Understanding Minor Attracted Persons

by

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An oral defense of this thesis took place on March 28, 2023 in front of the following examining committee:

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The above committee determined that the thesis is acceptable in form and content and that a satisfactory knowledge of the field covered by the thesis was demonstrated by the candidate during an oral examination. A signed copy of the Certificate of Approval is available from the School of Graduate and Postdoctoral Studies.

ABSTRACT

Minor attracted persons (MAPs) are a group of understudied individuals who acknowledge a sexual interest in children but who may never have offended against a child. They are often regarded the same as individuals who have sexually offended against children, regardless of their history of personal stance on adult/child sexual relationships. This means they experience significant stigma and face many barriers to accessing mental health treatment. This dissertation provides an exploratory analysis of the lived experiences of MAPs from 3 different perspectives. Study 1 is a qualitative analysis of online support forums for MAPs, examining offense avoidance strategies they use when in a position where they believe they could engage in a relationship with a child. Study 2 used mixed methods to look at how MAPs differed from non-MAPs on several mental health treatment targets and potential criminogenic needs, as well as their help-seeking experiences. Study 3 also used mixed methods, examining psychological professionals' stereotyped beliefs toward MAPs and their experiences and opinions about providing treatment to them. Overall, MAPs tend to prefer avoidance techniques when they feel they are presented with a potentially risky situation, using such strategies as complete avoidance or the use of a buddy system. In addition, they experience significantly more hopelessness and loneliness than non-MAPs, and less respect for authority. Though they have not had many positive therapeutic experiences, psychological professionals in my study mostly indicated a willingness to provide them with treatment predominantly

through a cognitive behavioural therapy lens. Implications for treatment, public perception, and prevention are discussed.

Keywords: Minor attraction; help-seeking; pedophilia; mental health; prevention

AUTHOR'S DECLARATION

I hereby declare that this thesis consists of original work of which I have authored. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

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The research work in this thesis that was performed in compliance with the regulations of Research Ethics Board under **REB Certificate numbers: #14048 and #14105**.

_____ Carisa M. Collins

STATEMENT OF CONTRIBUTIONS

The work described in Chapter 2 was conducted on a research summer exchange to the University of Kent, Canterbury, under the supervision of Dr. Caoilte Ó Ciardha. Furthermore, the chapter has been submitted for publication to Sexual Abuse:

> Collins, C. M., Harkins, L., & Ó Ciardha, C. (Under review). Learning from the near misses: offense avoidance strategies used by minor attracted persons. *Sexual Abuse*.

I collected the data, conducted the analysis, and wrote the manuscript with editing contributions from my co-authors.

The remaining chapters of this dissertation I am the sole author of and none have been submitted for publication. Where applicable I have used APA Referencing standards to credit ideas, research techniques, or measures that were not my own. I collected all data, conducted all analyses, and wrote all portions of this dissertation with input from my supervisor and dissertation committee at various points along the way.

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LIST OF ABBREVIATIONS AND SYMBOLS

DSM-5	The Diagnostic and Statistical Manual of Mental Disorders
CSA	Child Sexual Abuse
CBT	Cognitive Behavioural Therapy
BHS	Beck's Hopelessness Scale
PFQ-2	Personal Feelings Questionnaire – 2
BIS-11	Barratt's impulsiveness Scale – 11
IRI	Interpersonal Reactivity Index
MFQ	Moral Foundations Questionnaire
MANCOVA	Multivariate Analysis of Covariance
ANCOVA	Analysis of Covariance
BIPOC	Black, Indigenous, People of Colour

Chapter 1

1.1 Introduction

Most people experience sexual interest, sexual preferences, and sexual desires. Typically, these interests, preferences, or desires are directed toward peers and change and develop as we mature culminating in sexual experiences with age-appropriate partners throughout our lifetime. However, for some individuals this development and progression of sexuality follows an atypical trajectory and the object(s) of their sexual interest stops developing alongside them. For these people, their sexual interest is in children; a phenomenon which is known as pedophilia.

1.1.1 Pedophilia

Despite what relatively little is known and understood about pedophilia, the term nonetheless evokes universal fear and disgust in society and those with such a sexual interest are assumed to represent the worst that society has to offer. The terms *pedophile* and *child molester* tend to be conflated in the media and society at large, with there being an underlying assumption that anyone who has a sexual interest in children has harmed or will harm a child (e.g., Cantor, 2012; Jahnke et al., 2015). However, as will be discussed throughout this dissertation, this is not necessarily the case. These sensationalized ideas are demonstrated through the plethora of news articles highlighting cases of child sexual abuse (e.g., Hopkins, 2017) as well as websites dedicated to locating ‘known’ pedophiles living with a specific area (e.g., Criminal Watch Dog, n.d.).

There is also an assumption that having a sexual interest in children means that an individual is ‘sick’ or mentally ill; an assumption that is also false. In fact, The

Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013) differentiates between *pedophilia* and *pedophilic disorder.* People with pedophilic disorder experience intense and persistent sexual desire, in the form of fantasies or sexual behaviours, towards prepubescent children. One of the diagnostic requirements is that these fantasies and behaviours must cause some form of distress, impairment, or harm, however this harm does not have to be toward a child (American Psychiatric Association, 2013). Harming a child, whether directly or indirectly, is diagnostically significant and sufficient for a diagnosis of pedophilic disorder. However, the harm may also be in the form of self-harm or disruption to the individual's daily life. The DSM-5 also highlights that the existence of a paraphilia, such as pedophilia, is not sufficient for clinical diagnosis nor does it automatically qualify someone to need psychological treatment.

Research into the epidemiology of pedophilia is scarce so it is difficult to say exactly how many people have the paraphilia or paraphilic disorder. Self-report data indicates that anywhere from 0.5% to 2% of individuals may have a sexual interest in prepubescent children (Dombert et al., 2016), although Seto (2012) indicates that the prevalence of pedophilia could be as high as 5%. The DSM-5 purports that the highest percentage of the male population with pedophilic disorder is 3-5% and that the percentage of the female population may be a fraction of that. There has also been neurological research into some of the underpinnings of pedophilia that indicates there are some correlates with atypical neurology. For example, Cantor et al. (2004) tested the memory, handedness (which has been linked to illnesses or disabilities with abnormal brain development), and IQ of men with pedophilia. They found that

pedophilia was significantly related to non-righthandedness and significantly negatively correlated with both immediate and delayed recall as well as lower IQ. Cazala et al. (2019) compared the brain function of men with pedophilic disorder to those of men with typical age attractions matched for age, gender orientation, and handedness. Their results indicated that there are several brain regions which may mediate pedophilic disorder, such as the right inferior temporal gyrus. Unlike those with pedophilic disorder and aside from their acknowledgment of pedophilic interests, little is understood about a group with sexual interest in children known as Minor Attracted Persons.

1.1.2 Minor Attracted Persons

Those who are attracted to minors recognize the stigma that is associated with the term pedophile (e.g., Jahnke et al., 2015; Walker, 2019). For this reason, they prefer to use other labels to describe themselves. Unfortunately, there is not one agreed upon label or term to ascribe to individuals who are attracted to children, even among those individuals themselves (Jahnke et al., 2022). In addition, there is public backlash against any effort to humanize individuals with a sexual attraction to minors with labels other than ‘pedophile’ (e.g., Dearden, 2023; Kaplan, 2014). Some individuals who are attracted to minors identify with various 2SLGBTQIA+ labels, although this is also problematic as it aligns the queer community with a group viewed as predatory; a phenomenon they have endeavored to overcome (Walker, 2019). Although there are different labels, one term that appears to be accepted and favoured among those that are attracted to minors is “minor attracted persons” (Jahnke et al., 2022). For this reason, this term will be used throughout the remainder of this dissertation.

Minor attracted persons, or MAPs, is a term that can be used to refer to anyone with a sexual interest in a person under the age of consent (B4U-Act, 2020) and encompasses both pedophilia (i.e., attraction to pre-pubescent children; American Psychiatric Association, 2013) and hebephilia (i.e., attraction to pubescent adolescents; Stephens & Seto, 2015). These are commonly individuals who acknowledge having a primary sexual interest in children but report very little/no previous sexual contact with children and no intention to act on this interest in the future (Cantor & McPhail, 2016). This lack of intention is rooted in various motivations depending on a MAPs underlying ideological belief system which tends to fall into one of two camps: (1) those who denounce any sexual contact involving children or sexual exploitation material involving children, who identify themselves as 'Virtuous' Pedophiles; and (2) those who tend to believe sexual contact with children should be acceptable, who identify as 'ChildLove' Pedophiles.

1.1.2.1 'Virtuous' Pedophiles

The first group of MAPs refer to themselves as 'Virtuous Pedophiles'. Their philosophy is to acknowledge they have an unchangeable sexual interest in children that does not determine their worth as humans, but also to acknowledge and endorse the reality that relationships with children are inherently dangerous and harmful (Virtuous, 2016). Virtuous Pedophiles believe children need to be protected from the negative consequences that would stem from having sexual contact with them. They advocate for the public recognition of people with a sexual interest in children as moral individuals who are more than their attraction and they aim to help those individuals manage their sexual interest and live law-abiding lives. This group of individuals has a

contact-opposing philosophy; they condemn anyone who offends against a child, and do not approve of ideas that support offending against a child (Virtuous, 2016; Walker, 2021).

1.1.2.2 'ChildLove' Pedophiles

This group of MAPs also acknowledge and accept their sexual interest in children, but also identifies with the philosophy of 'childlove' (i.e., BoyLove, BoyChat, n.d.; or GirlLove, GirlChat, 2011). BoyLove refers specifically to interest in prepubescent or pubescent boys (BoyChat, n.d.), while GirlLove refers specifically to interest in prepubescent or pubescent girls (GirlChat, 2011). These terms encompass the idea that individuals not only have sexual feelings for children, but they can also develop romantic feelings for them. MAPs who embrace this philosophy feel that relationships with children should be normalized and decriminalized, as long as they are 'consensual'. They do not understand children cannot consent to these relationships or see the harm that can come to children as a result. They also reject the idea that relationships with children can cause long-term psychological harm, and often reverse the logic, stating that denying children access to relationships with adults can cause undue harm. This group of individuals has a contact-supportive philosophy; their attitudes reflect their desire to engage in sexual contact with children but that they avoid it due to the legal ramifications. This does not necessarily indicate that they have or will engage in sexual contact with children, despite the stories told in the media.

1.1.3 Child Sexual Abuse

Child sexual abuse is a public health issue that affects an appreciable proportion of children. In the United States alone, about one quarter of girls and one twelfth of boys

will experience child sexual abuse (CSA; Centers for Disease Control and Prevention, 2022). Internationally, these numbers are very similar with, on average, 8% of boys and 20% of girls experiencing some form of sexual abuse over their lifetime (Pereda et al., 2009), though estimates range as high as 17% for boys and 31% for girls (Barth et al., 2013). CSA is one of 10 Adverse Childhood Experiences that can have an enduring impact on the life of anyone who experiences it and comes with a lifetime economic burden in excess of nine billion dollars (Centers for Disease Control and Prevention, 2022).

There are many studies looking at the risk factors for both CSA victimization and perpetration (e.g., Agyapong et al., 2017; Bogaerts et al., 2004; Pérez-Fuentes et al., 2013; Stirpe & Stermac, 2003). Though being a victim is never the fault of the child, there are some risk factors that increase the likelihood that a child will be the victim of CSA. Assink et al. (2019) conducted a meta-analysis of 72 studies examining CSA and victimization and found 35 distinct risk factors. Prior or concurrent forms of abuse to either the victim or others within their family were among the strongest risk factors with correlations ranging from $r = 0.265$ to $r = 0.360$. One explanation for this relationship could be issues developing healthy and appropriate attachments among those who have been victimized by abuse, perpetuating a cycle of abuse for themselves or their offspring (e.g., Pérez-Fuentes et al., 2013). Other risk factors that showed strong correlations with CSA victimization were numerous family moves (6 or more; $r = 0.294$), if the child was female ($r = 0.290$), and having overbearing or overprotective parents ($r = 0.212$; Assink et al., 2019).

Similarly, Whitaker et al. (2008) conducted a meta-analysis looking at risk factors for CSA perpetration. They examined 89 studies to see which risk factors for people who committed sex offenses against children exhibited when compared to people who committed other types of offenses or to people who had not committed offenses. While people who committed sex offenses against children showed only a single difference to people who committed sex offenses against adults, they demonstrated several risk factors above and beyond those seen in people who committed non-sexual offenses and people who had not committed offenses. For example, people who committed sex offenses against children had significantly more familial risk factors than people who committed other types of offenses or to people who had not committed offenses (Whitaker et al., 2008). This included things such as history of abuse, controlling parenting style, and instability of parental figures. Sexual problems (e.g., deviant sexual interest; sexualized coping) and social deficits (e.g., empathy deficits; relationship difficulties) also differentiated people who committed sex offenses against children from people who committed other types of offenses or to people who had not committed offenses. Recently, Schuler et al. (2022) conducted a longitudinal study of men with pedophilia who had or had not offended against a child and men with attraction to adults and found stability for cognitive empathy deficits in pedophilic men who had offended against a child.

Although one of the strongest predictors of sexual abuse against children (Babchishin et al., 2015) is a primary sexual attraction to children (i.e., a key characteristic of pedophilia), a large proportion of sexual offenses against children are isolated acts of child abuse perpetrated by men without pedophilia or a primary sexual

interest in children (Blanchard et al., 2009). These individuals offend for a variety of reasons (e.g., loneliness, impulsivity) other than a primary sexual interest in children. In addition, there are many individuals with a sexual interest in children who have never committed a sexual offense against a child (i.e., MAPs; Beier et al., 2015).

1.1.3.1 Pedophilic Sex Offenders

There has also been research into the differences among people who commit various types of sex offenses (e.g., people who have committed rape, people who have committed offenses against children, people with pedophilic interests who have offended against children, people with child sexual abuse image offenses (previously referred to as child pornography)). For example, Long et al. (2013) examined how people who committed sex offenses, with or without known sex offenses against children, use sexually explicit images of children. Those with known offenses against children were found to consume higher quantities of sexually explicit images, as well as more graphic imagery. This difference in image use could also be used to reliably predict whether someone had known offenses or not (Long et al., 2013). Also, Sigre-Leirós et al. (2015) examined the offence supportive attitudes or rationalizations (i.e., cognitive schemas) of rapists, pedophilic and non-pedophilic child molesters, and people who had not committed offenses and found that the pattern of these schemas could be used to subtype pedophilic child molesters. Schuler et al. (2022) compared people with pedophilia who had committed sex offenses against children with men with pedophilia who had not offended against a child and found that people with pedophilia who had committed sex offenses against children demonstrated stable cognitive empathy deficits such that they are significantly worse at inferring the mental state of a

target individual than men with pedophilia who had not offended against a child or men with an attraction to adults.

1.1.3.1.1 Understanding Non-Convicted Pedophiles: Dunkelfeld Project.

Very little research, however, has examined individuals with a sexual interest in children outside of a criminal justice setting, possibly due to mandatory reporting laws or professional ethical mandates in the United States and Canada. These laws stipulate that individuals in particular professions (e.g., teachers, therapists, social workers, etc.) must report suspected abuse of a child to the appropriate authorities (e.g., Canadian Psychological Association, 2017; Child Welfare Information Gateway, 2016; Government of Ontario, 2010).These laws and mandates are certainly meant to protect children, however their language is unclear and rather ambiguous leaving uncertainty over the specific situations where a report must be made.

This means that these mandatory reporting laws may be a deterrent for pedophilic individuals who are outside the criminal justice system from seeking treatment, leaving a potentially large group of people out of the reach of psychological research scientists. One group of researchers referred to this as the ‘dark field’ (‘dunkelfeld’ in Germany where the study was conducted) of pedophilia (Beier et al., 2015). Beier and colleagues (2009) recruited self-identified individuals with a sexual interest in children for a treatment program designed specifically to address their needs. Pedophilic individuals within this dark field responded well to treatment showing reductions in several dynamic risk factors (i.e., those risk factors that are amenable to change) and an increase in sexual self-regulation, although most of the men reported ongoing problematic sexual behaviours. However, this treatment program was designed

with the specific goal of helping individuals with a sexual interest in children avoid offending (Beier et al., 2015). It used several intervention strategies (i.e., pharmacological, psychological, and sexological) to address its treatment targets and was designed based off of a broad cognitive-behavioural approach. The program did not take into account individuals who did not necessarily struggle to not offend, nor did it take into account the lived experiences of individuals with a sexual interest in children and how these could be used to help other individuals.

1.1.4 Current Study

To address the dearth of research that exists regarding MAPs, this dissertation consists of three exploratory studies examining several aspects of the lived experience of MAPs. Study 1 is a qualitative analysis of MAPs discussions regarding their behaviour around children to whom they are attracted. Through these discussions I analyze the particular behaviours or strategies they use to avoid offending behaviour in order to better understand how they remain offense free. In Study 2, I recruited MAPs through several forums and provided an anonymous survey asking about their offence avoidance strategies directly, their mental health needs, and the experiences they have with seeking help. Finally, in Study 3 I surveyed mental health professionals about their experiences with treating MAPs and their understanding of minor attraction.

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Chapter 2

2.1 Abstract

Some individuals with a sexual attraction to minors report little difficulty in living free of any sexual offending behaviour. However, for others, remaining offense free presents a challenge. The experiences of people with a sexual interest in children who do not offend is of particular interest from a prevention viewpoint and may inform the prevention of child sexual abuse. I conducted a thematic analysis to examine offense avoidance strategies discussed by Minor Attracted Persons (MAPs) on three online support forums. Results revealed four distinct strategies: avoidance, removal, limited contact, and non-sexual physical contact. It was possible to arrange the strategies in terms of increasing proximity to offending behaviour. I explored parallels between these themes and offense chain models and the relapse prevention literature.

Keywords: coping; minor attraction; paraphilia; sexual interests; prevention

2.2 Introduction

It is estimated that up to 1% of men may experience sexual attraction to prepubescent children, and even more to pubescent children (e.g., Ó Ciardha et al., 2022; Seto, 2017). Among men attracted to children there is a large proportion who report no offending behaviour involving children (e.g., Grady et al., 2019; Holt et al., 2020). Individuals who are aware of having a sexual interest in children are typically conscious of many reasons they cannot sexually interact with children. Thus, those who remain offense free must be using mechanisms for avoiding situations that may pose a risk of offending, whether consciously or unconsciously. With child sexual abuse affecting as many as 8% of boys and 20% of girls worldwide (e.g., Pereda et al., 2009; Stoltenborgh et al., 2015), it is important to understand the strategies that individuals who are sexually attracted to children may use to avoid committing offenses. Better understanding of successful strategies may lead to better prevention strategies, through better support for individuals with sexual interest in children. It may also lead to novel strategies to aid relapse prevention in individuals who have previously offended.

2.2.1 Minor Attracted Persons (MAPs)

Due to the stigma associated with the word ‘pedophile’ (e.g., Jahnke et al., 2015a), many individuals with a sexual interest in children prefer the term *Minor Attracted Person* (MAP) to describe themselves (Kramer, 2011). The term MAP refers to individuals with and without an offending history, and includes individuals with pedohebephilic sexual interests; that is a predominant sexual interest in prepubescent children (pedo-; American Psychiatric Association, 2013) or pubescent children (hebe-; Stephens & Seto, 2015). The percentage of individuals who currently experience this

pedohebephilic sexual interest is unknown, but estimates suggest that up to 9% of men experience sexual attraction to children (e.g., Ahlers et al., 2011; Seto, 2012) representing a nontrivial proportion of people.

MAPs acknowledge their minor attraction and many commit to living law abiding lives (Cantor & McPhail, 2016) for any number of reasons (e.g., to avoid punishment by the law, to protect children, for moral reasons, etc.). These individuals, as mentioned above, face incredible stigma from others (e.g., Jahnke et al., 2015a), as evidenced by the conflation of the terms ‘child molester’ and ‘pedophile’ in mainstream media (e.g., Howorun, 2015). As such, MAPs have incredible difficulty finding support from those around them (Levenson & Grady, 2019), with many never disclosing their sexual interests to another person (B4U-Act, 2011).

One form of support that MAPs have found is that of online communities and forums for people with sexual interest in children (e.g., Grady et al., 2019). While there is a risk that these communities provide validation of problematic sexual behaviours, they may also provide a space for MAPs to exchange resources, talk about living with minor attraction, and find individuals with shared experiences (e.g., Cantor & McPhail, 2016; Grady et al., 2019). There are several such online communities, or support organizations, and they differ in their perspectives on minor attraction and interactions with children. Support communities such as Virtuous Pedophiles (virped.org) and B4U-Act (b4uact.org) promote living within the law, and leading fulfilling lives for all MAPs. They provide education and support in working through issues related to healthy and legal sexuality, consequences of living with minor attraction (i.e., mental health issues such as depression and loneliness), and any other topics MAPs wish to discuss. Other

forums such as BoyChat (boychat.org) and GirlChat (annabelleigh.net) provide similar support, however, have a broader stance on the acceptability of adult/child relationships. While some of their members are committed to living within the confines of the law, others advocate for the normalization of adult-child relationships and believe that a child should be allowed to consent to sexual activity (BoyChat, n.d.). Such views could create a culture of acceptance of problematic sexual behaviour and the development of distorted views of adult-child relationships (Holt et al., 2010).

The stigma of minor attraction also makes it difficult to seek professional help (Levenson et al., 2017). This stigma comes not only from the public, but psychotherapists can also hold negative attitudes that affect their willingness to consider treating individuals with pedophilic sexual interests (Stiels-Glenn, 2010). However, many MAPs have attempted or wish to seek help in order to understand themselves better and learn how to regulate their emotions and sexual tensions/frustrations (B4U-Act, 2011). The Prevention Project Dunkelfeld sought self-identified individuals with pedohebphilic sexual interest expressing distress related to their attractions, to participate in a voluntary treatment program aimed at preventing them from committing sexual offenses against children (Beier et al., 2015). From the launch of the campaign until 2011, 596 individuals with a sexual interest in children came forward seeking help. In addition, Levenson et al. (2017) found that, among those who had committed a sexual offense, 20% of those who were attracted to children sought counselling or therapy prior to committing a sexual offense. Together, this indicates that at least some of those who are attracted to children *and* at risk for offending behaviour are in distress and seeking help that could prevent them from harming a child, highlighting the need for

treatment programs designed specifically for this population. In order to provide effective treatment and prevent offending, the specific treatment needs of MAPs must be identified, as well the protective factors that may help act as obstacles to offending.

2.2.2 Prevention

There are three tiers of prevention that can occur from a public health perspective. The most commonly used and researched tier is that of tertiary prevention. Tertiary prevention occurs after a crime, behaviour, disorder, or any other unwanted outcome has already occurred (McMahon, 2000**)**. A majority of research on child sexual abuse has been focused here, and many tertiary strategies have been identified to prevent recidivism for individuals convicted of sexual offenses against children. For example, rehabilitation, incarceration with long prison sentences, and forced sex offender registration are frequently used as tertiary strategies (Mitchell & Galupo, 2018). Secondary prevention strategies are those that target at-risk individuals in order to reduce their risk (McMahon, 2000). For example, the STOP IT NOW! (‘About Us’, 2019) program is designed to encourage individuals who are concerned about the well-being of a child to anonymously seek help and resources to prevent that child from being harmed. The program is aimed toward individuals who are concerned about their own behaviour, or that of another adult, toward a child, children who have been harmed or are questioning an adult’s behaviour toward them, and researchers looking to educate themselves or others.

Alternatively, primary prevention strategies target society as a whole in order to prevent a problematic behaviour before it occurs (e.g., McMahon, 2000; Pellai & Caranzano-Maitre, 2015). These strategies provide the knowledge, skills, and resources

necessary to prevent child sexual abuse from occurring. One such program targets school children in an effort to increase their autonomy in preventing abuse situations. Children are taught how to recognize situations that could put them at risk for abuse and how to react in a manner that is proactive and protects them (Pellai & Caranzano-Maitre, 2015). Importantly, children are taught that they are never responsible for any abuse that occurs; the blame and responsibility lie solely with the adult. The merit of these programs is that improving children's understanding of these types of offenses can help work towards keeping them safer.

Prevention work with MAPs could be seen to straddle primary and secondary prevention. For MAPs who are living offence free lives, primary prevention might involve work focusing on the mental wellbeing of those people and their experience of societal stigma. However, for those who are struggling with managing their sexual interest and feeling temptation to act on it, secondary prevention efforts could help these MAPs navigate the complexities of living with a sexual interest in children before they pose an imminent risk of offending. Currently, there is a dearth of such prevention opportunities as services available to those with a sexual interest in children are limited (Levenson et al., 2017). Many MAPs must navigate the prevention of child sexual abuse on their own, by learning how to cope with their sexual feelings.

2.2.2.1 Coping Strategies

Coping strategies differ from prevention strategies, although the two can overlap. Coping strategies are used to reduce an individual's stress level or help them deal with undesirable emotions or behaviours (Snyder, 1999). These are distinct from prevention strategies in that they are mechanisms for dealing with varied stressors/emotions as

opposed to prevention strategies which target a specific problem. A lot of work has examined coping strategies used by those with atypical sexual interest or who have sexually offended (e.g., Houtepen et al., 2016; Kear-Colwell & Swale, 2001; Marshall et al., 1999). For example, individuals who have sexually offended tend to have a negative preoccupation with sex and lack of emotion regulation (Jung & Jamieson, 2014). One study found that in order to cope with these issues, those who had committed sexual offenses tended to engage in sexual behaviours more often than individuals with mental illness who have committed other types of offenses (Jung & Jamieson, 2014). Specifically, individuals who sexually offended used fantasy and masturbation more frequently to relieve sexual tension. Individuals with a sexual interest in children, without known offenses, may rely on maladaptive emotion-focused coping when they fear their interests will be discovered (e.g., Grady et al., 2019; Jahnke et al., 2015b). This is partly due to the stigma related to living with such interests, such as that associated with being a pedophile (Jahnke et al., 2015a).

Recently, two studies (Jones et al., 2021; Stevens & Wood, 2019) have examined coping strategies that MAPs have developed to live with the reality of their sexual attractions. Jones et al. (2021), conducted a thematic analysis of coping strategies on select subforums of Virtuous Pedophiles, described above. Jones et al. (2021) identified eleven themes which they organized into three superordinate themes involving the acceptance of pedohebephilia, strategies to stay safe, and dealing with sexual arousal. Forum users appeared to value acceptance of their sexual interests, setting personal rules, and mental rehearsal of risky situations as ways of developing a resilience that would allow them to keep children and themselves safe. For example,

some MAPs reported that they would try to identify and rehearse potentially risky situations for themselves including any feelings they would have, how they would communicate, and what the child might be thinking. This involved developing an action plan in their minds, as well as thinking through the consequences of each course of action (Jones et al., 2021).

This above strategy resembles one that is currently used in treatment programs for people who have committed sexual offenses. For example, to improve people's awareness and regulation of their emotions, practitioners of cognitive behavioural therapy (CBT) use behavioural chain analysis to guide them to an understanding of the emotions they experienced before an offense occurred (Schaffer et al., 2010). Individuals who have offended are encouraged to make links between the triggering emotions and behaviour to get an idea of how these contribute to their decisions that bring them closer to offending. This aligns well with findings that some individuals who have sexually offended, including those with a sexual interest in children, lack the requisite affect regulation skills to properly identify an emotional experience and mitigate its effects on their behaviour (Gunst et al., 2017). The findings of Jones et al. (2021) indicate that some MAPs possess self-regulation skills that help them control their emotions and maintain appropriate boundaries.

Using a similar method to Jones et al. (2021), Stevens and Wood (2019) again examined coping strategies discussed by users of Virtuous Pedophiles. They identified 12 strategies that are used to help manage daily living, find prosocial alternatives, and develop a reliable support system. The most commonly used coping strategy was that of targeted interventions for pedophilic interests (i.e., psychotherapy and chemical

castration; Stevens & Wood, 2019). Peer support was also very common, since users could connect with others with whom they could empathize and look up to. Users also spoke about the benefit of discussing specific situations and getting advice from MAPs who had experienced something similar (Stevens & Wood, 2019). This is similar to a technique used in treatment programs for people who have committed sexual offenses. This technique, aimed at changing problematic behaviours, involves role-playing potential offense scenarios in order to develop appropriate skills that can be used to react to a stressful situation (e.g., Wheeler & Covell, 2014). For people who have committed sexual offenses, part of this is developing the skills necessary to engage in intimate relationships with age-appropriate, willing partners. Such skills, including communication, navigating consent, and developing intimacy, are taught and practiced first in a group setting and then developed further through homework assignments at outings (Wheeler & Covell, 2014).

2.2.3 Current Study

It is clear that there are individuals in society living with attraction to minors, undetected by law enforcement (Cantor & McPhail, 2016). It stands to reason that those who live with this attraction and *do not* offend are different than those with a sexual interest in children who *do* offend. One way these individuals may differ is in the decisions they make or strategies they use in the lead up to an opportunity to commit an offense. Those who do not offend may have particular strategies they use that allow them to refrain from engaging in offending behaviour. Learning about the strategies that have been effective for some individuals could be used to help others living with minor attraction, adding to the discussion of prevention of child sexual abuse. To supplement

existing strategies that put the onus on children and others to recognize and prevent abuse from occurring (Theaker, 2015), strategies identified in the current study may be introduced to individuals who are identified as having a sexual interest in children, whether they present an imminent risk or not. This could provide MAPs with strategies to prevent offending that they may never need but would nonetheless have on hand to use.

Given the infancy of this area of inquiry, there is a dearth of research to build upon and the few studies that have been done have several notable limitations. First, the work that has been done has focused on users of online forums for MAPs that have a clear stance against adult-child sex, such as Virtuous Pedophiles (e.g., Grady et al., 2019; Jones et al., 2021; Stevens & Woods, 2019). However, additional forums have been identified in the literature (e.g., Holt et al., 2010; Mitchell & Galupo, 2018; Seto, 2012) where alternative perspectives are expressed. By focussing on only one type of forum, past research may be missing out on the experiences of other individuals who may utilize a different set of strategies. In addition, past studies have examined specific subforums where it was probable there was discussion around coping (e.g., Jones et al., 2021; Stevens & Woods, 2019). This ignores the variability of situations which may require coping strategies that may be discussed more broadly in other subforums. Finally, general coping strategies have been discussed without consideration for the urgency of specific moments where a MAP may feel tempted to commit an offense. When in a position where an offense may be possible (e.g., considering accessing child exploitation material online, going to a location where children will be present), MAPs may need concrete actions that can be taken in order to avoid committing an offense.

Thus, the current study sought to examine all informal discussions between a larger range of MAPs from different types of online support communities, to determine what strategies are discussed for avoiding offending when a situation is described where someone had an opportunity to do so—in other words, the near misses. Better understanding of these strategies will add to the discussion of prevention of child sexual abuse.

2.3 Method

In this section, I report how I determined my sample size, and all data exclusions. Institutional ethical approval was not required as the study included secondary use of data with no identifiable information.

2.3.1 Data

In total, all 2365 threads over a 3-month period were pulled from three online support forums for minor attracted persons (MAPs). Threads cover a wide variety of topics, all with some relation to living with an attraction to minors. They also vary in length with some threads consisting of a single post or single word while others contain several pages worth of discourse between multiple different users. Of those 2365, 115 threads were included in the dataset for analysis that all included an explicit reference to a situation in which a MAP *could* have offended but chose not to engage in any harmful behaviour (e.g., they were in close proximity to a child they were attracted to; they accessed an exploitation material site that contained child exploitation material).

2.3.2 Forums

2.3.2.1 Virtuous Pedophiles

This forum is accessed only with permission from forum moderators, and by creating a username and password. Its content is aimed at MAPs who are law-abiding individuals and who express agreement with the founders' sentiment that sexual activity between a child and an adult is wrong (Virtuous Pedophiles, 2020). The forum aims to provide MAPs with a safe space to discuss their attraction and exchange information and advice on how to remain law abiding (Virtuous Pedophiles, 2020).

2.3.2.2 BoyChat

This forum is publicly accessed and requires no username or password for use. However, there is an option to create a permanent username that is recognized throughout the website and that can then not be used by anyone else (BoyChat, n.d.). It is a more inclusive forum, providing space for all MAPs regardless of their personal beliefs. There is, however, a general message of *boylove;* a term used to describe an all-encompassing (i.e., sexual, social, psychological, etc.) attraction to boys and the idea that boylove is a natural phenomenon that should not be criminalized (BoyChat, n.d.). Although they acknowledge sexual contact with children is illegal, some users of this forum take the position that sexual activity between adults and children is not harmful and that children should be able to choose.

2.3.2.3 GirlChat

Similar to its counterpart, BoyChat, this forum is publicly accessible with optional registration. While comprehensive, its general message is *girllove;* a term used to describe an all-encompassing (i.e., sexual, social, psychological, etc.) attraction to girls and the idea that girllove is a natural phenomenon that should not be criminalized (GirlChat, 2011).

2.3.3 Procedure

Data were collected from a 3-month period, between March 2016 and May 2016, by the first author from all three MAP forums. Individual threads, including original post and replies, were downloaded and saved to a thumb drive. A thematic analysis was conducted following the method of Braun and Clarke (2006). An inductive, bottom-up, approach was used in order to provide the richest answers possible to the research question and identify semantic themes within the data.

Familiarization with the data involved reading through all threads that were pulled from all three forums, acquiring a general idea of the content, noting any patterns in the data, and identifying those threads containing a specific reference to a potential offense. These references had to be specific and discuss a situation where the next logical step in an interaction was interpreted by a MAP as being an offense, but instead that MAP took action to not offend. Only these threads depicting a near-miss were included for analysis. During *initial code generation* the researcher read through the threads to identify more content. Codes were generated to identify and describe the specific actions taken in a possible offending situation (e.g. *walk* for a situation where a MAP walked away from the situation). All codes were then organized to *search for themes* to reflect similarities in the data items and to determine if a potential theme was represented therein. After searching for themes, all potential themes were *reviewed* for available supportive evidence, clarity, and distinctiveness. In the final stage of the process, the themes were given descriptive names and concise definitions.

2.4 Results

Overall, 54 threads contained an identifiable discussion of *how* an offense was avoided from which 89 quotes containing mention of an offence avoidance strategy from 53 unique usernames were utilized (although users can access multiple forums under different usernames, so it is possible some of these represent the same people). Posts from Virtuous Pedophiles provided the most quotes (49.4%; n = 44), followed by BoyChat (38.2%; n = 34), and lastly GirlChat (12.4%; n = 11). From these quotes, I identified 4 themes representing 19 strategies that MAPs articulated relating to situations in which a forum user was in a direct position where they believed they could offend. I have provided a complete list of all the strategies in Table 1, however in the interest of being concise I do not provide examples of each strategy. To ensure inter-rater reliability I undertook a peer-audit process, where I discussed the coding and interpretation at length with my co-investigators (Seale, 1999) similar to Blagden et al. (2018), who conducted a thematic analysis to describe how MAPs sexual interest impacted their psychosexual identity.

Given the protection of forum content behind a username and password system, consent to conduct the study was obtained from the forum moderators of Virtuous Pedophiles, however not from individual users. As such, no direct quotes will be used to ensure anonymity of the users and that there is no breach to consent. Rather, quotes will be paraphrased to maintain context and necessary details. This technique was also adopted for BoyChat and GirlChat quotes to ensure the data were not treated differentially.

2.4.1 Theme 1: Avoidance

The first theme encompassed eight strategies that used active avoidance of scenarios where an individual felt a situation could be tempting or could lead to offending behaviour. These were situations in which a MAP interpreted the behaviour of children in their presence as being indicative of sexual desire and used this as evidence that they knew sexual contact was likely or inevitable without some kind of intervention. It was identified in 74.1% (*n* = 40) of the threads and mentioned in 61.8% (*n* = 55) of the quotes. See Table 2 for a breakdown of how the themes were distributed by each forum.

Some uses of avoidance involved distinctly behavioural elements such as MAPs not putting themselves in a situation where they had the opportunity to engage in sexual contact with a child or access any online content that may tempt them to consume child exploitation material. Some uses of this strategy involved MAPs not entering into any such situation outright, never allowing themselves to be alone with a child with whom they *knew* or believed they could engage in sexual behaviour, and never consuming any pornographic (including legal) material.

For example, one user recommended “You should make your choices knowing what your limits are. If you think that going out together might be a risk of surrendering to your instinct, well, that's right to keep her distance” (Example 1). This was provided in response to a user who was seeking advice for proper conduct with a child they believed was reciprocating romantic and sexual feelings. As demonstrated through this example, the idea of simply distancing oneself from objects of affection was a common message across all the forums.

Similarly, other MAPs opted not to restrict who they may interact with, but rather ensure there was always a protective barrier in that they avoided ever being alone with a child or brought a supportive friend when the temptation would be too high. One MAP suggested that “if you decide to socialize with these kids, always remember it is always best to have another adult along” (Example 2). This involved some foresight to recognize that they (i.e., individual MAPs) may need additional support in situations involving an object of their affection.

Other uses of avoidance appeared to reflect cognitive abilities of affect regulation and problem solving to successfully avoid offending situations. MAPs used these strategies to simulate the emotion and sensation of enjoying a physical interaction with a child or to relieve any emotional or sexual tension a MAP was feeling. For example, one MAP discussed a young girl whom they were particularly attracted to and fond of. Their relationship to the girl’s parents provided many opportunities for this MAP to interact with her, however given their commitment to living a law-abiding life, they resorted to using fantasy to supplement any relationship they may want with her. They stated “I have to mostly have a fantasy relationship with her due to the law, etc. I wouldn’t trade her for any mere fantasy, of course, but nothing’s really going to happen with us anyway” (Example 3).

2.4.2 Theme 2: Removal

A second theme that emerged included four strategies whereby MAPs could remove themselves from any situation that could evolve into offending behaviour. It was identified in 33.3% (*n* = 18) of the threads and mentioned in 28.1% (*n* = 25) of the quotes (see Table I). This entailed a MAP believing they had an opportunity to offend

and choosing to not engage in any further behaviour that could increase that possibility. This is distinct from avoidance by the choice to attend activities or locations where children may be and leaving that situation when it was believed an advance had been made. In other words, avoidance occurs in anticipation of, whereas removal occurs in reaction to a potential offending scenario.

Examples of this strategy include leaving a location where a child to whom they were attracted was frequenting, or physically stopping the activity of a child the MAP interpreted as trying to have intimate contact with them. As a clear example of this strategy, one MAP sought advice on how to be around boys to whom they were attracted when they felt their sexual tension was reaching a breaking point. A peer advised this MAP that “it might be prudent to extract yourself from it before you make some serious mistakes” (Example 5).

Some MAPs exhibited the ability to recognize when a situation was too stimulating for them and that they needed to change the circumstances. This particular MAP described some horse-play with boy scouts they were responsible for that they felt had gone too far. They took action to remove themselves from the situation posing a risk before anything dangerous occurred by pushing away the child they believed to be instigating the contact, removing the others from having any physical contact with him, and sending all the children home: “I pushed the imp off of my chest, and kicked the others off of my legs. I ran for the light switch and turned it on. I then sent everyone home” (Example 6). This is distinct from the non-sexual physical contact theme (described below) in that the individual decided the contact was risky once it had

already begun. They recognized the need to remove themselves from the situation, rather than deciding, as a strategy, that non-sexual contact was acceptable.

Another method of removal was by educating a potential victim perceived by the MAP as attempting to engage in sexual behaviour. This education revolved around either the legal ramifications of adult-child sex, the physical and psychological risks that are posed by engaging in adult-child sex or some mix of both. Discussed in a later section, the language use in the examples of this strategy portrayed a difference in focus (i.e., child focused versus an "us" focus) as demonstrated below. This MAP was advising another poster who was struggling to decide if it was right to refuse contact with a young friend. They advised that the MAP explain to the child why sexual contact was inappropriate. They urged the poster to explain not only the legal ramifications but that their feelings for the child were too great to risk both of their safety: "choose to behave like an adult and tell this hypothetical boy making moves on you that the risks are too great legally and you love him too much to risk his safety and well being or your own" (Example 7).

2.4.3 Theme 3: Limited Contact

Allowing for limited contact with children, or allowing contact with only mainstream media depicting children, were strategies identified in 22.2% (*n* = 12) of the threads and mentioned in 14.6% (*n* = 13) of the quotes (see Table I). There were 4 limited contact strategies which involved only engaging in contact with children or mainstream media depicting children that some MAPs felt comfortable with engaging in without increasing any risk of offending behaviour. In other words, when they felt they had a potential opportunity to commit an offense, MAPs would establish their own

boundaries for behaving legally that were consistent with their individual comfort. This is distinct from removal where MAPs would remove themselves from any situation where there was a potential opportunity to offend.

Enjoying a purely platonic relationship with a child seemed to satisfy some MAPs' desire for closeness to a child while keeping their behaviour within the boundaries of the law. Despite the increased risk that this could pose, one MAP believed they were perfectly capable of engaging in such a relationship with a child with whom they were particularly enamored. This MAP felt in control stating that:

> Because he is very thoughtful and smart - and cautious - I've never worried that our friendship could be thrust outside of a platonic one, unless it was me who pushed it there - something which I have been adamant not to do, for reasons that to me are perfectly reasonable (Example 8).

However, it should be noted that this perspective would seem to put responsibility on the child if the MAP felt the child was doing something that *pushed the boundaries*.

Some MAPs felt comfortable with consuming erotic content depicting adults without a risk of engaging with child exploitation material, though they did recognize that it could be difficult to navigate the available content to find something they were interested in without stumbling down the proverbial rabbit hole into illegal content. Along with the example above regarding online content, this fear of accidently accessing child exploitation material demonstrates that some MAPs in this study tended to have presumptuous ideas regarding the ease with which they could happen across illegal material when it is actually quite difficult, which will be clarified further in the discussion. Similarly, MAPs were acutely aware that there was a risk of content they were

consuming being judged as child exploitation material. One MAP recommended keeping “nothing on your computer except the odd letter to your granny and watching NON bl/potentially deemed bl [boylove] type you-tubes, maybe a cooking video or two” (Example 10). This could include personal communications or any videos of children including those not involving lewd depictions.

2.4.4 Theme 4: Non-Sexual Physical Contact

The fourth theme that was reported involved three strategies of engaging in varying degrees of contact with children that is not typically perceived as sexual. It was identified in 33.3% (*n* = 18) of the threads and mentioned in 23.6% (*n* = 21) of the quotes (see table I). MAPs who used these strategies tended to fall somewhere along a spectrum in terms of their feelings about the acceptability of sexual contact with children. On the one extreme was intimate contact that was not overtly sexual (e.g., no direct stimulation of sexual organs) but that MAPs nonetheless found enjoyable in some way, and on the other was strictly affectionate contact that any adult would engage in. Some MAPs felt able to engage in a relationship with a child that included physical contact which they believed did not break the law in the strictest sense. For example, one MAP talked about their experience with children who may express curiosity about bodies that they interpreted as sexual curiosity and how to maintain the boundary between legal and illegal. They stated “I've managed to have some quite intimate relationships with toddlers/preschoolers, but I've kept it strictly within the law” (Example 11), by paying attention to where the child’s curiosity was directed in order to avoid engaging in any overtly sexual act. It is important to note that while potentially undetectable to onlookers, this behaviour may still be considered a crime depending on

the jurisdiction. For example, contact with any part of the body of a minor may be considered sexual interference under the *Canadian Criminal Code* (Criminal Code, 1985) if there were a sexual intent. Similarly, sexual offenses in the United Kingdom may occur without a child being consciously aware of what is happening and with touch that is over clothing (The Crown Prosecution Service, 2017).

Other MAPs felt it was acceptable to allow physical contact that was initiated by the child as long as they did not escalate to overtly sexual physical contact. They did not feel significant sexual tension to escalate the physical contact and would often engage in affectionate touch that they believed was perfectly legal. For example, a MAP suggested to a peer, who was in contact with several boys to whom they were attracted, that they:

> Walk the line. Make the comfort, well being, and happiness of boys your priority. But do it without being creepy. Making a kid happy will sustain you, even if your own need to express affection on a more intense level goes unrequited (Example 12)

2.4.5 Themes Across Forum Type

Table II shows the use of the four themes across forums. Virtuous Pedophiles used avoidance the most, followed by removal, non-sexual physical contact, and then limited contact. BoyChat users used avoidance the most, and equally used the other three. Finally, GirlChat users used avoidance the most, followed non-sexual physical contact, and removal and limited contact equally. Both strategies involving some physical contact were used more frequently by BoyChat and GirlChat users than by

Virtuous Pedophiles users and Virtuous Pedophiles users used either avoidance or removal more frequently than either of the contact strategies.

The language used when describing these strategies, particularly the contact strategies, also differed between Virtuous Pedophiles and BoyChat/GirlChat. The former tended to use language that emphasized the harm to children, and the responsibility of the MAP to identify their own boundaries and limitations. In contrast, the latter tended to use language that put some level of responsibility on the child rather than the adults in the situation (e.g., attributing a child's curiosity about the world to sexual curiosity; only explaining the legal consequences to a child) and described avoiding detection or testing the legal boundaries of their interactions with children. This difference is reflective of the different stances on adult/child sexual contact that are espoused by the different forum users. This difference in language use could also be reflective of riskier behaviour that may only be a step down from offending behaviour versus practical strategies that could be used by any individual.

2.5 Discussion

I was able to identify four themes representing 19 strategies from MAPs' discussions in online support forums. These themes were avoidance (i.e., complete avoidance of any situation with a potential risk), removal (i.e., removing a potential risk or removing oneself from a risky situation once it has been identified), limited contact (i.e., allowing innocuous or innocent contact without any sexual undertone), and non-sexual physical contact (i.e., contact that provided some gratification but may not be identifiable as overtly sexual by an observer). All of these strategies are discussed with varying frequencies. Some of the strategies, particularly within avoidance or removal,

are simple tools that MAPs use when in or near stressors. However, others, particularly in the limited contact or non-sexual physical contact themes, may represent strategies that help prevent individual MAPs crossing over from a risky to an illegal behaviour, but may not remove them entirely from a risky situation.

The strategies that were discussed can be arranged linearly in terms of proximity to offending behaviour. At the low end, some MAPs avoided any risk of sexual contact with a child by use of avoidance strategies to identify any potentially risky situation before it occurred. At the higher end, they avoided easily identifiable sexual contact with a child by engaging in risky contact behaviours that may or may not constitute offenses. This is not to say that they knowingly offended against a child, but rather that their behaviour reflected risk-taking and potentially problematic scenarios.

The strategies I identified differed from those found in the coping literature in that they were more specific and action-based extensions of general coping strategies (e.g., Jones et al., 2021; Stevens & Wood, 2019). Research on general coping for MAPs has indicated that they may search for positive experiences that do not involve children. For example, Stevens and Wood (2019) found that MAPs discussed the idea of monitoring their behaviour when they were near children. The strategies I have identified echo this idea in several ways, such as some MAPs ensuring they were not alone with a child so that they were more cognizant of their actions or may receive feedback from someone else. Jones et al. (2021) found that MAPs discussed the importance of having rules for their contact involving children. My results supported this finding with several of subthemes containing a rule the MAPs created for themselves for contact that may be considered appropriate. Safe internet behaviour, not possessing any risky images, and

engaging in legal affectionate touch (among others) all contain some reference to a particular threshold up to which some MAPs believe contact is appropriate.

Many MAPs appeared to understand that they were most vulnerable when they were in a state of sexual arousal (Ariely & Loewenstein, 2006; Imhoff & Schmidt, 2014), such as when they were allowed to be alone with a child to whom they were sexually attracted or when they were consuming mainstream media depicting children. Sexual arousal is a well evidenced risk factor for offending behaviour (e.g., Elliott & Babchishin, 2012; Finkelhor, 1984), especially when combined with an opportunity to offend (i.e., routine activities theory; Cohen & Felson, 1979). Thus, avoiding situations in which one might become aroused, such as in interactions with children, could eliminate the possibility of offending in that situation. This insight is consistent with evidence indicating that males may be more willing to engage in risky sexual behaviours when in a state of sexual arousal (Ariely & Loewenstein, 2006), and that sexual excitation is a common emotion to experience before an offense (Leclerc & Lindergaard, 2018).

2.5.1 Implications

Given the concurrent goals of facilitating help-seeking among MAPs (e.g., B4U-Act, 2011) and the public interest in prevention of child sexual abuse (e.g., Levenson et al., 2017), the findings of this study have several implications for treatment and/or policy. First, while each of these strategies were discussed in very different contexts, they all represent a specific use of self-regulation, or affect regulation; some more effective for addressing an opportunity to offend than others. For example, some subthemes in the avoidance strategy resemble an avoidant coping mechanism (i.e., minimizing or denying a problematic situation; Exner, 2003). However, MAPs who

employed some of these subthemes, such as bringing supervision or distracting oneself with another task, may recognize the risk involved in a situation and use problem solving skills to subdue any sexual desire they may have felt and determine the best course of action to protect themselves and children. This type of problem-solving behaviour may represent a protective factor against offending, even if the MAP is not expressly aware they are using problem-solving (Mitchell & Galupo, 2018). Previous research demonstrates that individuals who have sexually offended tend to have a decreased ability to use self-regulation (e.g., Mann et al., 2010; Mitchell & Galupo, 2018). According to Gunst et al. (2017), individuals who have sexually offended against children may demonstrate issues in regulating positive emotions and, like individuals who have committed other types of sexual offenses, exhibit difficulties identifying and recognizing their emotional experiences, or controlling their emotions. This can lead to the use of sex as a coping mechanism in response to the positive experience of anticipation or elation (Gunst et al., 2017). The problem-solving and self-regulation skills used by some MAPs in this study are possible avenues for prevention as they can offer specific strategies to utilize when faced with a perceived opportunity to offend. If MAPs demonstrate poor self-regulation skills, providing them with specific strategies may help them feel more confident in their ability to remain offense-free. A recent case study was reported involving a pastor who abused CSEM material and also self-identified as a MAP. This case study provides preliminary evidence that teaching self-regulation skills can prevent offending behaviour by offering alternative strategies to alleviate negative emotional states (Konrad et al., 2018).

Some MAPs in the current study worried about the potential to accidentally access child exploitation material when engaging with any online content. The example used above asserts that it may be quite easy to get lost in a pattern of clicking through various links online and some MAPs believe this leaves them susceptible to stumbling upon illegal material. Distressing as this may seem to MAPs, it is highly improbable for there to be child exploitation material 'hidden' among legal material (e.g., Steele, 2015). The legal ramifications for engaging with child exploitation material (e.g., sentences for distribution of child exploitation material range from a minimum of 1 year to a maximum of 14 years; *Criminal Code*, 1985) are severe enough to deter administrators of exploitation material websites from allowing such material to be remain accessible (*'YouPorn'*, 2019). In addition, accessing a pornography website is engaging in effortful behaviour with conscious processing of the material. It is difficult to conceive that this engagement would lead to 'accidentally' stumbling across illegal material. Rather, MAPs who struggle with this worry could be assisted to identify appropriate and reliable websites to utilize. This is similar to techniques that are used with adults in treatment for pornography addiction (e.g., Young, 2008). Rather than completely avoiding the use of the internet, a near impossible feat in today's culture, men in treatment for pornography addiction are assisted to use the internet appropriately while enhancing their offline life through activities they find enjoyable. While not avoiding pornography altogether, MAPs could be provided guidance on how to identify appropriate content and find enjoyment from that as much as they can; another use of self-regulation and self-control that could decrease MAPs' risk of offending (Ward & Hudson, 2000).

Another implication is that while each of the previously discussed strategies represents a distinct effort to avoid engaging in offending behaviour, I have also suggested that they can be arranged along a continuum in terms of their risk and proximity to offending behaviour. While acknowledging that many of the individuals using these strategies live offense-free lives, the strategies outlined could be seen as somewhat similar to the escalating risk associated with the levels of an offense chain (e.g., Ward et al., 1995). The notion of an offense chain comes from the relapse prevention literature (Pithers et al., 1983), and it encompasses all the factors leading up to a decision to offend including an offender's background, conscious and unconscious planning, arousal, cognitive distortions, and the internal consequences that perpetuate offending behaviour. Although it is certainly not a given that any MAP will offend, thinking about the stages of an offense chain could be helpful. Indeed, one of the objectives of creating an offense chain is to identify all the opportunities an individual has *not* to commit in the offense in the lead up to it, while also noting that it gets progressively more difficult to avoid an offense as one moves along the chain. It gives a sense of the extent to which their behaviour represents increasing risk, thus therapists may be able to tailor treatment to the needs of the individual MAP to further help them establish and maintain appropriate boundaries.

The themes of removal, limited contact, and non-sexual physical contact, in particular, appear to parallel the proximity to an offense in stages 2 and 3 of Ward et al.'s descriptive model of the offense chain (1995) for people who sexually offend against children. For example, the need to remove oneself from a situation may indicate that some degree of distal planning (stage 2 in Ward et al.'s model) has taken place,

perhaps unconsciously. Removal may reflect an effective strategy to intervene where such processes have taken place. Treatment drawing on this strategy could involve role play and problem solving to understand how their behaviour may be increasing their risk (i.e., distal planning) and how the strategies may be used more effectively. For example, MAPs who use education to avoid offending may be unconsciously engaging in distal planning. The act of educating the child may create an environment where the child learns to trust the MAP and this may make any desired sexual behaviour more likely. The difference in language use between forums could be particularly telling of such situations. While perhaps not intended as such, it could resemble grooming behaviour that intentionally gains the trust of a child for the purpose of sexual exploitation (Eneman et al., 2010). In such situations it may be possible to engage MAPs with discourse around consent versus assent so that there is a better understanding of helpful education for minors (see later discussion; Spriggs et al., 2019).

Similarly, some strategies within the limited contact theme such as affectionate touch initiated by the child, or even touch that is not intended for sexual gratification, may reflect the types of chance contact that are conceptualized as reflecting distal planning (Stage 2; Ward et al., 1995). MAPs may not recognize this type of contact as having any negative implications, believing that having a close (non-sexual) relationship with a child decreases the likelihood of an offense occurring because the contact is sufficiently satisfying without resorting to overtly sexual contact (Spriggs et al., 2019). However, closer relationships between perpetrator and victim can lead to even greater harm if an offense did occur (e.g., Zink et al., 2009).

The strategies within non-sexual physical contact represent the highest risk behaviours reported by MAPs in this study, similar to that seen at the third and fourth stages of an offense chain. This is where an individual engages in goal-directed, non-sexual contact in order to prime their victim for further contact and they interpret those events in a way that justifies the contact (i.e., cognitive distortions; Abel et al., 1989; Ward et al., 1995). These cognitive distortions have become a main target in treatment programs for people who have committed sexual offenses (e.g., 3RT, Wheeler & Covell, 2014; CBT; Yates, 2003). Some of the strategies used by MAPs in my study share similarities to these cognitive distortions, particularly those instances of contact strategies that use language indicative of acceptance of child-adult sex, a finding that was also discussed among the coping strategies identified by Jones et al. (2021). This type of thinking makes these strategies a possible avenue for prevention, even if the MAPs in the current study were adamant that the contact never escalated to overtly sexual acts. In fact, one newly developed treatment program found success in reducing cognitions that were supportive of child-adult sex and additional success in preventing (further) sexual crimes against children, over a more than 2-year period (Wild et al., 2020). Helping MAPs understand that even non-sexual contact with children can prime them for an offense (Ward et al., 1995) by increasing the amount of love and trust they have for the MAP (Eneman et al., 2010), can allow them to create better boundaries for themselves and children, and help to prevent any possible offense. Since a large proportion of individuals who commit sex offenses against children are known to the victim (Browne et al., 2018), leaving these distortions unchecked can increase a MAPs risk of offending behaviour even if they have never offended before.

Another possibility is that for some MAPs who do go on to offend, they may not understand the nuances between *consent*, or the autonomous, legal decision (Miller et al., 2004), and *assent*, or the child's basic understanding of a course of action and their expression of a preference (Miller et al., 2004). Some MAPs may assume that a child who agrees to an activity is consenting without fully considering that consent requires the individual to comprehend all of the consequences of their behaviour (Spriggs et al., 2019), something children are not able to do (Seto, 2012). For MAPs who may struggle with this, as was evident in the variation in language usage, providing them with the tools to understand the consequences of adult-child sex and the nuances of consent versus assent, may allow them to then use the education strategy when they encounter a situation they perceive as risky and better protect children. Treatment could focus on increasing MAPs appreciation for, not just understanding of, the issues around adult-child sex to ensure their use of education came from a place of protection rather than shame and guilt.

One final avenue for consideration is related to the differences in language usage among forum users. As previously mentioned, there appeared to be differences between the two types of forums in their use of language that was accepting of or opposing child-adult relationships. This is not dissimilar from how language usage on peer support forums can predict other negative actions or behaviours. For example, there are unique linguistic markers in online posts of individuals who have problematic alcohol use (e.g., Kornfield et al., 2018a, 2018b; van Swol et al., 2020). These markers can be used to predict future problems related to alcohol usage, suggesting that language has the capacity to convey thoughts, ideas, or emotional states that lead to

the development of problematic behaviours. If individuals could be identified based on their language usage, additional support could be provided to them lending further to prevention efforts.

2.5.2 Limitations and Future Directions

A number of limitations of this research should be acknowledged. First, my data was archival, gathered from online support forums. These posts were made without prompting from a researcher and all discussion that followed represented each user's own interpretation of the conversation. This means I was unable to ask any specific questions of the users to clarify content. As such, any interpretations or conclusions drawn from the data are subject to my interpretation of the content. It is possible that such conclusions are not aligned with the personal meaning of what each user wrote.

Similarly, although I took every effort to remain neutral and objective when analyzing this data it has to be acknowledged that as a teleiophilic individual I may have some personal biases or prejudices toward individuals with pedophilic sexual interests. This may have had an influence on the way the data was interpreted that would differ from how others would interpret it. I also experienced some periods of overwhelm or distaste with the content. When I noticed these feelings rising I was cognizant of making sure I distanced myself from it so I could reset and process them away from the context of trying to interpret the content.

In addition, the sample size might seem small, consisting of 54 threads and 89 quotes. However, this was the culmination of examination of thousands of threads. Given the relative infancy of this line of research (i.e., with non-offending MAPs) and the

difficulty in accessing such a secluded population, these findings provide important first steps that can serve as a basis on which future research can be built.

Future research should directly ask MAPs about their experiences with avoiding offending behaviour and what strategies they employed in such scenarios. These responses may enable us to get a more nuanced understanding of the strategies employed and acknowledged by MAPs in a way that is just not possible with the current findings. Additionally, presenting MAPs with specific hypothetical scenarios in which they could perceive an opportunity to offend may allow us to better understand when certain strategies are employed. Similarly, if scenarios are presented in various stages of an offense chain, we may be able to understand which strategies are best. This could allow individuals who are engaging in certain types of behaviour to learn specific techniques to help them refrain from that behaviour. Finally, it is safe to assume that a MAP who believed a child to whom they were attracted was attempting to engage in sexual behaviour with them, would likely experience sexual arousal. Therefore, future research should focus on understanding how MAPs who use strategies allowing for limited contact with children they are attracted to, manage this sexual arousal specifically.

2.5.3 Conclusion

I conducted a thematic analysis on the content of several online support forums for MAPs to determine what, if any, strategies they used to avoid offending when in a specific situation where an offense could have occurred. I found evidence for 4 distinct strategies that were all rooted in self-regulation. Avoidance, removal, limited contact, and non-sexual physical contact all involved MAPs recognizing the risk of a situation,

assessing what they were comfortable with handling without overtly engaging in offending behaviour, and acting accordingly. Although it is admirable that all these strategies represent attempts to avoid engaging in sexual behaviour that would harm a child, some of these strategies are still concerning and put children at risk. There was considerable variation in the language used to describe the strategies, blurring the lines between what could be an appropriate and effective strategy and risky behaviours reported by MAPs that may have been undetected offenses (in that it involves sexual motivation for the contact, even if the behaviour was not overtly sexual). Treatment with non-offending MAPs should focus on increasing MAPs self-regulation while educating them on the risks of adult-child relationships and addressing any cognitive distortions they may have regarding them. Using some of the strategies discussed by MAPs in the current study, treatment efforts could be directed towards helping MAPs to best make decisions regarding how to avoid or engage with situations that may pose a risk in ways that protect them and keep children safe.

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The authors take responsibility for the integrity of the data, the accuracy of the data analyses, and have made every effort to avoid inflating statistically significant results

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Table 1

Description of Strategies within each Theme

Strategy	Description of subtheme	N
Avoidance	Avoid a situation before it occurs	35
	Abstinence from any and all pornographic material	11
	Total abstinence from any sexual activity	6
	Masturbation	5
	Supervision when around children	4
	Fantasizing about interactions	3
	Distraction with another task	3
	Being patient until it is legal to engage	2
Removal	Leave when feeling uncomfortable	12
	Turning down an advance (verbal)	8
	Physically stopping an advance	7
	Educating a child about the potential dangers	6
Limited Contact	Safe internet practices	5
	No keeping risky pictures on computer or in home	4
	Engaging in a platonic relationship with a child	4
Non-sexual physical contact	Legal affectionate touch	12
	Constantly monitor own behaviour around children	12
	“Everything but” – No obviously sexual acts	7

Table 2

Distribution of Themes by Forum

Strategy	Forum	n	%
Avoidance	Virtuous Pedophiles	30	68.2
	BoyChat	17	50
	GirlChat	8	72.7
Removal	Virtuous Pedophiles	15	34.1
	BoyChat	9	26.5
	GirlChat	1	9.1
Limited Contact	Virtuous Pedophiles	3	6.8
	BoyChat	9	26.5
	GirlChat	1	9.1
Physical Contact not Involving Sexual Organs	Virtuous Pedophiles	8	18.2
	BoyChat	9	26.5
	GirlChat	4	36.4

Chapter 3

3.1 Introduction

There is a growing body of literature demonstrating that not every individual who sexually offends against a child is sexually attracted to children (e.g., Blanchard et al., 2009) and, conversely, that not every individual who is sexually attracted to children goes on to sexually offend against a child (e.g., Cantor & McPhail, 2016; Walker, 2021). However, society still uses the terms *pedophile* and *child molester* interchangeably (Cantor, 2012), assuming that anyone who expresses a sexual interest in children is dangerous and will inevitably act on these interests and abuse a child (Jahnke et al., 2015a). This stigma exists in spite of the fact that many individuals with a sexual interest in children (i.e., Minor Attracted Persons; MAPs) acknowledge having this attraction but express an intention to never act on it (Cantor & McPhail, 2016). This stigma toward individuals who are sexually attracted to children (e.g., Imhoff, 2015; Jahnke et al., 2015a; Levenson et al., 2017) creates an obstacle for those who wish to seek help for mental health issues related to their sexual interest.

3.1.1 Minor Attracted Persons

Research into the epidemiology of minor attraction is scarce. It is clear that attraction to minors has an early age of onset (e.g., Houtepen et al., 2016; Seto, 2012), is persistent across the lifespan and resistant to change (Seto, 2012), and represents not only sexual feelings but romantic ones as well (Martijn et al., 2020). This has led some researchers to conclude that minor attraction may represent a sexual age orientation similar to sexual gender orientation (e.g., Seto, 2012), given the similarities in presentation of the sexuality. While this could have implications for how individuals

with a sexual interest in children are portrayed and regarded in society, there remain clear differences in the way the sexual behaviour is accepted or not. One involves sexual behaviour between two parties who are capable of consenting to it (i.e., sexual gender orientation) while the other does not (i.e., sexual age orientation).

3.1.2 Stigmatization of MAPs

Despite the evidence that minor attraction may represent a distinct sexual age orientation (Seto, 2012), akin to sexual gender orientation, there is still widespread stigma against having a sexual interest in children (e.g., Imhoff, 2015; Jahnke et al., 2015a, b). For example, individuals with pedophilic sexual interests are judged as worse than other marginalized groups (i.e., people with alcoholism and people with sadist sexual interests; Jahnke et al., 2015a), and these negative judgements are worsened by the *pedophilia* label (Imhoff, 2015). In addition, the public is often influenced by the media regarding their perceptions of individuals with a sexual interest in children, which tends to create highly negative views (McCartan, 2004). The public tends to hold beliefs such as: individuals with a sexual interest in children are dangerous in general, but even more so to children and adolescents, they actively choose to target children to victimize them, and they should be isolated from the rest of society (Jahnke et al., 2015a). In addition, men with a sexual interest in children are perceived as more immoral and dangerous than men with typical sexual interest in adults, even if they have never engaged in offending behaviour (Jahnke, 2018a). Even psychological professionals show biases against individuals with a sexual interest in children that may influence their ability to provide treatment (e.g., Koops et al., 2016, Stiels-Glen, 2010).

Unsurprising given the incredible stigma associated with minor attraction (e.g., Jahnke et al., 2015a, b; Levenson et al., 2017; Mitchell & Galupo, 2018a), many MAPs report that they experience significant mental health issues. For example, when asked about their treatment needs, a majority of MAPs referenced issues outside of their sexual attraction such as anxiety and depression (Levenson & Grady, 2019), and feelings of hopelessness, shame, guilt, and a loss of identity (Levenson & Grady, 2017). One recent study examined how this loss of identity was related to psychological well-being (Lievesley et al., 2020). It was theorized that suppression of their (highly stigmatized) sexual interests could lead to more negative outcomes in the long-term by increasing MAPs' cognitive load and paradoxically, increasing rumination on their sexual interests. Overall, Lievesley et al. (2020) found that greater suppression of thoughts was correlated with lower psychological well-being, more guilt and shame, and more hopelessness. In addition, they found that MAPs who had lower levels of psychological well-being were more likely to indicate a desire for more support to manage issues related to their sexual interests. These results provide evidence for MAPs' need and desire for psychological intervention for more than just managing their sexual interests. Despite these issues, MAPs do not report favourable experiences with seeking help from mental health professionals.

3.1.3 Help-Seeking Among MAPs

Many MAPs report a desire to seek help from mental health services in order to better understand their sexual desire, learn sexual regulation strategies, and feel better able live with their sexual desire in a society that treats them as evil, among other reasons (B4U-Act, 2011). Unfortunately, many MAPs report either never seeking

treatment (e.g., for fear of being reported to authorities; B4U-Act, 2011), or experiencing negative reactions from mental health professionals (e.g., those endorsing stigmatizing beliefs about MAPs; e.g., Levenson et al., 2017; Walker, 2021) which indicates that there are many barriers to treatment for MAPs.

The barriers faced by MAPs come from a variety of sources. One of these barriers is stigma towards MAPs, specifically that which is promoted by mental health professionals. As noted previously, pedophilic disorder is one of the most stigmatized mental illnesses, with society believing individuals with pedophilia choose their attraction to children and that they are all dangerous to children and adolescents (Jahnke et al., 2015a). Some mental health professionals also hold unfavourable views that affect their willingness to provide therapeutic services to individuals with pedophilic sexual interests (Stiels-Glenn, 2010), although these views may be more amenable to change than those held by the general public (e.g., Jahnke et al., 2015b). Such stigma in mental health professionals can result in hesitancy from MAPs to seek out therapeutic services (B4U-Act, 2011) or difficulty finding a therapist with the appropriate knowledge and skills to provide treatment (Jahnke, 2018b).

An additional challenge is that mandatory reporting laws (i.e., the legal obligation to report any suspected child abuse, or people who pose an imminent threat to children) within many jurisdictions may complicate therapists' ability to provide effective treatment (e.g., B4U-Act, 2011; McPhail et al., 2018). Many mandatory reporting laws lack specificity as to when reports must be made so some therapists err on the side of caution to avoid legal ramifications (Johnston, 2017). Knowledge of mandatory reporting laws may give pause to MAPs who wish to seek treatment because even those who

have never acted on their desires fear being reported to authorities based merely on the fact that they have a sexual interest in children (B4U-Act, 2011).

In instances where mandatory reporting and stigma are not sufficient to deter MAPs from seeking treatment, lack of access to therapeutic services is an additional hurdle that many need to overcome. It can be difficult to find competent therapists who are knowledgeable about the unique needs of MAPs (Grady et al., 2019). They may not feel like they have the required skills to help with MAPs needs (Parr & Pearson, 2019). Though there are some knowledgeable therapists currently working with MAPs (e.g., Help Wanted, Letourneau et al., 2017; Prevention Project Dunkelfeld, The Prevention Network, 2018), finding such therapists may be difficult. MAPs are often unsure where to look or how to find therapists willing to provide therapy (e.g., Levenson et al., 2017; Parr & Pearson, 2019).

3.1.4 Treatment of MAPs

Given the aforementioned barriers to (non-mandated) treatment, very little research has examined individuals with pedohebephilic sexual interests in contexts other than a criminal setting, leaving a potentially large group of people out of the reach of psychological scientists. Beier et al. (2015) provided individuals with pedohebephilic sexual interests within this ‘dark field’ therapy for the purpose of preventing sexual offenses. They found that they responded well to treatment, showing reductions in several dynamic risk factors and an increase in sexual self-regulation, although most of the men report ongoing problematic sexual behaviours. Although this research has the benefit of being one of the first studies of MAPs, it remains limited by its treatment of MAPs as dangerous individuals in need of treatment to control their behaviour rather

than recognizing MAPs as individuals with their own needs and difficulties outside of their sexual interest that deserve consideration.

Despite the work of Beier and colleagues (2015), the unique needs of MAPs, outside of any attempt to reduce criminogenic risk factors, have not been empirically examined to a great extent. Most previous studies that have been conducted examine MAPs self-reported treatment needs (e.g., Grady et al., 2019; Levenson & Grady, 2019). For example, participants in Levenson and Grady's (2019) study identified several possible treatment targets that were not directly related to managing their sexual desire. Among these were addressing the stigma around minor attraction and the shame they felt as a result, depressive symptoms, and hopelessness regarding their sexuality. Similarly, MAPs reported significant levels of shame in relation to their sexual attraction and suggested that treatment should focus on the negative outcomes of this shame (Grady et al., 2019). They described negative psychological outcomes related to isolation and having to hide their attractions from those around them, such as frustration and hopelessness. Lievesley et al. (2020) similarly reported that MAPs who had internalized social stigma tended to report lower levels of psychological well-being. This was marked by low levels of hope regarding their future, a consequence the authors concluded was a result of feeling stuck due to their sexual attractions.

3.1.5 Current Study

The majority of the studies that have been conducted looking at the mental health needs of MAPs have been qualitative studies, allowing MAPs to openly discuss what they see as treatment needs and priorities. However, there is a dearth of quantitative research demonstrating the degree to which MAPs may be suffering and

what issues they may need treatment for. Lievesley et al. (2020) conducted one of the sole quantitative studies in this vein, however the focus of that study was less on treatment needs and more on help-seeking behaviour. The current study aims to fill this gap in understanding the treatment needs of MAPs and shed light on this 'dark field' of pedophilia by investigating the possible treatment needs and help-seeking experiences of MAPS. The objectives of this study are to determine: 1) the extent to which MAPs may be experiencing mental health issues, specifically hopelessness, shame, guilt, and loneliness; 2) whether they experience possible criminogenic needs, specifically: impulsivity, lack of empathy, and a lack of morality; and, 3) MAPs' experiences with help-seeking by examining who MAPs have disclosed their interests to, and how support systems may have helped manage, or intensified, their sexual desires.

3.2 Method

This study was approved by the University of Ontario Institute of Technology's Research Ethics Board (REB #14048). In addition, the study was designed with input with moderators from Virtuous Pedophiles and B4UAct. An earlier vision for this study considered offending history and additional criminogenic needs (e.g., antisociality, cognitive distortions, etc.), however the moderators were not willing to support this proposed line of research. The feedback I received indicated that I would not be given permission to access the users of those organizations if I chose to continue down that path. In discussion with those moderators, I decided to shift the focus from a study that could be perceived as assuming all MAPs will offend to one that highlighted the needs of MAPs as complex individuals.

3.2.1 Participants

Individuals were included for participation if they had completed at least one of the questionnaires leading to a total of 160 individuals in this study. Participants were nearly equally male and female (51.9% vs 46.3% respectively), majority Caucasian (55.6%; 16.3% South Asian, 6.3% each Black and Middle Eastern, 3.8% each East Indian, Latino/Hispanic, and Other, 2.5% West Indian, and 0.6% Native/Aboriginal), with an average age of 29.21 years (*SD* = 12.91). Two groups of participants were recruited; individuals who self-identify as pedophilic (as determined by their recruitment source; n = 84) and community members who were not known to self-identify as pedophilic (n = 76). Pedophilic participants were recruited from one of three online support groups for pedophiles; one of which was a 'Virtuous' (i.e., support intended to discourage sexual contact with children) support forum (Virped.org), and two 'ChildLove' support forums (annabelleigh.net; boychat.org). Community members consisted of undergraduate students and individuals recruited from social media via snowball sampling.

3.2.2 Procedure

Participants with pedophilia were recruited through the various online support forums listed above. A forum post was made on each of the three forums recruiting willing individuals. Community members were recruited via announcements on social media inviting participants to complete the study or through an online portal accessible through the university. The link to the study was active for 2 years, after which time the study was closed. Once participants clicked on the link, the survey page opened to the Informed Consent form. Participants were given the opportunity to read about the study and decide whether they would like to continue or withdraw from the study. Once participants read the Informed Consent form, and agreed to continue with the study,

they were presented first with the general information questionnaire. They were then presented the MFQ, the IRI, the UCLA Loneliness Scale, the BHS, the PFQ-2, and the BIS-11. These measures were displayed in random order, for all participants to eliminate any order effects. No questions in this survey were forced response, therefore participants could choose to answer only those questions they were comfortable answering making the *n* values different for each question. After participants completed all questionnaires, they were debriefed in full (Appendix S), using an online debrief form, and given the opportunity to leave comments or questions for the researchers.

3.2.3 Measures

Measures were selected based on their brevity and psychometric properties. Although several were considered, the ones I ultimately selected were relatively short to minimize the time commitment to complete the study while maintaining good reliability and validity.

3.2.3.1 Beck's Hopelessness Scale (BHS)

Beck's Hopelessness Scale (Beck et al., 1974) measures an individual's feelings of hopelessness. The scale consists of 20 items that ask about expectations for the future, feelings about the future, and loss of motivation. When tested for its psychometric properties, internal consistency for the scale was high, Chronbach's Alpha = 0.93, and the scale was shown to correlate with other measures of hopelessness (i.e., Beck Depression Inventory (pessimism item); $r = 0.63$, $p < 0.001$, Beck 1967; Stuart Future Test; $r = 0.60$, $p < 0.001$, Stuart, 1962, as cited by Beck et al., 1974).

3.2.3.2 Personal Feelings Questionnaire – 2 (PFQ-2)

The PFQ-2 (Harder & Zalma, 1990) measures an individual's feelings of shame or guilt. Participants are asked to rate 22 words that relate to shame and guilt based on how frequently they experience those feelings. Scores are then calculated for two subscales: Shame Proneness and Guilt Proneness. Both shame and guilt demonstrated acceptable internal consistency in validation samples (Harder & Zalma, 1990), Chronbach's Alpha = 0.78 and 0.72 respectively. Both subscales also demonstrated significant, positive correlations with depression (Shame: $r = 0.41$; Guilt: $r = 0.39$), public self-consciousness (Shame: $r = 0.30$; Guilt: $r = 0.46$), and self-derogation (Shame: $r = 0.39$; Guilt: $r = 0.46$) providing evidence for their construct validity (Harder & Zalma, 1990).

3.2.3.3 UCLA Loneliness Scale

The UCLA Loneliness Scale (Russell et al., 1978) measures individuals' perceptions of their social well-being. The scale contains 20 questions about how socially connected to others the individual feels. Internal consistency for the scale was very high, Chronbach's Alpha = 0.96, with a test-retest reliability of 0.73 in validation samples (Russell et al., 1978). Russell et al. (1978) found UCLA loneliness scores to strongly correlate to subjects' self-reported current loneliness ($r = 0.79$, $p < 0.001$), as well as depression ($r = 0.49$, $p < 0.001$) and anxiousness ($r = 0.35$, $p < 0.001$) lending support for the validity of the measure.

3.2.3.4 Barratt's Impulsiveness Scale – 11 (BIS-11)

Barratt's Impulsiveness Scale – Version 11 (Patton et al., 1995) measures an individual's impulsivity along 3 major traits: non-planning, cognitive, and motor. The scale consists of 30 items that ask participants to rate how often they engage in various

behaviours/actions. There are 6 inter-correlated subscales of the BIS-11: perseverance, self-control, cognitive instability, motor impulsiveness, attention, and cognitive complexity. Average internal consistency across development samples yielded a Chronbach's Alpha = 0.81, with individual values ranging from 0.79 to 0.83 (Patton et al., 1995). A systematic review of the psychometric properties of the BIS-11, the scale was found to demonstrate positive correlations with such impulse related behaviour as gambling, binge eating, suicidal ideation, and using alcohol as a coping mechanism (Vasconcelos et al., 2012).

3.2.3.5 Interpersonal Reactivity Index (IRI)

General empathy was measured using the Interpersonal Reactivity Index (Davis, 1980). This scale consists of 28 questions that examine individuals' reactions to the experiences of another person, falling on 4 subscales (perspective taking (PT); fantasy (FS); empathic concern (EC); personal distress (PD). Internal consistencies for the subscales range from 0.71-0.77, falling in the acceptable range, and test-retest reliability for the subscales ranges from 0.62-0.71 (Davis, 1980).

3.2.3.6 The Moral Foundations Questionnaire (MFQ)

The Moral Foundations Questionnaire (Graham et al., 2011) is used to determine participant's moral standards along 5 different foundations (Harm, Fairness, Ingroup, Authority, and Purity). The harm and fairness scales are thought to represent universal, individual ethical behaviour, ingroup and authority scales make up group morality and group dynamics, while the purity scale depicts a spiritual or religious morality (Graham et al., 2011). This questionnaire consists of 30 questions, answered on a 6-point Likert scale (0 = not at all relevant, 5 = extremely relevant). The average internal consistency

across all subscales falls in the good range, Cronbach's Alpha = 0.83, with a range of 0.65-0.84. There is also evidence for the validity of each subscale as each subscale correlated highest with measures of related criterion (Graham et al., 2011).

3.2.3.7 General Information Questionnaire

The general information questionnaire was developed specifically for this study. The questionnaire includes basic demographics information (i.e., age, gender, etc.), information regarding alcohol and drug use, questions about individuals' romantic relationships, what support systems an individual has/has sought, obstacles to help-seeking, and offense history.

3.2.4 Compensation

In exchange for participation, participants who self-identified as pedophilic and those recruited through social media were invited to enter a draw for a $100 Amazon gift card. Being entered into the draw was completely voluntary and required participants to enter their name and email address into a separate form from the survey in order to ensure their responses remain anonymous. In addition, it was not possible to identify which names were associated with which recruitment source. Undergraduates were compensated with course credit.

3.3 Results

In this sample of MAPs (*N* = 84), almost one third had never disclosed their sexual interests to another person (28.6%; *n* = 24). Of those that had disclosed, MAPs most commonly disclosed to a friend (19.0%; *n* = 16). Similarly, almost half of MAPs in this sample had never sought professional support for issues related to their minor attraction (45.2%; *n* = 38), and less than one third had sought individual therapy (27.4%;

n = 23). Of those who sought professional help, 14 found the support helpful in managing their sexual desires and 6 found that it hindered their ability to manage their sexual desires.

3.3.1 Mental Health Targets

MAPs and non-MAP community participants differed significantly in age, $t(103) = 6.27$, $p < 0.001$, and gender, $\chi^2(1) = 65.48$, $p < 0.001$, so both variables were included as covariates in all analyses. MAPs were significantly older ($M = 36.70$, $SD = 14.22$) and more likely to be male (98.2%) than community members (age: $M = 22.92$, $SD = 6.84$; male gender: 23.1%).

I conducted a one-way multivariate analysis of covariance (MANCOVA) to determine if MAPs significantly differed from community members on several mental health targets (i.e., loneliness, hopelessness, and feelings of shame and guilt). I found a significant multivariate difference between groups on the mental health targets when controlling for age and gender, Wilks's $\Lambda = 0.85$, $F(4, 62) = 2.75$, $p = 0.036$, $\eta^2 = 0.150$.

I then conducted individual analyses of covariances (ANCOVA) on the dependent variables as a follow-up to the MANCOVA. See Table 1 for means and standard deviations of each group for each mental health target. Using the Bonferroni method (Field, 2013), each ANCOVA was tested at the .013 level. MAPs experienced significantly more hopelessness than community members, $F(1, 65) = 5.23$, $p = 0.025$, $\eta^2 = 0.08$. The groups did not differ on feelings of shame, $F(1, 65) = 0.47$, $p = 0.497$, $\eta^2 = 0.01$, or guilt, $F(1, 65) = 1.23$, $p = 0.273$, $\eta^2 = 0.02$. However, MAPs also experienced significantly more loneliness than community members, $F(1, 65) = 9.99$, $p = 0.002$, $\eta^2 = 0.13$.

3.3.2 Potential Criminogenic Needs

3.3.2.1 Impulsivity

An identical procedure was used in order to determine if MAPs were more impulsive than community members. A one-way ANCOVA on the total BIS-11 score revealed no significant difference, $F(1, 54) = 2.90$, $p = 0.094$, $\square^2 = 0.05$.

I also conducted a one-way MANCOVA using the BIS-11 subscales to determine if MAPs significantly differed from community members. See Table 4 for means and standard deviations of each group. This also revealed a non-significant multivariate difference between groups, Wilks's $\square = 0.93$, $F(3, 52) = 1.29$, $p = .286$, $\square^2 = 0.07$.

3.3.2.2 Empathy

In order to determine if MAPs were less empathic than community members, I conducted a one-way ANCOVA on the total IRI score. Analysis revealed no significant difference, $F(1, 73) = 0.15$, $p = 0.70$, $\square^2 = 0.00$.

I also conducted a one-way MANCOVA using the IRI subscales to determine if MAPs significantly differed from community members. See Table 3 for means and standard deviations of each group. This revealed a non-significant multivariate difference between groups, Wilks's $\square = 0.94$, $F(4, 70) = 1.14$, $p = .345$, $\square^2 = 0.06$.

3.3.2.3 Morality

Finally, I conducted a one-way MANCOVA to determine if MAPs significantly differed from community members on facets of morality (i.e., harm, fairness, in-group loyalty, respect for authority, and purity). I found a significant multivariate difference between groups, Wilks's $\square = 0.66$, $F(5, 62) = 6.34$, $p < .01$, $\square^2 = 0.34$.

I conducted individual analyses of variances (ANOVA) on the facets as a follow-up to the MANOVA. See Table 5 for means and standard deviations of each group for each facet. Using the Bonferroni method, each ANOVA was tested at the .01 level. Community members were significantly more loyal to their in-group than MAPs, $F(1, 66) = 8.50$, $p = 0.005$, $\square^2 = 0.11$, showed more respect for authority, $F(1, 66) = 12.83$, $p = 0.001$, $\square^2 = 0.16$, and more purity, $F(1, 66) = 18.06$, $p < 0.01$, $\square^2 = 0.22$. The groups did not differ on fairness, $F(1, 66) = 1.73$, $p = 0.193$, $\square^2 = 0.03$, or doing harm, $F(1, 66) = 2.76$, $p = 0.101$, $\square^2 = 0.04$.

3.4 Discussion

Overall the results of this study indicate that MAPs report having distressing mental health issues that they are seeking support for. These needs are deserving of attention. In terms of mental health treatment targets, I found that MAPs in this sample were experiencing significantly more hopelessness and loneliness than the community participants but were not experiencing more shame or guilt. Similarly MAPs in this sample exhibited few criminogenic needs; they were no less empathic or impulsive than the community participants. On the other hand, this sample of MAPs did exhibit differences in morality when compared with the community participants. They scored lower in the domains of loyalty to an in-group, respect for authority, and purity, but did not score significantly different on fairness or doing harm.

These results lend empirical support to the self-report studies that have already been conducted. For example, Levenson and Grady (2019) identified loneliness as a common theme among MAPs, who tended to be isolated from others in their life since they could not be their authentic selves. In addition, they found that MAPs reported

suffering from depression and sadness related to being unable to achieve sexual gratification. Stevens and Wood (2019) also identified mental health issues as significant among MAPs, with many experiencing anxiety related to finding appropriate partners. These previous findings suggest that MAPs may have a more hopeless view about their future; a finding supported by the results of this study. Their attraction to children limits their opportunity for sexual gratification, particularly for those who are exclusively attracted to children, which may lead to their increased feelings of hopelessness.

A predominant theme across stigma research is that anyone with an attraction to children is viewed as a monster and poses a danger to society (e.g., Jahnke et al., 2015a, b). This is also evident in the media portrayal of all individuals who offend against children as having pedophilic sexual interests. This image of the 'monster' assumes a lack of empathy for others and an impulsive nature. Contrary to this belief, the findings of this study indicated MAPs are equally as empathic and impulsive as the community participants. In fact, Schuler et al. (2019) found that an empathy deficit was characteristic of individuals with pedophilic sexual interests only when they had committed contact offenses against a child. Individuals with pedophilic sexual interests who had not committed contact offenses against a child actually demonstrated enhanced empathic abilities. Similarly, men with pedophilic sexual interests who have not acted on their attractions discussed potential harm to a child in their choice to not act (Mitchell & Galupo, 2018b). This indicates a level of empathic concern for the well-being of children, contrary to the stigma ascribed to MAPs. In a similar study about the decision not to act, men with pedophilic sexual interests frequently discussed their

ability to control themselves either in general or through the use of problem-solving when making decisions (Mitchell & Galupo, 2018a). This finding is mirrored by the current findings, where MAPs did not score significantly differently than the community participants on impulsivity. In the same way that most teleiophilic individuals (i.e., those who are sexually attracted to adults) do not engage in offending behaviour simply because of their sexual age preference, MAPs do not inevitably offend against children simply because they may be attracted to them.

Similarly, such messaging ascribes an individual immoral quality to individuals with an attraction to children. The results of this study did not support such immorality; MAPs were not significantly more immoral in the domains of fairness or doing harm than the community participants. The domains of fairness and doing harm are those that are considered universal across cultures, and to represent individual ethical behaviour (Graham et al., 2011). In this respect, the MAPs in this sample uphold expectations for basic morality and are not the 'monsters' some believe them to be. In terms of group dynamics (i.e., authority and ingroup) MAPs did score significantly lower than the community participants. While it may be easy to regard this as evidence of an immoral quality, it may be more reflective of how minor attraction is treated in society. It is possible that MAPs find it difficult to respect an authority (e.g., law enforcement, medical professionals, judicial system, etc.) that consistently assumes they are all offenders and will inevitably hurt a child. Similarly, given the stigma associated with minor attraction and the limited support systems most MAPs have, it is understandable that they do not necessarily associate themselves with this ingroup or show a typical moral quality for ingroup members.

3.4.1 Limitations and Future Directions

One limitation of this study that deserves mentioning is that it does not discuss differences between those who have and have not offended against children. While it is important to gain a better understanding of the mental health needs of all MAPs, this could neglect important differences between those who have offended and those who have not. Future research should examine whether there are differing mental health needs between these two groups. This could provide important information about the specific risk factors for offending for MAPs and allow support and treatment to be provided prior to an offense for those who are at risk, thus aiding in the prevention of child sexual abuse.

Secondly, this study focuses on a limited number of mental health treatment targets that were identified through previous qualitative work. These likely do not depict a complete picture of all the mental health needs of MAPs. Additional work should focus on other targets (e.g., depression, anxiety, suicidal ideation, etc.) in order to better understand the unique struggles of MAPs. By developing a more complete picture of the needs of MAPs we can better understand how to assist them and develop treatment that is sensitive to their needs.

An additional limitation is related to the amount of complete data obtained. Since none of our questions were forced choice, many participants opted to complete only certain questionnaires in the study. This led to there being many different *n* values in the analyses, with some questionnaires having less than a 50% completion rate. The analyses may be affected by this in not only their power but by a possible self-selection bias of individuals who chose to complete each questionnaire. For example, individuals

may have avoided questionnaires that they found distressing which could lead to a positive skew on the results for that analysis.

3.4.2 Conclusion

This study examined the mental health needs of minor attracted persons (MAPs). Overall, I found MAPs to be struggling with hopelessness and loneliness, but they were not less empathic or more impulsive than the community participants. In addition, MAPs were equally as moral as the community participants in terms of individual morality and only showed differences when it came to group dynamics. These results indicate that MAPs have specific mental health needs for which they could benefit from treatment, but these needs are not reflective of the stigmatizing image of minor attracted depicted in mainstream media.

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Table 1

Comparison of MAP and Non-MAPs Mean scores across measures.

Measure		MAPs			Non-MAPs			Total		
		n	*M*	*SD*	*N*	*M*	*SD*	*n*	*M*	*SD*
MFQ	Harm	38	30.00	4.07	37	28.00	6.02	75	29.01	5.19
	Fairness		28.63	3.63		27.03	5.58		27.84	4.73
	Loyalty		16.68	5.48		23.16	5.30		19.88	6.27
	Authority		17.34	5.77		23.84	5.37		20.55	6.43
	Purity		13.37	6.37		24.43	6.18		18.83	8.36
	Total		67.67	13.30		69.36	12.40		68.48	12.83
IRI	PT	43	19.00	5.48	39	19.49	4.62	82	19.23	5.07
	FS		16.84	4.67		16.51	5.38		16.68	4.99
	EC		20.53	5.10		20.79	4.40		20.66	4.75

	PD		11.07	5.01		12.44	3.86	11.72	4.53
UCLA		34	36.44	12.90	39	16.31	13.37	73 25.68	16.52
BHS		34	10.06	6.50	39	3.49	3.28	73 6.55	5.60
PFQ2	Shame	34	17.47	9.23	39	15.31	7.47	73 16.32	8.35
	Guilt		10.65	5.62		8.82	4.54	9.67	5.12
BIS-11	Total	28	63.39	11.61	35	61.34	9.17	63 62.25	10.29
	Attention		17.61	4.66		16.40	3.82	16.94	4.22
	Motor		21.79	5.04		21.77	4.28	21.78	4.60
	NoPlan		24.00	5.07		23.17	4.02	23.54	4.50

Chapter 4

4.1 Introduction

Given the wide variety of potential negative repercussions of child sexual abuse (RAINN, 2017), it is important that psychological services be offered to those at greatest risk of abusing children in order to minimize this harm (Beier et al., 2009). One of the strongest predictors of sexual abuse against a child is a predominant sexual interest in children (Babchishin et al., 2015). Although this risk may never be actualized, it stands to reason that those with a sexual interest in children would pose a higher offending risk than others without such an interest. In addition to the risk of harm to children, *experiencing* a sexual interest in children can also take an emotional and social toll. Evidence suggests there is a higher prevalence of mental health issues among people who have committed sex offenses (e.g., Carlstedt et al., 2005). When this emotional toll brings harm and affects the individual's day to day functioning or when an individual harms a child (i.e., sexually offends against a child) an individual may actually be diagnosed with *pedophilic disorder* (American Psychiatric Association, 2013). However, this emotional toll is also evident when the person has never acted on their sexual interest in children or there is no significant harm to themselves (Walker, 2021). This increased risk of developing mental health issues highlights the importance of prevention efforts to ensure services are provided prior to the development of such issues. However, there are barriers to the provision of psychological services for individuals with a sexual interest in children, and in particular, those who choose not to engage in offending behaviour (Minor Attracted Persons or MAPs) who wish to seek support. These individuals are not entitled to care under a criminal justice umbrella

because they have not committed any crimes, thus their options for treatment are more limited.

4.1.1 Treatment Needs

Living with a sexual interest in children comes with significant emotional and social strain. Many MAPs report experiencing negative mental health outcomes related to their experience as a MAP (e.g., Cacciatori, 2017; Cohen et al., 2018; Walker, 2021). For example, in one study, almost one third of MAPs reported having had suicidal thoughts, while a quarter had made at least one suicide attempt (Levenson & Grady, 2019). In addition, over half of MAPs surveyed have indicated a desire to access mental health services for issues unrelated to managing their sexual attraction (i.e., not acting on their desires), such as having a negative self-concept, handling negative societal response to their attraction, and coping with sexual frustration (B4U-Act, 2011).

MAPs also report clinically significant mental health struggles for which access to mental health treatment would be beneficial (Walker, 2021). One of the most commonly reported reasons for seeking therapy among MAPs is feelings of hopelessness and depression (Cacciatori, 2017). In the previous chapter of this dissertation, MAPs in this sample reported significantly more hopelessness and loneliness than the community sample. Both emotional states have been shown to be precursors to depression and/or depressive symptoms in different populations (e.g., hopelessness in undergraduate students; Nalipay & Ku, 2019; loneliness in older adults; Holvast et al., 2015). Combined with the high incidence of suicidal ideation among MAPs (e.g., Cohen et al., 2020), there is little doubt about the need for MAPs to have access to mental health treatment.

Indeed, many MAPs report having sought, or having a desire to seek, mental health treatment (e.g., B4U-Act, 2011; Levenson & Grady, 2019; Walker, 2021).

4.1.2 Barriers to Treatment

There are likely many barriers that MAPs must overcome in order to access treatment. A few of these barriers are: perceived barriers, stigma, mandatory reporting, and lack of access to therapists with relevant experience.

4.1.2.1 Perceived Barriers

There are several deterrents that MAPs report experiencing when thinking about therapy. First and foremost, MAPs indicate that they do not seek mental health treatment for fear of being reported to authorities, despite many never having committed an offense against a child (e.g., Grady et al., 2019; Levenson et al., 2017). They also fear being judged or stigmatized for their attraction (Cacciatori, 2017), such as being typecast as a child molester or a danger (Grady et al., 2019). Furthermore, MAPs describe possible systemic barriers to accessing treatment citing lack of knowledgeable treatment providers, limited awareness of available services, and the high financial cost (e.g., Levenson & Grady, 2019). Not only are these *perceived* barriers experienced by MAPs, but there are additional tangible barriers to MAPs receiving mental health treatment.

4.1.2.2 Stigma

For MAPs, one major barrier on the path to treatment is stigma (i.e., negative judgment or assessment of a group) toward individuals with a sexual interest in children. Of all mental illnesses, pedophilic disorder is one of the most stigmatized. In comparison to individuals with alcoholism, those with pedophilic disorder have greater

anger and less pity shown towards them (Jahnke et al., 2015a). Furthermore, those with pedophilic disorder are feared more than individuals with alcoholism (Jahnke et al., 2015a). In addition to prejudice or stereotyped beliefs, individuals identified as pedophilic experience strong discrimination against them (Jahnke et al., 2015a). For example, large proportions of individuals discriminate against individuals with pedophilia by desiring greater social distance from them (Jahnke et al., 2015b). Nearly half of all individuals surveyed believe individuals with pedophilia should be imprisoned, while over a quarter express that individuals with pedophilia would be better off dead (Jahnke et al., 2015a).

Mental health professionals generally hold more positive views of those with mental illness than others (Peris et al., 2008). For example, people with mental health training indicate a greater belief in the competence of individuals with mental illness than people without any mental health training (Peris et al., 2008). However, even mental health professionals are not immune to stigmatizing attitudes (Jahnke et al., 2015b). Clinician attitudes toward individuals with pedophilia can greatly affect their willingness to treat individuals with pedophilic disorder (Stiels-Glenn, 2010), and the quality of the treatment they provide (Schulze, 2007). While many clinicians report fewer negative beliefs than community members, such as beliefs about the controllability of pedophilia and dangerousness of individuals with pedophilic disorder, a significant proportion still desire social distance from pedophilic individuals (Jahnke et al., 2015b). Additionally, many clinicians identify having a lack of knowledge or understanding about pedophilic disorder as a reason for their unwillingness to treat individuals with the disorder (Stiels-Glenn, 2010). For example, student mental health professional trainees

may be unaware of the distinction between an individual with pedophilia and a child molester (Walker et al., 2022) and thus unaware of their treatment needs.

4.1.2.3 Mandatory Reporting

An additional barrier to treatment is mandatory reporting laws that exist in countries such as the United States and Canada. These laws specify that anyone who suspects abuse of a child must report their suspicions to the appropriate authorities. Specifically, in the United States, anyone who 'suspects or has reason to believe' (Child Welfare Information Gateway, 2016, pg. 3) that a child has been or is in danger of being harmed must report that to law enforcement or child protective services (Child Welfare Information Gateway, 2016). Similarly, in Canada, individuals are required to report any child they believe to be in need of protection from a Children's Aid Society (CAS) under the Child and Family Services Act in their province (e.g., Government of Ontario, 2010). In addition to these legal duties, most psychological professional associations build an ethical duty to report into their mandates. For example, professionals registered with the Canadian Psychological Association are required to maintain client confidentiality "except as required or justified by law, or in circumstances of possible imminent serious bodily harm" (Canadian Psychological Association, 2017, pg. 17). While these laws are certainly meant to protect children, their language is unclear and rather ambiguous. This leaves many professionals in a position of uncertainty over whether or not they must report a particular situation. Given that a sexual interest in children is a strong predictor of child sexual abuse (Babchishin et al., 2015), it is understandable that mental health professionals may be uncertain about their reporting requirements should someone self-identify as being having pedophilic sexual interests.

4.1.2.4 Existing Treatments

Despite the aforementioned barriers, there are some existing treatment programs for MAPs. The first of such programs was the Prevention Project Dunkelfeld (PPD; Beier et al., 2009) which is run in Germany. This campaign used marketing and advertisements to seek individuals who self-identified as having a sexual interest in children and were concerned about their behaviour. They then provided group, in-person treatment that addressed several dynamic risk factors and problematic sexual behaviours (Beier et al., 2015). One reason it is possible to run this program is that there are strict mandatory confidentiality laws that exist in Germany, protecting individuals unless there is unequivocal evidence a crime has been committed already. In North America there are two similar programs (i.e., Stop It Now!; Talking for Change) that provide anonymous services for those concerned about their own behaviour or another's behaviour toward children. These services are certainly essential for those who need them and represent important steps in the effort of prevention of child sexual abuse. However, they are still predicated on the individual seeking treatment being an imminent risk or there being a concern about them offending, leaving out those who live at the intersection of having a sexual interest in children and having mental health concerns.

Although treatment options are available, many MAPs are not accessing them. There is a belief among MAPs that clinicians have a lack of understanding of their needs and would not be willing to help them or at least be knowledgeable about where to refer them to seek help. Currently, there is a dearth of research into what experiences clinicians have had treating MAPs and what they may believe about them.

4.1.3 Current Study

The current study aimed to add to the current knowledge base regarding clinicians' experiences with and willingness to provide mental health treatment to MAPs. The research questions were as follows:

(1) Do health professionals understand that sexual contact with a child is not a requirement for diagnosis of pedophilic disorder?

(2) Would health professionals be willing to treat someone who self-identifies as having sexual interest in children? Under what conditions?

(3) What experiences do health professionals have with treating individuals with sexual interest in children?

(4) Do health professionals have any stigmatizing beliefs regarding individuals with sexual interest in children? If so, do these affect their willingness to treat them?

4.2 Method

4.2.1 Participants

In total 26 participants took part in this study. Participants ranged in age from 31 to 70 years old, with an average age of 53.08 years (*SD* = 11.59). Majority were female (65.4%, *n* = 17; 26.9% male, *n* = 7; 2 missing responses), White (84.6%, *n* = 22; 7.7% Hispanic, *n* = 2; 2 missing responses), and heterosexual (80.8%, *n* = 21; 7.7% other, *n* = 2; 3.8% homosexual, *n* = 1; 2 missing responses). Participants held one of 3 designations: a PhD (*n* = 12; 46.2%), a Master's degree (*n* = 9; 34.6%), or an EdD (*n* = 3; 11.5%) [two responses were missing].

4.2.2 Procedure

Participants were recruited through the various psychological and medical associations listed above. The survey was available for 2 years, during which time two notices each were sent to the CPA and ATSA platforms, several emails were sent to each of the individual APA divisions, and several cold calls were made to the CPSO over a period of months. Once participants were provided a link to the study, they were redirected to the survey on the Qualtrics Platform (Qualtrics, Provo, UT). This link opened the survey page to the Informed Consent form where participants read about the study and decided whether they would like to continue or withdraw from the study. They were then presented with The Controllability Scale, The Dangerousness Scale, the Social Distance Scale, and a general information questionnaire all in a randomized order. After participants completed all questionnaires, they were debriefed in full and given the opportunity to leave comments or questions for the researchers. In total the survey took approximately 60 minutes.

4.2.3 Recruitment: Professional Associations

Several professional organizations were chosen to recruit participants from. Organizations were selected based on the possibility that professionals in that organization may have been in a position in which individuals with pedophilic sexual interests could possibly disclose those interests to them. Large and well-recognized organizations which allowed access to a large number of potential participants were targeted.

4.2.3.1 American Psychological Association

The American Psychological Association (APA) is the largest professional organization for psychology professionals (American Psychological Association, 2017).

It has over 100,000 members including students, researchers, clinicians, educators, and consultants. The organization aims to use psychological knowledge to benefit society and improve the lives of others (American Psychological Association , 2017). Within the APA there are 54 divisions that represent subdisciplines or topic areas. From these 54 divisions, I selected 23 that were potentially relevant to the current study or that may benefit from the current study. From these, those that allowed recruitment via mailing lists were identified. In the end participants were recruited from divisions 8 (Society for Personality and Social Psychology), 17 (Society of Counseling Psychology), 41 (American Psychology-Law Society), 42 (Psychologists in Independent Practice), and 44 (Society for the Psychology of Sexual Orientation and Gender Diversity).

4.2.3.2 Canadian Psychological Association

The Canadian Psychological Association (CPA) is very similar to the APA, including a similar membership structure and goals. The major difference is that the CPA aims to improve the lives of, and benefit, Canadian society (Canadian Pschyological Association, n.d.).

4.2.3.3 Association for the Treatment of Sexual Abusers

The Association for the Treatment of Sexual Abusers (ATSA) is an international organization whose mission is to prevent child sexual abuse. Its members are multidisciplinary, promoting professional excellence in the assessment, treatment, and management of sexual abusers.

4.2.3.4 College of Physicians and Surgeons of Ontario

The College of Physicians and Surgeons of Ontario (CPSO) is a regulatory body for medical professionals in Ontario. Using the doctor search function, I compiled

contact information for all general practitioner physicians in the Durham Region of Ontario. Once that information was compiled, an undergraduate research assistant cold called each physician to assess their willingness to participate in the study. Some provided email addresses to which I could forward the survey link, while others provided fax numbers to which I could send the information.

4.2.4 Data Collection

The platform Qualtrics (Qualtrics, Provo, UT) was used to host the questionnaire and collect the data. All data collected is the property of the researchers and is not stored on Qualtrics databases. IP address collection was turned off by using an 'Anonymize responses' feature, and names and email addresses are never collected by the website.

4.2.5 Measures

Several measures were used to assess attitudes toward treatment of individuals with pedophilic sexual interests.

4.2.5.1 The Controllability Scale

The Controllability Scale (developed by Jahnke et al., 2015a) measures beliefs about whether individuals with pedophilic sexual interests can control their sexual interest or not. It consists of 3 items rated on 7-point Likert scale (0 = *do not agree at all* to 6 = *completely agree*). Scores can range from 0 to 18, with higher scores indicating a belief that individuals with pedophilic sexual interests have choice regarding their sexual attractions. Jahnke et al. (2015a) report good reliability of the scale (Cronbach's α = 0.89).

4.2.5.2 The Dangerousness Scale

The Dangerousness Scale, developed by Jahnke et al. (2015a), measures individuals' beliefs about people with pedophilic sexual interests being a danger to others. It consists of 3 items rated on 7-Point Likert Scale (0 = *do not agree at all* to 6 = *completely agree*). Scores can range from 0 to 18, with higher scores indicating a belief that individuals with pedophilic sexual interests are dangerous to others. Jahnke et al. (2015b) report acceptable reliability at pretest (Chronbach's α = 0.70).

4.2.5.3 The Social Distance Scale

The Social Distance Scale was developed by Jahnke et al. (2015a) and addresses individuals' willingness to interact with other people at various levels of social contact. Its 6 items are rated on a 7-point Likert scale (0 = *do not agree at all* to 6 = *completely agree*). Scores can range from 0 to 36, with higher scores indicating a desire for more social distance from individuals with pedophilic sexual interests. Reliability has been reported as good (Cronbach's α = 0.82; Jahnke et al., 2015a).

4.2.5.4 General Information Questionnaire

The general information questionnaire was developed specifically for this study. This questionnaire includes basic demographics information (i.e., age, gender, etc.), and questions regarding willingness to treat individuals with pedophilia.

4.2.6 Compensation

In exchange for participation participants were invited to enter a draw for a $50 Amazon gift card. Being entered into the draw was completely voluntary and required participants to enter their name and email address into a separate form from the survey in order to ensure their responses remained anonymous.

4.3 Results

Response to this survey was limited and, ultimately, the 26 responses came from participants on the ATSA Listserv (n = 20) and the CPA R2P2 portal (n = 4) [two responses were missing]. Given this limited sample size, all presented results will be descriptive in nature. In addition, no questions were forced choice, therefore participants could choose which questions to respond to resulting in differing n-values for some questions.

4.3.1 Stigmatizing Beliefs

Overall, participants recognized that physical contact with a child was not a necessary requirement for a diagnosis of pedophilic disorder (n = 21). Participants did not have a strong belief that individuals with pedophilic sexual interests had influence over those interests (M = 2.29, SD = 2.44). Similarly, participants did not overly believe that individuals with pedophilic sexual interests were dangerous to others (M = 6.71, SD = 3.16). However scores for items regarding danger to children (M = 3.38, SD = 1.21) and adolescents (M = 2.54, SD = 1.59) were significantly higher than for adults (M = 0.79, SD = 1.03), $t_{child}(23) = 9.38$, $p < 0.001$, $d = 1.92$, $t_{adolescent}(23) = 5.68$, $p < 0.001$, d = 1.16, indicating participants believe individuals with pedophilic sexual interests are more dangerous to children or adolescents than they are to adults. Conversely, participants held strong desires to maintain social distance from individuals with pedophilic sexual interests (M = 31.04 SD = 5.45).

4.3.2 Treatment

Most of the participants in this study had treated an individual with pedophilic sexual interests in the past (76.9%, n = 20) while only 1 had not (3.8%). Treatment approaches were widespread and overlapping including cognitive behavioural therapy

(69.2%, *n* = 18), relapse prevention therapy (57.7%, *n* = 15), dialectic behaviour therapy (19.2%, *n* = 5), pharmacology (19.2%, *n* = 5), cognitive therapy (19.2%, *n* = 5), and behaviour therapy (15.4%, *n* = 4).

The vast majority of participants said they would be willing to treat an individual who had a sexual interest in children regardless of whether or not they had previously molested a child or used child sexual exploitation material (95.2%, *n* = 21) while only 1 participant responded no to these prompts (4.8%). Opinions about the best treatment approach varied with cognitive behavioural therapy being the most frequently endorsed (38.1%, *n* = 8), followed by relapse prevention (14.3%, *n* = 3), cognitive therapy (9.5%, *n* = 2), and pharmacological treatment (4.8%, *n* = 1). Some other approaches that were suggested include a combination of treatments, the good lives model, and RNR.

When asked what they would do if an individual disclosed a sexual interest in children to them, 18 indicated that they would treat the individual, while three indicated they would refer the individual to a more qualified colleague. No participants indicated they would report the individual to authorities (i.e., child protective services or police) or refuse the individual.

4.4 Discussion

Clinicians in this study understood the requirements of the diagnosis for pedophilic disorder; namely, that an individual did not need to have had contact with a child to be struggling with their sexual interest. This distinction is important when considering that current treatment models for people with pedophilia have been designed for people who have committed sexual offenses. If clinicians understand that offending is not a precursor to pedophilic disorder, or pedophilia, there is a greater

chance they would opt for different forms of treatment for MAPs who have not offended that may be more appropriate for their treatment needs.

Another important finding of this study is that contrary to the belief of MAPs, none of the participants in this study indicated they would report an individual with pedophilia to the police or to Children's Services. Fear of being reported is one of the most commonly cited reasons by MAPs for not seeking therapy (e.g., Grady et al., 2019), making these findings promising for the future of therapeutic relationships with this group of people. This stance of not reporting may be influenced by the relative recency of several new programs in North America such as the introduction of *Stop It Now!* (Stop It Now!, 2021) based in Massachusetts, the *Help Wanted* online course developed by a group in Maryland (Help Wanted, n.d.), and even more recently *Talking for Change* located in Canada (Talking for Change, 2021). These programs which provide service, anonymously or non-anonymously, to individuals who self-identify as having a sexual interest in children are gaining traction.

Despite holding very few stigmatizing beliefs about MAPs, this pool of psychological professionals still expressed a desire to maintain some social distance from them. This could simply be a lack of experience with MAPs, if the professionals in this study have limited experience, or a product of internalized bias. It may be difficult to overcome this bias when we are inundated with negative perceptions of MAPs from mainstream media. However, there is some work that indicates these sorts of stigmatizing beliefs may be changeable (e.g., Harper et al., 2021). For example, Jahnke et al. (2015b) provided therapists in training with a brief online intervention designed to reduce stigma and increase motivation to work with people with pedophilia. After the

intervention, motivation to work with people with pedophilia remained unchanged but endorsement of several stereotypes was significantly reduced, and these effects remained at follow-up. This could indicate that although these professionals reported fewer stigmatizing beliefs, there remains some internalized biases behind their lack of motivation to work with MAPs. Nonetheless, it is promising that a brief intervention could reduce stigmatizing beliefs. Although the later career clinicians in this study do not appear to share the same beliefs, it is possible that they may benefit from similar interventions.

Over ninety percent of these participants had provided treatment to an individual with a sexual interest in children using a diverse range of treatment approaches. The most common approach was cognitive behavioural therapy (CBT), followed closely by relapse prevention therapy (RPT). This appears to align with treatment approaches used with individuals with other paraphilias or sexual disorders and people who have committed sexual offenses (McGrath et al., 2010). For example, Hallberg et al. (2019) provided treatment to men with hypersexual disorder. They used a randomized control study to examine the effects of CBT on symptoms of hypersexual disorder and accompanying psychological effects similar to those experienced by participants in Study 2 (e.g., depression, distress, etc.). Those in the treatment group saw significant reductions in hypersexual symptoms, depression, and psychiatric distress. These effects remained post treatment and at 3-month follow-up, and at 6-month follow-up the treatment group was still maintaining a reduction in psychiatric distress.

4.4.1 Implications

One of the major implications of this study is that there may be a disconnect between MAP beliefs about how they will be treated by therapists and how the therapists feel about providing treatment to MAPs. This indicates a need to bridge the communication gap between them. If therapists could more easily communicate with MAPs about their willingness to treat them, it might eliminate some of the hesitancy of MAPs to reach out to therapists. Indeed, one of the major barriers to seeking therapeutic interventions identified by MAPs is a lack of awareness about the available services or therapists willing to see them (Levenson et al., 2017). Similarly, men in Cacciatori's (2017) study indicated that although there are a lot of professional services available, there were not many specifically geared toward the needs of MAPs. While there is no singular answer to how to bridge this communication gap, perhaps if there were a directory MAPs could use to find therapists willing to engage them in treatment, they may be more inclined to seek out services from these willing and qualified professionals.

Another implication from this study is the finding that clinicians' most commonly preferred method of treating MAPs may actually align with the treatment goals MAPs have for themselves. Over one third of the clinicians in this study indicated that they believed cognitive behavioural therapy (CBT) to be the most effective method of treating MAPs. CBT targets an individual's negative or maladaptive thinking patterns in order to alleviate psychological distress (American Psychological Association , 2017) and has been shown effective in treating depression and anxiety, addictive disorders, as well as eating disorders. In addition, CBT has been used in the treatment of paraphilic disorders (e.g., Baez-Sierra et al., 2016) and hypersexual disorder (e.g., Hallberg et al., 2019). It

could be that CBT could be a particularly useful treatment for MAPs as they frequently describe many negative mental health outcomes related to their sexual attraction (e.g., B4U-Act, 2011; Cacciatori, 2017; Shields et al., 2020; Walker, 2021). For example, among a group of 30 young adults almost half had experienced significant mental health problems after coming to the realization that they had a sexual interest in children (Shields et al., 2020). Most notable of these problems were depression and anxiety, and participants also disclosed experiencing guilt and self-hatred after internalizing the social messaging that having a sexual interest in children inherently meant there was something morally wrong with them. These types of thoughts and experiences are ideal targets for CBT treatment.

4.4.2 Limitations and Future Directions

There are two obvious limitations to this study that must be considered. First of all, the sample size is very small. Despite the organizations I sent the study to for data collection representing up to 7500 members or more, there was a very low response rate. This limits the comparisons that can be made and any inferences that can be made from the results. In addition, any results that were found have limited statistical power. Although the recruitment strategy was extensive, further studies should be done using an even broader data collection approach if possible, or offering more incentives for participation, in order to increase the sample size given the low response rate. This will allow us to draw firmer conclusions about what the results could mean.

Another limitation that must be noted is the relative homogeneity of the current pool of participants. More than three quarters of this sample came from ATSA's listerv. Given that ATSA deals with a specific set of individuals (i.e., sexual abusers), these

participants likely have very specialized knowledge around atypical sexual interests and sexual behaviour. This could mean they have particularly favourable views regarding minor attraction, leading to the current results. Nonetheless, even if future studies using medical professionals from more diverse backgrounds found less optimistic results, having any group of professionals with favourable opinions toward minor attraction is a good first step to having them treated with dignity and compassion.

4.4.3 Conclusion

This study examined what stereotyped beliefs clinicians hold toward MAPs, and what their experiences were with treating them. Overall, most clinicians in this sample had treated an individual who was attracted to children using a variety of treatment methods. Cognitive behaviour therapy stood out as the most commonly used treatment method which aligns with the treatment needs and desired expressed by MAPs.

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Chapter 5

5.1 Discussion

The aim of this dissertation was to examine several aspects of the lived experiences of Minor Attracted Persons (MAPs). In particular, 3 broad topics were investigated. First, I investigated offence avoidance strategies used by MAPs when faced with a situation where they believed they could engage in sexual contact with a child. This was examined in Study 1 using a thematic analysis of the content of several online support forums for MAPs. Conversations were identified in which a specific mention was made to a potential offending situation and examined I then the actions reportedly taken by MAPs to avoid that offending behaviour.

I was also interested in the mental health needs of MAPs and their experiences with seeking help, whether professional or personal. To do this, in Study 2, I used a mixed methodology where I (1) compared MAPs scores on a number of measures to those of a community sample and (2) asked about the experiences they had with various kinds of support systems they utilized. The specific mental health targets examined were hopelessness, loneliness, shame and guilt, and the criminogenic needs were morality and impulsiveness.

Finally, I investigated whether psychological professionals had any experience with treating MAPs and if so, whether stereotypical beliefs affected their willingness to treat an individual who expressed a sexual interest in children. In Study 3, I used mixed methods to survey psychological professionals from two different organizations. I presented them with several validated measures related to stereotypical beliefs about

MAPs, as well as a questionnaire I developed asking about their experiences with MAPs.

5.1.1 Understanding MAPs and Their Needs

In Study 1 I identified 19 strategies, across 4 major themes, that MAPs reported using when in a situation where they believe(d) sexual contact with a child was possible to occur. These strategies ranged from simple avoidance techniques, to removing oneself from the situation, allowing a limited amount of contact with a child, and, finally, engaging in non-sexual physical contact with a child. By far the most frequently endorsed strategies were within the avoidance realm. MAPs had a greater tendency to not put themselves in a situation to be tempted or aroused more so than to react to a developing situation that was ongoing.

In Study 2 I looked at the mental health needs and potential criminogenic risk factors that MAPs endorsed. I found that, when compared to a community sample, MAPs experienced more hopelessness and loneliness, but not shame or guilt. In addition, they exhibited less loyalty to an in-group than community members, less respect for authority, and less purity. These results are not surprising given the stigma attached to living with a sexual interest in children and the way MAPs have been treated by the public. Being treated like monsters has forced MAPs into isolation, leaving them with little to no peers to relate to (i.e., an in-group) and fearful of anyone in a position of authority. It is understandable they have considerable feelings of hopelessness and loneliness.

Study 3 examined stereotypical beliefs held by psychological professionals as well as their experiences and opinions on treating MAPs. While this sample did not

believe that MAPs were dangerous or that their sexual interests were uncontrollable, they did still desire some social distance from them. This could reflect some internal biases conflating having a sexual interest in children with offending against children, making it less likely for individuals to want to welcome MAPs into their inner circle. That being said, the vast majority of the current sample had previously treated someone with a sexual interest in children. Though a variety of treatments had been used, the most common was cognitive behaviour therapy. This makes sense when accounting for MAPs self-reported difficulties with feelings of worthlessness and hopelessness, and low self-esteem (e.g., Blagden et al., 2018).

5.1.2 Implications for Treatment

Combined, the results from these studies indicate several things. Firstly, the MAPs examined did not seem to be struggling to manage their feelings of sexual desire, but rather the accompanied challenges. I was able to identify 19 strategies that they use to remain offense free through their unprompted dialogue on support forums. MAPs in this study reported these experiences to their peers, rather than specifically being asked to think about or to recall such situations in order to discuss offense avoidance strategies. This indicates that their choices to remain offense free are inherent in their everyday conduct. In addition, when participants in Study 2 were asked to explain why many of the supports available to them were not helpful in managing their sexual desires they explained that this was simply not a reason they accessed such supports. Managing their sexual desire was not a problem for which they needed support. Indeed, even young people who are just coming to terms with their attraction note that not wanting to hurt someone and understanding the harmful consequences of acting on

their desires are enough to ensure they never offend against a child (Shields et al., 2020). One participant in Shields et al. (2020) study even made it a point to mention they wished that people understood MAPs did not have to continuously fight their desires. Similarly, the desire to not cause harm to a child was the most commonly mentioned reason for not offending among some MAPs, indicating a level of intrinsic motivation (Mitchell & Galupo, 2018). This is akin to the way individuals with typical sexual interests are able to control their behaviour towards individuals they are attracted to.

There may also be significant distrust of psychological professionals in general on the part of MAPs that is perhaps misplaced due to their unfortunate first experiences with therapists who were not qualified to attend to their unique needs. None of the psychological professionals in this study indicated that they would report an individual if they disclosed a sexual interest in children, even if they had offended in the past. In a large sample of Canadian psychological professionals, only about half indicated they would make a report if an individual disclosed current usage of child sexual exploitation material (Stephens et al., 2021). This effect was partially explained by stigmatizing beliefs, such that more associated stigma led to a higher likelihood of reporting. This discrepancy may also be explained by consideration of the location where a therapist practices. Bayram et al. (2021) found that there were differences in thoughts and understanding about pedophilia among therapists practicing in different parts of the world. It is possible that the laws that exist within a country may shape the way therapists view treatment with MAPs. Combined with my findings from Study 3 (i.e., the psychological professionals examined held very few stigmatizing and indicated they

would not report a MAP to authorities), this indicates that there may be help available for MAPs if they are able to identify qualified and willing therapists.

On the other hand, the burden of reaching this underserved population could be placed onto practitioners. It is well established that a strong, positive therapeutic alliance is essential for success in any psychological treatment (e.g., von Boetticher, 2021). One aspect of this alliance is trust; something MAPs themselves have pointed to as a barrier to accessing treatment (i.e., their lack of trust in competent professionals; B4U-Act, 2011; Fine, 1996). To break down this barrier and open the doors for MAPs to engage with therapeutic services, practitioners should aim to create a safe environment where MAPs can build trust (e.g., Chouliara et al., 2023; Clement et al., 2015; Kirsh & Tate, 2006). This should begin by creating a non-judgmental atmosphere, where MAPs can talk about what issues they are facing without fear of scrutiny (e.g., Smith et al., 2013). Another way practitioners can increase the trust MAPs have in them is to exhibit a genuine interest in their life experiences and circumstances that brought them to therapy (Kirsh & Tate, 2006). Stigmatized groups, like MAPs, have a deep seeded mistrust of therapists and doctors (e.g., Grady et al., 2019; Negash et al., 2022) that must be overcome if these groups are to be accessed and helped.

5.1.3 Implications for Prevention Efforts

One way to prevent offending behaviour is to ensure those at risk are equipped with suitable skills to navigate a tempting or potentially dangerous situation. In Study 1, I found that MAPs may be engaging in self-regulating behaviours and problem-solving when trying to avoid an offending situation. Self-regulation has been shown to be a core skill that is a focus in many different CBT programs that address issues such as eating

disorders (e.g., Presseller et al., 2022), depression (e.g., Barton et al., 2023), interpersonal violence in relationships (e.g., Murphy et al., 2022). This aligns with the most commonly used treatment method that was reported to be used among psychological professionals in Study 3. For MAPs who present for psychological treatment, self-regulation skills, developed through CBT, would be a logical focus. This treatment target may be particularly effective for youth who have not yet encountered risky situations but are coming to terms with an attraction to minors. Allowing these individuals space to practice and learn skills that could help them in the future, may prevent those who would have otherwise offended from ever doing so.

One of the most prominent obstacles to help seeking identified by MAPs, in this study and others (e.g., Grady et al., 2019; Levenson et al., 2017), is a sense of fear. This fear is related to being judged, being reported, and loss of something or someone important, among other things. If this fear stops a MAP from seeking psychological treatment when they are in need, this could increase the risk that they will go on to offend. However, it is possible this fear may be somewhat unfounded. At least in this study, psychological professionals did not indicate they would report MAPs to authorities providing some preliminary evidence against the fear of being reported. If more evidence could be provided that there are willing and capable therapists for MAPs, merging these conflicting realities between the fear experienced by MAPs and the reality that there are professionals available to them (who are unlikely to report them) could be another avenue for prevention. If MAPs were more aware of the services available to them, and the willingness of many professionals to treat them, it could allow

more individuals to get some help if they need it. This could, theoretically, reduce the number of individuals who go on to offend against a child.

5.1.4 Implications for Public Perceptions

Many in the general public view it as inevitable that MAPs will offend against a child, if they have not already. In news articles related to child molestation or sexual interest in children you often see words like ‘monster’, ‘convicted pedophile’, or ‘predator’. All of these words paint individuals with a sexual interest in children as dangerous, with no moral compass, and doomed to offend. However, MAPs in the current studies did not live up to this image. Firstly, they did not differ from the community sample on various aspects of morality (i.e., fairness and doing harm), nor impulsivity. This provides some evidence that could contradict the notion that they are doomed to seek out children to harm and will ultimately offend. MAPs did differ from a community sample in terms of morality in relation to respect for authority. Especially considering their potentially negative experiences with people in authority, such as police and therapists, it stands to reason that they would have less respect for anyone in an authority position. After the significant negative events that occurred in the summer of 2020 involving police brutality toward black, indigenous, and people of colour (BIPOC), favourable attitudes toward police decreased among BIPOC participants in a study by Verhaeghen and Aikman (2022). In other words, after highly negative experiences with authorities, BIPOC individual’s attitudes toward them decreased; in a similar way that MAPs negative experiences with authorities may understandably make them less likely to show respect for authority.

There is also a fear that MAPs cannot be around children and people do not want to risk having their child near a MAP. Keeping in mind the public perception of MAPs as inevitable offenders, this is evidenced by pedophile tracker websites, headhunter citizens who become hysterical when a sex offender notification comes out for their area, and the idea of stranger danger that is preached among children. In addition, participants consistently report desiring more social distance from individuals with a sexual interest in children than individuals with other mental illnesses or addictions (e.g., Jahnke et al., 2015; Jahnke, 2018). Contrary to this belief that children are in danger around MAPs, findings from the current studies highlight why MAPs are not inherently a danger to children simply because they have an attraction to them. MAPs identified numerous strategies that they use when concerned about their own behaviour. Most of these strategies involved avoidance of any potentially risky situation which would indicate that MAPs would often not put themselves in any situation to harm a child in the first place. Another highlight is the fact that MAPs in the current study did not differ from a community sample on the moral facet of doing harm. One way to interpret this finding is that MAPs would take no pleasure in harming another person, therefore may be no more likely to harm a child than anyone else.

5.1.5 Limitations

While limitations for each study have been discussed previously, I will highlight several generally applicable ones here. The most obvious limitation was the use of only a select number of online forums which limited the sample size and access to MAPs. Early in the development of these dissertation studies, Virtuous Pedophiles, BoyChat, and GirlChat were among the most well-known online support forums for MAPs. They

had been used in previous research (e.g., Jones et al., 2021) and were fairly accessible to researchers. Since then, the quantity of support forums has increased allowing for more MAPs to potentially be studied. Accessing a greater number of forums may have increased the power of study by providing a more diverse and broader group of MAPs. Having more participants would have allowed firmer conclusions to be drawn by increasing the power of the current studies. It may also have allowed us to hear from a wider group of MAP voices, giving us an even deeper insight into their lived experiences. However, in Study 1 2365 posts were examined which translated into a lengthy period of time devoted to thematic analysis of the posts, thus examination of more forums may not have been feasible.

Another limitation of the current studies is the lack of inclusion of MAP voices in the development of the studies. When considering the research questions and methodology for this dissertation certain assumptions about the experiences of MAPs were made based on previous research. For example, in Study 1 the assumption was made that MAPs find it challenging or taxing to remain offense free and that they would need specific strategies to avoid offending situations. While I could identify particular actions that MAPs took in situations where they thought they could have engaged in (what they viewed as) '*consenual*' sexual behaviour with a child, when prompted to provide their own strategies in Study 2 there was a general sentiment that they did not need any specific strategies. Several MAPs made it clear that in the same way most teleiophilic (i.e., attracted to age-appropriate adult partners) individuals do not sexually offend against someone just because they are attracted to them, MAPs too are easily able to not sexually offend against a child to whom they are attracted.

5.1.6 Future Directions

There is no shortage of directions in which this research could be taken. For example, from Study 1 we learned that MAPs engage in distinct strategies when in a situation where they believe they could engage in sexual contact with a child. This indicates that there may be a difference in decision-making skills and impulsivity between MAPs who do and MAPs who do not offend against children. Future research could test the impulsivity of people who have offended versus people who have not non-offended to determine if there is a difference that could account for one group choosing to offend against a child. Study 2 showed no difference in impulsivity between the sample of MAPs and a community sample. Presumably, this may reflect the fact that neither group is involved in criminal activity to my knowledge. Recently, Weidacker et al. (2022) published some preliminary data showing that such a difference between MAPs who have offended and those who have not offended may exist. They had MAPs perform a Stroop task while examining activations in the brain and measured response times and error rates. While initial analysis indicated there were some differences between MAPs who have not offended and those who have offended, these results were not significant after adjusting for multiple comparisons. Future research should attempt to examine this difference further.

Another avenue for research could be to develop and pilot a treatment group geared directly toward MAPs. Studies 2 and 3 provided some insight into the types of issues MAPs deal with and how psychological professionals think they would be best treated. Using this information, it may be possible to develop a targeted treatment program for MAPs to address their hopelessness and loneliness (as shown in Study 2),

as well as any other issues they may be experiencing. Effectiveness of the treatment program could be measured by assessing change on treatment targets from beginning to end of the treatment and at follow-up, ideally. While some anonymous services for MAPs exist (e.g., Talking for Change, Help Wanted, Stop It Now!, etc.) none exist, to my knowledge, that treat MAPs face to face on individual treatment targets that they have identified. Beier et al. (2015) did offer a treatment group for self-identified pedophiles, however this program borrowed principles from relapse prevention, which assumes that the participants have offended in that past. A new treatment program targeting MAPs from a people centered perspective would offer a new direction in the understanding of their struggles and how to provide support for individuals with a sexual interest in children.

5.1.7 Conclusion

Overall, the aim of this dissertation was accomplished: we learned many things about the lived experiences of MAPs. It was discovered that they engage in many different strategies to refrain from offending behaviour in Study 1. Study 2 demonstrated that they are struggling with some mental health challenges but may not have some of the criminogenic needs that are seen among individuals who have offended such as impulsivity and a lack of morality. They also have a lot of fear around seeking help from others, and many have never told anyone about their sexual interests. Also, there are at least some psychological professionals willing to treat those seeking professional support.

These findings have several implications for treatment, prevention, and public perception. This research adds to a growing body that demonstrates that not all

individuals with a sexual interest in children are predisposed to offend against them and may not necessarily deserve the label of ‘monster’ if they haven’t. It could be that MAPs are simply individuals who have non-trivial difficulties in their lives for which some therapists may be more than qualified to tackle. If the gap between MAPs beliefs about therapists and (some) therapists’ beliefs about MAPs could be closed, more individuals could engage in psychological treatment when they needed or wanted it.

Ultimately, the dissertation has also shown that despite the influx of recent research, there are still more questions to be answered. On the one hand, MAPs do not struggle with managing their sexual desires. However, they are struggling with hopelessness and loneliness, and have some differences in moral reasoning. Also, MAPs continue to have distrust and fear of being reported, despite the recent development of services targeting individuals with a sexual interest in children. It was evident in Study 3 that even if the program does not specifically target MAPs, there are psychological professionals who would not report them or refuse to help them. Research should continue to increase our understanding of this misunderstood group of individuals, with the ultimate aim of altering how they are viewed in society and how they are treated.

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Appendices

Appendix A

Forum Post

Good Day,

My name is Carisa Collins and I am a doctoral student from the University of Ontario Institute of Technology (UOIT). I am seeking participants for a research study entitled *Examination of Users of Different Types of Online Sexual Interest In Children Support Organizations*. This study is conducted online and will take approximately 60 minutes to complete. Your participation is greatly appreciated and would contribute to my doctoral research as well as a newly growing body of research.

This study has been approved by the UOIT Research Ethics Board REB [insert REB number] on [insert date].

If you are interested in learning more about this research please follow the link provided below.

Regards,
Carisa Collins, B.Sc.(Hons), M.A.
carisa.collins@uoit.net
Doctoral Student, Forensic Psychology
University of Ontario Institute of Technology

[URL to be provided here]

Appendix B

Community Recruitment Statement

a. To be used by student researcher:

Hello friends and family! I am looking for people to participate in a survey that forms part of my doctoral research. Participants need to be over the age of 18. The survey should approximately 60 minutes to complete, and you may be entered in a draw for a $100 Amazon gift card. If you are interested, please follow the link provided I would greatly appreciate it!

[URL to be provided here]

b. To be used by others:

Hello friends and family! I am looking for people to participate in a survey that forms part of my colleague's doctoral research. Participants need to be over the age of 18. The survey should approximately 60 minutes to complete, and you may be entered in a draw for a $100 Amazon gift card. If you are interested, please follow the link provided I would greatly appreciate it!

[URL to be provided here]

Appendix C

Consent Form

RESEARCH ETHICS BOARD
OFFICE OF RESEARCH SERVICES

Examination of Users of Different Types of Online Sexual Interest In Children Support Organizations

You are invited to participate in a research study entitled Examination of Users of Different Types of Online Sexual Interest In Children Support Organizations. This study has been approved by the UOIT Research Ethics Board REB [insert REB # assigned] on [insert date]. Please read this form carefully, and feel free to ask any questions you might have

Any questions regarding your rights as a participant, complaints or adverse events may be addressed to Research Ethics Board through the Ethics and Compliance Officer – researchethics@uoit.ca or 905.721.8668 x. 3693. If you have any questions concerning the research study or experience any discomfort related to the study, please contact the researcher Carisa Collins (carisa.collins@uoit.net) or Dr. Leigh Harkins (leigh.harkins@uoit.ca; 905-721-8668 ext. 5991).

Researcher(s):

This research is being carried out by Dr. Leigh Harkins (Academic Supervisor – Principal Investigator) and Carisa Collins (Doctoral Student – Co-Investigator).

Purpose and Procedure:

This study aims to investigate differences between users of online sexual interest support groups, with a particular focus on those who endorse different views on pedophilia. If you wish to participate you will be asked to complete several questionnaires that address personality traits, social well-being, offense history, drug/alcohol use, as well as some personal characteristics. Some of the questions are quite personal and might be upsetting to some people. Completion of the online questionnaires will take approximately 60 minutes. Data collection will be completed in October 2017.

Potential Benefits:

You will be given the option to enter your contact information into a draw for a $100CAD (or equivalent) Amazon gift card. However, you will not be required to provide your contact information if you do not wish. The contact information you provide for entry into the draw cannot be linked to your responses on the questionnaires. In addition, participation may help you develop a better understanding of how research works. By participating you will see how an online survey is set up and also experience the procedure from informed consent through to debrief.

Potential Risk or Discomforts:

Some of the questions in this study involve sexual preferences, attitudes, and challenges you face. It is possible you may feel uncomfortable revealing these behaviours/preferences. If you feel uncomfortable, you may stop at any time and leave questions blank. Should you feel uncomfortable you are encouraged seek professional support from a counsellor or therapist in your area. Please be assured that all your responses will be anonymous, and your responses will not be connected to you in any way. Furthermore, we are aware that many people have engaged different types of antisocial and illegal activities in the past. There will be no repercussions for answering the questionnaires honestly. Any information you will provide will be used anonymously, and aggregated with the data of the complete pool of participants. At any point in time during the study, you also have the right to discontinue the study without any consequences.

Storage of Data:
The information you provide will be entered into a computer database and stored on a password protected laptop accessible only by the research team. No identifying information will appear in the database. All the data will be aggregated to further protect the confidentiality of your responses. The data will be kept indefinitely and aggregated / grouped data may be shared with other researchers as required by the ethics and publication guidelines of psychology. If this is the case, none of your identifying information will be included.

Confidentiality:
It is entirely up to you if you want to take part. All data will remain anonymous by the investigator and research team. Please also rest assured that the principal investigator and research team will all be required to sign confidentiality agreements to further protect you. In addition, all data will be kept on a password protected computer, and will only be accessible to designated members of the research team.
Confidentiality will be provided to the fullest extent possible by law, professional practice and ethical codes of conduct. Your privacy shall be respected. No information about your identity will be shared or published without your permission, unless required by law.

Right to Withdraw:
Your participation is voluntary, and you can choose to answer only those questions that you are comfortable with in each questionnaire. The information that is shared will be held in strict confidence and discussed only with the research team. You may withdraw from the study at any time without consequence. If you withdraw from the research project at any time, any data that you have contributed will be removed from the study. As a participant, you are not waiving any rights to legal recourse in the event of research-related harm. To withdraw during the course of the study simply exit the survey window, and all of your data will be discarded without having been viewed. The process for withdrawing from the study after completion is as follows:
1. At the end of the study, you will be prompted to provide a memorable word. This word should be something that you will be able to remember, but that does not provide us with any identifiable information.

2. We recommend that you make note of your memorable word on you debrief form, or another location you can easily access (ex. Cell phone)
3. If you wish to withdraw you data, you can contact Dr. Leigh Harkins using the email provided on your debrief form.
4. When contacting Dr. Leigh Harkins, please clearly state your intent to withdraw your data, and provide your memorable word.
5. Providing your memorable word will allow for all data collected from you to be identified and destroyed. You do not have to provide a reason for withdrawal. Once you have stated your intent for your data to be withdrawn, it will not be viewed again, even in the process of withdrawal.
6. You will be contacted to confirm your data has been withdrawn from the study

Participant Concerns and Reporting:
This study has been approved by the UOIT Research Ethics Board REB [insert REB # assigned] on [insert date]. Any questions regarding your rights as a participant, complaints or adverse events may be addressed to Research Ethics Board through the Ethics and Compliance Officer – researchethics@uoit.ca or 905.721.8668 x. 3693. If you have any questions concerning the research study or experience any discomfort related to the study, please contact the researcher Carisa Collins (carisa.collins@uoit.net) or Dr. Leigh Harkins (leigh.harkins@uoit.ca; 905-721-8668 ext. 5991).

Debriefing and Dissemination of Results:
As a participant, you are entitled to be informed of the results of this study if interested. The results may be published in an academic journal and/or presented at an academic conference. Even in this form, all data will be aggregated and remain anonymous. If participants are interested in the results of this study please contact the academic supervisor at leigh.harkins@uoit.net.

Consent to Participate:

Please check each of the following items once they have been read and understood:

- ○ I am over 18 years of age
- ○ I have read the consent form and understand the study being described
- ○ I am aware of the contact details of the researchers outlined above in the event that I have any questions. I am free to ask questions about the study in the future.
- ○ I freely consent to participate in the research study, understanding that I may discontinue participation at any time without penalty.
- ○ I understand that that by consenting to participate I do not waive any legal rights or recourse.

○ I understand that that my anonymous data may be used in the future to examine research questions other than those outlined here.

Appendix D

Moral Foundations Questionnaire

Part 1. When you decide whether something is right or wrong, to what extent are the following considerations relevant to your thinking? Please rate each statement using this scale:

[0] = not at all relevant (This consideration has nothing to do with my judgments of right and wrong)
[1] = not very relevant
[2] = slightly relevant
[3] = somewhat relevant
[4] = very relevant
[5] = extremely relevant (This is one of the most important factors when I judge right and wrong)

_____Whether or not someone suffered emotionally
_____Whether or not some people were treated differently than others
_____Whether or not someone's action showed love for his or her country
_____Whether or not someone showed a lack of respect for authority
_____Whether or not someone violated standards of purity and decency
_____Whether or not someone was good at math
_____Whether or not someone cared for someone weak or vulnerable
_____Whether or not someone acted unfairly
_____Whether or not someone did something to betray his or her group
_____Whether or not someone conformed to the traditions of society
_____Whether or not someone did something disgusting
_____Whether or not someone was cruel
_____Whether or not someone was denied his or her rights
_____Whether or not someone showed a lack of loyalty
_____Whether or not an action caused chaos or disorder
_____Whether or not someone acted in a way that God would approve of

Part 2. Please read the following sentences and indicate your agreement or disagreement:

[0]	[1]	[2]	[3]	[4]	[5]
Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree

_____Compassion for those who are suffering is the most crucial virtue.

_____When the government makes laws, the number one principle should be ensuring that everyone is treated fairly.
_____I am proud of my country's history.
_____Respect for authority is something all children need to learn.
_____People should not do things that are disgusting, even if no one is harmed.
_____It is better to do good than to do bad.
_____One of the worst things a person could do is hurt a defenseless animal.
_____Justice is the most important requirement for a society.
_____People should be loyal to their family members, even when they have done something wrong.
_____Men and women each have different roles to play in society.
_____I would call some acts wrong on the grounds that they are unnatural.
_____It can never be right to kill a human being.
_____ I think it's morally wrong that rich children inherit a lot of money while poor children inherit nothing.
_____ It is more important to be a team player than to express oneself.
_____ If I were a soldier and disagreed with my commanding officer's orders, I would obey anyway because that is my duty.
_____ Chastity is an important and valuable virtue.

Appendix E

Interpersonal Reactivity Scale

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter next to the item number. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly as you can. Thank you.

ANSWER SCALE:

A	B	C	D	E
Does Not Describe Me Well				Describes Me Very Well

1. I daydream and fantasize, with some regularity, about things that might happen to me. _____

2. I often have tender, concerned feelings for people less fortunate than me. _____

3. I sometimes find it difficult to see things from the “other guy’s” point of view. _____

4. Sometimes I don’t feel very sorry for other people when they are having problems. ____

5. I really get involved with the feelings of the characters in a novel. _____

6. In emergency situations, I feel apprehensive and ill-at-ease. _____

7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it. _____

8. I try to look at everybody's side of a disagreement before I make a decision. _____

9. When I see someone being taken advantage of, I feel kind of protective towards them. _____

10. I sometimes feel helpless when I am in the middle of a very emotional situation. _____

11. I sometimes try to understand my friends better by imagining how things look from their perspective. _____

12. Becoming extremely involved in a good book or movie is somewhat rare for me. _____

13. When I see someone get hurt, I tend to remain calm. _____

14. Other people's misfortunes do not usually disturb me a great deal. _____

15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments. _____

16. After seeing a play or movie, I have felt as though I were one of the characters. _____

17. Being in a tense emotional situation scares me. _____

18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them. _____

19. I am usually pretty effective in dealing with emergencies. _____

20. I am often quite touched by things that I see happen. _____

21. I believe that there are two sides to every question and try to look at them both. _____

22. I would describe myself as a pretty soft-hearted person. _____

23. When I watch a good movie, I can very easily put myself in the place of a leading character. _____

24. I tend to lose control during emergencies. _____

25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while. _____

26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me. _____

27. When I see someone who badly needs help in an emergency, I go to pieces. _____

28. Before criticizing somebody, I try to imagine how I would feel if I were in their place. _____

Appendix F

UCLA Loneliness Scale

INSTRUCTIONS: Indicate how often each of the statements below is descriptive of you.

O indicates “I often feel this way”
S indicates “I sometimes feel this way”
R indicates “I rarely feel this way”
N indicates “I never feel this way”

1. I am unhappy doing so many things alone	O	S	R	N
2. I have nobody to talk to	O	S	R	N
3. I cannot tolerate being so alone	O	S	R	N
4. I lack companionship	O	S	R	N
5. I feel as if nobody really understands me	O	S	R	N
6. I find myself waiting for people to call or write	O	S	R	N
7. There is no one I can turn to	O	S	R	N
8. I am no longer close to anyone	O	S	R	N
9. My interests and ideas are not shared by those around me	O	S	R	N
10. I feel left out	O	S	R	N
11. I feel completely alone	O	S	R	N
12. I am unable to reach out and communicate with those around me	O	S	R	N
13. My social relationships are superficial	O	S	R	N
14. I feel starved for company	O	S	R	N
15. No one really knows me well	O	S	R	N
16. I feel isolated from others	O	S	R	N

17. I am unhappy being so withdrawn	O	S	R	N
18. It is difficult for me to make friends	O	S	R	N
19. I feel shut out and excluded by others	O	S	R	N
20. People are around me but not with me	O	S	R	N

Appendix G

Barratt Impulsiveness Scale

DIRECTIONS: People differ in the ways they act and think in different situations. This is a test to measure some of the ways in which you act and think. Read each statement and put an X on the appropriate circle on the right side of this page. Do not spend too much time on any statement. Answer quickly and honestly.

1. I plan tasks carefully.	1	2	3	4
2. I do things without thinking.	1	2	3	4
3. I make-up my mind quickly.	1	2	3	4
4. I am happy-go-lucky.	1	2	3	4
5. I don't "pay attention."	1	2	3	4
6. I have "racing" thoughts.	1	2	3	4
7. I plan trips well ahead of time.	1	2	3	4
8. I am self controlled.	1	2	3	4
9. I concentrate easily.	1	2	3	4
10. I save regularly.	1	2	3	4
11. I "squirm" at plays or lectures.	1	2	3	4
12. I am a careful thinker.	1	2	3	4
13. I plan for job security.	1	2	3	4
14. I say things without thinking.	1	2	3	4
15. I like to think about complex problems.	1	2	3	4
16. I change jobs.	1	2	3	4
17. I act "on impulse."	1	2	3	4
18. I get easily bored when solving thought problems.	1	2	3	4
19. I act on the spur of the moment.	1	2	3	4

20. I am a steady thinker.	1	2	3	4
21. I change residences.	1	2	3	4
22. I buy things on impulse.	1	2	3	4
23. I can only think about one thing at a time.	1	2	3	4
24. I change hobbies.	1	2	3	4
25. I spend or charge more than I earn.	1	2	3	4
26. I often have extraneous thoughts when thinking.	1	2	3	4
27. I am more interested in the present than the future.	1	2	3	4
28. I am restless at the theater or lectures.	1	2	3	4
29. I like puzzles.	1	2	3	4
30. I am future oriented.	1	2	3	4

Appendix H

Beck's Hopelessness Scale

This questionnaire consists of a list of twenty statements. Please read the statements carefully one by one. If the statement describes your attitude for the past week, including today, write 'T' or 'true'. If the statement is false for you, write 'F' or 'false'. Please be sure to read each sentence.

TRUE/FALSE?

1) I look forward to the future with hope and enthusiasm

2) I might as well give up because there's nothing I can do to make things better for myself

3) When things are going badly, I am helped by knowing that they can't stay that way for ever.

4) I can't imagine what my life would be like in ten years.

5) I have enough time to accomplish the things I most want to do.

6) In the future I expect to succeed in what concerns me most.

7) My future seems dark to me.

8) I happen to be particularly lucky and I expect to get more of the good things in life than the average person.

9) I just don't get the breaks, and there's no reason to believe that I will in the future.

10) My past experiences have prepared me well for my future.

11) All I can see ahead of me is unpleasantness rather than pleasantness.

12) I don't expect to get what I really want.

13) When I look ahead to the future I expect I will be happier than I am now.

14) Things just won't work out the way I want them to.

15) I have great faith in the future.

16) I never get what I want, so it's foolish to want anything.

17) It is very unlikely that I will get any real satisfaction in the future.

18) The future seems vague and uncertain to me.

19) I can look forward to more good times than bad times.

20) There’s no use in really trying to get something I want because I probably won’t get it.

Appendix I

Personal Feelings Questionnaire - 2

For each of the following listed feelings, to the left of the item number, please select a number from 0 to 4, reflecting how common the feeling is for you.

4 = you experience the feeling continuously or almost continuously
3 = you experience the feeling frequently but not continuously
2 = you experience the feeling some of the time
1 = you experience the feeling rarely
0 = you never experience the feeling

____1. embarrassment

____2. mild guilt

____3. feeling ridiculous

____4. worry about hurting or injuring someone

____5. sadness

____6. self-consciousness

____7. feeling humiliated

____8. intense guilt

____9. euphoria

____10. feeling "stupid"

____11. regret

____12. feeling "childish”

____13. mild happiness

____14. feeling helpless, paralyzed

____15. depression

____16. feelings of blushing

____17. feeling you deserve criticism for what you did

____18. feeling laughable

____19. rage

____20. enjoyment

____21. feeling disgusting to others

_____22. Remorse

Appendix J

General Information Questionnaire

Demographics

1. Age
2. Gender

   1 = Male, 2 = Female
3. Race/Ethnicity

   1 = Caucasian, 2 = Black, 3 = East Asian, 4 = South Asian, 5 = South East Asian, 6 = Middle Eastern, 7 = West Indian, 8 = Hispanic/Latino, 9 = Native/Aboriginal, 10 = Other (Please specify)
4. Religion

   1 = Christian, 2 = Jewish, 3 = Muslim, 4 = Buddhist, 5 = Hindu, 6 = Sikh, 7 = Other (Please Specify)

Alcohol Use

5. How many days per week do you consume alcohol?

   1 = 1 day, 2 = 2 days, 3 = 3 days, 4 = 4 days, 5 = 5 days, 6 = 6 days, 7 = 7 days, 0 = Never, I do not drink.
6. On average, how many drinks do you have each time you consume alcohol?

Drug Use

7. Which drugs have you used **in the past**? Check all that apply.

   1 = Depressants (e.g. Barbiturates), 2 = Stimulants (e.g. Methamphetamines), 3 = Hallucinogens (e.g. LSD), 4 = Dissociative Anesthetics (e.g. PCP), 5 = Narcotic

Analgesics (e.g. Heroin), 6 = Inhalants (e.g. Gasoline), 7 = Cannabis (i.e. Marijuana), 8 = None of the Above. I do not use drugs.

8. Which drugs are you **currently** using? Check all that apply.

   1 = Depressants (e.g. Barbiturates), 2 = Stimulants (e.g. Methamphetamines), 3 = Hallucinogens (e.g. LSD), 4 = Dissociative Anesthetics (e.g. PCP), 5 = Narcotic Analgesics (e.g. Heroin), 6 = Inhalants (e.g. Gasoline), 7 = Cannabis (i.e. Marijuana), 8 = None of the Above. I do not use drugs.

9. How many days per week do you use any of the above drugs?

   1 = 1 day, 2 = 2 days, 3 = 3 days, 4 = 4 days, 5 = 5 days, 6 = 6 days, 7 = 7 days, 0 = Never, I do not use drugs

Relationships

10. Are you currently involved in a romantic relationship?

    1 = Yes, 2 = No

11. How long have you been in your current relationship? (In Months)
12. What is the length of your longest relationship? (In Months)

Support Systems

13. Through which online support group did you access this survey?

    1 = VirPed.org, 2 = b4uact.org, 3 = boychat.org, 4 = annabelleigh.net, 5 = Other (Please specify)

14. Which online support groups have you been a member of **in the past**? Check all that apply.

    1 = VirPed.org, 2 = NAMbLA.org, 3 = b4uact.org, 4 = boychat.org, 5 = annabelleigh.net 6 = Other (Please Specify)

15. Which online support groups are you **currently** a member of? Check all that apply.

    1 = VirPed.org, 2 = NAMbLA.org, 3 = b4uact.org, 4 = boychat.org, 5 = annabelleigh.net 6 = Other (Please Specify)

16. How would you describe your involvement in your current support group(s)?

    1 = completely uninvolved, 2 = slightly uninvolved, 3 = active viewer (i.e. read but not post), 4 = mildly involved in discussion/ posting, 5 = Actively involved, 6 = Not Applicable

17. How long have you been a member of your current support group(s)? (In Months)

18. Have the online supports been helpful in managing your sexual desires?

    1 = Yes, 2 = No, 3 = Not Applicable

19. Please explain

20. Have the online supports encouraged your sexual desires?

    1 = Yes, 2 = No, 3 = Not Applicable

21. Please explain

22. What other non-professional supports have you sought, besides online support groups? Check all that apply.

    1 = Family member/Partner, 2 = Friend, 3 = Religious Leader, 4 = Teacher/Professor, 5 = Other (please Specify), 5 = None

23. What other professional supports have you sought? Check all that apply.

    1 = Individual Therapy, 2 = Group Therapy, 3 = Other, 4 = None

24. How long have you been receiving professional support (months)?

25. Have the other supports been helpful in managing your sexual desires?

    1 = Yes, 2 = No, 3 = Not Applicable

26. Please explain

27. Have the other supports encouraged your sexual desires?

    1 = Yes, 2 = No, 3 = Not Applicable

28. Please explain

29. Have the other supports hindered your ability to manage your sexual desires?

    1 = Yes, 2 = No, 3 = Not Applicable

30. Please explain.

31. What have been some obstacles to seeking help/support that you have faced?

32. To whom did you first disclose your sexual interest?

    1 = Family member, 2 = Friend, 3 = School teacher, 4 = Police officer, 5 = Therapist, 6 = Family Doctor, 7 = No one, 8 = Other

33. Please explain.

34. What strategies have you used to avoid offending behavior?

35. What strategies have you used to avoid offending behavior when you were in the company of a child (or children) you were attracted to?

36. What strategies have you used to avoid accessing images of children?

Offense History

37. Have you ever committed a sexual offense for which you have been **convicted** by a court of law?

    1 = Yes, 2 = No

38. Which type of sexual offense have you been convicted of? Check all that apply.

    1 = Contact Sexual Offense Against an Adult(e.g. sexual assault), 2 = Non-Contact Sexual Offense Against an Adult (e.g. Indecent Exposure), 3 = Contact Sexual Offense Against a Child, 4 = Non-Contact Sexual Offense against a Child (e.g. Child Pornography Offenses) 5 = None. I have not been convicted of a sexual offense.

39. Have you ever committed a non-sexual offense for which you have been **convicted** by a court of law?

    1 = Yes, 2 = No

40. Which type of non-sexual offense have you been convicted of? (Check all that apply)

    1 = Offenses against a person (Excluding sexual offenses; e.g. battery), 2 = Offenses against Property (e.g. theft), 3 = Incomplete crimes (e.g. Solicitation), 4 = Statutory Crimes (e.g. alcohol/drug related crimes), 5 = None. I have not been convicted of a non-sexual offense.

41. Please provide a memorable word. This should be a word you can remember, but attaches no personal meaning that can identify you. This word will allow you to withdraw your data at a later date should you no longer wish to participate. (e.g. MothersMaidenName1234)

Appendix K

Debrief Form

Firstly, thank you for participating in this study!

In this study you answered a series of questionnaires on your personality traits, social well-being, offense history, drug/alcohol use, as well as some personal characteristics. The purpose of this research is to examine differences between users of different online pedophilia support groups who endorse different views of pedophilia. All responses you gave over the course of this study are anonymous (i.e., they cannot be linked to your name) and will remain confidential in agreement with the research team's commitment to confidentiality.

This research will hopefully increase our understanding of individuals who endorse different views of pedophilia. Although we recognize that people have a variety of sexual interests and experiences, it is important to note that any sexual contact with children is illegal. For more information on this, please see http://www.stopitnow.org.

We recognize that due to the sensitive nature of the topics discussed in this study, you may feel upset or distressed. If you do feel upset as a result of this study, and feel the need to discuss the study content with a counsellor, please feel free to do so. Your personal health is of the utmost importance! As a research team, we want to ensure you feel supported following study completion. If you should feel distressed, upset, or simply would like to speak to a counsellor about this study, please feel free to contact a professional counselling service in your area or you can follow this link to free online anonymous services for those who are concerned about the welfare of a child or about their own history of victimization (http://www.stopitnow.org)

Do you have any questions about the study you would like to ask now?

Any questions regarding your rights as a participant, complaints or adverse events may be addressed to Research Ethics Board through the Ethics and Compliance Officer – researchethics@uoit.ca or 905.721.8668 x. 3693. If you have any questions concerning the research study or experience any discomfort related to the study, please contact Carisa Collins (carisa.collins@uoit.net; co-investigator) or Dr. Leigh Harkins (leigh.harkins@uoit.ca; 905-721-8668 ext. 5991; principal investigator).

Once again, THANK YOU for your participation in this study!

Appendix L

Announcement

Good Day,

You are being asked to participate in a research study entitled *Examination of Clinician Attitudes Regarding Treatment of Individuals With Pedophilia*. This study will examine the attitudes of practitioners who are members of professional organizations (e.g. APA, CPA, ATSA, BPS, CPSO). The study is conducted online and will take approximately 30 minutes to complete. Your participation is voluntary and greatly appreciated. It would contribute to my doctoral research as well as a newly growing body of research.

This study has been approved by the UOIT Research Ethics Board REB [#15-144] on [insert date] (Phone: 905.721.8668 ext. 3693, Email: researchethics@uoit.ca).

If you are interested in learning more about this research please follow the link provided below.

https://uoitsocialscience.eu.qualtrics.com/jfe/form/SV_9zv2Oh90HITuH8F

Regards,
Carisa Collins, B.Sc.(Hons), M.A.
carisa.collins@uoit.net
Doctoral Student, Forensic Psychology
University of Ontario Institute of Technology

Appendix M

Consent Form

RESEARCH ETHICS BOARD
OFFICE OF RESEARCH SERVICES

Examination of Clinician Attitudes Regarding Treatment of Individuals With Pedophilia

You are invited to participate in a research study entitled Examination of Clinician Attitudes Regarding Treatment of Individuals With Pedophilia. This study has been approved by the UOIT Research Ethics Board REB [#15-144] on [insert date]. Please read this form carefully, and feel free to ask any questions you might have. Any questions regarding your rights as a participant, complaints or adverse events may be addressed to Research Ethics Board through the Ethics and Compliance Officer – researchethics@uoit.ca or 905.721.8668 x. 3693. If you have any questions concerning the research study or experience any discomfort related to the study, please contact the researcher Carisa Collins (carisa.collins@uoit.net) or Dr. Leigh Harkins (leigh.harkins@uoit.ca; 905-721-8668 ext. 5991).

Researcher(s):

This research is being carried out by Carisa Collins (Doctoral Student) and Dr. Leigh Harkins (Academic Supervisor).

Purpose and Procedure:

This study aims to investigate attitudes held by psychological and medical professionals regarding the treatment of individuals with a sexual interest in children. Participants will be practitioners who are members of professional organizations (e.g. APA, CPA, ATSA, BPS, CPSO). If you consent to participate you will be asked to complete several questionnaires. These questionnaires address attitudes toward sexual activity with children, attitudes toward individuals with pedophilia, attitudes regarding treatment of individual with pedophilia, as well as some personal characteristics. Some of the questions are quite personal and might be upsetting to some people. The entire experiment will take approximately 30 minutes.

Potential Benefits:

Participation in this study might help you have a better understanding of your own attitudes towards pedophilia. You will also be entered into a draw for a $50 gift card if you are willing to provide your name via a second link after the completion of the study. Your responses to the questionnaire cannot be linked to any personal details provided via the second link to allow you to be entered into the draw.

Potential Risk or Discomforts:

Some of the questions in this study involve attitudes towards those with a sexual interest in children. It is possible you may feel uncomfortable revealing these

behaviours/preferences or upset imagining children being victimized. If you feel uncomfortable, you may stop at any time, leave questions blank, or seek professional support. Please be assured that all of your responses will be anonymous, and your responses will not be connected to you in any way. Any information you will provide will be used anonymously, and aggregated with the data of the complete pool of participants. At any point in time during the study, you also have the right to discontinue the study without any penalty. If you have any questions concerning the research study or experience any discomfort related to the study, please contact Carisa Collins (carisa.collins@uoit.net) or Dr. Leigh Harkins (leigh.harkins@uoit.ca; 905-721-8668 ext. 5991)

Storage of Data:
The information you provide will be entered into a computer database and stored on a password protected laptop accessible only by the research team (identified above). Double password protection will be provided on the data files, and they will be further encrypted to ensure no unauthorized access. No identifying information will appear in the database. All the data will be aggregated to further protect the confidentiality of your responses. The data will be kept indefinitely and aggregated / grouped data may be shared with other researchers as required by the ethics and publication guidelines of psychology. If this is the case, none of your identifying information will be included.

Confidentiality:
It is entirely up to you if you want to take part. All data will remain anonymous by the investigator and research team (identified above). Please also rest assured that the principal investigator and research team (identified above) will all be required to sign confidentiality agreements to further protect you. In addition, all data will be kept on a password protected computer, and will only be accessible to designated members of the research team (identified above).
Confidentiality will be provided to the fullest extent possible by law, professional practice and ethical codes of conduct. Your privacy shall be respected. There are some situations in which confidentiality may need to be breached - if you report the intention to harm yourself or someone else, or if you report committing a specific previous crime with a victim **that can be identified**. We also may have a duty to report any abuse to children under the age of 16 to the Children's Aid Society (i.e. if you provide unsolicited information about an identifiable victim). Please note that we have designed the questionnaires in a way that *should not* result in the situations described above, so please feel free to answer the yes or no questions honestly. We do ask, however, that you not provide any extra detail that would require a breach of confidentiality so your confidentiality can be maintained.

Right to Withdraw:
Your participation is voluntary, and you can choose to answer only those questions that you are comfortable with. The information that is shared will be held in strict confidence and discussed only with the research team (identified above). You may withdraw from the study at any time without consequence. If you withdraw from the research project at any time, any data that you have contributed will be removed from the study. As a

participant, you are not waiving any rights to legal recourse in the event of research-related harm. To withdraw during the course of the study simply exit the survey window, and all of your data will be discarded without having been viewed.

Participant Concerns and Reporting:
This study has been approved by the UOIT Research Ethics Board REB [#15-144] on [insert date]. If you have any questions, concerns, or complaints, you may contact Carisa Collins (carisa.collins@uoit.net) or Dr. Leigh Harkins (leigh.harkins@uoit.ca; 905-721-8668 ext. 5991). Any questions regarding your rights as a participant, complaints or adverse events may be addressed to Research Ethics Board through the Ethics and Compliance Officer – researchethics@uoit.ca or 905.721.8668 x. 3693.

Debriefing and Dissemination of Results:
As a participant, you are entitled to be informed of the results of this study if interested. The results may be published in an academic journal and/or presented at an academic conference. Even in this form, all data will be aggregated and remain anonymous. If participants are interested in the results of this study please contact the academic supervisor at leigh.harkins@uoit.ca.

Consent to Participate:
Please check each of the following items once they have been read and understood:

- ○ I am over 18 years of age
- ○ I have read the consent form and understand the study being described
- ○ I am aware of the contact details of the researchers outlined above in the event that I have any questions. I am free to ask questions about the study in the future.
- ○ I am aware that my data may be shared/aggregated with other researchers in the future as is frequently required in psychology.
- ○ I freely consent to participate in the research study, understanding that I may discontinue participation at any time without penalty.
- ○ I understand that that by consenting to participate I do not waive any legal rights or recourse

Appendix N

The Controllability Scale

Please indicate your level of agreement with each of the following statements:

1. A dominant sexual interest in children is something that one can choose.

0 1 2 3 4 5 6
Do not agree at all *Completely Agree*

2. People with a dominant sexual interest in children have taken a deliberate decision to have these interests.

0 1 2 3 4 5 6
Do not agree at all *Completely Agree*

3. People have the choice whether they have a dominant sexual interest in children or not.

0 1 2 3 4 5 6
Do not agree at all *Completely Agree*

Appendix O

The Dangerousness Scale

Please indicate your level of agreement with each of the following statements:

1. A person with a dominant sexual interest in children poses a danger to children.

0 1 2 3 4 5 6
Do not agree at all *Completely Agree*

2. A person with a dominant sexual interest in children poses a danger to adolescents.

0 1 2 3 4 5 6
Do not agree at all *Completely Agree*

3. A person with a dominant sexual interest in children poses a danger to adults.

0 1 2 3 4 5 6
Do not agree at all *Completely Agree*

Appendix P

The Social Distance Scale

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

1. Would have these persons as friends.

0 1 2 3 4 5 6
Do not agree at all *Completely Agree*

2. Would accept these persons in my neighborhood.

0 1 2 3 4 5 6
Do not agree at all *Completely Agree*

3. Would accept these persons as colleagues at work.

0 1 2 3 4 5 6
Do not agree at all *Completely Agree*

4. Would talk to them.

0 1 2 3 4 5 6
Do not agree at all *Completely Agree*

5. These persons should be incarcerated.

0 1 2 3 4 5 6
Do not agree at all *Completely Agree*

6. These persons should better be dead.

0 1 2 3 4 5 6
Do not agree at all *Completely Agree*

Appendix Q

General Information Questionnaire

Demographics

1. Age
2. Gender

   1 = Male, 2 = Female
3. Race/Ethnicity

   1 = White/Caucasian, 2 = Black/African-American, 3 = Hispanic, 4 = Asian/Pacific Islander, 5 = Native American/Native Canadian, 6 = Other
4. Religion

   1 = Christian, 2 = Jewish, 3 = Muslim, 4 = Buddhist, 5 = Hindu, 6 = Sikh, 7 = Other (Please Specify)
5. Sexuality

   1 = Heterosexual, 2 = Homosexual, 3 = Bisexual, 4 = Asexual, 5 = Other (Please Specify)

Professional Affiliations

6. How did you hear about our study?

   1 = CPA R2P2 Portal, 2 = ATSA Research Portal, 3 = APA Mailing List, 4 = BPS Mailing List, 5 = Other
7. What professional organizations are you affiliated with? (Select all that apply)

   1 = CPA, 2 = APA, 3 = ATSA, 4 = BPS, 5 = Other
8. What is your professional designation (e.g. PsyD)?

Treatment Attitudes

9. Which of the following items is a characteristic of a pedophile? Check all that apply.

   1 = Sexual Interest in Children, 2 = Sexual Fantasies about Children, 3 = Physical contact with a child, 4 = Viewing child pornography, 5 = Personal Distress, 6 = Other. Please Specify

10. Is physical contact with a child necessary for a diagnosis of pedophilia?

    1 = Yes, 2 = No

11. A. What would you do if an individual disclosed a sexual interest in children to you? Select all that apply.

    1 = Report them to Child Services, 2 = Report them to Police, 3 = Refuse to see them, 4 = Refer them to a colleague better suited to their needs, 5 = Treat them, 6= Other. Please Specify.

    B. Please explain.

12. Have you ever treated an individual who was a pedophile?

    1 = Yes, 2 = No

13. If so, what treatment approach did you use?

    1 = Psychoanalytic, 2 = Cognitive Behaviour Therapy, 3 = Dialectical Behaviour Therapy, 4 = Aversion Therapy, 5 = Exposure Therapy, 6 = Relapse Prevention, 7 = Pharmacological, 8= Cognitive Therapy, 9 = Behaviour Therapy, 10 = Other

14. A. Did you find it effective?

    1 = Yes, 2 = No

    B. Please explain.

15. A. Would you be willing to treat an individual if you knew they were a pedophile?

    1 = Yes, 2 = No

    B. Please Explain.

16. Would you be willing to treat an individual if …

		Please Explain.
a. … you knew they were a pedophile?	○ Yes ○ No	
b. … you knew they were a pedophile who had previously molested a child?	○ Yes ○ No	
c. … you knew they were a pedophile who had never molested a child?	○ Yes ○ No	
d. … you knew they were a pedophile who had accessed child pornography?	○ Yes ○ No	
e. … you knew they were a pedophile who had never accessed child pornography?	○ Yes ○ No	

17. What could increase the likelihood of you being willing to treat an individual with pedophilia? Please specify.

18. What treatment approach do you feel is best suited to individuals with pedophilia?

    1 = Psychoanalytic, 2 = Cognitive Behaviour Therapy, 3 = Dialectical Behaviour Therapy, 4 = Aversion Therapy, 5 = Exposure Therapy, 6 = Relapse Prevention, 7 = Pharmacological, 8= Cognitive Therapy, 9 = Behaviour Therapy, 10 = Other

19. Are you aware that there are individuals who have a dominant sexual interest in children who chose not to offend and live law-abiding lives?

    1 = Yes, 2 = No

20. Please explain.

Appendix R

Recruitment Request

THANK YOU FOR PARTICIPATING!

Did you find this survey interesting?
Do you think this type of research is useful and necessary?
Did this survey make you think about your own views and attitudes?

If you answered yes to any of these questions, please feel free to send the survey link to your colleagues! We would greatly appreciate your help with getting our survey out there!

[enter survey link here]

Appendix S

Debrief Form

Firstly, thank you for participating in this study, it is a huge help!

In this study, you answered a series of questionnaires that address attitudes toward individuals with pedophilia, attitudes regarding treatment of individual with pedophilia, as well as some personal characteristics. The purpose of this research is to examine attitudes held by psychological and medical professionals regarding the treatment of individuals with a sexual interest in children. All responses you gave over the course of this study are anonymous (i.e., they cannot be linked to your name) and will remain confidential in agreement with the confidentiality agreements the research team has signed. This research has the potential increase our understanding of psychological and medical professionals' attitudes regarding treating individuals with pedophilia and whether or not they may be willing to treat individuals with pedophilia. In addition, this research may identify possible barriers to treatment of individuals with pedophilia that may exist.

We acknowledge that not everyone may be comfortable with the idea of individuals with sexual interests in children being allowed carry on living their lives and not intervening in some way to ensure the protection of children. However, it is important to recognize that many of these individuals exist and lead law abiding lives with no intention of ever acting on these sexual interests. To learn more about individuals with a dominant sexual interest in children and their struggles please visit www.virped.org.

We recognize that due to the sensitive nature of the topics discussed in this study, you may feel upset or distressed. If you do feel upset as a result of this study, and feel the need to discuss the study content with a counsellor, please feel free to do so. Your personal health is of the utmost importance! As a research team, we want to ensure you feel supported following study completion. If you should feel distressed, upset, or simply would like to speak to a counsellor about this study, please feel free to contact a professional counselling service in your area or you can follow this link to free online anonymous services for those who are concerned about the welfare of a child or about their own history of victimization (http://www.stopitnow.org)

Do you have any questions about the study you would like to ask now?
If you have any further questions, concerns, or complaints about this study, you may contact Dr. Harkins (leigh.harkins@uoit.ca; 905-721-8668 ext. 5991). Any questions regarding your rights as a participant, complaints or adverse events may be addressed to Research Ethics Board through the Ethics and Compliance Officer – researchethics@uoit.ca or 905.721.8668 x. 3693.

Once again, THANK YOU for your participation in this study!

Appendix T

Chapter 3 Ethics Approval

From: researchethics@uoit.ca
Subject: Change Request Approval Notice - REB File #14105 (received May 27th, 2019)
Date: May 28, 2019 at 7:46 AM
To: Harkins Leigh(Primary Investigator) leigh.harkins@uoit.ca
Cc: Collins Carisa(Student Lead/Post-Doctoral Lead) carisa.collins@uoit.net, researchethics@uoit.ca

Date:	*May 28, 2019*
To:	*Leigh Harkins*
From:	*Ruth Milman, REB Chair*
File # & Title:	*14105 - Examination of Users of Different Types of Online Sexual Interest in Children Support Organizations*
Status:	***CHANGE REQUEST APPROVED (received May 27th, 2019)***
Current Expiry:	***February 01, 2020***

Notwithstanding this approval, you are required to obtain/submit, to UOIT's Research Ethics Board, any relevant approvals/permissions required, prior to commencement of this project.

The University of Ontario, Institute of Technology (UOIT) Research Ethics Board (REB) has reviewed and approved the change request related to the research study named above. This request has been reviewed to ensure compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2 2014), the UOIT Research Ethics Policy and Procedures, and associated regulations. As the Principal Investigator (PI), you are required to adhere to the research protocol described in the REB application as last reviewed and approved by the REB.

Under the Tri-Council Policy Statement 2, the PI is responsible for complying with the continuing research ethics reviews requirements listed below.

Renewal Request Form: All approved projects are subject to an annual renewal process. Projects must be renewed or closed by the expiry date indicated above ("Current Expiry"). Projects not renewed 30 days post expiry date will be automatically suspended by the REB; projects not renewed 60 days post expiry date will be automatically closed by the REB. Once your file has been formally closed, a new submission will be required to open a new file.

Change Request Form: If the research plan, methods, and/or recruitment methods should change, please submit a change request application to the REB for review and approval prior to implementing the changes.

Adverse or Unexpected Events Form: Events must be reported to the REB within 72 hours after the event occurred with an indication of how these events affect (in the view of the Principal Investigator) the safety of the participants and the continuation of the protocol (i.e. un-anticipated or un-mitigated physical, social or psychological harm to a

Appendix U

Chapter 4 Ethics Approval

Date:	*June 27, 2018*
To:	*Leigh Harkins*
From:	*Shirley Van Nuland, REB Chair*
File # & Title:	*14048 - (15-144) Examination of Clinician Attitudes Regarding Treatment of Individuals With Pedophilia*
Status:	***CHANGE REQUEST APPROVED (received June 4, 2018)***
Current Expiry:	***August 01, 2018***

Notwithstanding this approval, you are required to obtain/submit, to UOIT's Research Ethics Board, any relevant approvals/permissions required, prior to commencement of this project.

The University of Ontario, Institute of Technology Research Ethics Board (REB) has reviewed and approved the change request related to the research proposal cited above. This request has been reviewed to ensure compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2 (2014)) and the UOIT Research Ethics Policy and Procedures. You are required to adhere to the protocol as last reviewed and approved by the REB.

Continuing Review Requirements (all forms are accessible from the IRIS research portal):

- **Renewal Request Form**: All approved projects are subject to an annual renewal process. Projects must be renewed or closed by the expiry date indicated above ("Current Expiry"). Projects not renewed 30 days post expiry date will be automatically suspended by the REB; projects not renewed 60 days post expiry date will be automatically closed by the REB. Once your file has been formally closed, a new submission will be required to open a new file.
- **Change Request Form**: Any changes or modifications (e.g. adding a Co-PI or a change in methodology) must be approved by the REB through the completion of a change request form before implemented.
- **Adverse or Unexpected Events Form**: Events must be reported to the REB within 72 hours after the event occurred with an indication of how these events affect (in the view of the Principal Investigator) the safety of the participants and the continuation of the protocol (i.e. un-anticipated or un-mitigated physical, social or psychological harm to a participant).
- **Research Project Completion Form**: This form must be completed when the research study is concluded.

Always quote your REB file number (**14048**) on future correspondence. We wish you success with your study.

Dr. Shirley Van Nuland	Janice Moseley
REB Chair	Research Ethics Officer
shirley.vannuland@uoit.ca	researchethics@uoit.ca

NOTE: If you are a student researcher, your supervisor has been copied on this message.