The Stigmatisation of Minor Attracted Persons

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Chapter 1: Thesis Overview

Introductory Chapter

Thesis Overview

'Minor-attracted persons' (MAPs) is a term referring to individuals who are sexually attracted to children. They are a highly stigmatised group (Jahnke et al., 2015). MAPs who experience stigmatisation report greater mental health difficulties (Levenson & Grady, 2019) and exhibit increased levels of risk of committing sexual offenses against children (Jahnke, 2018). People who are close to stigmatised individuals can experience stigma by association, or 'associative stigma'(Östman & Kjellin, 2002). Existing research suggests that interventions can reduce public and professionals' stigma and negative attitudes towards MAPs; however, the overall success of these interventions remains unclear. The aims of this thesis are to address these gaps in the evidence base by conducting: a systematic review of the effectiveness of stigmatisation reduction interventions towards MAPs (Chapter 2), and a cross-sectional empirical study exploring how psychologists' associative stigma, attitudes towards MAPs, wellbeing at work, and empathy are associated with their support for the treatment of, willingness to work with, and dehumanisation of MAPs (Chapter 3).

In Chapter 2, a systematic literature review was carried out to identify and synthesise all existing research regarding the efficacy of different types of intervention strategies for reducing the stigmatisation towards MAPs. Ten papers were included in this systematic review. To be eligible, studies needed to be written in English, and examine outcomes following interventions or strategies that aimed to reduce stigmatisation (including shifting attitudes) towards MAPs. The interventions reported within the identified studies included direct contact, video-based contact, education, and use of language. Results found evidence for the effectiveness of anti-stigmatisation interventions towards MAPs; however, it remains challenging to ascertain which is the most effective intervention due to limited data and studies implementing several interventions simultaneously. These findings support the need for further investigation into the most effective means for reducing stigmatisation towards

MAPs which may in turn, remove barriers for psychological intervention to prevent child sexual abuse.

Chapter 3, the empirical paper, drew on recommendations from the systematic review in exploring how clinical psychologists' experiences of associative stigma, workplace wellbeing and empathy are associated with their attitudes toward MAPs. Trainee and qualified clinical psychologists (n = 241) were recruited to an online survey, and asked to complete a series of online, anonymous questionnaires. Multiple linear regression was used to analyse the relationship of the predictor variables with each outcome measure: support for the treatment of, willingness to work with, and dehumanisation of MAPs. Findings showed that anger towards MAPs and low cognitive empathy were associated with less support for treatment policies for MAPs. Additionally, significant associations of a desire for more social distance from MAPs, heightened fear and anger towards MAPs, and low cognitive empathy, with less willingness to work with MAPs, were also observed. Finally, heightened perceptions of the dangerousness of MAPs, and low pity towards MAPs, were associated with greater dehumanisation of MAPs. The results revealed that stigmatising and negative attitudes held by trainee and clinical psychologists in the UK towards MAPs are associated with reduced support for the treatment of, willingness to work with, and dehumanisation of MAPs. The clinical implications regard the need to work with professionals to reduce their negative attitudes towards MAPs to ensure that MAPs can access clinicians who support their treatment, would be willing to work with them, and see them as human and worthy of help. Creating a climate and environment in which MAPs feel able to access treatment and support will ultimately help to reduce any potential risks that some members of this stigmatised group may progress toward acting on their sexual interest.

Both the systematic review (chapter 2) and empirical paper (chapter 3) will be submitted to the journal *Sexual Abuse*. These chapters are written as separate papers in the required style for publication (appendix 1.1).

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Chapter 2: Systematic Review

A Systematic Review of the Effectiveness of Strategies to Reduce Negative Attitudes towards Minor Attracted Persons

Abstract

Objectives: This review examines the effectiveness of stigmatisation reduction interventions towards minor attracted persons (MAPs). MAPs are a highly stigmatised group, and this stigma can act as a barrier to accessing appropriate support. This is especially problematic given that support can reduce the risk of MAPs acting on their sexualised thoughts towards children. This review synthesises the evidence base of the effectiveness of anti-stigmatisation interventions towards MAPs.

Methods: Online searches were conducted on 29/04/2021 using HDAS NICE (OpenAthens) of five databases (MEDLINE, PsycINFO, PubMed, BNI, and CINAHL). Eligible studies examined outcomes following anti-stigmatisation interventions towards MAPs. Eligible outcomes included judgements of punitive attitudes; stigmatising attitudes; desired social distance; stereotypes; and affective responses.

Results: Ten eligible papers were identified, involving a range of interventions including direct contact, video-based contact, education, and use of language. Findings revealed evidence for the effectiveness of anti-stigmatisation interventions towards MAPs; however, it remains challenging to ascertain which is the most effective due to limited data, diverse methodology, and studies implementing several interventions simultaneously.

Conclusions: Further research is required to investigate the most effective means at reducing stigmatisation towards MAPs which may in turn, remove barriers for psychological intervention to prevent child sexual abuse.

Keywords

Systematic Review; Minor Attracted Persons; Stigmatisation; Negative Attitudes; Intervention

Introduction

Minor attraction is an umbrella term which covers all age ranges of sexual attractions towards children (Walker & Panfil, 2017). For the purpose of our research, we define children as any person under the legal age for providing consent to participate in sexual activities in the United Kingdom (i.e., 16 years of age). 'Minor-attracted persons' (MAPs) is the preferred term used by people who are sexually attracted to children (Kramer, 2011), and encompasses a broad range of chronophilic categories of sexual attraction, including hebephilia (sexual attraction to pubescent children), ephebophilia (sexual attraction to postpubescent adolescent minors), and paedophilia (sexual attraction to prepubescent children) (Lievesley et al., 2020). In contrast, child sexual abuse refers to criminal acts perpetrated against children. The sexual abuse of children can occur in person or remotely and is known to cause a myriad of adverse physical and psychological health outcomes (Maniglio, 2009).

Although the two concepts (i.e., sexual interest in children and sexual abuse of a child) are often wrongly conflated, they are not interchangeable (Feelgood & Hoyer, 2008; Harrison et al., 2010). Attraction toward a minor, if not acted on, is not illegal. Not all MAPs sexually abuse children, and not all people who sexually abuse children identify as MAPs. Indeed, evidence suggests that most MAPs do not commit any offenses against children (Goode, 2009).

Despite this, minor attraction is a divisive and controversial topic (Seto, 2008), and MAPs constitute a highly stigmatised group (McCartan, 2004). They are consistently rated as being amongst some of the most feared and loathed groups of people in society (Feldman & Crandall, 2007; Jahnke, 2018). MAPs are often the target of strong negative emotions and social distancing, even when compared with other highly stigmatised groups (Jahnke et al.,

2015). Moreover, the stigmatisation and punitive attitudes towards MAPs are widely considered as being socially acceptable (Imhoff, 2015).

Stigmatisation is a subjective experience (Schulze & Angermeyer, 2003), defined as a "deeply discrediting" attribute; labelling the person as "deviant, flawed, limited, spoiled, or generally undesirable" (Goffman, 1963, p. 3). The process of stigmatisation entails prejudiced and negative opinions which indiscriminately overemphasise the bearers' social handicap (Crisp et al., 2005). When groups of people are stigmatised, it can lead to prejudice and discrimination (Corrigan et al., 2001); punitive attitudes (Imhoff, 2015); and denial of their basic humanity (Boysen et al., 2020). In turn, this can contribute towards a higher risk of adverse health outcomes (Stangl et al., 2019), and in the case of MAPs, may contribute to the presence of risk-factors that heighten the chance of a sexual offence being committed, either in person or online (e.g., use of child sexual exploitation material).

Because of the risks associated with stigmatising attitudes towards MAPs, these attitudes carry a societal humanitarian cost, with MAPs being likely to experience many barriers in accessing mental healthcare support. This can occur through internalised stigmatisation (Lievesley et al., 2020); judgmental and negative attitudes from service providers (Jahnke et al., 2015; Levenson & Grady, 2019); the expected stigmatisation from service providers (Parr & Pearson, 2019); and stigma-related stress (Jahnke et al., 2015).

Moreover, these attitudes may indirectly lead to an increased risk of sexual offending against children. This is either because of a lack of support (Mann et al., 2010; Beier et al., 2015; Helmus et al., 2015; Wittström et al., 2020), or because of the deleterious effects of experiencing stigmatisation on factors that might usually protect against committing a sexual offence (Whitaker et al., 2008). Reducing stigmatisation toward MAPs is therefore an

important public health concern that is relevant to sexual abuse prevention and protecting children from harm.

Several studies have examined how interventions can lead to reductions in the level of stigmatising attitudes that people hold. Stigma reduction strategies such as direct contact, social marketing, counselling, and education-based approaches have shown statistically significant declines in measures of stigma towards stigmatised populations, including people living with HIV (human immunodeficiency virus) / AIDS (acquired immune deficiency syndrome) (Brown et al., 2005), and mental health difficulties (Thornicroft et al., 2016). For a review see Rao et al. (2019). Although the extent to which these stigma reduction interventions lead to practical change and improved living conditions for the stigmatised population remains unclear, the benefits of these campaigns and interventions are worthy of further investigation.

The application of similar approaches to reduce the stigmatisation held towards MAPs may contribute to achieving an environment in which MAPs feel secure in accessing support services and might ultimately reduce the risk that a person might act on their sexual interests. Negative attitudes are not only limited to members of the general public, some healthcare professionals also appear to hold negative attitudes towards MAPs, which may limit treatment provision (Lievesley et al., 2022). Similarly, anti-stigma campaigns could help to prevent the low expectations of society towards MAPs from turning into self-fulfilling prophecies of abuse among the targets of those expectations (Maruna et al., 2009).

As proposed by Lawrence and Willis (2021), there is a need for researchers to understand how students, professionals, and the general public's attitudes towards MAPs may be shifted through a variety of stigma reduction strategies. Currently, it is unclear how effective different stigma reduction strategies and interventions are at reducing the

stigmatisation, and changing negative attitudes, towards MAPs. The aim of this review is to systematically search, identify and synthesise the available evidence reporting on the effectiveness of all MAP stigmatisation reduction strategies. An existing review in this area has been published but was limited by the inclusion of empirical studies that focused on child sexual abusers as well as MAPs. For example, the review of reducing public stigma towards MAPs by Lawrence and Willis (2021) included a study by Wurtele (2018) which measured attitudes toward child sexual offenders. The incorrect conflation of child sexual abusers with MAPs in these reviews means that the effectiveness of stigmatisation reduction interventions may be skewed by responses toward people who have sexually offended. Further differences between reviews arose from differing inclusion criteria, and consequently differences in the selection of studies; specifically, whether 'use of language' could be considered as an intervention. Finally, this review included recent studies which were not available for inclusion in prior reviews.

The aims of this systematic review were to 1) identify and synthesise all available literature on interventions to reduce levels of stigmatisation towards MAPs and their effectiveness; 2) describe and characterise the methodological standard of research evidence; and 3) suggest areas for further research. Results of this review can be used to inform public policy about 'what works' in effective stigmatisation reduction campaigns. This has major clinical implications regarding the risk reduction of child sexual abuse, as well as improvements to the health and wellbeing of MAPS.

Methods

Search Strategy

The review protocol was registered on PROSPERO, (CRD42021258781) prior to data collection (appendix 2.1). Studies were identified through systematically searching the following electronic databases: BNI, CINAHL, Medline, PubMed, and PsycINFO. These

databases were searched from their earliest records until 29th of April, 2021. The same terms and databases were then used to rerun further searches in an updated search on the 9th of December, 2021. No additional papers were identified. The search strategy used a combination of terms associated with minor attraction (paedophil* OR pedophil* OR 'minor attract*') and stigma (stigma* OR attitud* OR dehumanis* OR discrim* OR perspectiv* OR opinion* OR percepti* OR feel* OR thought* OR idea* OR stance* OR disgust*). As well as electronic databases, several additional search strategies were conducted. The British Library e-theses online service (EThOS) was screened for any relevant doctoral theses in the grey literature; the Open Science Framework was searched for any relevant studies; reference lists of key papers were screened; authors of selected key papers and experts in the field were contacted to enquire whether they knew of any published or unpublished studies; ResearchGate was screened for studies in progress; Google Scholar was searched for any other unidentified records. No additional papers were identified through any of these processes.

Study Eligibility

To be eligible, studies were required to: a) be written in English, b) involve adult (18 years and over) participants, c) include a measure of stigmatisation or attitudes towards MAPs, d) and report on the outcomes of an intervention designed to alter attitudes or stigmatisation towards MAPs.

Studies that did not report on an intervention, e.g., correlational studies, were not eligible for review. Studies were only eligible for review if they included one or more outcome measures of stigmatisation or shifts in otherwise negative or punitive attitudes. Studies could take place in any setting, including laboratory, online, and real-world settings such as clinical conferences, therapy rooms, classrooms etc.

Since it is already established that the general public regard sexual offenders extremely negatively (Fortney et al., 2007), any studies that employed measures which were not adequately modified for MAPs were excluded (e.g., the Perceptions of Sex Offenders Scale (PSO) and Attitudes to Sexual Offenders Scale (ATS-21)), as it is likely that including these measures could lead to harsher stigmatisation. Consequently, unless papers explicitly stated that they had adequately modified measures for use with MAPs that were originally designed for use with people who had sexually offended, these measures were excluded from the narrative synthesis. If authors specified how they modified measures that focussed on people who have sexually offended to be suitable for reporting attitudes towards MAPs, these were included.

Quality Assessment

The Critical Appraisal Skills Programme (CASP, 2020) Randomised Controlled Trial Standard Checklist was used to methodologically quality assess the selected studies. This tool has eleven questions to guide the rater in systematically appraising aspects of randomised control trials (RCT). The Newcastle-Ottawa Scale (NOS) (Wells et al., 2000) was used to assess the quality of nonrandomised studies in meta-analyses. This was a deviation from the research protocol registered on PROSPERO which stated that the NOS would be used to assess all selected papers; however, since there were only two papers which were nonrandomised the researchers believed this to be most appropriate. The CASP and NOS provided an assessment of the risk of bias. For the purposes of quality assessment an external reviewer assessed a random 10% of the selected studies. All disagreements were discussed in detail to achieve a consensus score.

Data Extraction

The first author reviewed full text articles and extracted data for: publication (whether it was published in a peer-reviewed journal), geographical information, sample characteristics

(population type, age, gender, and ethnicity), and design characteristics (stigma reduction intervention, measures used for stigmatisation of MAPs, assessment method, design, setting, and whether there were any follow ups). Statistical information was extracted for descriptive purposes as it was important to know group size (*n*), mean differences between groups (*M*), standard deviations (*SD*), effect size if reported (Cohen's *d*), statistical significance (*p*-values) to understand changes in outcome measures, whether the difference between intervention vs. control was significant, and how big the difference was (statistical effect size). A random sample of data extraction for 30% of the included studies was checked for consistency by other members of the research team and no discrepancies were identified.

Quantitative Synthesis

The study team intended to conduct a meta-analysis and extract the relevant measures of effect size to determine if there were a sufficient number of studies suitable for inclusion. This plan was registered on PROSPERO (CRD42021258781); however, based on methodological variance and differences in outcome measures, a quantitative synthesis was not possible.

Narrative Review

The narrative synthesis (rather than meta-analysis) comprised of three stages: 1) developing a preliminary synthesis of the investigation; 2) determining the outcome; and 3) comparing this with similar studies. Stage one included extracting key characteristics of the investigation, for example, the design and content of the intervention. Stage two included assessing whether the study reported conclusive findings in line with an assessment of the risk of bias. Finally, stage three used the information from both previous stages to explore relationships within and between studies in this area of research (e.g., type of intervention: direct-contact, video-based contact, education, and language).

Expert by Experience Consultation

The review was developed in collaboration with 'experts-by-experience'. Firstly, a person with lived experience of being the survivor of child sexual abuse was consulted to assess whether the potentially emotive nature of the topic was adequately considered. They provided feedback on whether the review was balanced, considering the impact on survivors of child sexual abuse as well as the welfare and public health dilemma of MAPs. Secondly, the study team recruited a non-offending MAP from the Virtuous Paedophiles network (www.virped.org) to provide feedback on whether they felt that the review was appropriate and balanced. They provided feedback on the language used within the review and the balance between the welfare of MAPs and risk of child sexual abuse. Together, the experts by experience gave invaluable input and helped the study team enhance our understanding of minor attraction, whilst remaining compassionate towards the experience of MAPs and sensitive to the potential risk of child sexual abuse.

Results

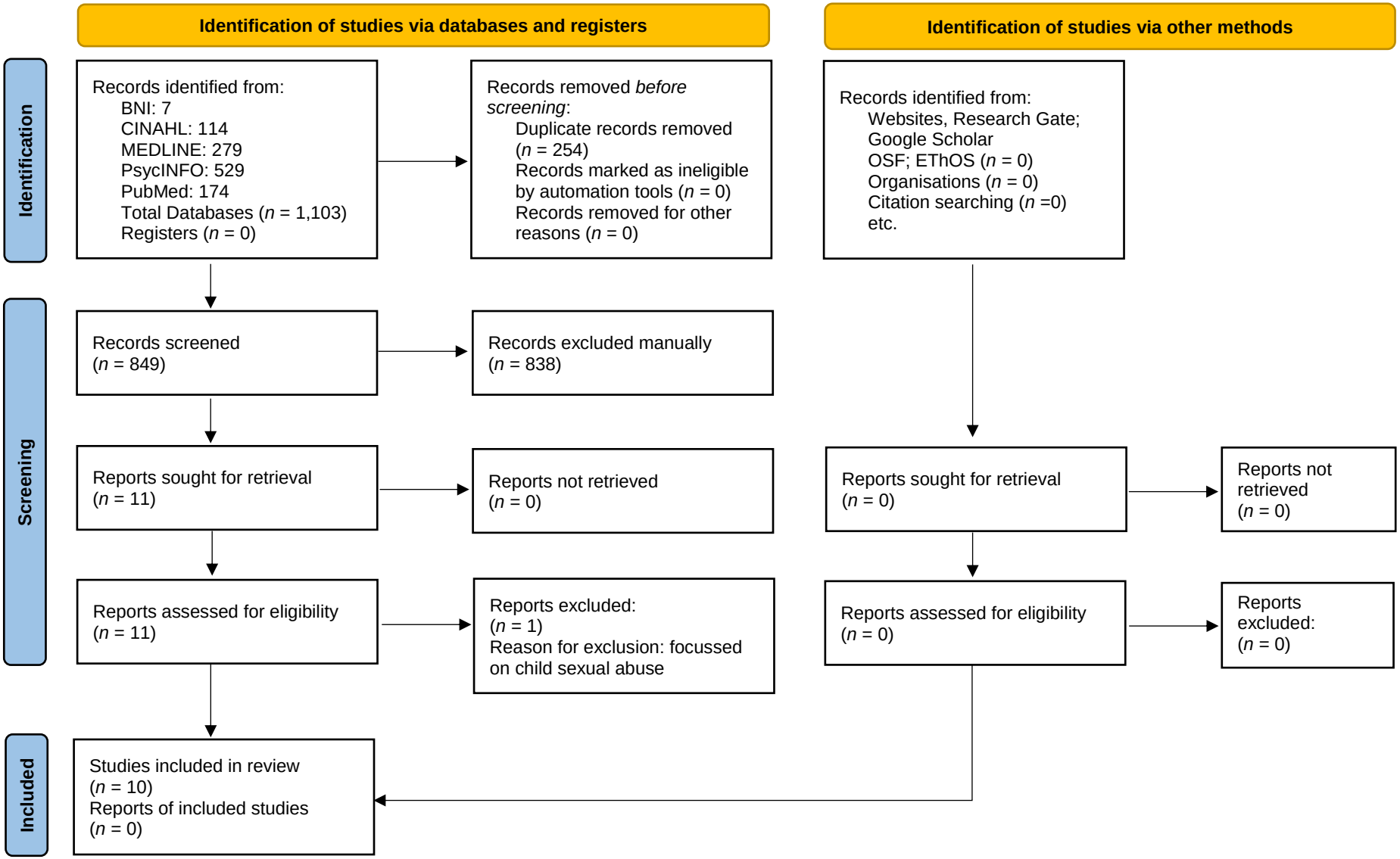
Screening and Selection

A total of 1,103 records were identified. Following the removal of duplicates, 849 individual titles and abstracts were screened. At this stage, to check for consistency in selection, a random selection of all records (50%; n = 425 papers) were independently assessed by a second reviewer. The rate of agreement was calculated as 99.8% (1 discrepancy), indicating excellent internal agreement.

Next, full text articles of all potentially relevant papers were independently assessed for inclusion by both reviewers. Consensus was achieved by discussion of all uncertainties and discrepancies and agreement between reviewers was reassessed at 100%. This process is outlined in Figure 1, using the PRISMA 2020 flow diagram for new systematic reviews including searches of databases, registers and other sources (Page et al., 2021).

Figure 1

PRISMA Flow Diagram



Sample Characteristics

Table 1 displays the characteristics of the samples within the ten journal articles included in this review. The sample size of the studies varied between 89 and 539, with a total of 2299. All studies which were conducted face-to-face, and took place in either Europe or the United States. Participants were exclusively members of the public, and included students (n = 306), therapists (n = 94), and therapists in training (n =137). Most studies had samples which were predominantly female (60%). Often studies did not report ethnicity or race (6/10), of those which did most participants were White.

Table 1

Sample Characteristics

Study	Country	Participants	*n*	Average Age in Years (SD)	Male (%)	Ethnicity / Race
(Harper et al., 2018)	UK	Students	100	22.53 (6.48)	19%	N/A
(Heron et al., 2021)	Netherlands	Students	162	21.25 (2.18)	17.9%	N/A
(Boardman & Bartels, 2018)	UK	Public & Students	89	27.76 (12.58)	32.58%	N/A
(Levenson & Grady, 2019a)	United States	Therapists	94	52 (14.4)	30%	85% White 14% Minority
(Harper et al., 2021)	UK	Public	539	36.78 (13.75)	50%	N/A
(Jara & Jeglic, 2021)	Worldwide	Public	205	36.73	64.9%	65.4% White, 17.6% Asian, 4.4% Black, 3.9% Latinx, 8.8% Other
(Imhoff, 2015) Study 1	Worldwide	Public	142	27.60 (9.2)	25.35%	N/A
(Imhoff, 2015) Study 2	Worldwide	Public	203	29.6 (8.6)	62.07%	73.89% White
(Imhoff & Jahnke, 2018)	United States	Public	423	32.5 (11.0)	60.28%	72.3% White
(Jahnke, 2018)	United States	Public	205	33 (9)	58%	69% White
(Jahnke et al., 2015)	Germany	Trainee Therapists	137	30.34 (5.39)	17.5%	N/A

Study Characteristics

Table 2 displays the study characteristics of the ten investigations included in this review. Most studies (8/10) were RCT. Only one of the ten studies included an assessment method which was not wholly based on self-report, whilst only two studies assessed outcome at a follow-up time point.

Table 2

Study Characteristics

Study	Intervention	Design	Setting	Assessment Method	Measure	Follow Up
(Harper et al., 2018)	Video-based Contact; Education	RCT, 2 (Condition: Narrative vs. Informative) × 2 (Time: Pre- vs. Post-Manipulation)	University	Self-report, Implicit Measures	mMDS-SO; SPS; mAS; MT	None
(Heron et al., 2021)	Direct Contact; Education	One-Group Pretest-Posttest Design	University	Self-report	SPS	None
(Boardman & Bartels, 2018)	Video-based Contact	RCT, 3 (Condition: Nonoffender vs. Offender vs. Control, Interview) × 2 (Age: Older vs. Younger)	University	Self-report	SPS; JQ	None
(Levenson & Grady, 2019a)	Education	One-Group Pretest-Posttest Design	Conference	Self-report	AWMAP	None
(Harper et al., 2021)	Video-based Contact; Education	RCT, 2 (Condition: Narrative vs. Informative; between-participants) × 3 (Time: Baseline vs. Immediate Change vs. Follow-Up)	Online	Self-report	SPS	4 Months
(Jara & Jeglic, 2021)	Education	RCT, (Control vs. Substance Use vs. MAP)	Online	Self-report	ATMAP	None

(Imhoff, 2015) Study 1	Language	RCT, (Paedophilia Label vs. Descriptive Term)	Online	Self-report	SPS	None
(Imhoff, 2015) Study 2	Language	RCT, (Paedophilia Label vs. Descriptive Term)	Online	Self-report	SPS	None
(Imhoff & Jahnke, 2018)	Language	RCT, 2 (Label: Paedophilia vs. No Label) × 2 (Intentionality: Low vs. High)	Online	Self-report	SPS	None
(Jahnke, 2018)	Education	RCT, 2 (Non-offending Motivation: Internal vs. External) × 2 (Sexual orientation: Paedophilic vs. Teleiophilic)	Online	Self-report	SPS; SI; AR2	None
(Jahnke et al., 2015)	Education; Video-based Contact	RCT, (Anti-stigma Intervention vs. Control, Responsible Parenting)	Online	Self-report	SPS; MWPwP; AR1; Stereotypes	1 Week - 2 Months

Note. RCT = randomised control trial; mMDS-SO = modified Moral Disengagement Towards Sexual Offenders Scale; SPS = Stigma and Punitive Attitudes toward Paedophiles Scale; mAS = modified Absorption Scale; MT = Mouse Tracking; JQ = Judgement Questionnaire; AWMAP = Attitudes about Working with MAPs; ATMAP = Attitudes Toward MAPs; SI = Stigma Inventory; AR1 = Affective Responses 1 (sympathy, anger); AR2 = Affective Responses 2 (fear, disgust, anger); MWPwP = Motivation to Work with People with Paedophilia; Stereotypes = controllability, dangerousness

Interventions

There are no defined typologies to group different types of MAP stigma interventions. Therefore, the research team identified four categories of intervention type from the included studies: direct contact, video-based contact, education, and use of language. Direct contact referred to interventions in which participants met with a MAP face-to-face, including listening to a MAP talking in person, or interacting with them through discussions, or question and answer sessions. Interventions that employed remote electronic communication devices were categorised as video-based contact, which included participants watching pre-recorded video clips of MAPs or interacting with MAPs using remote electronic communication devices. Video-based contact required electronic visual and auditory exposure to a MAP and provided participants with personal stories or 'narrative humanisation' of MAPs, in the first-person. Education included interventions with a taught component about minor attraction via a range of approaches including lectures, expert opinion videos, and reading printed or electronic information. Participants could read theoretically about MAPs, or even personal vignettes and stories from MAPs, but they did not hear or see any MAPs in person or electronically. Finally, language entailed investigations which varied the wording of written or oral stimuli. These investigations focused on the effect of the presence or absence of specific words, labels, and terminology.

Across the ten studies, four broad categories of anti-stigma interventions and strategies were employed. One study included direct contact (Heron et al., 2021), five studies reported on interventions that used video-based contact (Jahnke et al., 2015; Boardman & Bartels, 2018; Harper et al., 2021; Harper et al., 2018; Levenson & Grady, 2019c), seven studies used educational interventions (Harper et al., 2018; Harper et al., 2021; Heron et al., 2021; Jahnke, 2018; Jahnke et al., 2015; Jara & Jeglic, 2021; Levenson & Grady, 2019c), and two studies employed language based interventions (Imhoff, 2015; Imhoff & Jahnke, 2018b).

Several studies compared the effects of multiple interventions against each other. For instance, Harper et al. (2018) implemented video-based contact which was compared with informational presentations on minor attraction delivered by experts in the field (education). Other investigations used study designs which implemented two interventions simultaneously. For instance, Heron et al., (2021) reported the results of a study that included meeting a MAP (direct contact) and attending an educational lecture (education).

Across the ten studies, we identified ten explicit measures of stigmatisation and negative attitudes that were employed as outcome measures. Measures included a modified version of the Moral Disengagement Towards Sexual Offenders Scale (mMDS-SO; Harper, 2016), replacing "sex offender(s)" with "paedophile(s)" terminology; the Stigma and Punitive Attitudes toward Paedophiles Scale (SPS; Imhoff, 2015); a Judgement Questionnaire (JQ); the self-devised Motivation to Work with People with Paedophilia (MWPwP; Jahnke et al., 2015); the self-devised Attitudes about Working with MAPs (AWMAP; Levenson & Grady, 2019a); the self-devised Attitudes Toward MAPs (ATMAP; Jara & Jeglic, 2021); the Stigma Inventory (SI; Jahnke et al., 2015); Affective Responses sympathy and anger (AR1; Jahnke et al., 2015); Affective Responses fear, disgust, and anger (AR2; Jahnke, 2018b); and Stereotypes controllability and dangerousness (Jahnke et al., 2015). Additionally, two implicit measures of stigmatisation and negative attitudes were used. This included a modified version of the Absorption Scale (mAS; (Green & Brock, 2000) and software for Mouse Tracking (MT; (Freeman & Ambady, 2010).

Quality Assessment of Selected Studies

The CASP was used to rate the eight RCTs and the NOS was used two rate the two nonrandomised studies. The results of the risk of bias assessment are displayed in Table 3. Notably, all studies performed strongly in the first section of the CASP, which assessed the basic study design, and in the first section of the NOS, which assessed studies' selection of

participants. All studies included a clearly focused research question; adequate study design to assess the intervention; clearly stated populations and outcome measures. For the eight RCTs, the process of randomisation was appropriate for the purpose of eliminating bias. All but one study accounted for all the participants who had entered the study, providing rates of attrition and exclusions after randomisation.

The second section of the CASP rates whether studies were methodologically sound, indicating a mixture in performance. Within psychological research it is challenging to 'blind' participants to the control or intervention, as they will often immediately be aware of which arm of the trial they are in through their participation. Few (5/10) papers stated whether investigators were 'blind' to the intervention, or whether the people assessing the outcomes were 'blinded'. Several (2/10) studies documented some of their blinding processes, but none disclosed their processes at every stage. Most (7/10) of the RCTs accounted for the baseline characteristics of each study group, confirming that there were no significant differences between the study groups that could affect the outcomes. Lastly, apart from the experimental intervention, each study group received the same level of care in all the RCTs. This was clearly defined in their study protocol with identical measures and follow-up intervals for each study group.

Thirdly, in considering the results of the studies, most were only partial in their comprehensive reporting. Whilst outcomes were clearly specified and measured, power calculations were often not conducted, and of the few that did report power calculations, some acknowledged that they were underpowered. Similarly, the estimate of the size of intervention effect was only occasionally reported via the inclusion of confidence intervals. Thus, there exists an increased risk of bias via the false reporting of positive effects (Coe, 2002). Additionally, studies often did not fully list their procedures, rendering it difficult to assess whether the intervention outweighed any potential harms and costs. It is possible that it

may have been distressing for participants to think about MAPs and engage with their personal affective responses. Relatively few studies contained any pre-emptive warnings that tasks contained material that could be considered offensive or emotive. Participant information sheets, debriefing processes, and further avenues of support were not always adequately documented within the text or supplementary materials. Furthermore, relatively few papers considered the financial viability of the intervention. Many interventions did not require specific skills development or training; however, without cost-effective analysis it remains challenging to consider their pragmatic application on a large scale.

In assessing the final section of the CASP, and whether the results will help locally, this was mostly positive. Only the results of one study could not be applied to a local population owing to a lack of baseline measurements. Given the scarcity of studies investigating the reduction of stigmatisation towards MAPs, these papers constitute the best available evidence base.

Finally, as previously noted, Table 2 shows that all but one of the studies purely employed self-reporting methodology, and the NOS appraisal of the two non-RCTS indicated a weakness in the ascertainment of exposure, with records entirely based on self-report. This raises the risk of researcher-related bias. Most studies highlighted a need for future research to employ alternate means of gathering data through structured interviews, behavioural task analysis, and the use of secure records. The results of these studies should therefore be interpreted with some degree of caution.

Table 3

Assessment of the Risk of Bias

Study	Clearly focussed research question	Randomisation	Attrition Rate Reported	Blinding Processes Reported	Similar Study Groups	Groups Treated Equally	Comprehensive Reporting of Effects	Precision of the Estimate of Intervention Reported	Harms & Costs Assessed	Results Applicable to Local Context	Greater Value than Existing Interventions
(Harper et al., 2018)	Yes	Yes	Yes	Unsure	Unsure	Yes	Partially	Yes	Yes	Yes	Yes
(Heron et al., 2021)	Yes	N/A	Yes	No	N/A	N/A	Partially	No	No	Yes	Yes
(Boardman & Bartels, 2018)	Yes	Yes	Yes	Partially	Yes	Yes	Yes	No	Yes	Partially	Partially
(Levenson & Grady, 2019a)	Yes	N/A	No	No	N/A	N/A	Partially	No	No	Yes	Yes
(Harper et al., 2021)	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Unsure	Yes	Yes
(Jara & Jeglic, 2021)	Yes	Yes	Yes	Unsure	Yes	Yes	Partially	Yes	Yes	Yes	Yes
(Imhoff, 2015) Study 1 and 2	Yes	Yes	Yes	Partially	Yes	Yes	Partially	Yes	Unsure	Yes	Yes
(Imhoff & Jahnke, 2018)	Yes	Yes	Yes	Partially	Yes	Yes	Partially	Yes	Yes	Yes	Yes

(Jahnke, 2018)	Yes	Yes	Yes	Partially	Yes	Yes	Yes	Yes	Partially	Yes	Yes
(Jahnke et al., 2015)	Yes	Yes	Yes	Partially	Yes	Yes	Partially	Yes	Unsure	Yes	Yes

Narrative Synthesis of Findings

Direct Contact

Only one study investigated the effectiveness of reducing stigma through direct contact with a MAP. The pilot study of Heron et al. (2021)included an educational lecture and a 50-minute presentation from a MAP. During the presentation, participants listened to a MAP discussing their life experiences, their realisation of their sexual attraction towards children, coping strategies, and a 30-minute question and answer session. Findings revealed significantly diminished negative attitudes towards MAPs regarding their dangerousness, intent, deviance, and punitive attitudes. Further qualitative thematic analysis revealed participants' interest on the topic and their appreciation towards the MAP; the combination of quantitative and qualitative analysis allowed for a deeper understanding into where and why shifts occurred. This single group study design could not account for the effectiveness of direct contact as this occurred alongside the educational intervention.

Video-based Contact

Next, video-based contact with MAPs was investigated in five studies. All reported improvements in stigmatisation, with four reporting significant reductions in participants' punitive attitudes and perceptions of MAPs' dangerousness.

Jahnke et al. (2015) investigated the effects of an online 10-minute anti-stigma intervention of video-based contact with a MAP and written psychoeducational material. Video-based contact involved excerpts from a documentary in which a MAP discussed their sexual interest in children, their experience of mental health difficulties, and therapeutic experiences. This was compared against a control group of participants who received similar stimuli on violence-free parenting. Motivation to work with MAPs remained unchanged, but there were significant reductions in perceptions of MAPs' controllability and dangerousness, anger, pity, and social distance. The effects on perceived controllability, anger, and social

distance were still present in the considerably varied follow-up range of one week to two months afterwards, although slightly reduced. It is unclear whether changes occurred due to video-based contact or education as both interventions were delivered alongside each other.

Boardman and Bartels (2018) assigned participants to one of six conditions. In the first arm, all clips were a 30-second video of a 47-year-old pixelated male. In the experimental condition participants viewed a video of a non-offending MAP who wanted help managing his attraction to children. In the two control conditions participants either viewed a video of a MAP who had committed child sexual abuse but wanted help to not offend anymore, or a male who wanted help following a failed job interview. In the second arm, all clips were a 30-second video of a 15-year-old pixelated male. Across both arms the videos were identical except for the name, age, and familial information. Similarly, the script was identical except for the contextual information pertinent to the condition. No baseline assessment judgements were taken meaning that it cannot be concluded whether video stimuli was successful in reducing stigmatising views towards MAPs. Participants' responses were in the expected direction, with participants in the MAP condition reporting lower dangerousness and punitive attitudes following the video clip compared to participants in the other two arms; however, no differences were found between conditions on participants' existing attitudes towards MAPs and child sexual abusers. Authors suggested that such attitudes may be more enduring and, thus, less likely to be affected by brief video-based stimuli. The lack of a pre/post design limits the extent to which firm conclusions can be drawn.

Two studies by Harper et al. (2018; 2021) both investigated the effectiveness of video-based contact, comparing this with an expert opinion educational video. The video intervention entailed a clip from a television documentary in which a MAP provided narrative humanisation of their sexual interest in children. In both studies, the narrative humanisation video condition conveyed the same message of minor attraction constituting a

sexual interest or orientation, and that more services are required to help those who do not want to sexually abuse children. Across both studies, video-based contact conditions led to significantly greater pre to post reductions in the stigmatisation and punitive attitudes towards MAPs, compared to the education conditions. Furthermore, only the video-based conditions reduced this at an implicit level.

Levenson and Grady (2019c) investigated the effects of training participants at clinical-therapy professional conferences in how to respond to MAPs seeking counselling for their sexual interests. They used a pre-test/post-test design with no control condition. Video-based contact included video and audio clips humanising MAPs' experiences. Results showed significant changes in participants attitudes toward MAPs, indicating an increased willingness to work with this population and improved feelings of competence in service provision. It is not possible to determine whether these changes occurred due to the video-based contact or education since both occurred simultaneously.

Education

The most popular type of anti-stigma intervention were educational, with seven studies revealing mixed results. Three studies reported significant reductions in perceptions of MAPs' dangerousness, whilst one reported a significant increase. Similarly, punitive attitudes were significantly reduced in two studies, but increased in another, while perceptions of MAPs' deviance significantly reduced in one study, but increased in another.

Heron et al. (2021) explored the effectiveness of an educational lecture alongside a presentation delivered by a MAP. The educational component consisted of a 45-minute lecture delivered by researchers on child sexual abuse and minor attraction, statistics, risk factors, and information on offense prevention interventions. Significant reductions were found in participants' perceptions of MAPs' dangerousness, intent, deviance, and punitive

attitudes; however, this could not solely be accounted for by education as this was delivered alongside direct contact with a MAP.

Harper et al. (2018; 2021) both delivered educational interventions in the form of expert opinion videos. This included information on the neurobiological basis of paedophilia as a sexual orientation presented by Dr. James Cantor. Harper et al., (2018) found significant reductions in the stigmatisation and punitive attitudes held towards MAPs. Harper et al. (2021) reported mixed results with reduced perceptions of dangerousness and intentionality, yet increased levels of deviance. All of these effects were still present after four months.

Similarly, Jara and Jeglic (2021) investigated the effect of written psychoeducational materials regarding MAPs. This entailed a one-page article developed by the researchers on child sexual abuse, minor attraction, treatments, and attitudes towards treatment. Following the intervention, participants to report significantly more negative attitudes, and perceived MAPs as being more dangerous. Furthermore, participants were more likely to view treatment as a waste of resources, and report that MAPs were fundamentally different and could not be reasoned with. Authors noted that the educational intervention may not have had the desired effects since exposing participants to common myths may have subtly reinforced them, or led to mistrust due to the lack of citations within the information.

Jahnke et al. (2015)'s ant-stigma investigation included written psychoeducational information and video-based contact with a MAP. The education component consisted of a short text providing general information, common myths about minor attraction, child sexual abuse, and treatments. It was not possible to determine whether the significant reductions in controllability, dangerousness, anger, pity, and social distance were due to the education or video-based contact since both occurred alongside each other.

Jahnke (2018b) also explored the effects of providing participants with varying levels of information to educate them about minor attraction. Participants read one of four vignettes about a paedophilic (sexual attraction towards children) / teleiophilic (sexual attraction towards adults) man with intrinsic (e.g., moral convictions) / extrinsic (e.g., fear of being caught and punished) motivations to live offense free. Results showed that education about paedophilic orientations and extrinsic non-offending motivation led participants to hold significantly stronger negative apprehensions and emotions, higher social distance, and punitive attitudes.

Lastly, Levenson and Grady (2019c) evaluated the effects of an anti-stigma intervention which included video-based contact alongside educating therapists about how to respond to MAPs seeking counselling. This included a training protocol which discussed minor attraction, mandatory reporting, specific therapeutic strategies, and offered a framework for providing ethical clinical services to nonoffending MAPs. Results showed significant pre to post changes in participants attitudes towards MAPs, indicating an increased willingness to work with this population and improved feelings of competence in providing services. It is not possible to determine whether these changes occurred due to the education or video-based contact as both were provided within the same intervention.

Language

Two studies investigated the effects of language on the stigmatisation of MAPs. Imhoff (2015) examined the impact of using the label “paedophilia” against the descriptive term “sexual interest in (prepubescent) children”. Participants were provided with written information in which all items either included terms such as ‘paedophiles, paedophilic, or paedophilia’, or ‘sexual interest in children’. Results showed that the “paedophilia” label led to significantly lower ascriptions of intentionality and more punitive attitudes.

These findings were replicated by Imhoff and Jahnke (2018b), who wo used the same procedures but also manipulated the extent to which MAPs' sexual desire was described as being malleable vs. non-malleable. Findings revealed no significant differences regarding sexual desire, and more punitive attitudes towards the "paedophilia" label as opposed to descriptive term "sexual interest in prepubescent children".

Discussion

To our knowledge, this is the first systematic review to investigate the effectiveness of interventions and strategies aimed at reducing the stigmatisation, and negative attitudes, towards MAPs. In contrast to earlier reviews, this reviewed focussed specifically on the stigmatisation of MAPs, and did not include studies that focussed more broadly on attitudes toward MAPs as well as people who had a sexual offense history. The stigmatisation of MAPs was once considered "a blind spot in stigma research" in 2013 (Jahnke & Hoyer, 2013, p. 169), yet the studies reviewed here highlight the ways in which the scope of investigation has broadened considerably over time.

Across the ten studies examined in this review, the evidence largely suggests that interventions are effective at reducing levels of stigmatisation held towards MAPs, with 7/10 interventions deemed to be effective. Despite these promising results, several factors limit the extent to which robust and generalisable conclusions can be drawn about the most effective type of intervention. This is important given the extreme levels of stigmatisation that MAPs already face, and should anti-stigma campaigns be ineffective, or worse, accidentally add to stigmatisation, this could have extremely adverse effects. Wakefield and colleagues (2010) demonstrate how this can occur, noting how behaviour change campaigns can fall short and backfire, due to several factors, including the campaigns' design, delivery, content, and funding.

Some of the included studies, such as Boardman and Bartels (2018), did not factor in an assessment of participants' baseline judgments. This prevented a comparison of pre- and post-intervention, meaning it remains unclear whether the intervention was successful in reducing negative attitudes toward MAPs. Another design issue which created difficulties is the simultaneous combination of intervention strategies, e.g., education and video-based contact. It is possible that some aspects of these combined anti-stigma interventions worsened the stigmatisation of MAPs, particularly as Jara and Jeglic (2021) demonstrated an increase in negative attitudes and less support for the treatment of MAPs following education. Thus, it is important that future research can clarify the precise effects of individual and combined intervention types to provide a more complete understanding of intervention effectiveness. A final design issue was that only two of the ten studies assessed stigma-related outcomes beyond the immediate post-intervention period (i.e., at follow-up). This means that the medium- to long-term effects of these interventions remain largely unknown.

Next, there may be variability in the delivery of interventions from study to study, which poses a challenge to understanding effectiveness, perhaps most notably in relation to education: Heron et al., (2021) and Levenson and Grady, (2019c). Teaching is a demanding and complex task, and delivering a lecture to over 150 students would have required skills in public-speaking as well as sensitivity to the potentially emotive content of the topic. Some consideration therefore needs to be given to different skill sets among those delivering the intervention, including lecturers' skillset, levels of preparation, and personality. Instruments which gather data and performance criteria from students about the quality of teaching (Griffin & Care, 2015) could be used to ascertain the teaching standards required for effective anti-stigma interventions and ensure reliability for widespread application. Expert opinion videos and written materials circumnavigate any variability in the delivery of educational interventions as the content and delivery remains constant.

Next, when considering the content of interventions, most had clearly defined protocols, available supplementary materials, and comprehensively reported outcomes. Studies were generally of good quality, yet it was difficult to directly compare studies with different assessment methods and wide variation in stigma outcome measures. There were twelve measures of stigmatisation towards MAPs in total. The most popular was the Stigma and Punitive Attitudes toward Paedophiles Scale (SPS; Imhoff, 2015), used in seven of the ten studies. This measured stereotypes, affective responses, and discriminatory intentions, yielding five separate outcomes. However, even within these seven studies there were slight variations, with some studies only employing a subset of the available subscales. Thus, the methodological variance across interventions, including differences in design, outcomes, and use of different stigmatisation measures, rendered meta-analytic procedures difficult to implement.

Finally, when considering funding, the quality appraisal in this review noted that few studies published information about sources of funding or the cost to run the intervention procedures, and no studies performed an economical evaluation. This prevented an assessment of whether interventions were cost-effective, and therefore pragmatic on a large scale. In summary, the relatively small body of research, as well as the diversity of the interventions, experimental conditions, and outcome measures poses several challenges that prevent definitive conclusion from being drawn about the kinds of interventions that are likely to be most effective at reducing stigmatisation towards MAPs. Despite this, our review has identified that interventions can significantly reduce stigmatisation and improve attitudes towards MAPs.

To conclude, overall, the studies included in this review were of good methodological quality, but there were nonetheless some features of the studies reviewed here that raise concerns about potential risk of bias. Firstly, there was a high prevalence of female

participants, with the proportion of the sample who were female in two of the studies exceeding 80%: Heron et al., (2021) and Harper et al., (2018). These studies were conducted in university settings and consisted entirely of psychology student populations. Prior research from Barlow and Cromer (2006) found that women and psychology students are often overrepresented within research samples. Therefore, the high prevalence of female participants may be representative of this population, but the extent to which results are generalisable is unknown. Stiels-Glenn (2010) found that compared to males, there were fewer female psychotherapists who reported that they would be willing to work with MAPs, suggesting potential sex differences in attitudes toward MAPs. Further constraints in generalisability are posed from the overall sample population being homogenous and WEIRD (Western, Educated, Industrialised, Rich, and Democratic; (Henrich et al., 2010), and recruitment methods largely utilising direct approach and self-selection methodology. Levenson and Grady (2019) note how this could result in participant samples who are more open to learning about MAPs, or amenable to changing their beliefs and attitudes.

Limitations

This review was hampered by several key limitations. Firstly, there was limited sociodemographic data available on the participants of the interventions, meaning it was not possible to extract information on participants' sexuality; levels of education; political leanings; religion; occupation type; average income; or whether they had children. Although several studies assessed participant variables and reported their associations with different outcome measures, this was not done consistently enough to allow for any comparisons to be made across studies. For instance, Imhoff and Jahnke, (2018b) found a moderate correlation between political orientation and stigma and punitive attitudes ($rs \leq .25$), and Jahnke et al., (2015) found a small effect size for parents of children below the age of consent reporting an increased desire for social distance from MAPs ($b = .26$).

Secondly, the small number of studies included in our review reflects the modest amount of research that has been conducted in this area. Only one study by Heron and colleagues (2021) investigated direct contact with a MAP and compared the effects of direct contact with other anti-stigma interventions. Direct contact has produced some of the strongest effect sizes (Corrigan et al., 2012; Livingston et al., 2011) among interventions that aim to reduce levels of stigmatisation towards various targets. Further investigation is essential to understand whether this is effective at reducing stigmatisation towards MAPs, with cross-cultural generalisability.

Thirdly, few studies of multi-level stigma interventions were identified in this review, and few studies reported measures of practical significance (i.e., effect size). The spread of data extracted in this review highlights the methodological variability and diversity of outcome measures employed during intervention research in this area. This makes comparison challenging and restricts the extent to which definitive conclusions can be drawn about how meaningful these interventions are (in terms of creating large reductions in stigmatisation towards MAPs). Differences in design, methodology, and outcome measures also precluded a quantitative synthesis of the size and consistency of the effects of interventions to reduce negative attitudes toward MAPs.

Finally, this review consisted of investigations which almost solely used self-report methodology. The implications of this are that the ecological validity remains unclear, that is, the extent to which participants would genuinely be less stigmatising in their behaviour (as opposed to purely their attitudes) towards MAPs post-intervention or after some follow-up period. This could include whether participants would be more likely to offer their assistance to MAPs.

Future Directions

Future research should seek to address these limitations and consideration should be given to the following suggestions. Firstly, to mitigate against biases surrounding self-report, future studies should employ alternative measures of negative and stigmatising attitudes and behaviour toward MAPs, while studies that do rely on self-report may benefit from the inclusion of a measures of socially desirable responding. Future investigations could use social desirability scales such as Ray (1984) to consider whether social desirability concerns may in part explain intervention effects. For example Imhoff (2015) and Imhoff and Jahnke (2018b) measured participants' propensity for giving socially desirable responses and showed that this was positively related to punitive attitudes against MAPs, a notable deviation from the norms of prejudice research. Measures other than self-report that may be employed include behavioural outcomes, such as charity donation tasks (Kersbergen & Robinson, 2019), or the measurement of implicit attitudes (Harper et al., 2018).

Future studies should capture adequate sociodemographic information and examine the extent to which these characteristics are moderators of change from pre- to post-intervention. In doing so, future research that evaluates the success of these interventions can help to reveal not only 'what works' but also 'who for'.

Furthermore, future studies should also consider options to increase truthful or attentive responding. Although some of the studies reviewed here used online surveys and/or crowdsourcing for data collection, few incorporated attentional checks to reveal inattentive respondents. Multiple screening items measuring participants' attention has been shown to improve the interplay between individuals and study characteristics (Kung et al., 2018), thereby increasing data quality and the validity of findings (Berinsky et al., 2014). This could in turn bolster the robustness of the evidence base.

Finally, in summary of these recommendations, future investigations ideally should be ‘gold-standard’: randomised and controlled (Hariton & Locascio, 2018), with trial arms implementing singular interventions to allow attribution of outcome differences to the specific intervention. Studies should be well powered and capture adequate sociodemographic information to understand for whom interventions work. These investigations should capture high quality pre-, post-, and follow-up data, using primary outcome measures that are valid and reliable. Yet, any such future examination of interventions to reduce the stigmatisation towards MAPs whilst important, should be balanced against concern for the welfare of participants, for whom it may be distressing to think about MAPs, be exposed to the intervention, or engage with emotionally. This review revealed that several studies did not clearly document whether participant wellbeing was adequately considered in information sheets, debriefing processes, and signposting to further avenues of support. Anti-stigmatisation interventions towards MAPs are still in their relative infancy, but it is important to consider the potential unintended consequences of prior attitude and behaviour change campaigns, especially should these be adapted to widespread application using social media (Cho & Salmon, 2007). Future reviews should consider including these ethical concerns and the potential harms caused by intervention in their cost-benefit analyses.

Conclusions

Results from this systematic review provide evidence for the effectiveness of anti-stigmatisation interventions towards MAPs. It remains difficult to ascertain which is the most effective intervention strategy due to limited data, methodological variations, inconsistent use of stigmatisation related outcome measures, and studies applying several interventions at once. These findings support the need for further investigation to identify the most effective strategies for reducing stigmatisation towards MAPs.

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Chapter 3: Empirical Study

What Predicts Clinical Psychologists' Willingness to Work with Minor Attracted Persons?

Abstract

Objective: This empirical study investigated how clinical psychologists' associative stigma, attitudes towards 'minor attracted persons' (MAPs), wellbeing at work, and empathy are associated with their support for the treatment of, willingness to work with, and dehumanisation of MAPs.

Methods: Trainee and qualified clinical psychologists (n = 241) self-reported their experience of associative stigma, wellbeing at work, cognitive and affective empathy, attitudes towards, support for the treatment of, willingness to work with, and dehumanisation of MAPs.

Results: Multiple linear regressions showed that heightened anger towards MAPs and low cognitive empathy were associated with less support for treatment policies for MAPs. Additionally, a desire for more social distance from MAPs, heightened fear and anger towards MAPs, and low cognitive empathy, were associated with less willingness to work with MAPs. Finally, increased perceptions of the danger of MAPs, and low pity towards MAPs, were associated with heightened dehumanisation of MAPs.

Conclusions: Some psychologists stigmatise MAPs which is associated with their support for the treatment of, willingness to work with, and dehumanisation of MAPs. Clinical implications involve ensuring that MAPs can access clinicians who support their treatment, are willing to work with them, and see them as human. Further research establish ecological validity.

Keywords

Minor Attracted Persons; Clinical Psychology; Stigmatisation; Dehumanisation; Child Sexual Abuse Prevention

Introduction

‘Minor attracted persons’ (MAPs) is an umbrella term used to describe individuals with sexual attraction towards children across a broad range of chronophilia categories. This includes individuals classed as nepiophilic (i.e., sexual attraction to toddlers and infants), hebephilic (pubescent children), ebhebophilic (postpubescent adolescent minors), and paedophilic (prepubescent children) (Craig & Bartels, 2021; Lievesley et al., 2020). The term ‘MAP(s)’ was collaboratively developed by mental health professionals and individuals who are attracted to minors (B4U-ACT, 2022), and is used within this study to prevent further pejorative and pathologising labelling associated with terms such as ‘paedophilia’ (Levenson & Grady, 2019b).

In the context of the present research, the term MAPs is used to denote individuals with a sexual interest in children but who do not act on these attractions. They are sometimes also referred to as ‘non-offending paedophiles’, ‘people with paedophilia’ (PWP), ‘virtuous paedophiles’, and ‘non-offending minor attracted persons’ (NOMAPs) (Walker & Panfil, 2017). Despite common misperceptions, the term MAP, although referring to people who have a sexual attraction toward one/more of the listed chronophilia categories, is not used to refer to people who have had sexual contact with a child or accessed child sexual exploitation material (Cantor & McPhail, 2016; Seto, 2018). This distinction is important when considering distinct assessments of risk and treatment needs for people who are sexually attracted to, or who have committed a sexual offence against, a child. Not all people who are sexually attracted to a child will commit a sexual offence, and not all child sex offences are committed by people with a sexual interest in minors (Camilleri & Quinsey, 2008).

Emerging evidence suggests that in terms of treatment needs, MAPs may be “a neglected population”(Sorrentino & Abramowitz, 2021, p. 21), who are likely to have a greater prevalence of psychiatric difficulties (B4U-ACT., 2011; Stevens & Wood, 2019) and

risk of suicide (Cohen et al., 2020), compared with the general population. They are often the target of extreme negative attitudes (Jahnke et al., 2015; Imhoff, 2015), and face barriers in accessing psychiatric support (Levenson & Grady, 2019). Aside from the ethical obligation to ensure that everyone in society has fair and equal access to treatment, such issues may prevent MAPs from accessing effective treatment that could support them to live offence-free lives (Jones et al., 2021).

MAPs are a highly stigmatised group (Jahnke et al., 2015; McCartan, 2004). Stigmatisation is the "deeply discrediting" characterisation of an individual or group as being "deviant, flawed, limited, spoiled, or generally undesirable" (Goffman, 1963, p3). Stigmatisation is associated with adverse health outcomes (Stangl et al., 2019), and can lead to people being denied their basic humanity (Boysen et al., 2020). Harper et al., (2021) notes how the stigmatisation and dehumanisation of MAPs occurs through closely related mental processes. Dehumanised individuals are more likely to face harmful social and societal actions including harsher punishment (Bastian et al., 2013) and less allocation of resources (Kteily et al., 2015; Markowitz & Slovic, 2020), contributing towards adverse health outcomes (Stangl et al., 2019). This is pertinent for MAPs, a group who are often publicly conflated with sexual offenders (Feelgood & Hoyer, 2008), and depicted in the media as "monster", "fiend", and "beast" (Harper & Hogue, 2014). This overt and explicit belief that a group is less human is known as blatant dehumanisation (Kteily et al., 2015). Alongside MAPs, other groups who commonly suffer blatant dehumanisation include people with obesity (Kersbergen & Robinson, 2019); people in prison (Bain et al., 2013); and people with substance use difficulties (Jahnke et al., 2015; Brown, 2020).

Risk factors for child sex abuse are known to include family factors, externalising and internalising behaviours, social deficits, sexual problems, and attitudes/beliefs (Whitaker et al., 2008). Stigmatising and negative attitudes towards MAPs may indirectly increase the risk

of child sexual abuse through the deleterious effects on factors that might usually protect against committing an offence. Protective factors against sexual offending can include the capacity for emotional intimacy, employment or constructive leisure activities, and an optimistic and motivated attitude to desistance (Robbé et al., 2015). A reduction in these can lead to negative impacts on internalising behaviours such as depression, low self-esteem, poor coping; problems in social deficits such as social skills and loneliness (Whitaker et al., 2008); or weakened abilities to control and regulate behaviours (Inzlicht et al., 2006).

The spread of stigma to people who are closely connected with stigmatised individuals is known as 'courtesy stigma' or 'associative stigma' (Corrigan & Kleinlein, 2006; Goffman, 1963). Lea et al. (2016) reports that professionals who work with those who have sexually offended can also experience associative stigma. An example of this is where the families and partners of those with sexual convictions experience tainted identities due to their affiliation with the convicted person (Farkas & Miller, 2007). Within the mental health profession, clinicians who work with people with 'serious mental illnesses' can experience associative stigma. This is particularly problematic as it can contribute to internalised stigmatisation and disempowerment for clinicians (Wang et al., 2018); hinder recovery and erode empathy (Yanos et al., 2017); reduce resilience (Chang et al., 2019), worsen service user and provider relationships (Verhaeghe & Bracke, 2012); and result in a poorer quality of care (Schulze, 2007; Verhaeghe & Bracke, 2012; Yanos et al., 2017).

The experience of associative stigma has been shown to be related to psychological distress (Quinn & Chaudoir, 2009), reduced resilience (Chang et al., 2019), and burnout (Yanos et al., 2017). One way in which services can remedy these negative impacts is by improving their employees' wellbeing at work, which is thought to reduce burnout (Schaufeli et al., 2016). If mental health services do not invest in clinicians' wellbeing at work, it can impede the quality of care they offer service users (Verhaeghe & Bracke, 2012).

Associative stigma has also been shown to be related to empathy, with evidence suggesting that associative stigma can erode mental health professionals' empathy for persons with severe mental health difficulties (Yanos et al., 2017). Empathy involves a comprehension of other people's experiences (cognitive empathy) as well as the ability to vicariously experience the emotional experience of others (affective empathy) (Reniers et al., 2011). These two factors of empathy are commonly referred to as cognitive empathy, that is, the ability to construct a working model of the thoughts, feelings and beliefs of others, and affective empathy, referring to the ability to be sensitive to and vicariously experience the feelings of others (Reniers et al., 2011).

Empathy has traditionally been characterised by experiencing feelings of warmth, compassion, and concern for others, expressed through provisions of care or displays of sympathy (Davis, 1983). However, although empathy can motivate kindness, it can also spur cruel and irrational actions under some circumstances (Bloom, 2017). For instance, seeing a person harmed by another and vicariously experiencing the pain of the victim may provoke feelings of anger and aggression towards the perpetrator. Similarly, in situations of intergroup conflict, feelings of schadenfreude (pleasure at others' pain) can be provoked that are inconsistent with feelings of warmth and care (Cikara et al., 2011). Likewise, empathising with survivors of abuse may motivate harsher attitudes towards potential perpetrators. These contrasting feelings provoked by a sense of empathy highlight the potential negative side-effects of experiencing the emotions of another.

Santamaría-García et al. (2017), found that mental health professionals – including, but not limited to, clinical psychologists – can both exhibit higher levels of empathic concern, and favour harsher punishments for perpetrators of harm, than other groups. The British Psychological Society (BPS) highlights how clinical psychologists are often the most appropriate professionals to treat people who have been referred for help with a history of

child sexual abuse (BPS, 2016). Clinical psychologists therefore play an important role in responding to minor attraction and concerns surrounding sexual abuse, and it is important to understand clinical psychologists' views towards MAPs.

To our knowledge, no study has investigated psychologists' attitudes towards MAPs. Within the field of mental health, prior research has investigated different groups' attitudes towards MAPs. For instance, among psychology students, Gunnarsdottir (2018) found that a greater familiarity with perpetrators of child sex abuse was associated with an increased motivation to work therapeutically with MAPs. Similarly, Harper et al. (2018) and Heron et al. (2021) found that psychology students held stigmatising and punitive attitudes towards MAPs, but that these can be reduced through video-based contact and direct-contact with MAPs. Walker et al. (2022) reported that half of the social service students they surveyed believed clients who identify themselves as MAPs must be automatically reported to the police. Among trainee and qualified therapists, Jahnke and colleagues (2015) found that stigmatising attitudes, negative affective responses, and social distance regarding MAPs could be improved via anti-stigma interventions. Similarly, (Levenson & Grady, 2019b) found that anti-stigma interventions led to an increased willingness to work with MAPs and improved feelings of competence in service provision competence. Lastly, among primary healthcare providers, Lievesley et al. (2022) found that additional training, focusing on increasing comfort around working with MAPs was associated with a greater willingness to work with MAPs. Aside from this, previous research has focussed either on the public's perception of MAPs (Harper et al., 2021; Imhoff, 2015;Jara & Jeglic, 2021), or attitudes towards child sex offenders which, as discussed, is not an interchangeable group with MAPs (Feelgood & Hoyer, 2008).

The Present Study

This study aimed to explore the impact of stigmatising attitudes toward MAPs, associative stigma, workplace wellbeing, and empathy on clinical psychologists' willingness to work with, support for the treatment of, and blatant dehumanisation of MAPs. Information on sociodemographic factors, which are associated with mental health professionals empathic functioning and wellbeing, were also collected and controlled for in analyses. The importance of these factors is underscored by findings that age is positively correlated with resilience in mental health professionals (Chang et al., 2019), and the number of years of professional experience is associated with empathy (Santamaría-García et al., 2017). Gender differences have also been observed, suggesting that female practitioners may be less willing to work with MAPs (Stiels-Glenn, 2010), while clinicians who were sensitised to the public health dilemma of MAPs, perhaps through a process of exposure to working with MAPs, tend to show more empathic and understanding reactions to this client group Jahnke, Philipp and Hoyer (2015).

The outcomes of this study will aid understanding of those factors that predict harsher attitudes towards MAPs, with the overarching aim of improving services available to MAPs, and ultimately protecting children from child sexual abuse.

It was hypothesised that participants who held more negative attitudes towards MAPs (Jahnke et al., 2015), higher levels of associative stigma (Yanos et al., 2017), lower levels of wellbeing at work (Schaufeli et al., 2016), lower cognitive empathy, and higher affective empathy (Reniers et al., 2011), will show less support for the treatment of MAPs, less willingness to work with MAPs (Jahnke et al., 2015), and more blatant dehumanisation of MAPs (Kteily et al., 2017).

Methods

Design

A cross-sectional survey design was used in which participants completed a battery of self-report measures during a single online session. The measures were related to associative stigma, wellbeing at work, cognitive and affective empathy, attitudes toward, support for the treatment of, willingness to work with, and dehumanisation of MAPs.

Expert by Experience Consultation

The study was developed in collaboration with several 'experts-by-experience'. Firstly, a person with lived experience of being the survivor of child sexual abuse was consulted to assess whether the potentially emotive nature of the topic was adequately considered in the study design and survey materials. They provided feedback on whether the investigation was balanced; considering the impact on survivors of child sexual abuse as well as the welfare and public health dilemma of MAPs. Secondly, the study team recruited a non-offending MAP from the Virtuous Paedophiles network (www.virped.org) to provide feedback on whether they felt that the study was appropriate. They trialled the study and provided feedback on the measures and language used within the investigation. They also provided feedback on the balance between the welfare of MAPs and risk of child sexual abuse. Thirdly, a qualified consultant clinical psychologist with experience of working with MAPs provided consultation regarding the recruitment materials and investigation. They too trialled the study and provided feedback to confirm its feasibility. Together, the experts by experience gave invaluable input and helped the study team to enhance our understanding of minor attraction, whilst remaining compassionate towards the experience of MAPs and sensitive to the potential risk of child sexual abuse.

Ethics

Ethical approval was granted by the University of Liverpool Health and Life Sciences Research Ethics Committee (Ref: 8498) (appendix 3.1). The investigation followed

guidelines from the National Institute for Health Research (NIHR) and the main investigator completed the Introduction to Good Clinical Practice (GCP) training.

Participants

Participants were recruited via the social media platforms Twitter and LinkedIn, and through emails to all clinical psychology training programmes within the United Kingdom (UK) (see appendix 3.2 and 3.3). Adverts and invitational emails specified that the study aimed to understand psychologists' attitudes towards working with 'people with a dominant sexual interest in children' in the context of providing psychological treatment. This language was used since the label 'paedophilia' (and it is assumed MAPs) has been shown to predict harsher negative attitudes than this descriptive term (Imhoff, 2015) (appendix 3.4). To be eligible for inclusion, participants had to be aged 18 years or over, English speaking, and employed as a trainee or qualified clinical psychologist in the UK.

Power Analysis

A power analysis conducted using G*Power (version 3.1) (Erdfelder et al., 2009) indicated a minimum required sample size of $N = 129$. Sample size was calculated to detect a medium-sized effect using linear multiple regression (increase in R^2), with four tested predictors (cognitive empathy, affective empathy, wellbeing at work, associative stigma) and five sociodemographic predictors (age, years of professional experience, gender, prior experience of working with MAPs, qualification status), with an alpha level of $p = .05$, and 95% power (appendix 3.5). We specified a medium sized effect as there was no directly comparable study to determine a likely effect size.

Procedure

Individuals interested in taking part were invited to read the information sheet (appendix 3.6) and data storage plan (appendix 3.7). The information sheet and all study

materials were securely hosted online using Qualtrics software (www.qualtrics.com/uk) (version 2021). Potential participants were made aware of the aims and inclusion criteria of the study including possible risks and anticipated benefits. Next, participants were asked to provide their informed consent before continuing to the questionnaires (appendix 3.8). Signposting was included in the information sheet and debriefing materials for participants who were concerned about their mental health or the sexual behaviours of themselves or someone they know.

Participants were asked to read and agree to the study's definition of minor attraction using the term 'people with a dominant sexual interest in children' to refer to people who are sexually oriented toward children (appendix 3.9). It explicitly outlined the differences between minor attraction and child sexual abuse. Participants were then asked to provide sociodemographic information before completing all measures in the following order: associative stigma, attitudes towards MAPs, wellbeing at work, cognitive and affective empathy, dehumanisation, willingness to work with MAPs, and support for the treatment of MAPs. After completing the survey, participants read the debrief sheet. All participants were then given the option to be entered into a draw to win online shopping vouchers or to keep up to date with dissemination of the findings (appendix 3.10). The study took approximately 20 minutes to complete.

Measures

Demographic Information. Participants were asked to identify their age, qualification status (trainee / qualified), number of years' of professional experience within clinical psychology, gender, and whether they had prior experience of working with MAPs (yes / no).

Attitudes towards MAPs. The Attitudes towards People with Paedophilia Scales (Jahnke et al., 2015) (appendix 3.11) were used to assess participants attitudes towards

MAPs. This fifteen-item Likert scale measures 1) stereotypes, agreement with the beliefs that minor attraction is controllable (controllability, e.g., ‘a dominant sexual interest in children is something that one can choose’) and agreement with the beliefs that MAPs are dangerous (dangerousness, e.g., ‘a person with a dominant sexual interest in children poses a danger to children’); 2) affective responses towards MAPs, that is, fear, pity, and anger (e.g., ‘when I think of a person with a dominant sexual interest in children, I feel fear’); and 3) discriminatory intention, social distance (e.g., ‘these people should be incarcerated’) from MAPs. Every item was rated on a seven-point Likert scale (0–6) ranging from ‘do not agree at all’ to ‘completely agree’. This scale was modified by replacing ‘people with paedophilic interests’ (PWP) to ‘people with a dominant sexual interest in children’, in line with wording used throughout the investigation, and to avoid language that has been shown to provoke stigmatising responses. Higher scores indicated more negative attitudes towards MAPs. Internal consistency ranged between acceptable and excellent across the three subscales of controllability, dangerousness, and social distance, that is Cronbach’s α was each above 0.750. See table 4 for the ratings of individual subscales internal reliability.

Associative Stigma. The Clinical Associative Stigma Scale (CASS) (Yanos et al., 2017) (appendix 3.12) measures clinicians’ experience of associative stigma, with indicators including:1) negative stereotypes about professional effectiveness (e.g., ‘I have heard people outside of the mental health field express the view that mental health professionals don’t know what they are doing/can’t really help’); 2) discomfort with disclosure (e.g., ‘when I have met a new person at a social gathering, I am reluctant to discuss my work with people with serious mental illness’); 3) negative stereotypes about people with mental illness (e.g., ‘when I tell them about the work that I do, people outside of the mental health field remark that the work must be “scary”’); and 4) stereotypes about professionals’ mental health (e.g., ‘when I tell someone about the work I do, they ask me if I am analysing them during

conversations'). The scale included nineteen items scored on a four-point Likert scale. Participants were instructed to think about their work with adults with serious mental illnesses and to report the frequency of different experiences. Response options included 1 = never; 2 = rarely, if it had occurred only once or twice; 3 = sometimes, if it had occurred repeatedly but irregularly; and 4 = often, if it occurred regularly. Possible scores range from 19 – 76, with higher scores indicating higher levels of associative stigma. Cronbach's α was above 0.750 (see table 4) indicating acceptable internal reliability.

Wellbeing at Work. The Work and Well-Being Survey (UWES) (Schaufeli et al., 2016) (appendix 3.13) is a seventeen-item Likert scale that measures the protective factors to burnout across three subscales: 1) vigour (e.g., 'at my work, I feel bursting with energy'), 2) dedication (e.g., 'I find the work that I do full of meaning and purpose'), and 3) absorption (e.g., 'when I am working, I forget everything else around me'). Participants were asked to 'please read each statement carefully and decide if you ever feel this way about your job'. Participants responded on a seven-point Likert scale, indicating how often they had felt that way, ranging between '0' / 'never' to '6' / 'always' or 'everyday'. Higher scores indicated increased levels of wellbeing at work, and therefore less burnout. Cronbach's α was above 0.850 (see table 4) indicating good internal reliability.

Cognitive and Affective Empathy. The Questionnaire of Cognitive and Affective Empathy (QCAE) (Reniers et al., 2011) (appendix 3.14) is a thirty-one-item scale which assesses cognitive and affective components of the empathic response. Cognitive items enquired about perspective taking (e.g., 'I can easily tell if someone else wants to enter a conversation') and online simulation (e.g., 'when I am upset at someone, I usually try to 'put myself in his shoes' for a while'). Affective items enquired about emotion contagion (e.g., 'I am inclined to get nervous when others around me seem to be nervous'), proximal responsivity (e.g., 'I often get emotionally involved with my friends' problems'), and

peripheral responsivity (e.g., ‘I often get deeply involved with the feelings of a character in a film, play or novel’). Participants were asked to respond on a four-point Likert scale, indicating how much they agreed or disagreed with each item. Response options included 1 = strongly disagree; 2 = slightly disagree; 3 = slightly agree; 4 = strongly agree. Higher scores indicated higher levels of cognitive or affective empathy. Cronbach’s α was above 0.750 for cognitive empathy and affective empathy indicating acceptable internal reliability. See table 4 for the ratings of individual subscales internal reliability.

Support for MAPS Treatment. The ‘Support for MAPs Treatment Scale’ is a self-devised scale created by the authors developed specifically for this research (appendix 3.15). The scale includes four items that asks participants to indicate their support for treatment policies for people with a ‘dominant sexual interest in children’. Every item was rated on a seven-point Likert scale (0–6) ranging from ‘do not agree at all’ to ‘completely agree’. Higher scores indicate increased levels of support.

The first (‘I believe that it is worth attempting to treat people with a dominant sexual interest in children, who have never committed a sexual crime’) and third (‘Treating people with a dominant sexual interest in children who have never committed a sexual crime is a waste of resources’) items both exclusively focussed on non-offending MAPs. Scores from these two items were combined to form a support for MAPs treatment scale and showed good internal reliability (2 items; α = .846).

The scale was also used to infer participants’ support for treatment policies for MAPs who had committed sexual offences. The second (‘I believe that it is worth attempting to treat people with a dominant sexual interest in children, who have committed a sexual crime’) and fourth (Treating people with a dominant sexual interest in children who have committed a

sexual crime is a waste of resources') items both exclusively focussed on offending MAPs. Scores from these two items showed good internal reliability (2 items; α = .818).

Willingness to work with MAPs. The Therapy Motivation Scale for Psychotherapists (Jahnke et al., 2015) (appendix 3.16) is a three-item Likert scale which assesses participants' willingness to offer psychotherapy to people with a 'dominant sexual interest in children'. Every item is rated on a seven-point Likert scale (0–6) ranging from 'do not agree at all' to 'completely agree'. Participants rate their rate of agreeableness across the following items: 'I would be willing to offer psychotherapy to people with a dominant sexual interest in children, who have never committed a sexual crime', and 'I would like to attend vocational courses to treat people with a sexual interest in children' both exclusively focussed on non-offending MAPs. The third item was used to assess participants' willingness to work with people with a dominant sexual interest in children who have committed a sexual crime. Cronbach's α was above 0.750 (see table 4) indicating acceptable internal reliability.

Dehumanisation. The Ascent of Humans (AOH) Scale (Kteily & Bruneau, 2017) (appendix 3.17) consists of a one-hundred-point slider scale positioned underneath five ascending silhouettes which indicated the evolutionary stages between apes and humans. Participants used the evolution of man scale to rate how evolved or human they considered the average member of each group to be. Target groups included MAPs, three highly dehumanised groups (people who are in prison for committing criminal offences, people who are medically classed as having obesity, and people who are labelled as being 'drug addicts') and a reference group (people who are from the United Kingdom). Participants were told: 'People can vary in how human-like they seem. Some people seem highly evolved, whereas others seem no different than lower animals. Using the image below as a guide, indicate using the sliders how evolved you consider the average member of each group to be.' Lower scores indicated the target as being less evolved, less human-like, and therefore indicated

more blatant dehumanisation. Higher scores indicate that the group is perceived as being more evolved, or more human-like. The score for 'dehumanisation of MAPs' was calculated by subtracting participants dehumanisation towards the control group ('people who are from the United Kingdom') from MAPs.

Internal Consistency between Scales

See table 4 for an assessment of internal ratings of reliability for all outcome measures. The Cronbach alpha coefficient values for all outcome measures was over .750, suggesting good internal ratings of reliability.

Table 4

Internal-reliability of Measures

Scale	Subscale	Number of Items	Cronbach's Alpha
Attitudes towards MAPs	Controllability	3	.943
The Attitudes towards People with Paedophilia Scales	Dangerousness	3	.779
	Social Distance	6	.852
Clinical Associative Stigma Scale (CASS)	N/A	19	.775
Work and Wellbeing Survey	N/A	17	.898
Questionnaire of Cognitive and Affective Empathy	Cognitive Empathy	19	.864
	Affective Empathy	12	.789
Support for the Treatment of MAPs Scale	N/A	2	.846
Therapy Motivation Scale for Psychotherapists	N/A	2	.771

Statistical Analysis

Statistical Package for the Social Sciences (SPSS) (version 27) (IBM, 2019) was used to analyse the data. Multiple linear regression analysed the relationship of the predictor variables (attitudes towards MAPs, associative stigma, wellbeing at work, cognitive and affective empathy) with each outcome measure (support for the treatment of MAPs,

willingness to work with MAPs, and dehumanisation of MAPs). Step one of each model included all socio-demographic predictors (age, qualification, number of years' of professional experience within clinical psychology, gender, and prior experience of working with MAPs). In a second step, participants' attitudes towards MAPs (controllability, dangerousness, affective responses, and social distance) were included. In a third step, each of the predictor variables were included (i.e., associative stigma, wellbeing at work, cognitive empathy, and affective empathy).

Further statistical analysis was used to determine differences between questionnaire items relating to MAPs and offending MAPs. This included the support for MAPs treatment (support for treatment of MAPs who had vs. had not committed a sexual offence), and willingness to work with MAPs (relative to willingness to work for with MAPs who had vs. had not committed a sexual offence). Paired samples *t*-tests and frequency data was used to infer differences.

Results

A total of 293 participants were recruited to the study. Twenty-five participants did not complete the full survey, resulting in a final sample of $n = 241$. Most participants identified as female (85.5%), with the value being roughly representative of the percentage of female applicants for NHS clinical psychology training places in the UK (Clearing House, 2020). Because a minority of respondents identified as a gender other than female or male, response categories were recoded as 'female' and 'not female', which included 'male', 'agender', 'non-binary / third gender', and 'prefer not to self-describe'. Most participants were currently in training and had no prior experience of working with MAPs.

Table 5 shows demographic information for the sample and provides descriptive statistics for each of the measures. Table 5 shows that dehumanisation was shown towards all

groups, with some participants reporting more dehumanisation towards the control group than MAPs. Participants were significantly more likely to dehumanise MAPs, than people who are in prison for committing criminal offences (t = .623, p = .036); people who are medically classed as having obesity (t = .751, p >.001); people who are labelled as being ‘drug addicts’ (t = .735, p >.001); and people who are from the United Kingdom (t = .873, p = .004) (appendix 3.18).

Table 5

Descriptive Statistics

Variable		*n* (%) or M (SD)	Range
Qualification Status	Trainee	*194* (80.5%)	
	Qualified	*47* (19.5%)	
	Age	34.29 (6.10)	21 – 58
Gender	Female	*206* (85.5%)	
	Male	*30* (12.4%)	
	Prefer not to self-describe	*1* (.4%)	
	Non-binary / third gender	*2* (.8%)	
	Agender	*1* (.4%)	
Years of professional experience within clinical psychology		6.73 (5.08)	0 – 31
Prior experience of working with MAPs	Yes	*98* (40.7%)	
	No	*143* (59.3%)	
Controllability		7.66 (3.03)	3 – 21
Dangerousness		12.47 (2.62)	3 – 21
Social Distance		28.20 (5.43)	6 – 41
Fear		3.66 (1.43)	1 – 7
Pity		4.45 (1.20)	1 – 6
Anger		4.01 (1.36)	1 – 7
Associative Stigma		44.58 (6.14)	28 - 65
Wellbeing at Work		86.55 (11.66)	48 - 118
Cognitive Empathy		62.49 (6.40)	43 – 76
Affective Empathy		35.28 (5.00)	21 – 47
Support for Treatment of MAPs		12.46 (2.10)	2 – 14
Support for Treatment of Sexually Offending MAPs		12.70 (1.90)	2 – 14
Willingness to Work with MAPs		11.54 (2.59)	2 – 14
Willingness to Work with Sexually Offending MAPs		5.32 (1.72)	1 – 7
Blatant Dehumanisation Scale	MAPs	92.40 (16.46)	0 – 100
	People in prison	93.71 (13.90)	21 – 100
	People who are medically obese	96.02 (8.90)	50 – 100
	People labelled as ‘drug addicts’	95.20 (10.62)	38 – 100
	People from the UK (control)	94.95 (12.14)	4 – 100

Correlation between Variables

Table 6 shows a correlation matrix, highlighting interrelationships between demographics, scales, and subscales. The three affective responses (anger, fear, and pity) were all significantly correlated with each other and with controllability, dangerousness, and social distance. As expected, cognitive and affective empathy were highly correlated.

Table 6

Correlation Matrix

	Qualification Status (ρ)	Age	Gender (ρ)	Years of Professional Experience	Prior Experience Working with MAPs (ρ)	Controllability	Dangerousness	Social Distance	Fear	Pity	Anger	Associative Stigma	Wellbeing at Work	Cognitive Empathy
Age	<.001**													
Gender (ρ)	.004**	.019												
Years of Professional Experience	<.001**	<.001	.822											
Prior Experience Working with MAPs (ρ)	.009**	.008**	.162	<.001**										
Controllability	.257	.128	.907	.372	.276									
Dangerousness	.793	.675	.975	.709	.076	<.001**								
Social Distance	.702	.561	.477	.726	.009**	<.001**	<.001**							
Fear	.266	.168	.056	.322	<.001**	<.001**	<.001**	<.001**						
Pity	.057	.034*	.683	.014*	.835	.001**	.004**	<.001**	.052					
Anger	.037*	.088	.009**	.204	<.001**	<.001**	<.001**	<.001**	<.001**	.208				
Associative Stigma	.139	.742	.537	.297	.282	.016*	.831	.616	.175	.620	.858			
Wellbeing at Work	.398	.092	.039*	.370	.098	.735	.984	.133	.356	.612	.751	.664		
Cognitive Empathy	.262	.506	.110	.026*	.265	.054	.539	.532	.868	.078	.477	.004**	<.001**	

Affective Empathy	.084	.315	.004**	.128	.153	.222	.952	.690	.067	.015*	.070	.048*	.477	<.001**

Note. Correlations are parametric, Pearson Correlation; ρ = Nonparametric Correlation, Spearman Rho; ** Correlation is significant at the 0.01 level (2-tailed); * Correlation is significant at the .05 level (2-tailed).

Hierarchal Regressions

Support for the Treatment of MAPs. Table 7 outlines the results of the regression analysis of participants' support for the treatment of MAPs.

Table 7

Regression Analysis of Support for the Treatment of MAPs

Model	Predictor	Unstandardised Beta	SE (standard error of Beta)	t	p	95% Confidence Intervals
1	Qualification Status	.729	.138	1.459	.146	-.256 – 1.713
	Age	-.073	-.210	-1.934	.054	-.146 – .001
	Gender	-.037	-.006	-.091	.927	-.825 – .752
	Years of Professional Experience	.040	.098	.932	.352	-.045 – .126
	Prior Experience Working with MAPs	.264	.062	.922	.357	-.299 – .827
2	Qualification Status	.650	.123	1.335	.183	-.309 – 1.610
	Age	-.071	-.206	-1.931	.055	-.144 – .001
	Gender	-.192	-.032	-.485	.628	-.970 – .587
	Years of Professional Experience	.051	.124	1.204	.230	-.033 – .135
	Prior Experience Working with MAPs	.464	.109	1.593	.113	-.110 – 1.038
	Controllability	-.037	-.053	-.759	.449	-.132 – .059
	Dangerousness	.058	.073	.914	.362	-.068 – .185
	Social Distance	.028	.071	.801	.424	-.040 – .095
	Fear	.078	.053	.672	.502	-.150 – .306
	Pity	.227	.129	1.940	.054	-.004 – .457
	Anger*	-.352	-.228	-2.538	.012*	-.625 – -.079
3	Qualification Status	.600	.113	1.228	.221	-.363 – 1.563
	Age	-.064	-.186	-1.717	.087	-.137 – .009
	Gender	-.112	-.019	-.279	.781	-.906 – .681
	Years of Professional Experience	.037	.089	.848	.397	-.049 – .122
	Prior Experience Working with MAPs	.493	.115	1.685	.093	-.083 – 1.069
	Controllability	-.026	-.037	-.518	.605	-.124 – .072
	Dangerousness	.042	.053	.658	.511	-.084 – .169
	Social Distance	.027	.070	.786	.433	-.041 – .096
	Fear	.075	.051	.645	.520	-.155 – .305
	Pity	.194	.111	1.639	.103	-.039 – .428

Anger*	-.333	-.215	-2.389	.018*	-.608 – -.058
Associative Stigma	.003	.010	.144	.885	-.042 – .048
Wellbeing at Work	<.001	-.003	-.040	.968	-.024 – .023
Cognitive Empathy*	.052	.157	2.175	.031*	.005 – .098
Affective Empathy	-.008	-.019	-.267	.790	-.066 – .050

Note. * = statistical significance, $p < .05$

Step 1 of the regression model for 'support for MAPs treatment' was not significant $F(5, 235) = 1.032$, $p = .399$, $R^2_{Adjusted} = .001$. Model 2, $F(11, 229) = 2.328$, $p = .010$, $R^2_{Adjusted} = .057$, and model 3, were a significant fit to the data $F(15, 225) = 8.647$, $p = .011$, $R^2_{Adjusted} = .064$. Parameter estimates from model 3 showed that higher anger and lower cognitive empathy were associated with less support for the treatment of MAPs (see table 7).

Willingness to Work with MAPs. Table 8 outlines the results of the regression analysis of participants' willingness to work with MAPs.

Table 8

Regression Analysis of Willingness to Work with MAPs

Model	Predictor	Unstandardised Beta	SE (standard error of Beta)	t	p	95% Confidence Intervals
1	Qualification Status	-.239	-.037	-.399	.690	-1.419 – .941
	Age	-.058	-.138	-1.302	.194	-.147 – .030
	Gender	.033	.005	.069	.945	-.911 – .978
	Years of Professional Experience	.008	.016	.161	.872	-.094 – .111
	Prior Experience Working with MAPs**	-1.315	-.250	-3.841	<.001 **	-1.990 – -.641
2	Qualification Status	-.329	-.050	-.665	.507	-1.303 – .645
	Age	-.072	-.171	-1.939	.054	-.146 – .001
	Gender	-.305	-.042	-.760	.448	-1.094 – .485
	Years of Professional Experience	.041	.080	.947	.344	-.044 – .126
	Prior Experience Working with MAPs	-.544	-.103	-1.842	.067	-1.127 – .038
	Controllability*	-.100	-.117	-2.035	.043*	-.196 – -.003

	Dangerousness*	.131	.132	2.019	.045*	.003 – .259
	Social Distance**	.173	.364	4.960	<.001**	.105 – .242
	Fear*	-.267	-.148	-2.276	.024*	-.499 – -.036
	Pity	.093	.043	.780	.436	-.141 – .326
	Anger*	-.351	-.184	-2.494	.013*	-.628 – -.074
	Qualification Status	-.276	-.042	-.565	.573	-1.237 – .686
	Age*	-.075	-.177	-2.022	.044*	-.149 – -.002
	Gender	-.043	-.006	-.107	.915	-.836 – .749
	Years of Professional Experience	.037	.073	.858	.392	-.048 – .122
3	Prior Experience Working with MAPs	-.516	-.098	-1.767	.079	-1.092 – .059
	Controllability	-.064	-.075	-1.286	.200	-.162 – .034
	Dangerousness	.114	.116	1.785	.076	-.012 – .241
	Social Distance**	.170	.357	4.904	<.001**	.102 – .238
	Fear**	-.305	-.169	-2.622	.009**	-.535 – -.076
	Pity	.053	.024	.445	.657	-.181 – .286
	Anger*	-.348	-.183	-2.498	.013*	-.622 – -.073
	Associative Stigma	-.040	-.095	-1.764	.079	-.085 – .005
	Wellbeing at Work	.009	.042	.767	.444	-.014 – .033
	Cognitive Empathy*	.053	.130	2.230	.027*	.006 – .100
	Affective Empathy	.042	.081	1.425	.155	-.016 – .100

Note. * = statistical significance, $p < .05$; ** = statistical significance, $p < .01$

The regression for ‘willingness to work with MAPs’ showed that model 1 was a significant fit to the data $F(5, 235) = 3.705$, $p = .003$, $R^2_{Adjusted} = .053$. Model 2, $F(11, 229) = 13.259$, $p < .001$, and $R^2_{Adjusted} = .360$, and model 3, were also a significant fit to the data $F(15, 225) = 10.977$, $p < .001$, and $R^2_{Adjusted} = .384$. Parameter estimates showed that younger participants, lower social distance, lower fear, lower anger, and higher cognitive empathy, were associated with increased willingness to work with MAPs.

Dehumanisation of MAPs. Table 9 outlines the results of the regression analysis of participants’ dehumanisation of MAPs.

Table 9

Regression Analysis of Dehumanisation of MAPs

Model	Predictor	Unstandardised Beta	SE (standard error of Beta)	t	p	95% Confidence Intervals
1	Qualification Status	1.396	.041	.429	.668	-5.008 – 7.799
	Age	-.135	-.061	-.553	.581	-.615 – .346
	Gender	1.060	.028	.407	.684	-4.067 – 6.187
	Years of Professional Experience	-.007	-.003	-.025	.980	-.563 – .549
	Prior Experience Working with MAPs	.557	.020	.300	.765	-3.105 – 4.219
2	Qualification Status	1.717	.050	.571	.569	-4.209 – 7.644
	Age	-.106	-.048	-.467	.641	-.554 – .341
	Gender	1.390	.036	.570	.569	-3.417 – 6.197
	Years of Professional Experience	-.185	-.070	-.704	.482	-.703 – .333
	Prior Experience Working with MAPs	-1.318	-.048	-.733	.465	-4.862 – 2.227
	Controllability	.301	.067	1.007	.315	-.288 – .889
	Dangerousness*	.815	.157	2.064	.040*	.037 – 1.594
	Social Distance	-.109	-.044	-.514	.608	-.529 – .310
	Fear	-.105	-.011	-.147	.883	-1.513 – 1.303
	Pity*	-2.564	-.227	-3.550	<.001**	-3.987 – -1.141
	Anger	1.346	.135	1.572	.117	-.342 – 3.033
3	Qualification Status	1.575	.046	.521	.603	-4.379 – 7.528
	Age	-.105	-.047	-.457	.648	-.559 – .349
	Gender	1.340	.035	.538	.591	-3.566 – 6.246
	Years of Professional Experience	-.116	-.044	-.435	.664	-.643 – .410
	Prior Experience Working with MAPs	-1.271	-.046	-.703	.483	-4.834 – 2.292
	Controllability	.171	.038	.556	.579	-.435 – .778
	Dangerousness*	.872	.168	2.196	.029*	.089 – 1.654
	Social Distance	-.155	-.062	-.720	.472	-.578 – .268
	Fear	-.010	-.001	-.014	.989	-1.431 – 1.411
	Pity**	-2.462	-.218	-3.358	.001**	-3.908 – -1.017
	Anger	1.128	.113	1.308	.192	-.571 – 2.827
	Associative Stigma	.183	.083	1.304	.193	-.094 – .461
	Wellbeing at Work	.057	.049	.765	.445	-.090 – .204
	Cognitive Empathy	-.282	-.133	-1.920	.056	-.571 – .007

Affective Empathy	.153	.056	.840	.402	-.205 – .511

Note. * = statistical significance, $p < .05$; ** = statistical significance, $p < .01$

The regression for 'dehumanisation of MAPs' showed that model 1 was not a significant fit to the data $F(5, 235) = .149$, $p = .980$, $R^2_{Adjusted} = -.018$. Model 2, $F(11, 229) = 4.386$, $p < .001$, and $R^2_{Adjusted} = .134$, and model 3, were a significant fit to the data $F(15, 225) = 3.566$, $p < .001$, and $R^2_{Adjusted} = .138$. Parameter estimates from model 3 showed that higher dangerousness, and lower pity, were associated with increased dehumanisation of MAPs.

Differences between MAPs and Offending MAPs

Paired *t*-tests showed that participants were significantly less likely to support the treatment of MAPs who had not committed a sexual offence ($M = 12.456$, $SD = 2.103$), compared with MAPs who had committed a sexual offence ($M = 12.697$, $SD = 1.903$) ($t = -2.142$, $p = .033$) (appendix 3.19), and were significantly more likely to offer psychotherapy to MAPs who had never committed a sexual crime ($M = 6.01$, $SD = 1.283$), compared to MAPs who had committed a sexual crime ($M = 5.32$, $SD = 1.715$) ($t = 10.224$, $p < .001$) (appendix 3.20). In case participants felt unable to personally deliver such psychotherapy, they were asked whether they would attend vocational courses. Participants showed a high degree of willingness, with 196 of the 241 participants agreeing that they would be willing to learn more about treating MAPs.

Discussion

Summary of Findings of Support for the Treatment of MAPs

In this study we aimed to investigate how clinical psychologists' associative stigma, attitudes towards MAPs, wellbeing at work, and empathy were associated with their support for the treatment of, willingness to work with, and dehumanisation of MAPs. We found that participants with more negative attitudes, specifically anger, and lower scores of cognitive empathy, showed less support for the treatment of MAPs. Associative stigma, wellbeing at work, and affective empathy were not found to be significant predictor variables.

In this study, it was found that 40.2% of participants who were qualified or trainee clinical psychologists reported anger towards MAPs, and anger was associated with less support for treating MAPs. This proportion is somewhat lower than that reported by Jahnke al. (2015), who found that 84% of participants from the general public reported anger towards MAPs, but is nonetheless indicative that almost half of the current sample hold stigmatising attitudes that are not supportive of treatment and could hinder the support offered to people who are attracted to minors (appendix 3.21). This may be problematic as psychologists are in a position to deliver psychotherapeutic interventions with MAPs, something which is considered to be essential in preventing child sexual abuse (Jahnke al., 2015). Our findings highlight the possibility that clinical psychologists would benefit from anti-stigma interventions, some of which have successfully been shown to reduce anger and discrimination towards MAPs (Imhoff & Jahnke, 2018; Jahnke et al., 2015). Similarly, it could be beneficial to provide information and support to psychologists during their clinical training around working psychotherapeutically with MAPs, to contribute towards the prevention of child sexual abuse.

As well as high levels of anger, low cognitive empathy also emerged as a significant predictor of support for treating MAPs. Cognitive empathy refers to processes such as

perspective-taking and mentalising (Mazza et al., 2014), therefore participants with lower ratings of cognitive empathy may have been less able to theoretically consider the perspective of a MAP. Similarly, participants who reported higher levels of cognitive empathy may be better able to consider the perspective of MAPs and empathise with the difficulties of experiencing potentially unwanted and distressing thoughts about children, fostering greater compassion towards the public health dilemma of treating MAPs. Similar to core medical (General Medical Council, 2017) and psychiatry (Royal College of Psychiatrists, 2010) training, clinical psychology training typically does not contain any information about minor attraction. It is therefore unlikely that participants would have previously learned about, or had time within this investigation, to consider the nuanced, emotive, and beneficial outcomes from treating MAPs.

Surprisingly, results showed that participants believed that it was less worthwhile attempting to treat MAPs than it was for MAPs who had committed a sexual offence. This could suggest that participants did not believe psychotherapy to be effective in preventing the occurrence of child sexual abuse. All participants will have had some level of clinical psychology training, yet compared with forensic psychology training they may not have had as much exposure to managing risk, therefore could have been unaware that psychotherapy can prevent offending and problematic behaviours. Various psychotherapeutic approaches have shown significant improvements for this, with cognitive behavioural therapy holding some of the strongest effect sizes: small to medium for treating substance abuse issues, and medium to large effect sizes for treating anger and aggression (Hofmann et al., 2012), and gambling (Gooding & Tarrier, 2009). Within forensic settings, cognitive behavioural interventions are the most common form of treatment (Moster et al., 2008). A meta-analysis from Hanson et al. (2009) found that treated sexual offenders, the majority of whom had taken part in a manualised, cognitive behavioural intervention in either Europe or North

America, had significantly lower general (31.8% vs 48.3%) and sexual (10.9% vs 19.2%) recidivism rates, compared with comparison groups. This further supports the potential benefits that would occur from providing information during clinical training around working psychotherapeutically with MAPs to prevent offending behaviours.

Summary of Findings of Willingness to Work with MAPs

In our study, participants with more negative attitudes towards MAPs, including increased social distance, and levels of fear and anger, and participants with lower cognitive empathy, showed less willingness to work with MAPs. These findings are similar to the 'support for treatment' outcome variable, as stigmatising attitudes and affective reactions deter participants from providing interventions. An increased number of predictor variables were associated with 'willingness to work', perhaps as this required participants to directly engage with MAPs ('I would be willing to offer psychotherapy to people with a dominant sexual interest in children, who have never committed a sexual crime') as opposed to theoretically supporting their treatment ('I believe that it is worth attempting to treat people with a dominant sexual interest in children, who have never committed a sexual crime'). One possible explanation may be that as participants were more directly involved with this process – offering psychotherapy – there were higher levels of fear and social distancing.

By assisting service-providers such as psychologists to gain a thorough clinical understanding, and helping to develop more positive attitudes toward MAPs, individuals at risk of committing sexual offences against children might be better able to access and receive support prior to offending (Cantor & McPhail, 2016; Harper et al., 2018). Levenson and Grady (2019b) note that it would be unrealistic to expect that all clinicians would become fully equipped to work with this population. Furthermore, this may be unnecessary, as after training, clinical psychologists tend to specialise within certain fields of practice. Yet, it could be beneficial to expose psychologists during their training to information that would

challenge common assumptions and negative judgments about MAPs (Levenson & Grady, 2019c), which might have the benefit of increasing willingness to work with this group and lower the risk to potential victims of child sexual abuse.

Training programmes should consider those methods that might be most effective for reducing negative attitudes and increasing understanding with minor attracted people. For example, a pilot study showed that direct contact with a MAP showed promising results among psychology students, who reported less punitive attitudes following contact (Heron et al., 2021). This is in keeping with evidence which would suggest that the most effective anti-stigma interventions arise from personal contact with members of out-groups (Griffiths et al., 2014). Guidance from the BPS (2020) has called for increased learning from providers who have lived experience of mental health difficulties in challenging stigma, to adopt a more normalising and valuing stance, during clinical psychology training. If this approach could safely be applied to people with lived experience of minor attraction it could help shift professional attitudes, reduce the desire for social distance, lower emotions such fear and anger, and allow clinicians to employ empathy and a greater willingness to provide treatment.

Our results also showed that older participants reported less willingness to work with MAPs. There may be several possible explanations for this. Perhaps older participants had previously worked with MAPs and found this difficult, while younger participants may also be more likely to be in training, and yet to specialise within a particular field of clinical psychology, and therefore remain open to the idea of working with MAPs. However, it should be noted that both ‘prior experience working with MAPs’ and ‘qualification status’ were not significant predictors of willingness to work with MAP. Although conventional wisdom states that younger people tend to hold more liberal values (Glenn, 1974), and therefore may be more open to the notion of working with MAPs, political attitudes tend to remain largely stable over the long term, (Peterson et al., 2020), and there is limited evidence

regarding political orientation and stigmatisation. For example, Jahnke (2018) found that liberal values did not affect self-reported cognitive apprehensions, emotions, or punitive attitudes towards MAPs, whilst Imhoff and Jahnke (2018b), found only a moderate correlation between political orientation, stigma and punitive attitudes ($rs \leq .25$). Age has previously only been found to significantly impact upon attitudes towards sexual offenders when it is the age of the offender, not the participant, that is examined (Harper, 2012; Sahlstrom & Jeglic, 2008).

In our investigation 90.4% of participants reported that they would be willing to offer psychotherapy to MAPs. This was slightly more than the 81.3% of participants who reported that they would be willing to attend vocational courses to treat MAPs. This was unexpected as it was presumed that it may be easier for participants to learn about working with MAPs, rather than offering direct work themselves. It raises questions over the accessibility of training courses such as educational interventions which aim at reducing barriers to working with MAPs (see Chapter 2).

Summary of Findings of Dehumanisation of MAPs

Participants who felt less pity towards MAPs, and those who believed MAPs were more dangerous, showed more blatant dehumanisation. Previous research has found pity to be associated with less aversion and avoidance, and more willingness to help (Eisenberg et al., 2010). However, aside from benign reactions, pity can also lead to disrespect (Harris & Fiske, 2006). For MAPs, pity has been associated with increased acceptance (Jahnke, 2018b), yet this may not necessarily lead to more effective treatment. Boleyn-Fitzgerald (2003) differentiates between three types of caring: fearful pity, aloof pity, and compassion, arguing that the latter remains a plausible ideal for healthcare professionals.

The extent to which people perceive MAPs as representing a danger toward children can be predicted by emotions of disgust, anger, and fear towards MAPs (Jahnke, 2018b). Our investigation found that participants who felt little pity towards MAPs were also likely to see them as being less human, something which could be problematic for the effective treatment of MAPs. Whilst examining the relationship between therapeutic climate and the effectiveness of cognitive behavioural therapy for sexual offenders, Beech and Hamilton-Giachritsis (2005) found that dehumanisation by clinicians was associated with worse treatment outcomes, specifically pro-offending attitudes. One of the main aims of psychotherapy with MAPs is to ensure that they do not act on their sexual attraction towards children (Seto, 2008), therefore it may be beneficial to employ narrative humanisation strategies (presenting personal stories of MAPs) as these have shown long-term effectiveness at reducing stigmatisation, dehumanisation, and perceptions of dangerousness of MAPs (Harper et al., 2021). Additionally, it could be helpful for clinical training to have specific teaching on MAPs and the relationship of this group with child sexual abuse. Examining a cost-benefit analysis of treating this group could help alleviate strong emotions, provide clarification, and reduce the notion of dangerousness.

Associative Stigma, Wellbeing at Work, and Affective Empathy

Associative stigma, wellbeing at work, and affective empathy were not significantly associated with any predictor variables. Findings from Yanos et al., (2017) suggested that among mental health professionals, associative stigma is related to experiences of burnout, weakly related with disengagement, and moderately with emotional exhaustion. It is thought that this could erode their compassion toward people with serious mental illness, and diminish the effectiveness of treatment offered by mental health to support MAPs. Although minor attraction is not considered a serious mental illness, and instead refers to a person's direction of sexual attraction, we also predicted that participants who reported higher levels

of associative stigma would feel less able to provide quality care. However, our findings did not support this notion.

Likewise, we explored whether wellbeing at work was associated with the stigmatisation and dehumanisation of MAPs. Schaufeli et al., (2016) notes that engaged employees are connected with their work activities, and better able to deal with work demands. This entails being more willing to invest in effort in one's work despite challenges. It was expected that participants who reported higher levels of wellbeing at work would be more robust to associative stigma, experience less psychological distress, hold more compassionate views towards MAPs, and support their treatment. Again, however, we found no evidence to support this hypothesis.

Finally, it was expected that across each of the investigation's outcome measures, cognitive empathy would predict more compassionate responses towards MAPs, while affective empathy would be associated with experiencing the pain of child sexual abuse survivors, and may be associated with harsher attitudes towards MAPs. Reniers et al., (2011) notes that affective empathy involves a rapid recognition of another person's emotions using facial expressions, body gestures, and voice inflections. These processes enable the individual to be sensitive to, and vicariously experience the feelings of, another. Although the findings reported here do not show an association of self-reported trait empathic responding with support for treatment of or dehumanisation of MAPs, alternative designs may have better elicited a state empathic response which may have affected participants responses. For example, in this study, participants did not see or hear directly from another person with either lived experience of minor attraction or experience of sexual abuse. It is possible that alternative designs may have helped to elicit more of a state affective empathic response that might have yielded differences in support for treating or blatant dehumanisation of MAPs. Despite the lack of investigation into the impact of working with people who are sexually

attracted to children (Bach et al., 2018), Clarke and Roger (2002) note a high incidence rate of reported 'psychological damage' from this work amongst treatment providers, thereby potentially limiting the capacity for empathic responding. In our findings, the hypotheses regarding cognitive empathy were supported; however, the affective empathy hypotheses were not as no significant associations were found with this and any outcome variables.

Limitations

The present study had three key limitations. Firstly, a cross-sectional design was employed meaning that causality cannot be inferred. Although our findings revealed significant associations between predictor and outcome variables, these correlational effects should not be interpreted as evidence of causal effects.

Secondly, the use of questionnaires as part of a cross-sectional study allowed for the recruitment of a relatively large number of participants, yet this population was likely to have been homogenous and WEIRD (Western, Educated, Industrialised, Rich, and Democratic (Henrich et al., 2010)). All participants were recruited from a Western, industrialised, democratic country, were either educated to or in training to receive a doctoral level qualification, and were either salaried employees of the NHS, with trainees employed at Band 6 (£32,306 per annum) (Change, 2021), or working for private healthcare providers and likely to be earning far more. Therefore, participants in training are remunerated at a level that is above the median annual pay for full-time employees in the UK for the tax year ending April 2021 (£31,285) (Office for National Statistics, 2021). Our study did not capture sociodemographic information on ethnicity, but it may be assumed that the majority of respondents were White, with 78% of recent applicants to NHS clinical psychology training being of White ethnicity (Clearing House, 2020). Lastly, our sample mostly comprised of females, and previous research has indicated that fewer female clinicians agreed to work with

MAPs (Stiels-Glenn, 2010). Caution should be applied in generalising our findings to a larger, more representative sample.

Thirdly, our investigation relied on a self-report assessment method, with participants providing a self-assessment of their opinions, attitudes, and abilities. Rosenman et al. (2011) discussed the potential unreliability with this method as respondents may offer a biased self-assessment, misunderstand the measurement, or comply through social-desirability to 'look good', even though the survey was anonymous.

Future Directions

For the purpose of our study, we employed the cognitive and affective scales of the Questionnaire of Cognitive and Affective Empathy. Each of these scales consists of several smaller subscales that may have been better related to the proposed outcomes. Our investigation did not find any significant associations between the affective empathy scale and any outcome variables. Future research could examine the individual subscales of the affective empathy scale: emotion contagion, proximal responsivity, and peripheral responsivity to determine whether any of these may be associated with attitudes towards MAPs. Researchers may consider focussing on the peripheral responsivity subscale, as this does not require close social contact and exists in a 'detached context' (Reniers et al., 2011, p. 90). This would therefore be suitable for participants reporting on their attitudes towards MAPs despite potentially having never worked with this group.

Previous findings from Schmidt and Weiner (1998) suggest that affective reactions such as anger are typically shown towards stigmatised conditions which are perceived to be controllable. On the other hand, attributions of uncontrollability can lead to consideration that a stigmatised individual is not to blame for their condition, in turn, triggering more compassionate responses (Schmidt & Weiner, 1998). In our investigation, controllability was

not significantly associated with any outcome variable. The high levels of self-reported anger (40.2%) in our study could be accounted for through the social cognitive theory of attitudes: as participants' subconscious (or affective) responses were triggered and used to make snap judgments about this group, in the absence of empirically accurate information to negate such judgments (Lawrence & Willis, 2021). Future investigations could vary the extent to which participants might perceive MAPs as having choice over their sexual orientation, through altering the amount of accompanying empirical information on minor attraction, to further understand the associations with attitudes held towards them.

Future studies may wish to capture further sociodemographic information which may relate to participants' stigmatisation. These could include variables such as whether participants have had personal experience of child sexual abuse, either personally, professionally or via family and friends; whether participants have children; whether participants follow a particular religion; profession; etc. Our investigation found that older participants reported less willingness to work with MAPs, future analyses of sociodemographic information should explore whether or not this relationship reflects participants being parents, or having had personal or professional experience of child sexual abuse, both of which would be more likely amongst older participants. Our investigation opted to limit the amount of sociodemographic information captured to ensure that participants were confident that they would remain anonymous. Future studies should recruit larger, more diverse samples (e.g., using crowd funding websites) and ask for additional demographic information without compromising the confidentiality of the sample.

Additionally, as an alternative to explicit (self-report) measure of attitudes, future research could also employ implicit measures. Cognitions at the implicit level are believed to be out of individuals' conscious control or awareness, therefore less prone to falsification than self-report (Wolff et al., 2015). Consequently, implicit measures are particularly helpful

in socially sensitive domains (Gawronski & de Houwer, 2014) and considering that minor attraction remains a divisive and controversial topic (Seto, 2008), they may be particularly useful for further scientific discovery. Recent investigations from Harper et al., (2018) have begun to incorporate such methodology using mousetracking to gain insight into participants' subconscious attitudes towards MAPs. Should future investigations utilise similar indirect measurement procedures they could bypass the likely limitations of social desirability and self-presentation, thereby improving the quality of data. Nevertheless, these methodologies may also have inherent limitations with recent evidence suggesting that implicit attitude tests often do not predict real world behaviour (Machery, 2022; Mitchell & Tetlock, 2017).

Likewise, future research could incorporate a behavioural outcome in assessing the stigmatisation and dehumanisation of MAPs. Previous research from Kersbergen and Robinson (2019) used charity donation tasks to investigate blatant dehumanisation, revealing actual behaviour effects of dehumanisation. Future investigations into clinicians' attitudes towards MAPs could tailor this approach with pragmatic design elements relating to waiting lists, number of therapy sessions offered, or measures of therapeutic alliance.

Conclusion

This study explored whether associative stigma predicts clinical psychologists' attitudes and willingness to work with MAPs. The study identified three main findings regarding trainee and qualified clinical psychologists in the UK. Firstly, significant associations were reported between anger, low cognitive empathy, and less support for the treatment of MAPs; secondly, between social distance, fear, anger, low cognitive empathy, and willingness to work with MAPs; and thirdly, between dangerousness, low pity, and the dehumanisation MAPs. These results controlled for qualification status, age, gender, number of years' experience, and prior experience of working with MAPs. Associative stigma, wellbeing at work, and affective empathy were not found to be significant predictor variables.

The findings reported here suggest that trainee and clinical psychologists in the UK hold stigmatising and negative attitudes towards MAPs, and that these are associated with their support for the treatment of, willingness to work with, and dehumanisation of MAPs. The study suggests variables which may be targeted to reduce negative attitudes towards MAPs and this may in turn improve the quality of psychological intervention to prevent child sexual abuse. Future research should build on these findings to further examine these associations. Such research may consider employing design methods which can make causal inference, and assessments which move beyond self-report methodology.

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Appendix 1.1 Sexual Abuse Author Guidelines

Manuscript Submission Guidelines

SA uses an online submission and review platform. Manuscripts should be submitted electronically to http://mc.manuscriptcentral.com/sajrt. Authors will be required to set up an online account on the SAGE Track system powered by ScholarOne. From their account, a new submission can be initiated. Authors will be asked to provide the required information (author names and contact information, abstract, keywords, etc.), complete submission checklist, and to upload the "title page" and "main document" separately to ensure that the manuscript is ready for blind review. Supplemental materials (e.g., additional tables, figures) can also be uploaded, when applicable, and will need to be prepared for blind review. The site contains links to an online user's guide (Get Help Now [add web link]) for help navigating the site.

Manuscripts are subjected to blind peer review and require the author's name(s) and affiliation listed on a separate page. Any other identifiable information, including any references in the manuscript, the notes, the title, supplemental materials, and reference sections, should be removed from the paper and listed on separate pages.

Manuscripts should be prepared according to the guidelines set forth in the Publication Manual of the American Psychological Association (7th ed.). This includes stipulations regarding page layout, manuscript sections and headings, and formatting of references, tables, and figures. DOI numbers when available for listed references are to be included. Effect sizes and confidence intervals are reported, where appropriate.

Each submission should also include an abstract between 150 and 200 words and 4-5 keywords.

Authors should also ensure appropriate statements have been included in the submission and the Submission Checklist completed.

Submission of a manuscript implies a commitment by the author to publish in the journal. If the manuscript is accepted, the editors assume that any manuscript submitted to *SA* is not currently under consideration by any other journal.

If you are interested in open access, click here. The standard article processing charge for SAGE Choice is 3,000 USD/1,600 GBP. The fee excludes any other potential author fees levied by some journals (such as color charges) as well as taxes where applicable.

Author Statements

SA strives for objectivity and transparency in research. As such, we request authors to disclose information relevant for the Editors, reviewers, and readers of this journal.

Statement 1: Statistical Significance Statement

Authors should provide information on their study design and analysis that can increase the risk of spurious significant findings (colloquially referred to as *p*-hacking):

1. In the Acknowledgement section, empirical manuscripts should include the statement, "*The authors takes responsibility for the integrity of the data, the accuracy of the data analyses, and have made every effort to avoid inflating statistically significant results.*"
2. In the Method section, empirical manuscripts may consider including the statement, "*We report how we determined our sample size, all data exclusions (if any), all manipulations, and all measures in the study*", from the 21 Word Solution (Simmons, Nelson, & Simonsohn, 2012). Authors should also include the following elements in the Method section:
3.
    0. Report how sample size was determined and what rule was used to stop data collection;
    1. Report the total number of any excluded cases or observations, and the reasons for making these exclusions;
    2. Report all dependent variables that were analyzed for the research question(s), whether reaching statistically significant thresholds or not;
    3. If applicable, report all relevant manipulations or conditions, whether successful or not;
    4. Specify whether analyses were *prespecified* prior to data collection- in order to address the specific research question- or *exploratory*-

implemented after examination of the data and/or prespecified analyses (see Head et al. [2015], for further information);

5. Cite prior publication of some or all of the data reported in the manuscript, to assist in future meta-analysis.

These guidelines are intended to be aspirational, to encourage greater transparency and reproducibility. Submissions that cannot address all these points will still be considered and accepted for publication in *SA*.

We recognize that these guidelines are more easily implemented for manuscripts reporting experimental designs, but may not be suitable for other types of studies that are commonly submitted to *SA*. For example, it is common in our field for a study to use data from a large database that have led to multiple publications using some or all of the data. Citing all prior publications (Element f) would be excessive in length, and might not be possible if the authors are not aware of all the published work that has used this database. In this particular example, we suggest that the authors clearly describe the database and cite prominent studies using the database, so that the readers understand where these data come from. Large databases may also have many measures, not all of which would have been analyzed for the purpose of the submitted study. In such cases, reporting all the measures would again be excessively long. Instead, the authors are asked to report all variables that were examined for the research questions (Element a).

Qualitative study designs are another submission that do not easily fit these elements and where the 21 Word Solution might not be appropriate. For qualitative studies, Element a (reporting how sample size was determined), Element b (reporting any included cases), and Element f (citing prior publications that use some or all of the data) are usually applicable.

The 21 Word Solution would also not be applicable to meta-analyses, but much of the elements (i.e., Element B, C, E, and F) are pertinent. Finally, review or theoretical submissions that do not present any statistical analyses would not require these statements.

Statement 2: Role of Funding Sources

Authors must identify any financial support received to conduct the research and/or preparation of the manuscript. Authors should specify if the funding source had any

involvement in the research and/or preparation of the manuscript. The absence or presence of funding does not preclude eligibility for publication in the journal.

Statement 3: Disclosure of Financial Interests
All authors must disclose any financial interests, such as a financial stake in a measure or service described in the manuscript, or a close, current personal relationship with someone (e.g., partner/spouse, family member) who has a financial stake in a measure or service that is described. A financial interest does not preclude eligibility for publication in the journal.

Statement 4: Research ethics approval
Authors must include a statement in the Methods section regarding institutional research ethics review and approval, if applicable. If not applicable, a short rationale should be provided (e.g., not applicable or not required).

Open Science Badging

Sexual Abuse encourages open science practices, which includes preregistration of studies, providing open study materials, or providing study data in a public repository. To qualify, preregistration, open materials, and open data should be on a publicly accessible website in a format that is time-stamped, immutable, and permanent.

To recognize these practices, we are introducing Open Science Framework (OSF) badging to articles published in this journal. For more information about these badges, see the OSF Wiki. Badging is not required for submission, peer review, or publication.

Preregistration badges are currently for Registered Reports only. Authors are asked to be mindful of ethical issues, copyright, and feasibility when considering the sharing of materials or data.

If you wish to apply for OSF badging, please ensure you mention this in your cover letter, complete our disclosure form and include it with your submission.

Authors are encouraged to be thoughtful about the connotations of language used in their manuscripts to describe persons or groups. Person-first language (e.g., "persons with sexual offense histories", "individual who has been adjudicated for…",

“child/adolescent with sexual behavior problems”) is generally preferred because it is often more accurate and less pejorative than terms like “sex offender”. Terms like “sex offender” imply an ongoing tendency to commit sex offenses, which is inaccurate for many persons who have been convicted for sex offenses given current sexual recidivism base rates. Similarly, the term suggests a homogeneous group defined and stigmatized on the basis of criminal behaviors that may have taken place infrequently or many years in the past. Person-first language is also consistent with APA style guidelines for reducing bias in written language (see American Psychological Association). Authors will sometimes need to refer to current legal terms such as "Sexually Violent Predator" laws in the US; in such cases the legal term can be placed in italics or in quotation marks. Additional guidance on this recommendation can be found in the 7th edition of the APA Publication Manual, Willis (2018), and Willis and Letourneau (2018).

Appendix 2.1. PROSPERO Study Protocol

PROSPERO
International prospective register of systematic reviews

NHS National Institute for Health Research

UNIVERSITY of York
Centre for Reviews and Dissemination

Systematic review

A list of fields that can be edited in an update can be found here

1. * Review title.

Give the title of the review in English

A Systematic Review on the Effectiveness of Strategies to Reduce Negative Attitudes towards Minor Attracted Persons

2. Original language title.

For reviews in languages other than English, give the title in the original language. This will be displayed with the English language title.

3. * Anticipated or actual start date.

Give the date the systematic review started or is expected to start.

18/08/2021

4. * Anticipated completion date.

Give the date by which the review is expected to be completed.

30/04/2022

5. * Stage of review at time of this submission.

This field uses answers to initial screening questions. It cannot be edited until after registration.

Tick the boxes to show which review tasks have been started and which have been completed.

Update this field each time any amendments are made to a published record.

The review has not yet started: No

PROSPERO
International prospective register of systematic reviews

NHS National Institute for Health Research

Review stage	Started	Completed
Preliminary searches	No	No
Piloting of the study selection process	Yes	Yes
Formal screening of search results against eligibility criteria	Yes	Yes
Data extraction	No	No
Risk of bias (quality) assessment	No	No
Data analysis	No	No

Provide any other relevant information about the stage of the review here.

[1.* Named] contact.

The named contact is the guarantor for the accuracy of the information in the register record. This may be any member of the review team.

Chris Millar

Email salutation (e.g. "Dr Smith" or "Joanne") for correspondence:

Mr Millar

7. * Named contact email.

Give the electronic email address of the named contact.

Chris.millar@liverpool.ac.uk

8. Named contact address

Give the full institutional/organisational postal address for the named contact.

9. Named contact phone number.

Give the telephone number for the named contact, including international dialling code.

07791634865

10. * Organisational affiliation of the review.

Full title of the organisational affiliations for this review and website address if available. This field may be completed as 'None' if the review is not affiliated to any organisation.

University of Liverpool

Organisation web address:

[1.* Review] team members and their organisational affiliations.

Give the personal details and the organisational affiliations of each member of the review team. Affiliation refers to groups or organisations to which review team members belong. **NOTE: email and country now MUST be entered for each person, unless you are amending a published record.**

Mr Chris Millar. University of Liverpool
Dr Steven Gillespie. University of Liverpool
Dr Eric Robinson. University of Liverpool

12. * Funding sources/sponsors.

Details of the individuals, organizations, groups, companies or other legal entities who have funded or sponsored the review.

Health and Life Sciences Research Ethics Committee (Psychology, Health and Society)

Grant number(s)

State the funder, grant or award number and the date of award

University of Liverpool D. Clin. Psychol. Research Review Committee, internal funding grant of £1, 000.00 awarded on 01.10.2020.

13. * Conflicts of interest.

List actual or perceived conflicts of interest (financial or academic).

None

14. Collaborators.

Give the name and affiliation of any individuals or organisations who are working on the review but who are not listed as review team members. **NOTE: email and country must be completed for each person, unless you are amending a published record.**

Dr Eric Robinson. University of Liverpool
Mrs Alison Bryant. Liverpool Experts by Experience

15. * Review question.

State the review question(s) clearly and precisely. It may be appropriate to break very broad questions down into a series of related more specific questions. Questions may be framed or refined using PI(E)COS or similar where relevant.

How effective are intervention strategies at reducing the stigmatisation towards minor attracted persons?

16. * Searches.

State the sources that will be searched (e.g. Medline). Give the search dates, and any restrictions (e.g. language or publication date). Do NOT enter the full search strategy (it may be provided as a link or attachment below.)

Database searches will take place within the HDAS NICE (OpenAthens) facility. Five databases will be searched which have all been chosen as they contain literature that relates to psychological practice relevant to the investigation. The five search databases are: MEDLINE, PsycINFO, PubMed, BNI and CINAHL.

A scoping search on 16.09.2021 used the following search terms which were included and applied to each of the databases listed:

(paedophil* OR pedophil* OR minor attract* OR MAP*) AND (stigma* OR attitud* OR dehumanis* OR discrim* OR perspectiv* OR opinion* OR percepti* OR feel* OR thought* OR idea* OR stance* OR disgust*)

These search terms are deliberately broad to maximise the scope of the review. A thorough search and collection of literature was made on 16.09.2021.

A further follow up search will be made a month before thesis submission / publication in April 2022 in order to identify any new studies for inclusion (forward and backward searches).

One restriction was applied: Studies written in English language only. There are no restrictions on search dates.

17. URL to search strategy.

Upload a file with your search strategy, or an example of a search strategy for a specific database, (including the keywords) in pdf or word format. In doing so you are consenting to the file being made publicly accessible. Or provide a URL or link to the strategy. Do NOT provide links to your search **results**.

Alternatively, upload your search strategy to CRD in pdf format. Please note that by doing so you are consenting to the file being made publicly accessible.

Do not make this file publicly available until the review is complete

18. Condition or domain being studied.

Give a short description of the disease, condition or healthcare domain being studied in your systematic review.

Stigmatisation is a subjective experience felt differently between individuals and groups of people' (Schulze & Angermeyer, 2003). Stigma has been defined as “an attribute which is deeply discrediting”, which labels the stigmatised person as “deviant, flawed, limited, spoiled, or generally undesirable” (Goffman, 1963). The stigmatisation of groups of people can lead to adverse health outcomes, social rejection (Corrigan, Edwards, Green, Diwan & Penn, 2001; Imhoff, 2015), and denial of their basic humanity (Boysen, Isaacs, Tretter & Markowski, 2019) leaving them susceptible to hostility and neglect (Haslam & Loughnan, 2014).
Minor attracted persons (MAPs) refers to people who are sexually oriented toward children. We define children as any person under the legal age for providing consent to participate in sexual activities in the UK (16 years of age).

Child sexual abuse refers to criminal acts perpetrated against a child. Although the two concepts (i.e., sexual interest in children and sexual abuse of a child) are often wrongly conflated, they are not interchangeable. Sexual interest in children is not a criminal offence.

This review measures stigma towards MAPs. There are various explicit measures of stigma including perceived dangerousness, intentionality, social distancing, punitive attitudes, etc., and implicit measures of absorption, mouse tracking, etc.

19.* Participants/population.

Specify the participants or populations being studied in the review. The preferred format includes details of both inclusion and exclusion criteria.

Studies will be eligible for inclusion if they measured stigmatisation and attitudes of adults (18 years and over), towards MAPs. Eligibility criteria for participants include a range of groups including students, psychotherapists, psychotherapists in training, and the general public.

Stigma must relate towards MAPs. This refers to individuals who report being sexually attracted to children. MAPs is the preferred term by individuals who self-identify as being attracted to underage minors (Cohen, Ndukwe, Yaseen & Galynker, 2018; Kramer, 2011) and encompasses a broad range of chronophilic categories of sexual attraction towards children including hebephilia (sexual attraction to pubescent children), ephebophilia (sexual attraction to postpubescent adolescent minors) and, the most well-known, paedophilia (sexual attraction to prepubescent children) (Lievesley, Harper & Elliott, 2020). The terms MAP and 'paedophile' are often wrongly conflated with child sexual abuse (CSA) (McCartan, 2004). Studies which focus on CSA participants are excluded from the review.

Exclusion criteria for participants entail minor-attracted persons themselves as internalised stigma is not being reviewed. Also excluded from this population are non-empirical studies, case reports, other systematic reviews or conference abstracts. Additionally, studies that do not capture the stigmatisation of the target population, MAPs, are excluded.

20.* Intervention(s), exposure(s).

Give full and clear descriptions or definitions of the interventions or the exposures to be reviewed. The preferred format includes details of both inclusion and exclusion criteria.

Review of original studies which examine intervention strategies aimed at reducing stigmatisation (including shifting attitudes) towards MAPs. Studies will be eligible if they include one or more outcome measures of stigmatisation or shifts in otherwise negative or punitive attitudes.

Examples of explicit negative and punitive attitudes and stigmatisation towards MAPs:

- Stigma and Punitiveness Scale / Stigma and Punitive Attitudes about Paedophilia (Imhofff, 2015)
- Attitudes towards sex offenders scale (Hogue & Harper, 2015)
- Attitudes toward minor attracted persons (ATMAP; Jara & Jeglic, 2020)

- Perceptions of Sex Offenders Scale
- The Stigma Inventory / – controllability, dangerousness, affective responses, social distance (Jahnke, 2014)
- Therapy Motivation Scale
- Moral Disengagement Towards Sexual Offenders Scale (MDS-SO; Harper, Bartels, & Hogue, 2016)
- Self-devised punitive attitudes scale
- Self-devised attitudes (towards MAPs) scale
- Self-devised judgement questionnaires
- Self-devised emotions scale
- Self-devised cognitive antecedents scale
- Self-devised stigma scales
- Self-reported attitude change

Examples of implicit / indirect negative and punitive attitudes and stigmatisation towards MAPs:

These measures are not validated measures of stigmatising attitudes, they have nonetheless been used to examine negative or punitive attitudes, and there is some evidence that negative attitudes toward some groups, assessed using implicit or indirect measures.

- Go/No-Go Association Task
- Absorption Scale'
- Mouse tracking

11. Comparator(s)/control.

Where relevant, give details of the alternatives against which the intervention/exposure will be compared (e.g. another intervention or a non-exposed control group). The preferred format includes details of both inclusion and exclusion criteria.

Interventions are compared against other interventions, control groups, and includes uncontrolled designs.

12. Types of study to be included.

Give details of the study designs (e.g. RCT) that are eligible for inclusion in the review. The preferred format includes both inclusion and exclusion criteria. If there are no restrictions on the types of study, this should be stated.

We will include original studies that examined outcomes following interventions aimed at reducing stigmatisation (including shifting attitudes) towards MAPs.

There are no restrictions on the types of study eligible to be included in the review. Examples of study designs include, but are not limited to, randomised control trials, pilot or feasibility trials, and one sample pre-post studies.

Exclusion criteria include studies where minor-attracted persons themselves are the participants of the intervention, as internalised stigma is not being reviewed. Also excluded from this review are non-empirical studies, case reports, other systematic reviews or conference abstracts. Additionally, studies that do not capture the stigmatisation of the target population, MAPs, are excluded.

There are no restrictions on the types of study eligible to be included in the review. Examples of study designs include, but are not limited to, randomised control trials, pilot trials, and one sample pre-post studies.

[13.] Context.

Give summary details of the setting or other relevant characteristics, which help define the inclusion or exclusion criteria.

There are no restrictions on the types of settings eligible to be included in the review. Examples of study settings include field studies, university settings, online, and in clinical environments.

[14.] Main outcome(s).

Give the pre-specified main (most important) outcomes of the review, including details of how the outcome is defined and measured and when these measurement are made, if these are part of the review inclusion criteria.

The intended outcome is to review the evidence base underlying interventions and strategies intended to reduce the stigmatisation held by different groups towards minor attracted persons. This can be measured by explicit measures of attitudinal shifts, less longing for social distance, decreased perceptions of dangerousness, increased motivation to work with this population, less support for harsh policies, etc. This can also be measured by implicit measures which include mouse tracking, go-no go reactions,
Mostly these measures can be taken before and after intervention. Some include long-term follow ups. Some studies will only allocate one group to the intervention arm and one to the control. It is essential that all studies include an intervention along with a quantitative measure of stigma or attitude; this will quantify change and provide support towards the main outcome.

The main outcome is to establish the effectiveness of interventions and strategies of reducing stigmatisation towards MAPs.

Measures of effect

Please specify the effect measure(s) for you main outcome(s) e.g. relative risks, odds ratios, risk difference, and/or 'number needed to treat.

Primary outcome: Stigmatisation and attitudes

A narrative synthesis of data will be adopted based on 1) description of the relevant findings (direction and significance) in the quantitative studies, 2) a count of findings from quantitative studies that confirm versus disconfirm the hypothesised relations, and 3) an evaluation of the robustness based on the quality of the

extracted data vs. the risk of potential bias.

The minimum number of studies required for the review is 10. A formal synthesis when reviewing these studies will evaluate the statistical outputs (t and F statistics, means and SDs for pre post intervention in the intervention and control groups, and measures of effect size including Cohen's d) using SSPS. If there are sufficient number of studies, meta-analysis will be considered and relevant measures of effect extracted.

25. * Additional outcome(s).

List the pre-specified additional outcomes of the review, with a similar level of detail to that required for main outcomes. Where there are no additional outcomes please state 'None' or 'Not applicable' as appropriate to the review

Not applicable.

Measures of effect

Please specify the effect measure(s) for you additional outcome(s) e.g. relative risks, odds ratios, risk difference, and/or 'number needed to treat.

26. * Data extraction (selection and coding).

Describe how studies will be selected for inclusion. State what data will be extracted or obtained. State how this will be done and recorded.

Data will be extracted as described by Polanin et al (2019) using the following items as a framework: the author, year of publication, country, study aims, study design, description of the sample, setting, intervention, method to assess stigma/emotion/attitude/perspective shift, and a description of the relevant findings, including the direction and significance of the reported relations. Agreement shall be reached through discussion with the reviewing team.

Studies which are published in peer-reviewed scientific journals will be selected for inclusion. Grey and unpublished literature are included and will maximise the scope of the review.

27. * Risk of bias (quality) assessment.

State which characteristics of the studies will be assessed and/or any formal risk of bias/quality assessment tools that will be used.

The Newcastle-Ottawa scale will be used to assess the quality of non-randomised studies. The Newcastle-Ottawa scale has three domains: selection, comparability and exposure/outcome. A study may be awarded a maximum of 10 stars across these three sections.

The revised Cochrane risk of bias tool will be used to assess the quality of randomised studies. This considers the paper in regards to aspects of trial design, conduct, and reporting. Within each domain, a series of questions ('signalling questions') aim to elicit information about features of the trial that are relevant to risk of bias. A proposed judgement about the risk of bias arising from each domain is generated by an

algorithm, based on answers to the signalling questions. Judgement can be 'Low' or 'High' risk of bias.

A random selection of studies will be co-rated by another reviewer to assess for accuracy. Any disagreements will be discussed and resolved by a third reviewer. As well as the quality assessment tool reviewers shall consider the following items in terms of assessing risk:

- INADEQUATE METHOD INFO
- RANDOM ALLOCATION
- SMALL
- PRE-REGISTRATION
- CONFLICTS OF INTEREST
- DATA QUALITY MEASURES
- BLINDING
- STUDY DESIGN
- LANGUAGE
- SAMPLING BIAS

28. * Strategy for data synthesis.

Describe the methods you plan to use to synthesise data. This **must not be generic text** but should be **specific to your review** and describe how the proposed approach will be applied to your data. If meta-analysis is planned, describe the models to be used, methods to explore statistical heterogeneity, and software package to be used.

A narrative synthesis of data will be adopted based on 1) description of the relevant findings (direction and significance) in the quantitative studies, 2) a count of findings from quantitative studies that confirm versus disconfirm the hypothesised relations, and 3) an evaluation of the robustness based on the quality of the extracted data vs. the risk of potential bias.

The minimum number of studies required for the review is 10. A formal synthesis when reviewing these studies will evaluate the statistical outputs (t and F statistics, means and SDs for pre post intervention in the intervention and control groups, and measures of effect size including Cohen's d) using SSPS.

There are three researchers involved in this process. Any discrepancies will be resolved through discussion and voting on decisions. This will ensure results are interpreted through a valid and reliable means.

29. * Analysis of subgroups or subsets.

State any planned investigation of 'subgroups'. Be clear and specific about which type of study or participant will be included in each group or covariate investigated. State the planned analytic approach.

Not applicable

30 [Type] and method of review.

Select the type of review, review method and health area from the lists below.

Type of review

Cost effectiveness
No

Diagnostic
No

Epidemiologic
No

Individual patient data (IPD) meta-analysis
No

Intervention
No

Living systematic review
No

Meta-analysis
No

Methodology
No

Narrative synthesis
Yes

Network meta-analysis
No

Pre-clinical
No

Prevention
No

Prognostic
No

Prospective meta-analysis (PMA)
No

Review of reviews
No

Service delivery
No

Synthesis of qualitative studies
No

Systematic review
Yes

Other
No

Health area of the review

Alcohol/substance misuse/abuse
No

Blood and immune system
No

Cancer
No

Cardiovascular
No

Care of the elderly
No

Child health
No

Complementary therapies
No

COVID-19
No

Crime and justice
No

Dental
No

Digestive system
No

Ear, nose and throat
No

Education
No

Endocrine and metabolic disorders
No

Eye disorders
No

General interest
No

Genetics
No

Health inequalities/health equity
No

Infections and infestations
No

International development
No

Mental health and behavioural conditions
No

Musculoskeletal
No

Neurological
No

Nursing
No

Obstetrics and gynaecology
No

Oral health
No

Palliative care
No

Perioperative care
No

Physiotherapy
No

Pregnancy and childbirth
No

Public health (including social determinants of health)
Yes

Rehabilitation
No

Respiratory disorders
No

Service delivery
No

Skin disorders
No

Social care
No

Surgery
No

Tropical Medicine
No

Urological
No

Wounds, injuries and accidents
No

Violence and abuse
No

31. Language.

Select each language individually to add it to the list below, use the bin icon to remove any added in error.
English

There is not an English language summary

32. * Country.

Select the country in which the review is being carried out. For multi-national collaborations select all the countries involved.

England

33. Other registration details.

Name any other organisation where the systematic review title or protocol is registered (e.g. Campbell, or The Joanna Briggs Institute) together with any unique identification number assigned by them. If extracted data will be stored and made available through a repository such as the Systematic Review Data Repository (SRDR), details and a link should be included here. If none, leave blank.

34. Reference and/or URL for published protocol.

If the protocol for this review is published provide details (authors, title and journal details, preferably in Vancouver format)

Add web link to the published protocol.

Or, upload your published protocol here in pdf format. Note that the upload will be publicly accessible.

No I do not make this file publicly available until the review is complete

Please note that the information required in the PROSPERO registration form must be completed in full even if access to a protocol is given.

35. Dissemination plans.

Do you intend to publish the review on completion?

Yes

Give brief details of plans for communicating review findings.?

Dissemination of findings will be achieved in several means. These include publication in a peer-reviewed scientific journal; publication in the University of Liverpool library within the author's doctoral thesis; sharing of findings within the University of Liverpool's Doctorate of Clinical Psychology Research Conference; sharing of findings at other suitable research conferences; sharing findings with all participants who opted-in to keeping up to date with the study's results.

36. Keywords.

Give words or phrases that best describe the review. Separate keywords with a semicolon or new line. Keywords help PROSPERO users find your review (keywords do not appear in the public record but are included in searches). Be as specific and precise as possible. Avoid acronyms and abbreviations unless these are in wide use.

attitudes, narratives, dehumanisation, stigmatisation,

37. Details of any existing review of the same topic by the same authors.

If you are registering an update of an existing review give details of the earlier versions and include a full bibliographic reference, if available.

38. *Current review status.

Update review status when the review is completed and when it is published.New registrations must be ongoing so this field is not editable for initial submission.

Please provide anticipated publication date

Review_Completed_not_published

39. Any additional information.

Provide any other information relevant to the registration of this review.

40. Details of final report/publication(s) or preprints if available.

Leave empty until publication details are available OR you have a link to a preprint (NOTE: this field is not editable for initial submission). List authors, title and journal details preferably in Vancouver format.

Give the link to the published review or preprint.

Appendix 3.1. Ethical Approval

UNIVERSITY OF LIVERPOOL

Health and Life Sciences Research Ethics Committee (Psychology, Health and Society)

25 February 2021

Dear Dr Gillespie

I am pleased to inform you that your application for research ethics approval has been approved. Application details and conditions of approval can be found below. Appendix A contains a list of documents approved by the Committee.

Application Details

Reference:	8498
Project Title:	Clinical psychologists' attitudes towards working with minor-attracted persons
Principal Investigator/Supervisor:	Dr Steven Gillespie
Co-Investigator(s):	Mr Chris Millar, Dr Eric Robinson
Lead Student Investigator:	-
Department:	Psychological Sciences
Approval Date:	25/02/2021
Approval Expiry Date:	Five years from the approval date listed above

The application was **APPROVED** subject to the following conditions:

Conditions of approval

Please note: this approval is subject to the University's research restrictions during the pandemic, as laid out on the research ethics webpages. Therefore, wherever possible, research should be conducted via remote means which avoid the need for face-to-face contact with human participants during the pandemic. The process for requesting an exemption to these restrictions is described on the research ethics webpages.

- All serious adverse events must be reported to the Committee (ethics@liverpool.ac.uk) in accordance with the procedure for reporting adverse events.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the study, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor changes, or leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form within the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

Health and Life Sciences Research Ethics Committee (Psychology, Health and Society)

iphsrec@liverpool.ac.uk

0151 795 5420

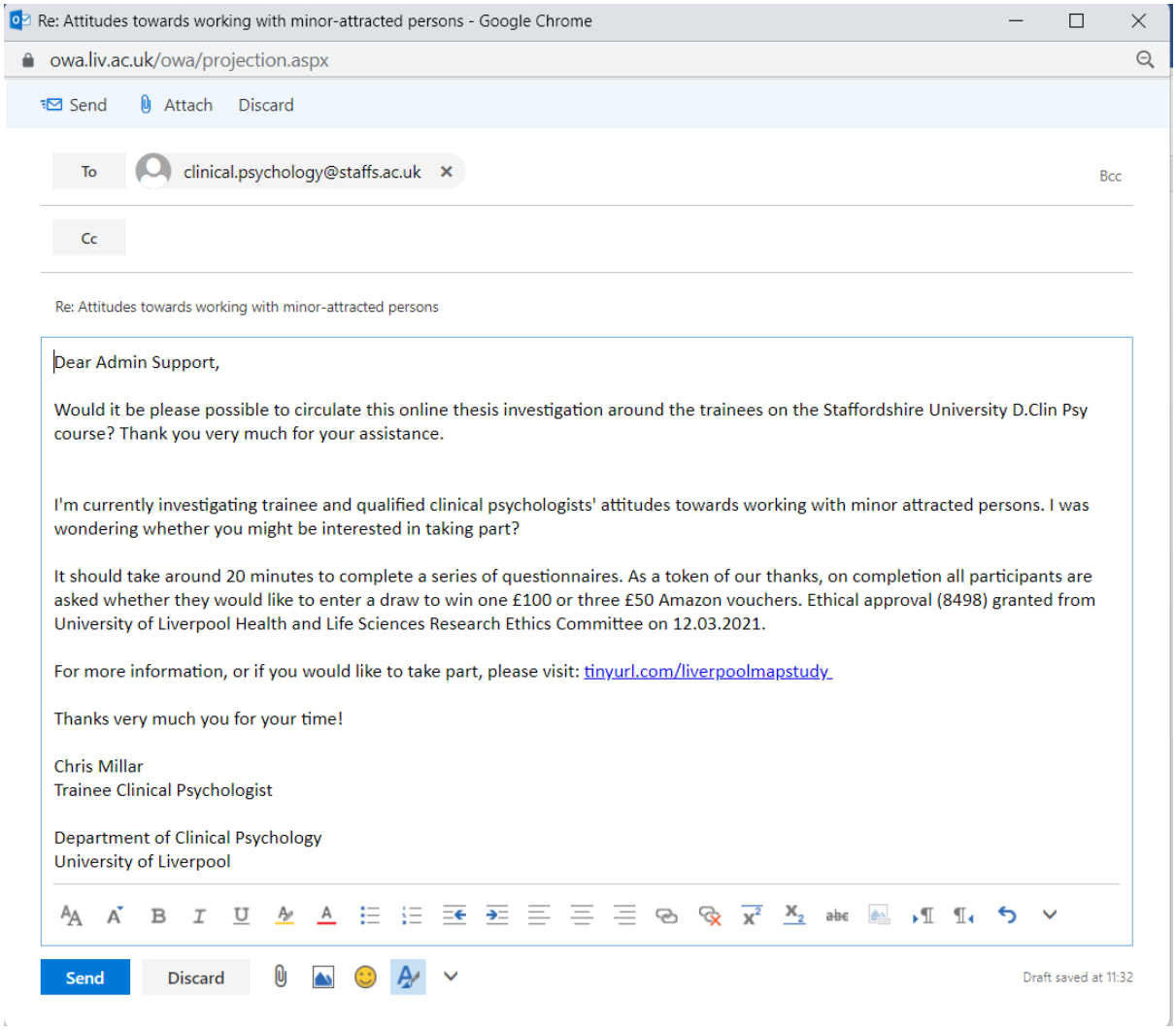
Appendix - Approved Documents

(Relevant only to amendments involving changes to the study documentation)

The final document set reviewed and approved by the committee is listed below:

Document Type	File Name	Date	Version
Study Proposal/Protocol	Full Research Proposal Documentation	18/08/2020	1.2
Evidence Of Peer Review	Chris Millar Proposal RRC Approval letter 01.10.2020	01/10/2020	1
Questionnaire	Study Questionnaires V2	15/12/2020	2
Questionnaire	Qualtrics Sociodemographic Information Form	19/02/2021	1
Advertisement	Advert V4	19/02/2021	4
Participant Information Sheet	Participant Information Sheet V4	19/02/2021	4
Debriefing Material	Debrief Form V4	19/02/2021	4
Participant Consent Form	Consent Form V3	19/02/2021	3

Appendix 3.2. Recruitment Email



Appendix 3.3. Twitter

Appendix 3.4. Recruitment Advert, V4

UNIVERSITY OF LIVERPOOL

Clinical psychologists' attitudes towards working with minor-attracted persons

We are exploring how willing clinical psychologists' are to work with minor-attracted persons (MAPS), defined as 'people with a dominant sexual interest in children'.

We are inviting trainee and qualified clinical psychologists across the UK to answer a series of standardised online questionnaires.

Can you take 20 minutes to complete anonymous questionnaires about how you think and feel about others, your work engagement, and attitude towards MAPS?

- Any trainee / qualified clinical psychologist in the UK, aged 18+ can take part.
- Participants must speak English, and have internet access.
- All information is completely anonymous.
- All participants can enter a draw for **one £100** or **three £50 Amazon vouchers**, as a token of our thanks.

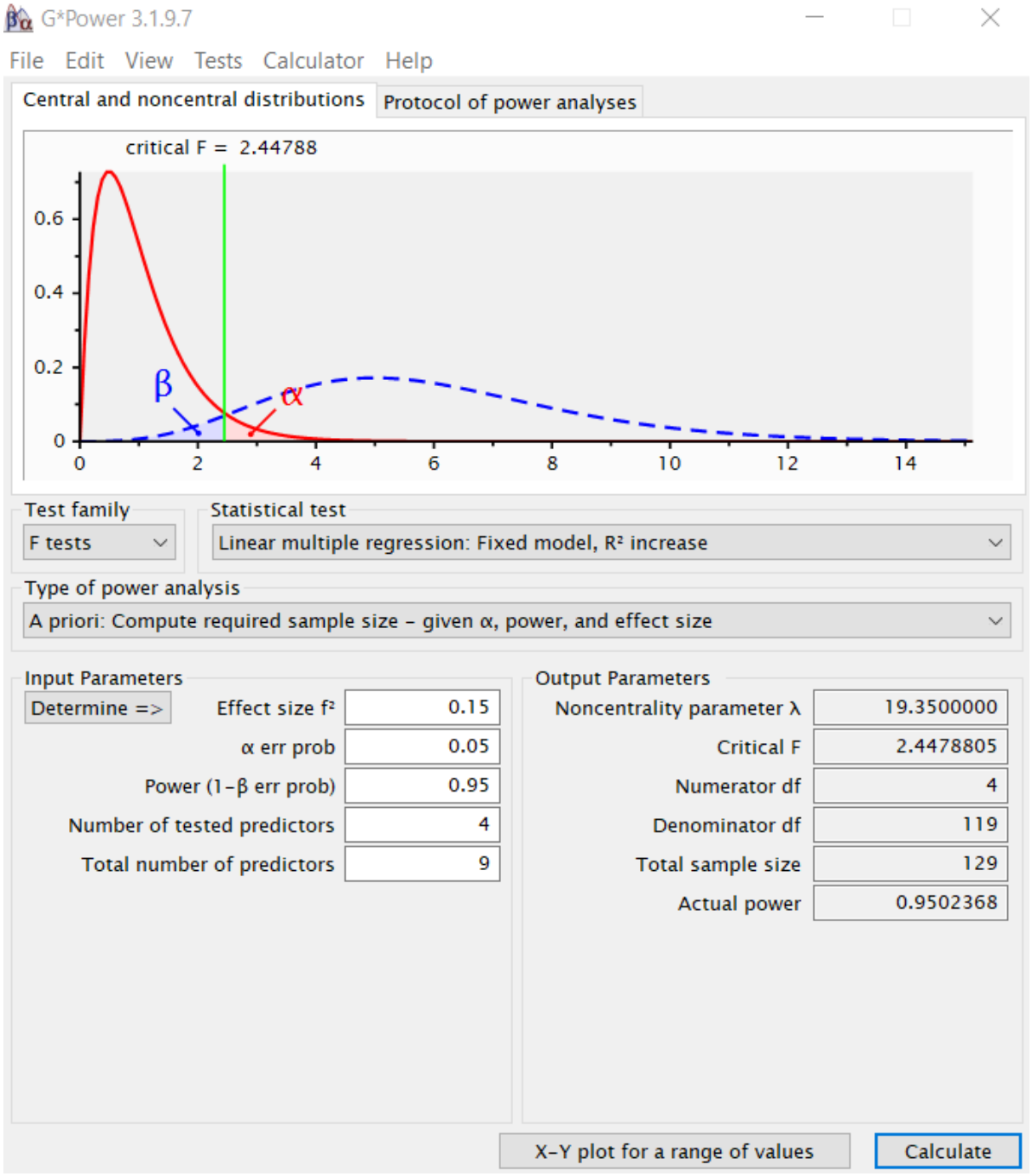
For more information, please visit:
tinyurl.com/liverpoolmapstudy

Scan the QR code:

Email: mapstudy@liverpool.ac.uk

V4, 19.02.2021

Appendix 3.5. G* Power



Appendix 3.6. Participant Information Sheet, V4

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Please ask us if there is anything that is unclear or if you would like further information.

Who is conducting this research?

My name is Chris Millar and I am Trainee Clinical Psychologist at the University of Liverpool. This research will be completed in part-fulfilment of the Doctorate in Clinical Psychology qualification.

What is the purpose of this research?

This study explores how clinical psychologists' attitudes are associated with their willingness to work with minor-attracted persons (MAPS). We define MAPS as 'people with a dominant sexual interest in children', to refer to people who are sexually oriented toward children, regardless of their preferential or predominant age of sexual attraction, even if children are not the exclusive or preferred focus of sexual attraction.

We are using standardised online questionnaires that will enquire about the ways in which you think and feel about others, work engagement, perceptions about others, and attitude towards MAPS.

It is hoped that the results of this study will provide a better understanding of some of the factors which influence how participants work with MAPS, in turn, reducing the risk of child sexual abuse.

Do I have to take part?

You are under no obligation to take part in this study; it is completely your choice. All participation is voluntary and you are free to stop taking part at any time without giving any reason.

What will happen if I take part?

You will be asked to complete an informed consent form to confirm that you understand what is involved, and whether or not you agree to take part in the study. You will be asked to provide some simple information about you (for example, age, years of experience, gender, prior experience working with MAPs, and training / qualified status).

You will then be invited to complete a series of questionnaire items asking about

experiences at work, feelings of stigmatisation, and working with MAPS. We are trying to understand how associative stigma affects clinical psychologists' attitudes and willingness to work with minor-attracted persons (MAPS). Participation will take around 20 minutes to complete all study measures.

Who can take part?

This study is for trainee or qualified clinical psychologists in the UK, who are aged 18+. Participants must be able to speak English, and have access to the internet via a PC / laptop computer / tablet / smart phone.

What are the risks?

Because of the nature of the research, some of the questions ask about attitudes towards people with paedophilia (for example, 'what do you think about people with a dominant sexual interest in children?'). If you think that responding to items of this nature will cause you considerable distress, then you should not take part. If you do feel uncomfortable or distressed while completing the study, please make use of support networks available to you.

What if I feel distressed or upset?

The research team are unable to offer any clinical advice or guidance on the subjects involved in this study. We have provided web addresses and contact details for relevant helplines, including StopItNow!, which offers confidential advice and support to anyone who is concerned about their own or someone else's inappropriate sexual behaviour with a child in the UK; B4U-ACT, offers confidential online support for family members and friends of MAPs; Victim Support (UK), offers support and information to anyone who is concerned about domestic abuse, including sexual abuse in the home; MIND, offers information and signposting for people who are concerned about mental health related issues; and the Samaritans (UK), offers confidential telephone support to anybody who is experiencing distress. This information can be found at the end of this page, and on a separate page following study completion.

We will not ask you to provide, or have access to, any personally identifiable information about you. This means that we are unable to provide individual feedback regarding your results and we will not know who has completed the survey. If you would like support for your physical or mental health, please contact your GP, or contact your nearest Accident and Emergency Services department (call 111 or 999) if you feel that your own or somebody else's life is in crisis.

Is it confidential?

Your data will remain entirely confidential. We will not ask you to provide any personally identifiable information. All data will be entirely anonymous. We will not collect IP addresses.
If participants wish to enter the draw their email address will be stored separately to all study data and will not be possible to link with individual responses to the survey items.

What are the benefits?

All participation in the research will provide valuable information to help increase our understanding of the factors that influence clinical psychologists' attitudes towards working psychologically with MAPS, with the ultimate aim of promoting offence free lives and reducing the risk of child sexual abuse.

What if I do not want to carry on with the study?

If, at any point, you no longer want to take part in the research, you can stop completing the questionnaire and any information already provided will not be used in the study. Because all data will be anonymous, it will not be possible for you to access your data or request that your data is withdrawn because we will not be able to identify which data belongs to you.

Are there any expenses or payments?

After completing the survey you will be invited to participate in a draw to win one of a number of Amazon vouchers (1 x £100, 3 x £50). To enter this draw, you will be directed to a separate Qualtrics survey to input your email address. This information will be stored separate to all study data and will not be possible to link with individual responses to the survey items.

What will you do with the data?

Once recruitment is complete, the research team will analyse the information. The research will be published as part of my Doctorate in Clinical Psychology thesis. The results of the study will be written up for publication in relevant, peer reviewed scientific journals and/or shared at relevant conferences or workshops. The results may also be shared with relevant organisations and networks. Your responses will be anonymous meaning that you cannot be identified by name in any dissemination of the results.
All data will be stored in accordance with the University's Research Data Management policy. Anonymous research data may be made available alongside published articles or as part of a data repository, consistent with best practices in open science, or by use of other authorised researchers to support future research. This will remain the responsibility of the data custodian (the Chief Investigator, Dr Steven Gillespie) who will be responsible for the data until it is destroyed, after a minimum of 10 years, in accordance with the University's

Research Data Management policy.

Who has reviewed the study?

This project has been peer reviewed by the Doctorate in Clinical Psychology Research Review Committee at the University of Liverpool and has been subject to ethical review by the University of Liverpool Ethics Committee.

Can I have a copy of the findings?

If you wish to keep up to date with future publication, you will be directed to a separate Qualtrics survey to input your email address. This information will be stored separately from your data.

What if there is a problem?

If you are unhappy with the research, or there is any problem, please let us know by contacting Chris Millar (chris.millar@liverpool.ac.uk) or Steven Gillespie (steven.gillespie@liverpool.ac.uk) and we will do our best to help.
If you remain unhappy or have a complaint that you do not want to come to us with, please contact the Research Governance Officer (ethics@liv.ac.uk) and provide details of the study and your complaint.

Who will have access to my anonymous data?

Chris Millar, Student Investigator; Dr Steven Gillespie, Chief Investigator; Dr Eric Robinson, Co-Investigator; Expert by Experience (survivor of CSA), Alison Bryant.

Who can I contact if I have further questions?

If you would like any further information, please contact Chris Millar at chris.millar@liverpool.ac.uk.

◉ I have read and understood the information sheet and would like to take part in the study

Appendix 3.7. Data Storage Plan

Information on how my data will be used

How will my data be collected?	Your data will be collected via online questionnaires. We will not ask you to provide any personally identifiable information, so your responses cannot be linked to you.
How will my data be stored?	Data will be stored in accordance with the University's Research Data Management policy. It will remain the responsibility of the data custodian (the Chief Investigator) who will be responsible for the data until it is destroyed in accordance with the University's Research Data Management.
How long will my data be stored?	The data custodian will be responsible for the data until it is destroyed after a minimum of 10 years in accordance with the University's Research Data Management policy.
What measures protect the security and confidentiality of my data?	The questionnaires are completed anonymously to ensure confidentiality. All data collected will be stored in accordance with the University's Research Data Management policy.
Will my data be anonymised?	All data used in the research will be anonymous. We will not have access to any personally identifiable information about you. IP addresses will not be recorded as part of your responses.
How will my anonymous data be used?	The results of the study will be written up for publication in relevant, peer reviewed scientific journals and/or shared at relevant conferences or workshops. The research will be published as part of my Doctorate in Clinical Psychology thesis. The results may also be shared with relevant organisations and networks. Your responses will be anonymous meaning that you cannot be identified by name in any dissemination of the results.
Who will have access to my anonymous data?	Chris Millar – Student Investigator Dr Steven Gillespie – Chief Investigator Dr Eric Robinson – Co-Investigator Expert by Experience (survivor of CSA) – Alison Bryant Anonymous research data may also be made available alongside published articles or as part of a data repository, consistent with best practices in open science.

Will my data be archived for use in other research projects in the future?	In line with the University of Liverpool's Data Management Policy, anonymised research data may be made available for sharing and use by other authorised researchers to support future research.
How will my data be destroyed?	The data will be destroyed in accordance with the University's Research Data Management Policy.

Sources of Information and Support

StopItNow!
Telephone: 0808 1000 900 (available 9am - 6pm, Mon – Fri)
Webpage: https://www.stopitnow.org.uk/concerned-about-your-own-thoughts-or-behaviour/concerned-about-use-of-the-internet/

B4U-ACT
Telephone: +1 410 871 8156
Webpage: https://www.b4uact.org/
Email: b4uact@b4uact.org

Victim Support
Telephone: 0808 1689 111 (available 24/7)
Webpage: https://www.victimsupport.org.uk/crime-info/types-crime/domestic-abuse

National Crime Agency Child Exploitation and Online Protection
Telephone: 0370 496 7622 (available 24/7)
Email: communication@nca.gov.uk
Webpage: https://www.thinkuknow.co.uk

MIND
Telephone: 0300 123 3393 (available 9am – 6pm, Mon – Fri, except bank holidays)
Webpage: https://www.mind.org.uk/information-support/helplines/
Email: info@mind.org.uk
Text: 86463

The Samaritans

Telephone: 116 123 (available 24/7)
Email: jo@samaritans.org (24 hour response time)

I have read and understood the information on how my data will be used. and sources of information and support, and would like to take part in the study.

Appendix 3.8. Participant Consent Form, V4

Please read the following statements and select whether you agree with them.

I confirm that I am a trainee or qualified Clinical Psychologist, aged 18+, living in the United Kingdom.

- Yes

I confirm that I have read and have understood the participant information sheet dated 19/2/2021 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

- Yes

I understand that taking part in the study will involve completing questionnaires that enquire about experiences at work, feelings of stigmatisation, and working with minor-attracted persons (MAPS). I understand that some items may feel uncomfortable.

- Yes

I understand that my participation is voluntary and that I am free to stop taking part at any time without giving any reason, until the data is submitted.

- Yes

I understand that any data I submit will be anonymous. I understand that because my data is anonymous, I will not be able to request access to, or request that my data are withdrawn or destroyed.

- Yes

I understand that my anonymous data may be made available online or shared with other authorised researchers to support future research.

- Yes

I understand that the information I provide will be held securely and in line with data protection requirements at the University of Liverpool, accessible only by the study team.

- Yes

I agree to take part in the above study.

- Yes

Appendix 3.9. Definition

In this study, we use the term 'people with a dominant sexual interest in children' to refer to people who are sexually oriented toward children. This is regardless of the preferential or predominant age of sexual attraction, even if children are not the exclusive or preferred focus of sexual attraction. For the purposes of this study, we define children as any person under the legal age for providing consent to participate in sexual activities. In the UK that is any person under 16 years of age.

Please note that a sexual interest in children does not constitute a criminal offence.

Child sexual abuse refers to criminal acts perpetrated against a child. This can happen in person or remotely, and cause a myriad of adverse physical and psychological health outcomes. Although the two concepts (i.e., sexual interest in children and sexual abuse of a child) are often wrongly conflated, they are not interchangeable. Not all people with a sexual interest in children sexually abuse children, and not all people who sexually abuse children have a sexual interest in children.

○ I have read and understood this definition.

Appendix 3.10. Participant Draw and Future Contact

This information is separate from your responses in the survey, and cannot be linked.

If you wish to keep up to date with future publication please enter your email address below.

To enter the draw to win Amazon vouchers please enter your email address below.

Appendix 3.11. Attitudes towards People with Paedophilia Scales

Please select an option which best represents your feelings towards people with a dominant sexual interest in children.

What do you think about people with a dominant sexual interest in children?

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

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

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

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

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

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree

- Completely agree

How dangerous are people with a dominant sexual interest in children for other people in general?

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

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

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

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

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

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

When I think of a person with a dominant sexual interest in children, I feel fear.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

When I think of a person with a dominant sexual interest in children, I feel pity.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

When I think of a person with a dominant sexual interest in children, I feel anger.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

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

I would have these people as my friends.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree

- Strongly agree
- Completely agree

I would accept these people in my neighbourhood.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

I would accept these people as colleagues at work.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

I would talk to them.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

These people should be incarcerated.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

These people should better be dead.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

Appendix 3.12. Clinical Associative Stigma Scale

Please answer the following questions.

I have heard people outside of the mental health field express the view that mental health professionals don't know what they are doing / can't really help.

- Never
- Rarely
- Sometimes
- Always

I have heard people outside of the mental health field express the belief that mental health professionals are to blame when people with serious mental illness harm themselves or others.

- Never
- Rarely
- Sometimes
- Always

I have heard people state or joke that work with people with serious mental illness is a job that doesn't require much skill.

- Never
- Rarely
- Sometimes
- Always

I have heard people state or joke that work with people with serious mental illness is a job that no one would want to do if they had the choice.

- Never
- Rarely
- Sometimes
- Always

I have heard other people say that the work I do is useless.

- Never

- Rarely
- Sometimes
- Always

I have heard other people say that the work I do is easy / could be done by anyone.

- Never
- Rarely
- Sometimes
- Always

When I have met a new person at a social gathering, I am reluctant to discuss my work with people with serious mental illness.

- Never
- Rarely
- Sometimes
- Always

When I am with other mental health professionals who do not work with people with serious mental illness, I am reluctant to discuss my work with this population.

- Never
- Rarely
- Sometimes
- Always

When I am with friends who work outside of the mental health field, I am reluctant to discuss my work with people with serious mental illness.

- Never
- Rarely
- Sometimes
- Always

When I am with relatives who work outside of the mental health field, I am reluctant to discuss my work with people with serious mental illness.

- Never
- Rarely
- Sometimes
- Always

When I tell them about the work that I do, people outside of the mental health field express concern for my safety related to my work with people with serious mental illness.

- Never
- Rarely
- Sometimes
- Always

When I tell them about the work that I do, people outside of the mental health field express that it must be sad because people with serious mental illness don't improve in treatment.

- Never
- Rarely
- Sometimes
- Always

When I tell them about the work that I do, people outside of the mental health field remark that the work must be "scary."

- Never
- Rarely
- Sometimes
- Always

When people find out that I work with individuals with serious mental illness, they tell me they could never do that type of work.

- Never
- Rarely
- Sometimes
- Always

In media depictions that I have encountered, mental health professionals are depicted as engaging in unethical behaviour (for example, sexual relationships with clients).

- Never
- Rarely
- Sometimes
- Always

In media depictions that I have encountered, mental health professionals are depicted as having personal psychological problems.

- Never
- Rarely
- Sometimes
- Always

I have heard people state or joke that mental health professionals help others because they do not want to confront their own psychological problems.

- Never
- Rarely
- Sometimes
- Always

When I tell someone about the work I do, they ask me if I am analysing them during conversations.

- Never
- Rarely
- Sometimes
- Always

I have heard people state or joke that mental health professionals must be "crazy."

- Never
- Rarely
- Sometimes
- Always

Appendix 3.13. Work and Well-Being Survey

The following 17 statements are about how you feel at work. Please read each statement carefully and decide if you ever feel this way about your job.

At my work, I feel bursting with energy.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

I find the work that I do full of meaning and purpose.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

Time flies when I am working.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

At my job, I feel strong and vigorous.

- Never

- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

I am enthusiastic about my job.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

When I am working, I forget everything else around me.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

My job inspires me.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

When I get up in the morning, I feel like going to work.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less

- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

I feel happy when I am working intensely.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

I am proud of the work that I do.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

I am immersed in my work.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

I can continue working for very long periods at a time

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week

- Very Often / A few times a week
- Always / Every day

To me, my job is challenging.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

I get carried away when I am working.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

At my job, I am very resilient, mentally.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

It is difficult to detach myself from my job.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

At my work, I always persevere, even when things do not go well.

- Never
- Almost Never / A few times a year or less
- Rarely / Once a month or less
- Sometimes / A few times a month
- Often / Once a week
- Very Often / A few times a week
- Always / Every day

Appendix 3.14. Questionnaire of Cognitive and Affective Empathy

People differ in the way they feel in different situations. Below you are presented with 31 characteristics that may or may not apply to you. Read each characteristic and indicate how much you agree or disagree with the item by ticking the appropriate box. Answer quickly and honestly.

I sometimes find it difficult to see things from the 'other guy's' point of view.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

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

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

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

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

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

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

When I am upset at someone, I usually try to 'put myself in his shoes' for a while.

- Strongly Agree
- Slightly Agree

- Slightly Disagree
- Strongly Disagree

Before criticising somebody, I try to imagine how I would feel if I was in their place.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I often get emotionally involved with my friends' problems.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I am inclined to get nervous when others around me seem to be nervous.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

People I am with have a strong influence on my mood.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

It affects me very much when one of my friends seems upset.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I often get deeply involved with the feelings of a character in a film, play or novel.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I get very upset when I see someone cry.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I am happy when I am with a cheerful group and sad when the others are glum.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

It worries me when others are worrying and panicky.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I can easily tell if someone else wants to enter a conversation.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I can pick up quickly if someone says one thing but means another.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

It is hard for me to see why some things upset people so much.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I find it easy to put myself in somebody else's shoes.

- Strongly Agree
- Slightly Agree

- Slightly Disagree
- Strongly Disagree

I am good at predicting how someone will feel.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I am quick to spot when someone in a group is feeling awkward or uncomfortable.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

Other people tell me I am good at understanding how they are feeling and what they are thinking.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I can easily tell if someone else is interested or bored with what I am saying.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

Friends talk to me about their problems as they say that I am very understanding.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I can sense if I am intruding, even if the other person does not tell me.

- Strongly Agree
- Slightly Agree
- Slightly Disagree

- Strongly Disagree

I can easily work out what another person might want to talk about.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I can tell if someone is masking their true emotion.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I am good at predicting what someone will do.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I can usually appreciate the other person's viewpoint, even if I do not agree with it.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I usually stay emotionally detached when watching a film.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

I always try to consider the other fellow's feelings before I do something.

- Strongly Agree
- Slightly Agree
- Slightly Disagree
- Strongly Disagree

Before I do something I try to consider how my friends will react to it.

- Strongly Agree

- Slightly Agree
- Slightly Disagree
- Strongly Disagree

Appendix 3.15. Support for MAPS Treatment Scale

Please select an option which best represents support for treatment policies for people with a dominant sexual interest in children.

I believe that it is worth attempting to treat people with a dominant sexual interest in children, who have never committed a sexual crime.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

I believe that it is worth attempting to treat people with a dominant sexual interest in children, who have committed a sexual crime.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

Treating people with a dominant sexual interest in children who have never committed a sexual crime is a waste of resources.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

Treating people with a dominant sexual interest in children who have committed a sexual crime is a waste of resources.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

Appendix 3.16. Therapy Motivation Scale for Psychotherapists

Please select an option which best represents your willingness to offer psychotherapy to people with a dominant sexual interest in children.

I would be willing to offer psychotherapy to people with a dominant sexual interest in children, who have never committed a sexual crime.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

I would be willing to offer psychotherapy to people with a dominant sexual interest in children, who have committed a sexual crime.

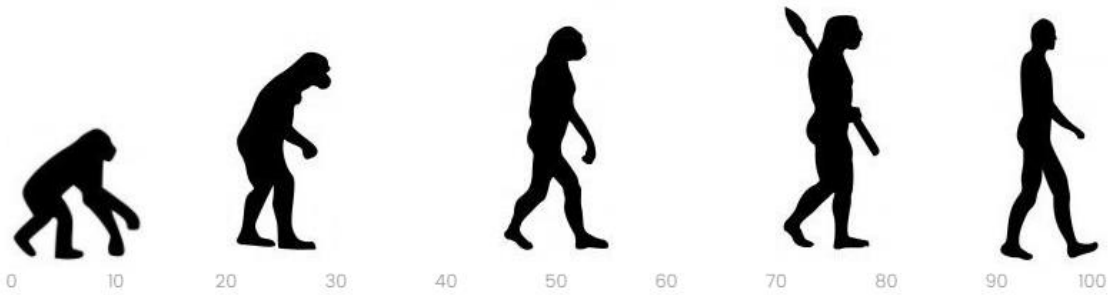
- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

I would like to attend vocational courses to treat people with a sexual interest in children.

- Do not agree at all
- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree
- Completely agree

Appendix 3.17. Ascent of Humans Scale

People might vary in how human-like they seem. Some people may seem highly evolved, whereas others might seem no different than lower animals. Using the image below as a guide, indicate using the sliders how evolved you consider the average member of each group to be.



How evolved do you consider people who are primarily sexually attracted to children?

How evolved do you consider people who are in prison for committing criminal offences?

How evolved do you consider people who are from the United Kingdom?

How evolved do you consider people who are medically classed as having obesity?

How evolved do you consider people who are labelled as being 'drug addicts'?

Appendix 3.18. Dehumanisation Raw Data

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
People who are primarily sexually attracted to children?	241	.00	100.00	92.3983	16.45876
How evolved do you consider people who are in prison for committing criminal offences?	241	21.00	100.00	93.7137	13.89803
People who are medically classed as having obesity?	241	50.00	100.00	96.0166	8.89287
People who are labelled as being 'drug addicts'?	241	38.00	100.00	95.1992	10.61179
People who are from the United Kingdom?	241	4.00	100.00	94.9502	12.14039
Valid N (listwise)	241				

Pairwise Comparisons

Measure: MEASURE_1

(I) Dehumanise	(J) Dehumanise	Mean Difference (I-J)	Std. Error	Sig.[b]	95% Confidence Interval for Difference[b] Lower Bound	Upper Bound
1	2	-1.315*	.623	.036	-2.543	-.088
	3	-3.618*	.751	<.001	-5.098	-2.139
	4	-2.801*	.735	<.001	-4.248	-1.354
	5	-2.552*	.873	.004	-4.272	-.832
2	1	1.315*	.623	.036	.088	2.543
	3	-2.303*	.457	<.001	-3.203	-1.403
	4	-1.485*	.397	<.001	-2.268	-.703
	5	-1.237	.742	.097	-2.699	.225
3	1	3.618*	.751	<.001	2.139	5.098
	2	2.303*	.457	<.001	1.403	3.203
	4	.817*	.294	.006	.238	1.397
	5	1.066	.602	.078	-.120	2.253
4	1	2.801*	.735	<.001	1.354	4.248
	2	1.485*	.397	<.001	.703	2.268
	3	-.817*	.294	.006	-1.397	-.238
	5	.249	.635	.695	-1.001	1.499

5	1	2.552*	.873	.004	.832	4.272
	2	1.237	.742	.097	-.225	2.699
	3	-1.066	.602	.078	-2.253	.120
	4	-.249	.635	.695	-1.499	1.001

Based on estimated marginal means

*. The mean difference is significant at the .05 level.

b. Adjustment for multiple comparisons: Least Significant Difference (equivalent to no adjustments).

Appendix 3.19. Support for the Treatment of MAPs Raw Data

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
SupportS1plusRS3	241	2.00	14.00	12.4564	2.10336
SupportOffendingMAPsS2plusRS4	241	2.00	14.00	12.6971	1.90273
Valid N (listwise)	241				

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	SupportS1plusRS3 & SupportOffendingMAPsS2plusRS4	241	.625	<.001

Appendix 3.20. Willingness to Work with MAPs Raw Data

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
I would be willing to offer psychotherapy to people with a dominant sexual interest in children, who have never committed a sexual crime.	241	1	7	6.01	1.283
I would be willing to offer psychotherapy to people with a dominant sexual interest in children, who have committed a sexual crime.	241	1	7	5.32	1.715
Valid N (listwise)	241				

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	I would be willing to offer psychotherapy to people with a dominant sexual interest in children, who have never committed a sexual crime. - I would be willing to offer psychotherapy to people with a dominant sexual interest in children, who have committed a sexual crime.	.697	1.058	.068	.563	.831	10.224	240	<.001

I would be willing to offer psychotherapy to people with a dominant sexual interest in children, who have never committed a sexual crime.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Do not agree at all	4	1.7	1.7	1.7
	Strongly disagree	2	.8	.8	2.5
	Disagree	4	1.7	1.7	4.1
	Undecided	13	5.4	5.4	9.5
	Agree	53	22.0	22.0	31.5
	Strongly agree	43	17.8	17.8	49.4
	Completely agree	122	50.6	50.6	100.0
	Total	241	100.0	100.0	

I would be willing to offer psychotherapy to people with a dominant sexual interest in children, who have committed a sexual crime.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Do not agree at all	11	4.6	4.6	4.6
	Strongly disagree	9	3.7	3.7	8.3
	Disagree	17	7.1	7.1	15.4
	Undecided	28	11.6	11.6	27.0
	Agree	51	21.2	21.2	48.1
	Strongly agree	41	17.0	17.0	65.1
	Completely agree	84	34.9	34.9	100.0
	Total	241	100.0	100.0	

I would like to attend vocational courses to treat people with a sexual interest in children.

	Frequency	Percent	Cumulative Percent
Do not agree at all	8	3.3	3.3
Strongly disagree	7	2.9	6.2
Disagree	13	5.4	11.6
Undecided	17	7.1	18.7
Agree	61	25.3	44.0
Strongly agree	46	19.1	63.1
Completely agree	89	36.9	100.0
Total	241	100.0	

Appendix 3.21. Anger Raw Data

When I think of a person with a dominant sexual interest in children, I feel anger.

		Frequency	Percent	Cumulative Percent
Valid	Do not agree at all	6	2.5	2.5
	Strongly disagree	21	8.7	11.2
	Disagree	74	30.7	41.9
	Undecided	43	17.8	59.8
	Agree	67	27.8	87.6
	Strongly agree	21	8.7	96.3
	Completely agree	9	3.7	100.0
	Total	241	100.0	