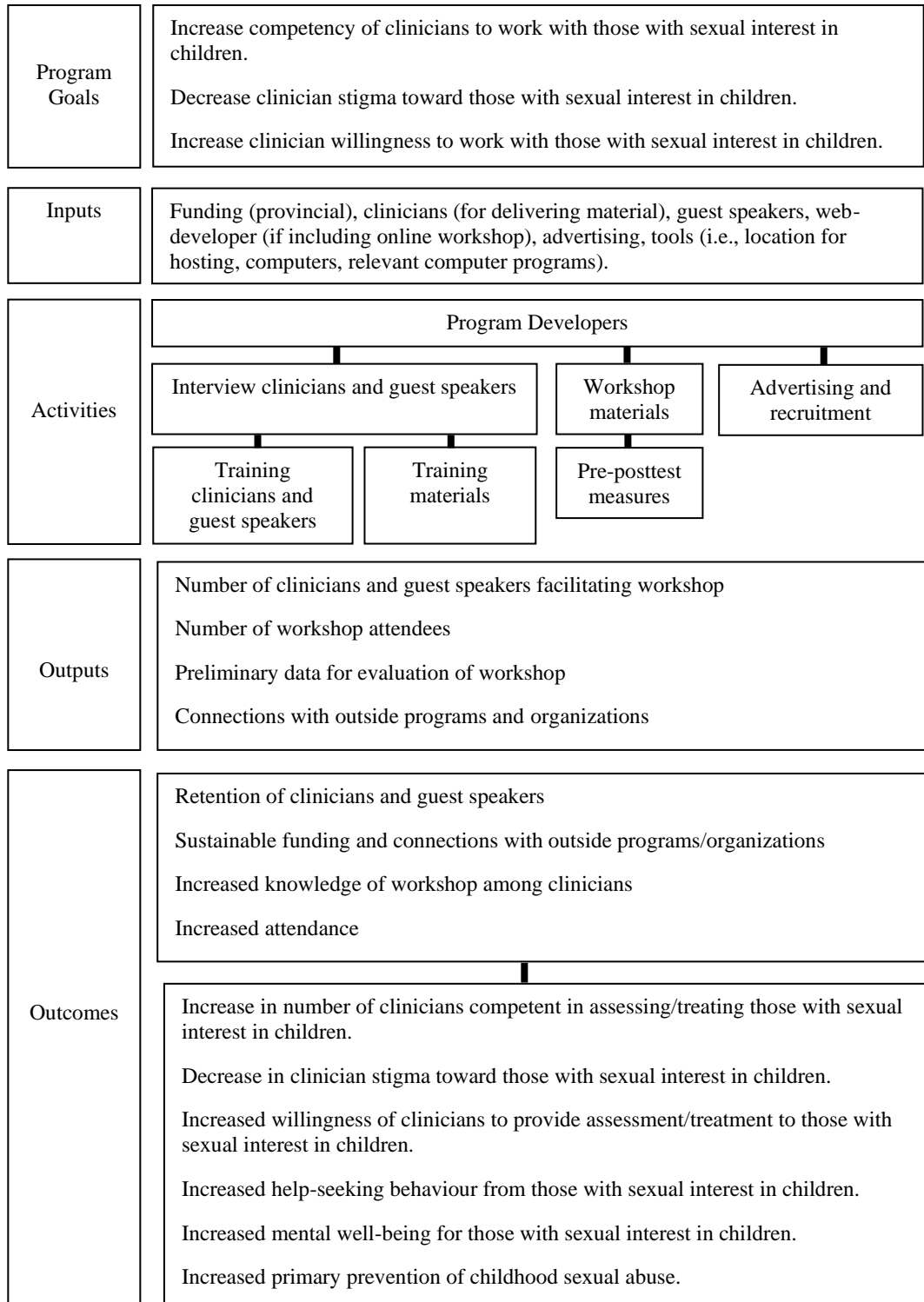
Table 9

Topics to Include in an Educational Workshop for Clinicians in Order of Importance.

Topic	Key Points
Understanding sexual interest in children	<ul style="list-style-type: none"> - General human sexuality - Paraphilias - Interest vs behaviour - Etiology - Static nature of sexual interest
Assessing risk and ethical reporting	<ul style="list-style-type: none"> - Understanding and explaining confidentiality limits to client - Determining imminent risk for offending - Mandatory reporting laws in area of workshop - Balancing reporting with harm reduction
Stigma and therapeutic relationship	<ul style="list-style-type: none"> - Lived experiences of those with sexual interest in children - Creating a safe space - Responding to disclosure of sexual interest in children
Treatment	<ul style="list-style-type: none"> - Therapeutic strategies - Importance of client goals - Common mental health issues in those with sexual interest in children - CBT and compassion-focused therapy - Navigating “alternative strategies”

Figure 1

Sample Logic Model for Evaluating Educational Anti-Stigma Workshop



Appendix A

Background Questions

1. Age
2. The sex you were assumed at birth
 - a. Female
 - b. Male
 - c. Other (please specify)
 - d. Prefer not to answer
3. The gender you identify with
 - a. Woman
 - b. Man
 - c. Transwoman
 - d. Transman
 - e. Gender fluid/gender queer
 - f. Other (please specify)
 - g. Prefer not to answer
4. Ethnic background
 - a. Asian – East (e.g. Chinese, Japanese, Korean)
 - b. Asian – South (e.g. Indian, Pakistani, Sri Lankan)
 - c. Asian – South East (e.g. Malaysian, Filipino, Vietnamese)
 - d. Black – African (e.g. Ghanaian, Kenyan, Somali)
 - e. Black – Caribbean (e.g. Barbadian, Jamaican)
 - f. Black – North American (e.g. Canadian, American)
 - g. First Nations
 - h. Indian – Caribbean (e.g. Guyanese with origins in India)
 - i. Indigenous / Aboriginal *not included elsewhere*
 - j. Inuit
 - k. Latin American (e.g. Argentinean, Chilean, Salvadorian)
 - l. Métis
 - m. Middle Eastern (e.g., Egyptian, Iranian, Lebanese)
 - n. White – European (e.g. English, Italian, Portuguese, Russian)
 - o. White – North American (e.g. Canadian, American)
 - p. Mixed heritage (e.g. Black-African and White-North American), please specify:
 - q. None of these apply to me. I identify as (please specify):
 - r. Do not know
 - s. Prefer not to say
5. Political orientation
 - a. Very liberal

- b. Liberal
 - c. Slightly Liberal
 - d. Moderate/Middle of the road
 - e. Slightly Conservative
 - f. Conservative
 - g. Very Conservative
 - h. Libertarian
 - i. Don't Know/Not Political
 - j. Other (please specify)
 - k. Prefer not to answer
6. In which country do you reside?
- a. Canada
 - b. United States
 - c. Other (please specify)
7. To which profession do you belong?
- a. Physician
 - b. Psychologist
 - c. Psychiatrist
 - d. Counsellor/psychotherapist
 - e. Occupational Therapist
 - f. Social Worker
 - g. Nurse
 - h. Mental Health Nurse
 - i. Behaviour Therapist
 - j. Student
 - k. Other (please specify)
8. What is the highest degree that your professional designation is based on?
- a. I am currently a student in a professional or graduate program
 - b. Bachelor's degree/ Bachelor's degree (honours)
 - c. College degree
 - d. Medical degree
 - e. Postgraduate degree
 - f. Master's degree
 - g. Doctoral degree
9. How many years of experience in this profession do you have? (open ended)
10. Which of the following client groups do you have competency to treat? (check all that apply)

- a. Those with general mental health issues (e.g. depression, anxiety)
- b. Those who have been in conflict with the law for reasons other than sexual offending/sexual behaviour problems (e.g. violent offending)
- c. Those who have committed sexual offences
- d. Those with paraphilic interest (not including sexual interest in children)
- e. Those with sexual interest in children
- f. Those with sexual health problems (e.g. sexual compulsivity) or sexual disorders (e.g. erectile dysfunction) other than paraphilias or sexual interest in children
- g. Those seeking sex therapy
- h. Those seeking couples' therapy

11. For which of the following areas of concern or focus have you provided assessment and/or treatment? (check all that apply)

- a. General mental health issues (e.g. depression, anxiety)
- b. Being in conflict with the law for reasons other than sexual offending/sexual behaviour problems (e.g. violent offending).
- c. Problems related to committing sexual offences
- d. Paraphilic interest (not including sexual interest in children)
- e. A sexual interest in children
- f. A sexual health problem (e.g. sexual compulsivity) or sexual disorder (e.g. erectile dysfunction) other than paraphilias or sexual interest in children
- g. General sex therapy
- h. Couples' therapy

Vignettes

C1: Manage mental health unrelated to sexual interest; no offence

You are a clinician working in a private practice and provide general mental health treatment to clients in the community. You are accepting new clients in your practice and have been referred a new client by a local family physician who regularly refers clients to you. The referral information states that the client presents with difficulties with low mood that is causing functional impairment and distress in their daily life. The referral information also states that the client reported sexual interest in children; however, they have been managing this well, there is no functional impairment or distress, and they have

no history of sexually offending against children. The client would like treatment to focus on their low mood.

C2: Manage mental health unrelated to sexual interest; contact offence

You are a clinician working in a private practice and provide general mental health treatment to clients in the community. You are accepting new clients in your practice and have been referred a new client by a local family physician who regularly refers clients to you. The referral information states that the client presents with difficulties with low mood that is causing functional impairment and distress in their daily life. The referral information also states that the client reported sexual interest in children; however, they have been managing this well, there is no functional impairment or distress. In the past, the client was convicted for sexual offending against children. The client would like treatment to focus on their low mood.

C3: Manage sexual interest; no offence

You are a clinician working in a private practice and provide general mental health treatment to clients in the community. You are accepting new clients in your practice and have been referred a new client by a local family physician who regularly refers clients to you. The referral information states that the client presents with low mood; however, they have been managing this well, there is no functional impairment or distress. The referral information also states that the client reported sexual interest in children that is causing functional impairment and distress in their daily life, but they have no history of sexually offending against children. The client would like treatment to focus on their sexual interest in children.

C4: Manage sexual interest; contact offence

You are a clinician working in a private practice and provide general mental health treatment to clients in the community. You are accepting new clients in your practice and have been referred a new client by a local family physician who regularly refers clients to you. The referral information states that the client presents with low mood; however, they have been managing this well, there is no functional impairment or distress. The referral information also states that the client reported sexual interest in children that is causing functional impairment and distress in their daily life. In the past, the client was convicted for sexually offending against a child. The client would like treatment to focus on their sexual interest in children.

Follow-up Vignette Questions

1. Would you agree to provide mental health treatment to the client described in the vignette if they were referred to your clinical practice?
 - a. Yes
 - b. No

2. (If no) For what reason would you turn down the referral described in the vignette?
 - a. I would not treat this client due to my own beliefs towards individuals with sexual interest in children
 - b. I would not treat this client due to my lack of competency in providing mental health treatment to individuals with sexual interest in children
 - c. Both
 - d. Other (please specify)

Workshop Questions

1. Would you be willing to participate in a workshop to increase competency in providing mental health care to individuals with sexual interest in children?
 - a. Yes

- b. No
- c. Maybe

2. If a workshop were to be developed that increased competency to treat individuals with sexual interest in children,, what do you think should be included for it to be effective? Please answer this question even if you would be unwilling to attend such a workshop (open).

3. What barriers might interfere with participation in such a workshop?

Appendix B

Table 1

Changes Made to ATS-21 in the Development of the APSIC Scale

ATS-21 (Hogue & Harper, 2019) items	APSIC (Roche & Stephens, 2019) items
<ul style="list-style-type: none"> • Sex offenders are different from other people • Most sex offenders are victims of circumstances and deserve help • Sex offenders have feelings like the rest of us • It is not wise to trust a sex offender too far • I think I would like a lot of sex offenders • Give a sex offender an inch and they take a mile • Sex offenders need affection and praise just like anybody else • Trying to rehabilitate sex offenders is a waste of time and money • Sex offenders are no better or worse than other people • You have to be constantly on your guard with sex offenders • If you give a sex offender your respect, he'll give you the same • Sex offenders only think about themselves 	<ul style="list-style-type: none"> • Individuals with sexual interest in children are different from other people • Most individuals with sexual interest in children have themselves been victims of sexual abuse • Individuals with sexual interest in children have feelings like the rest of us • It is not wise to trust individuals with sexual interest in children too far • I think I would like a lot of individuals with sexual interest in children • Individuals with sexual interest in children are emotionally immature • Individuals with sexual interest in children need affection and praise just like anybody else • Trying to provide mental health treatment to individuals with sexual interest in children is a waste of time and money • Individuals with sexual interest in children are no better or worse than other people • You have to be constantly on your guard with individuals with sexual interest in children • If you give an individual with sexual interest in children your respect, they will give you the same • Individuals with sexual interest in children only think about themselves

- There are some sex offenders I would trust with my life
 - Most sex offenders are too lazy to earn an honest living
 - I wouldn't mind living next door to a treated sex offender
 - Sex offenders are just plain mean at heart
 - Sex offenders are always trying to get something out of somebody
 - Sex offenders are immoral
 - I would like associating with some sex offenders
 - Sex offenders only respect brute force
 - If sex offenders do well in prison/hospital, they should be let out on parole
 - There are some individuals with sexual interest in children I would trust with my life
 - Most individuals with sexual interest in children are manipulative
 - I wouldn't mind living next door to an individual with sexual interest in children
 - Individuals with sexual interest in children are afraid of relationships with adults
 - Individuals with sexual interest in children are less intelligent than others
 - Individuals with sexual interest in children are immoral
 - I would like to associate with some individuals with sexual interest in children
 - Individuals with sexual interest in children are incapable of controlling their sexual urges
 - Individuals with sexual interest in children should be treated as any other member of the community
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Appendix C

Background Questions

1. Age
2. The sex you were assumed at birth
 - a. Female
 - b. Male
 - c. Other (please specify)
 - d. Prefer not to answer
3. The gender you identify with
 - a. Woman
 - b. Man
 - c. Transwoman
 - d. Transman
 - e. Gender fluid/gender queer
 - f. Other (please specify)
 - g. Prefer not to answer
4. Ethnic background
 - a. Asian – East (e.g. Chinese, Japanese, Korean)
 - b. Asian – South (e.g. Indian, Pakistani, Sri Lankan)
 - c. Asian – South East (e.g. Malaysian, Filipino, Vietnamese)
 - d. Black – African (e.g. Ghanaian, Kenyan, Somali)
 - e. Black – Caribbean (e.g. Barbadian, Jamaican)
 - f. Black – North American (e.g. Canadian, American)
 - g. First Nations
 - h. Indian – Caribbean (e.g. Guyanese with origins in India)
 - i. Indigenous / Aboriginal *not included elsewhere*
 - j. Inuit
 - k. Latin American (e.g. Argentinean, Chilean, Salvadorian)
 - l. Métis
 - m. Middle Eastern (e.g., Egyptian, Iranian, Lebanese)
 - n. White – European (e.g. English, Italian, Portuguese, Russian)
 - o. White – North American (e.g. Canadian, American)
 - p. Mixed heritage (e.g. Black-African and White-North American), please specify:
 - q. None of these apply to me. I identify as (please specify):
 - r. Do not know
 - s. Prefer not to say
5. Relationship status

- a. Single
 - b. Dating
 - c. Committed relationship
 - d. Common law or living together
 - e. Engaged
 - f. Married
 - g. Divorced
 - h. Widowed
 - i. Other (please specify)
 - j. Prefer not to answer
6. We are interested in the strength of your sexual interest to individuals across the lifespan. A score of 0 means that you have no sexual interest to individuals in that group and a score of 100 represents maximum attraction. You can assign the same score to multiple categories:
- a. Please rate your sexual interest in males ages 0 to 5
 - b. Please rate your sexual interest in females ages 0 to 5
 - c. Please rate your sexual interest in males ages 6 to 10
 - d. Please rate your sexual interest in females ages 6 to 10
 - e. Please rate your sexual interest in males ages 11 to 14
 - f. Please rate your sexual interest in females ages 11 to 14
 - g. Please rate your sexual interest in males ages 15 to 16
 - h. Please rate your sexual interest in females ages 15 to 16
 - i. Please rate your sexual interest in males aged 17+
 - j. Please rate your sexual interest in females aged 17+

Mental Health Provider Questions

1. In your opinion, do you believe that mental health professionals have the necessary skills to provide effective counselling to MAPs?
2. (IF YES /MAYBE/ NO TO ABOVE) Why do you believe that mental health professionals have/might have/do not have the necessary skills to provide effective counselling to MAPs? (OPEN).
3. If an educational workshop were to be developed, what are some things that you feel mental health professionals should be educated on in order to provide effective counselling to MAPs? (OPEN).
4. What is something negative that you fear could occur in seeking counselling from a mental health professional? (OPEN)

5. Have you ever wanted counselling or support from a mental health provider (e.g. psychologist, social worker) for concerns **unrelated** to your sexual interest in children?
 - a. Yes
 - b. No
 - c. Prefer not to answer

6. If yes, have you actively sought counselling or support from a mental health provider (e.g. psychologist, social worker) for concerns **unrelated** to your sexual interest in children?
 - a. Yes
 - b. No
 - c. Prefer not to answer

7. How many times in the past have you sought counselling or support from a mental health provider (e.g. psychologist, social worker) for concerns **unrelated** to your sexual interest in children? (dropdown menu)

8. Overall, how positive was your experience with the mental health professional who provided counselling or support for concerns **unrelated** to your sexual interest in children?
 - a. Extremely positive
 - b. Moderately positive
 - c. Slightly positive
 - d. Neither positive nor negative
 - e. Slightly negative
 - f. Moderately negative
 - g. Extremely negative

9. Have you ever wanted counselling or support from a mental health provider (e.g. psychologist, social worker) for concerns **related** to your sexual interest in children?
 - a. Yes
 - b. No
 - c. Prefer not to answer

10. If yes, have you actively sought counselling or support from a mental health provider (e.g. psychologist, social worker) for concerns **related** to your sexual interest in children?
- Yes
 - No
 - Prefer not to answer
11. How many times in the past have you sought counselling or support from a mental health provider (e.g. psychologist, social worker) for concerns **related** to your sexual interest in children? (dropdown menu)
12. (IF THEY HAVE RECEIVED COUNSELLING FOR SEXUAL INTEREST)
What were some strategies that the mental health professional used that you found to be helpful? (OPEN)
13. (IF THEY HAVE RECEIVED COUNSELLING FOR SEXUAL INTEREST)
What were some strategies that the mental health professional used that you found NOT to be helpful? (OPEN)
14. Overall, how positive was your experience with the mental health professional who provided counselling or support for concerns related to your sexual interest in children?
- Extremely positive
 - Moderately positive
 - Slightly positive
 - Neither positive nor negative
 - Slightly negative
 - Moderately negative
 - Extremely negative
15. For what purpose did you (would you have) seek (sought) the help from a mental health professional?
- How to disclose your sexual interest in children to others (e.g., family, friends)
 - Managing general mental health concerns such as depression or anxiety that are **directly related** to sexual interest in children
 - Managing general mental health concerns such as depression or anxiety that are **unrelated** to sexual interest in children
 - Coping with having a sexual interest in children
 - Managing or establishing romantic relationships with adults
 - Improving self-concept/self-esteem

- g. Dealing with stigma related to sexual interest in children
- h. Managing the intensity of your sexual interest in children
- i. Learning strategies to prevent offending
- j. I would not have been in need of help from a mental health professional
- k. Other (please specify)

16. Have you ever disclosed your sexual interest to the mental health professional?

- a. Yes
- b. Somewhat
- c. No
- d. Prefer not to answer

17. On average, how positive was the experience of disclosing your sexual interest in children to your treatment provider?

- a. Extremely positive
- b. Moderately positive
- c. Slightly positive
- d. Neither positive nor negative
- e. Slightly negative
- f. Moderately negative
- g. Extremely negative

18. In detail, please describe how the mental health professional reacted to your disclosure of your sexual interest (OPEN).

19. In disclosing your sexual interest to a mental health professional, what would their ideal response be? (OPEN).