

## Exploring therapeutic bias towards adolescent non-offending minor attracted people using a mixed methods approach: "We experience fear too!"

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**Exploring Therapeutic Bias Towards Adolescent Non-Offending Minor Attracted  
People Using a Mixed Methods Approach: "We experience Fear Too!"**

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A Thesis submitted to the University of Wolverhampton

Faculty of Education, Health and Wellbeing.

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**Presentations**

Ball, K. (2022, July 15-16). *Exploring therapeutic bias towards Non-Offending Minor Attracted People using Humanisation Training* [Poster presentation]. BPS Division of Counselling Psychology Annual Conference 2022, Royal College of Physicians, London. (Appendix A).

### Abstract

This research demonstrates a commitment to preventing Child Sexual Abuse, supporting Non-Offending Minor Attracted People (Non-Offending MAPs) in managing their attractions lawfully, promoting ethical scholarship, reducing stigma, and fostering psychological safety among professionals. This research does not endorse identity politics for Non-Offending MAPs but advocates for nuanced, harm-reduction therapy that prioritises both public safety and human dignity. There is widespread misinformation conflating child sex abuse with Non-Offending MAPs, resulting in stigmatisation and societal distancing. Non-Offending MAPs are sexually attracted to children but suppress their attraction. Due to societal stigma, Non-Offending MAPs often struggle to seek or receive therapy, which in a professional context may manifest as therapeutic bias. Research on adolescent Non-Offending MAPs is limited, and adolescence is typically the age when sexual attraction first appears.

Adolescents represent a vulnerable population in mental health care as they are navigating rapid developmental changes, whilst often starting therapy at the directive of adults. Despite needing early intervention, therapeutic engagement with adolescent Non-Offending MAPs may be shaped by therapeutic biases and risk-focused therapy that compromise the therapeutic alliance and limit treatment effectiveness.

A mixed-method approach explores therapeutic bias in relation to adolescent Non-Offending MAPs. The quantitative phase analysed data using a 2 (Condition: Humanisation Video Training Vs Control- between groups) X 2 (Client Type Vignette: Humanisation Adolescent vs. Non-humanised) X 2 (Time: Pre vs. Post stigma scores: within groups examining the three Stigma Inventory Scale factors: Cognitive Beliefs, Affective Reaction and Social Distancing). Additionally, the analysis included the Questionnaire of Cognitive and Affective Empathy (QCAE), measuring Total Empathy scores and the Connor-Davidson Resilience Scale (CDRISC), measuring Total Resilience, as fixed covariates. The qualitative Interpretative Phenomenological Analysis (IPA) phase involved semi-structured interviews with four therapists to explore their experiences working with Adolescent Non-Offending MAPs.

Pre and Post Stigma Cognitive Belief scores and the training group were statistically significant. Covariate analyses found that Total Empathy was significantly associated with Stigma Affective Reaction. Total Resilience was significantly associated with Stigma

Affective. Total Empathy scores significantly influenced Stigma Social Distancing scores. From the IPA, five superordinate themes were identified: Stigma and Societal Narratives, Constructing Non-Offending MAPs' Identity, Therapeutic Engagement and Boundaries, Therapist Factors - Emotional Impact of Working with Adolescent Non-Offending MAPs, and Systemic Barriers and Professional Issues.

The findings highlight that a humanisation intervention reduced Stigma Cognitive Belief Scores. Additionally, covariate analyses highlighted the role of resilience and empathy in stigma reduction in Social Distancing and Affective Reaction. The qualitative findings suggest that therapists also experience stigma and how stigma is embedded in the narrative of therapeutic work. Overall, this thesis highlights a need for a therapist stigma bias development framework to support professionals working with adolescent Non-Offending MAPs to recognise and address therapeutic bias to increase resilience and empathy. This study makes a significant contribution to the field of psychology by being the first to explore adolescent Non-Offending MAPs from a therapeutic bias perspective through a critical realist counselling psychology lens.

*Keywords:* Adolescent, Non-Offending Minor-Attracted Persons (Non-Offending MAPs), Interpretative Phenomenological Analysis (IPA), Mixed Methods, Therapeutic Bias, Stigma, Humanisation Interventions, Empathy.

## Chapter One: Introduction

### 1.1 Researcher Positionality and Reflexivity

As the researcher, my positionality has evolved significantly throughout this study. Initially, I approached the topic of Non-Offending Minor Attracted Persons (Non-Offending MAPs) from a clinical forensic perspective and viewed this attraction as inherently abnormal. My work is framed by having experience of working with both survivors and perpetrators of Child Sexual Abuse (CSA). There is widespread misinformation from lay theories resulting in stigmatisation and societal distancing towards Non-Offending MAPs who are sexually attracted to children, but do not act on the attraction and do not commit a criminal offence but are perceived as ‘child sex abusers’ and/ or ‘paedophiles. Non-Offending MAPs often struggle to seek and/or receive therapy due to experiencing or perceiving societal stigma, which in a professional context may present as therapeutic bias (therapeutic stigma). This may then be a barrier to therapeutic support and result in mental health issues. The critical literature review explores therapeutic bias in relation to working with adolescent Non-Offending MAP clients. However, during data analysis, I started to reassess this position. The consistency and depth of participant narratives, especially those describing lifelong, non-offending attraction patterns, led me to considering Non-Offending MAPs as having an innate, unchangeable orientation. This prompted a cautious realisation that minor attraction is also perceived as a sexual orientation, one that exists outside the realm of consensual adult relationships and requires specific ethical safeguards.

This shift in reframing Non-Offending MAPs was not just intellectual; it also had emotional dimensions. I noticed moments of surprise and discomfort, especially when participants shared their experiences of stigma as therapists. Having never encountered such stigma in my own clinical practice, I became more aware of how professional identity

interacts with societal perceptions. As a researcher, I experienced indirect stigma when discussing my study publicly, with responses such as “These people should be imprisoned” or “Why would you research this?” revealing societal judgements and the emotional labour involved in conducting ethically sensitive research. Discussions on social media heightened this tension, as I observed researchers being publicly shamed for engaging with Non-Offending MAPs topics. When sharing my study online, I deliberately used the term “Non-Offending” to define ethical boundaries and distance myself from offending behaviour, both as a form of self-protection and to reflect the broader climate of fear and misunderstanding around this subject.

These experiences shaped the interpretative stance of the thesis. I adopted a biopsychosocial framework that combines biological predispositions, psychological vulnerabilities, and social stressors. This model allowed me to study the development and distress of Non-Offending MAPs without pathologising their identity or minimising risk. It also highlighted the need for conceptual clarity, especially in avoiding comparisons between child sex offenders and lesbian, gay, bisexual, transgender, queer and more (LGBTQ+) individuals, as such comparisons could undermine civil rights and child protection efforts.

My positionality reflects a commitment to prevent CSA, support Non-Offending MAPs to manage their attractions lawfully, promote ethical scholarship, reduce stigma, and foster the psychological safety of professionals. This thesis does not endorse identity politics for Non-Offending MAPs but advocates for nuanced, harm-reduction therapy that prioritises both public safety and human dignity. I recognise that there are ethical concerns about academia collaborating with MAP advocates and minimising the risk of child sex abuse, without fully acknowledging the dangers involved.

## 1.2 Structure of the Thesis

This thesis comprises seven chapters: Chapter One introduces the researcher's positionality, recognises the importance of exploring stigma bias, provides an overview of the thesis, highlights key definitions, outlines research aims, and provides a historical context. Chapter Two offers a literature overview and the underpinning stigma theory surrounding Therapeutic Bias in relation to Non-Offending MAPs. The thesis explores why it is important to research this concealed area due to the psychological and emotional impact of the perceived stigma that Non-Offending MAPs experience, and the difficulties qualified therapists and psychologists may also encounter if there are no training interventions. Chapter Three presents the methodology reflecting on the ontology and epistemology used in the study. Chapter Four presents the quantitative phase of the mixed methods approach, exploring a therapeutic training intervention using pre- and post-tests aimed to explore whether a training intervention could reduce stigma bias and support professionals to competently work therapeutically with Non-Offending MAPs. Chapter Five presents the qualitative phase of the mixed-methods approach, exploring the therapeutic experiences of working with adolescent Non-Offending MAPs. The qualitative phase is linked to the quantitative phase to enhance a future training intervention by exploring the recent experiences of qualified psychologists and therapists working with adolescent Non-Offending MAPs. Chapter Six presents an overall discussion and conclusion that bridges the two phases, discussing future implications for the field of counselling psychology. The thesis concludes with Chapter Seven, which forms a reflective appraisal of the research process and development as a Scientific-Practitioner.

### 1.3 Introduction to Research Topic

Counselling Psychologists are in a key position to be able to support marginalised groups who experience stigma. The World Health Organisation (2001, p.16) defines stigma as ‘a mark of shame, disgrace or disapproval resulting in an individual being rejected, discriminated against and excluded from participating in a number of different areas of society.’

There appears to be a scarcity of research and widespread misinformation regarding Non-Offending MAPs who are sexually attracted to children but do not act on the attraction nor commit a criminal offence and are perceived inaccurately as ‘Child Sex Abusers’ and ‘Paedophiles’. However, it is not known who seeks psychological support due to the stigma influenced by these societal beliefs. This dehumanisation results in lower therapeutic alliances and unsuccessful therapeutic outcomes (Beech & Hamilton-Giachritsis, 2005). Imhoff and Jahnke (2018) highlight that labels such as paedophilia may result in punitive attitudes. Individuals who experience societal stigma related to minor attraction may internalise these negative attitudes, leading to thought suppression and behavioural avoidance. This internalised stigma is associated with reduced psychological well-being (Harper et al., 2018; Lievesley et al., 2020) and increased risk of suicidal ideation linked to their sexual identity (Cohen et al., 2018). Subsequently, Non-Offending MAPs may be perceived as a threat and then ostracised (Jahnke & Hoyer, 2013) and unable to seek support to manage emotions, resulting in further stigmatisation and societal distancing. Non-Offending MAPs may struggle to seek and/or receive therapy due to experiencing or perceiving societal stigma, which in a professional context may present as therapeutic bias as a form of stigma. According to Ahmedani (2011), societal stigma is prevalent in mental health and is often attributed by professionals working in services, acting as a further barrier to seeking help. This therapeutic bias can prevent individuals from receiving the support they

need. Jahnke et al. (2014) and Stiel-Glenn (2010) suggest that therapists are likely to encounter Non-Offending MAPs in their practices, but these clients might be shunned or refused treatment. Chronos and Jahnke (2024) concur that there is a dichotomy of experiences in Non-Offending MAPs therapy, oscillating between empathy and rejection. If Non-Offending MAPs experience rejection from therapists, it may result in adverse mental health outcomes. Therapists and Psychologists may also lack the training to work successfully with Non-Offending MAP clients. There may be confusion in practice as therapists may break confidentiality if minor attraction is disclosed, even without other risk factors being observed (Stephens & McPhail, 2021). This may then prevent Non-Offending MAPs from seeking therapy or using non-disclosure in therapy (Jahnke et al., 2023). Jahnke et al.'s (2023) research suggests that Non-Offending MAP clients who did not perceive a therapist's reaction to disclosure as supportive reported less improvement in therapy. Being able to disclose in therapy highlighted a stronger therapeutic alliance.

#### **1.4 Definition of Terms**

This section explains the terminology encountered in this research, providing an understanding of the complexity and confusing language that can create tensions among researchers, therapists, the public, and within the minor attraction community. There appears to be no clear consensus on terminology.

##### ***1.4.1 The Academic Use of the Term 'Minor Attracted Persons' (MAPs)***

'Minor Attraction' is an umbrella term meaning a person is sexually attracted towards children and may or may not act on the attraction. Jackson et al. (2022) highlight that Minor Attraction and Paedophilia overlap in the research literature. Within the context of Minor Attraction, numerous ambiguous terms are used; with only some differentiating between offending and not offending, which will be outlined below.

This research aims to clarify the academic use of the term MAPs, as its meaning varies widely from sexual orientation and identity to diagnosis. Farmer et al. (2024) emphasised that the term MAPs originated from pro-paedophilia groups but has increasingly been adopted by academic researchers to reduce stigma. Farmer et al. (2024) conducted a rapid review of 30 peer-reviewed studies from 2015 to 2023 examining the ethical implications of using MAPs terminology, warning that it could unintentionally minimise the perceived risk of child sexual abuse. Findings suggested that the term MAPs is used inconsistently across studies. Many studies tend to portray MAPs sympathetically, framing them as an oppressed sexual orientation subject to stigma and discrimination. There are current ethical concerns that some academics may be collaborating with MAP advocates and downplaying the risk of child sex abuse, without fully recognising the dangers involved. Consequently, this study will use the term Non-Offending MAPs.

#### ***1.4.2 Non-Offending Minor Attracted Persons (Non-Offending MAPs)***

The term Non-Offending Minor Attracted Person (Jackson et al., 2022) is often referred to using many different phrases, such as Non-Offending MAPs (Parr & Pearson, 2019), People with Sexual Interests, People with interest in children, Virtuous Paedophiles (VIRPED/ VPs), Non-Offending Paedophiles (Cantor & McPhail, 2016), Minor Attracted Persons (MAPs) (B4U-ACT, 2011a; Freimond, 2013; Reisman & Strickland, 2011), People with Paedophilia (Heron et al., 2021; Jahnke et al., 2015a), Nonoffending Pedohebephilic individuals (Tenbergen et al., 2021), Pedohebephiles (Chronos & Jahnke, 2024; Jahnke et al., 2023), Sexual Interest in Children (SIC) (Tozdan et al., 2023), MAP Actors, People with Sexual Interest in Prepubescent Children, Nepiophiles, Hebephiles, Ephebophiles and Minor Attracted Adults, Paedophilic Sexual Interest. The author of this thesis has chosen to use the term Non-Offending MAPs to differentiate, as the terms used are often wrongly confused

with those who commit sexual offences. Some researchers prefer to use the term MAP, perceiving it as perhaps a more neutral term (Jahnke et al., 2022); however, a divide persists even within the Non-Offending Minor Attraction community regarding the preferred term. It is also acknowledged that the term Non-Offending MAPs may be perceived as stigmatising in a comparable way that the word paedophile may also be stigmatising, as it potentially implies tentative links to forensic populations; you either offend, or you desist from offending. As the researcher on this topic, I am attempting to clarify that this group does not intend to offend, whereas using the term MAPs does not differentiate, and the public may still perceive it as offensive, resulting in increased stigmatisation. As Beier et al. (2009) highlight, not all those with a sexual attraction towards children will go on to offend.

Research suggests Non-Offending MAPs vary in the language used to identify themselves, with no clear consensus. Jahnke et al. (2022) used a mixed methods approach and highlighted that labels of Minor Attracted Person and Paedophile appear to be deemed the least conflicting and accepted compared to other terms such as Pedohebephilia. Jahnke et al. (2022) provided insight into how these individuals may assume or reject labels, either by self-labelling or being labelled externally by others. According to Imhoff (2015), labels such as paedophile resulted in more punitive attitudes than alternative labels such as sexual interest in children. This thesis uses the term Non-Offending MAPs to highlight that these individuals are attracted towards children of any age but suppress this sexual attraction and therefore do not commit a criminal sexual offence, emphasising that being attracted to children does not usually develop into someone acting on their sexual thoughts.

### *1.4.3 Non-Offending MAPs Age*

According to the research, Non-Offending MAPs participants are aged from 18 to 80 years old and predominantly male (i.e., Cacciatori, 2017; Freimond, 2020; Houtepen et al., 2016; Levenson & Grady, 2019). Perhaps reflecting ‘westernised stereotypes’ in line with societal public perception of Sex Offenders. B4U-ACT (2011a) interviewed Non-Offending MAPs, highlighting that the initial attraction age was 12 and a realisation at age 14 that they were attracted to younger children, but they did not obtain therapy until adulthood. Suicidal thoughts were highest between 14 and 16 years. Only 40% of young people surveyed would seek help from professionals due to previous experiences of not being treated ethically or experiencing judgements where they were deemed dangerous and likely to act upon their attraction (B4U-ACT, 2011b). This means that the therapy may become more risk-focused, and there may be therapeutic bias from negative judgements towards the person. Therapy then accentuates the risk of child sexual abuse rather than the therapy seeker's well-being (Jahnke et al., 2014). This bias reinforces the stigma experienced, resulting in many adolescents not accessing therapy until adulthood, and then found the focus of professionals was predominantly addressing the offending paedophilia (B4U-ACT, 2011a, Jahnke et al., 2015b).

There appears to be a paucity of research exploring adolescent and Non-Offending MAPs often framed from a negative perception that they are dangerous and need to be treated (Jimenez-Arista & Caldera, 2024). The adolescent age may be considered between childhood and adulthood, 10 to 19 years old (World Health Organisation, 2023). Sawyer et al. (2018) suggest that up to 24 years would reflect the cultural, social, and biological changes in the last century, which have exacerbated an earlier onset of puberty. However, despite an earlier onset of puberty, there is often a delay in transitions into adult roles (such as ending education). Furthermore, biologically the adolescent brain may continue developing until the

age of 25 years due to immaturities in the prefrontal cortex and the limbic system (Arain et al., 2013). Considering this, in this thesis, the age of adolescence will be framed as 10 to 25 years old. Sexual orientation is highlighted to form between childhood and early adolescence (APA, 2008) and is perceived to be an interpretation rather than a choice (Saray, 2017).

There is further tension surrounding whether Non-Offending MAPs should be labelled during adolescence, as it could be part of the exploration of identity and a developmentally significant time when confusion is common. It might not be clear when someone is attracted to a child of a similar age. As this attraction might not become apparent until later adolescence/early adulthood, when the attraction to minors is more evident due to the increase in age difference between Non-Offending MAPs and the child. Houtepen et al.'s (2016) research found that Non-Offending MAPs struggled during puberty with accepting their attraction towards children as they were still making sense of themselves. Houtepen et al. (2016) suggest that being open to others through early intervention and recognising the risk, as well as providing social support, would have been beneficial for adolescent Non-Offending MAPs.

Seto (2012) considers paedophilia to be denoted by its early onset and is stable over time. This would imply that if an adolescent was sexually attracted to younger children, then this would continue throughout the lifespan and be static. Evanhoff (2022) revisited Seto's trajectory of sexual orientation, finding further support that attraction was stable over time. Freimond (2013) suggests Non-Offending MAPs may become aware of their attraction at an early age and experience mental health issues such as stress.

#### ***1.4.4 The 'Dual Role' of Therapists Working with Minor Attracted Persons and the Protective Function of Societal Stigma***

For adolescent Non-Offending MAPs, this developmental stage may coincide with the emergence of stigmatised attraction patterns, heightening psychological distress and isolation. Clinicians and researchers face a dual ethical duty to protect children from harm while also shielding Non-Offending MAPs from stigma-related harm.

From a forensic and therapeutic perspective, this dual responsibility requires clear boundaries, ethical clarity, and compassionate engagement. Research plays a protective role by enhancing understanding of Non-Offending MAPs development, risk factors, and coping mechanisms. It helps promote child safety through prevention rather than a reactive approach.

Seto's research on heritability and neurodevelopmental factors related to sexual interests emphasises the importance of distinguishing between attraction and behaviour, recognising that certain elements of sexual preference may be biologically motivated rather than voluntarily chosen (Seto, 2017). Combining developmental science with anti-stigma frameworks allows for a more nuanced and ethically informed approach to supporting Non-Offending MAPs.

#### ***1.4.5 The Offending Rate of Non-Offending MAPs***

By definition, Non-Offending MAPs report no history of sexual offences against minors. However, community-based surveys and support groups reveal that 10-15% of respondents admit to at least one offence involving a minor (B4U-ACT, 2023; Harper & Lievesley, 2020). It is recognised that self-report bias caused by stigma and legal fears may lead to under-reporting of offending behaviours.

#### ***1.4.6 Understanding Historical Context***

To understand Non-Offending MAPs, it is important to understand the construct and historical discourse that underpins the current stigma experienced by Non-Offending MAPs. This adversely influences public perceptions (including therapists) towards Non-Offending MAPs, which has paved the way for today's debates about how they should be framed.

Historically, Paedophilia evolved from the Middle Ages when child-to-adult sexual relationships were socially accepted. There was a shift in perspectives as Psychiatrist Krafft-Ebbing (1840-1902) and Albert Moll (1862-1939) moved away from framing sexual deviancy as a symptom of a mental disorder, but instead considered this an innate sexual instinct and diversity (Oosterhuis, 2012).

Moral changes in society laws in the 19th century have led to the reshaping of the context of Paedophilia and fuelling the stigma that all Paedophilic individuals abuse children (Blanchard et al., 2001). Cantor (2014) defines Paedophilia as a person who is attracted to children regardless of whether they act on the attraction. Contrastingly, Feelgood and Hoyer (2008) highlight that paedophilia is often constructed as an act of child sexual abuse. Stigma related to the framing of paedophilia plays a significant role in maintaining stigma towards Non-Offending MAPs.

#### ***1.4.7 Medicalisation of Non-Offending MAPs: Paedophilia and Paedophilic Disorder?***

'*Paedophilia*' is an umbrella term meaning a person is a Paedophile and may or may not act on their attraction towards children. Most research has tended to focus on paedophilia, which is defined as a sexual attraction to prepubescent children aged from three years to 10 years (Seto, 2017). The Diagnostic and Statistical Manual of Mental Disorders 5, DSM-5 (American Psychological Society, 2013) also frames paedophilia as a disorder.

According to the medical diagnostic model, the DSM-5 (APA, 2013) implores a structuralist functionalist approach which classifies paedophilia as a ‘Paedophilic Disorder’ of at least 6 months of recurring sexual fantasies, sexual urges or behaviours that involve sexual activity of a child less than 13 years old (prepubescent child)”. The individual must have acted on their sexual urges, or they will have caused distress or relational problems. The individual must be 16 or older and at least five years older than the child. There are also further categories of minor attraction, such as being exclusive or non-exclusive, which means they can be attracted to different age groups and to specific groups (e.g., to males or females, or both). There are also subgroups according to the age of Paedophile (prepubescent), Hebephilia (pubescent and adolescent), and Ephebophilia (late adolescent 15 years – 17 years).

The DSM-5 highlights that there is a difference between Paedophile and Paedophilic disorder.

If individuals report an absence of feelings of guilt, shame, or anxiety about these impulses and are not functionally limited by their paraphilic impulses (according to self-report, objective assessment, or both), and their self-reported and legally recorded histories indicate they have never acted on their impulses, then these individuals have a ‘paedophilic sexual interest’ but not ‘paedophilic disorder. (APA, 2013, p.698).

This confuses professionals, but the research theme suggests that not all child sex offenders are attracted to children, and of those individuals who are attracted to children, most will not ever commit a crime of child abuse. There has been a notable shift in the DSM-4 to 5, whereby ‘paedophilia’ is classified as a disorder; only when it results in clinically significant distress or impairment related to the individual’s sexual interests. This remains the case even in the absence of any criminal offence or enacted behaviour.

Under the DSM Non-Offending MAPs would meet the diagnostic criteria under Paedophilic disorder (if they were attracted to children aged 11 or younger). The DSM-5 suggests the individual must have acted on their sexual urges, or they will have caused distress or relational problems. Someone who is concealing their identity and internalising felt stigma will probably at some point experience emotional distress, and this then impacts them relationally due to not being able to communicate about their attraction and knowing they will never act on their attraction. The DSM-5 would then say they have 'Paedophilic Disorder'. However, someone under the age of 16 cannot be labelled with this term. This may then mean younger people who experience minor attraction do not receive support from therapeutic services if the criteria and clinical threshold are not met. The DSM implies Non-Offending MAPs are 'disordered' and thus creates a power imbalance, increasing the stigma they already encounter as society perceives them as deviant or dangerous. In a similar way to those who perpetrate sexual offences are demonised and considered to be monsters (Balmer & Sandland, 2012).

The ICD-11 highlights 'Paedophilic Disorder' as sexual arousal, which may manifest as sexual fantasies, thoughts or urges towards pre-pubescent children. Someone who is a Non-Offending MAP may be classified as having Paedophilic disorder if they are distressed by their thoughts. Exploring the DSM-5 and the ICD-11, the above definitions could be problematic for Non-Offending MAPs.

#### ***1.4.8 Contentions: 'Disorder' or Suppressed Sexuality***

So far, there has been little agreement on a much-debated question of how we understand Non-Offending MAPs. There appear to be multiple contentions in the topic as to whether Non-Offending MAPs should be framed as a 'disorder' or as a sexual orientation, and whether this attraction should then be perceived as a sexual attraction.

From a sexual attraction perspective, it has been noted that Non-Offending MAPs also report experiencing romantic, caring love and affection towards children (Houtepen et al., 2016). Jahnke et al. (2015a) suggest there may also be sexually related fantasies and desires. As these fantasies are not allowed by law to be acted upon, then fantasies may become suppressed, and then Non-Offending MAPs do not disclose their attraction. This may exacerbate mental health issues from not being able to live fulfilling lives, resulting in guilt and shame.

Evidence suggests Paedophilia and minor attraction are forms of sexual orientation (Freimond, 2013; Seto, 2012; Vrangalova & Savin-Williams, 2012). There is a growing awareness that paedophilia is not a choice (Lawrence & Willis, 2024). This is a controversial notion, as it frames minor attraction as stable and static (Grundmann et al., 2016; Seto, 2012), and the age of onset typically occurs during adolescence (Seto, 2008). Wurtele (2008) suggests therapy may be impacted by the therapist's underlying philosophy of how they perceive Non-Offending MAPs. If a therapist perceives the attraction as an innate sexual orientation or sees someone who is seeking supportive mental health therapy, they may experience a more favourable therapeutic experience.

Exploring the Power Threat Meaning Framework (PTMF: Johnstone & Boyle, 2018) brings a newer perspective on how Power, Threat, Meaning and Threat Responses can be brought together to understand the impact on Non-Offending MAPs. Negative structural power or power that an individual can employ over another may create a threat response, which leads to psychological distress. The PTMF focuses on what has happened to the person, how this has affected them, how they made sense of this, and their strengths and narrative story. The PTMF incorporates research on how social, psychological, and biological factors influence an individual's mental health. It also recognises how the PTMF can be influenced by a person's resources, such as personal resilience and how the individual

interprets what has happened to them and making meaning is essential in understanding Non-Offending MAPs experiences.

Applying the PTMF to Non-Offending MAPs suggests a need to focus on what has happened to the person, understand the role of power and how the individual expresses this as they make sense of their own narrative. In terms of Non-Offending MAPs, the PTMF would consider how the individual's response to the stigma threat is assumed as coping and survival experiences rather than perceiving the Non-Offending MAPs as dysfunctional and having a clinical 'disorder' and further pathologising the individual. However, it may also be important to recognise that some individuals may perceive diagnostic terminology as useful and a way of accessing support or therapy. The PTMF focuses on subjective experience and moves away from a medicalised approach.

Consequently, Non-Offending MAPs who are pathologised and then seek therapy may become more risk-focused, paralleling the therapeutic support offending minor-attracted people receive in the criminal justice system. In contrast, Cantor (2014) identifies the primary need for therapy to support psychosocial elements and the secondary need to be risk focused. Lievesley et al. (2020) highlight the importance of assuming more strength-based approaches, such as Acceptance Commitment Therapy (ACT), rather than the therapy becoming more about wanting the person to change their feelings towards children. Whilst some research has been conducted around sexual orientation and Non-Offending MAPs, there have been attempts to draw upon Queer Criminology. Walker and Panfil (2017) highlight how Non-Offending MAPs have parallels with the LGBTQ+ population.

Queer Criminology can serve as a framework for understanding Non-Offending MAPs. Walker and Panfil (2017) argue that both groups experience negative discriminatory stigma resulting from non-normative sexual identities. Controversial terminology may contribute to further perceptions of criminalisation. Using a queer lens, Walker and Panfil

(2017) suggest that Non-Offending MAPs are perceived negatively, similar to the LGBTQ+ community, and are often labelled as ‘sex offenders’. Walker and Panfil (2017) highlight that Non-Offending MAPs are sometimes considered part of a broader LGBTQ+ population. However, this association often meets resistance within LGBTQ+ communities due to fears of dehumanisation and the perception of MAPs as predatory. Although Walker and Panfil (2017) highlight parallels in identity formation, increasing evidence also suggests that Non-Offending MAPs could be framed as a sexual orientation. Walker and Panfil (2017) highlight that conversion therapy exists for Non-Offending MAPs with the notion that this attraction could be changed. However, whether Non-Offending MAPs are portrayed as a sexual disorder or a sexual orientation, the negative connotations towards Non-Offending MAPs persist (Jara & Jeglic, 2021). It remains important to focus on reducing risk from a harm perspective. As Farmer et al. (2024) suggest, research needs to remain separate from the political agendas of pro-paedophile groups, and careful research should avoid distortions that are not amplified in academia. Academic comparisons between paedophilia and same-sex attraction—particularly those highlighting parallels in stigma, identity development, or minority stress—carry significant ethical and conceptual risks. Although both groups have historically faced societal marginalisation, the nature of that marginalisation, its legal consequences, and its association with harm differ fundamentally.

Same-sex attraction involves consensual relationships between adults and is recognised internationally as a protected identity under human rights frameworks (Chan et al., 2025). Paedophilic attraction, however, relates to a sexual interest in children, who are categorically unable to give consent. This distinction is not merely semantic; it is vital for both civil rights advocacy and child protection policies (Seto, 2018). While both groups may face stigma, therapeutic engagement must be guided by ethical boundaries that uphold the rights and safety of children while recognising the psychological needs of Non-Offending

MAPs. As Challa et al. (2025) argue, addressing therapeutic bias requires clinicians to navigate complex moral terrain with reflexivity, empathy, and a commitment to safeguarding. This thesis asserts that therapeutic bias toward Non-Offending MAPs, particularly adolescents, must be critically examined without conflating distinct identities or compromising ethical standards.

Conflating these experiences, even within stigma research, can unintentionally reinforce damaging narratives that equate consensual adult relationships with exploitative dynamics. This framing risks undermining the civil rights of LGBTQ+ individuals and damaging public trust in child sexual abuse prevention efforts. Recent stigma literature highlights that non-offending MAPs face profound invisibility and voicelessness, often portrayed as criminals regardless of their behaviour, and are excluded from therapeutic and social support systems due to fear-driven narratives. Nonetheless, recognising this stigma should not compromise conceptual clarity or ethical boundaries.

Academics must oppose frameworks that suggest equivalence in identity politics, therapeutic needs, or civil rights advocacy. Instead, research should focus on context-specific analyses that recognise the lived realities of both groups without erasing their differences. This involves maintaining clear distinctions between attraction and behaviour, between identity and risk, and between stigma and accountability. As Seto (2017) stresses, understanding the neurodevelopmental factors of sexual interests is crucial, but it must be combined with strict ethical safeguards and a commitment to child protection.

#### ***1.4.9 What is Therapeutic Bias?***

This section will define the term '*Therapeutic Bias*,' which refers to the values, personal beliefs, and attitudes a therapist holds about their client. Therapeutic bias may be unconscious or implicit and impede the quality of therapeutic care the therapist provides. These unconscious or implicit biases are attitudes or stereotypes that are strongly held

prejudices against a particular group (Chapman et al., 2013), which unconsciously influence our understanding, actions, and decisions. Therapeutic biases are complex and vary depending on the ingrained formed perceptions. They do not just oppose polarities (e.g., positive or negative) but are often confusing and ambivalent. They can be challenging to uncover and occur without purposeful intention (Dovidio & Fiske, 2011).

**1.4.9.1 The Importance of Focusing on Therapeutic Bias in Relation to Adolescent Non-Offending MAPs.** The World Health Organisation (2024) suggests that one in seven adolescents develop mental health issues such as anxiety or depression before reaching adulthood, and most experience repeated episodes. Failing to address adolescent mental health problems can have long-term effects that carry into adulthood, impacting both physical and mental health and limiting opportunities for a fulfilling life. Adolescence is deemed a crucial period of vulnerability, shaped by the interaction of biological, psychological, and social stressors (Engel, 1977). It is important to recognise adolescence both as a risky phase and as an opportunity for intervention. Early engagement with therapeutic support can reduce psychological distress, improve self-awareness, and promote ethical, non-harmful coping strategies. Adolescents are more likely to disengage from therapy and lack autonomy (WHO, 2021) as they may access therapy due to the initiative of another, and the therapeutic relationship is important to prevent disengagement. (Barca et al., 2020). Therapeutic engagement with adolescents is often influenced by therapeutic biases that compromise the therapeutic alliance and limit treatment efficacy (Challa et al., 2025; Mandangu et al., 2025).

Therapeutic Biases, such as cognitive and affective biases, including anchoring and confirmation bias, are heuristic shortcuts that typically operate outside conscious awareness. Although these biases have been extensively studied in other contexts, their specific impact on psychotherapy remains underexplored.

Yager et al. (2021) argue that these biases can significantly influence clinical assessment, formulation, and therapeutic conduct, often shaping decisions in subtle but meaningful ways. Yager et al. (2021) identify key biases relevant to psychotherapy and demonstrate their effects through clinical vignettes. Importantly, emphasising how biases can distort therapist perceptions, reinforce countertransference, and lead to alliance ruptures, especially when working with stigmatised populations. Strategies to reduce these influences include reflective practice, supervision, and targeted educational interventions. These biases are not merely interpersonal; they reflect broader systemic and cultural stigmas that position adolescents as passive recipients of care rather than active agents in their own therapy.

This insight directly informs the current thesis, which examines how therapist bias, whether conscious or unconscious, can influence engagement with non-offending MAPs. It highlights the importance of therapeutic bias and stigma awareness training, as well as reflexivity in clinical decision-making, especially when working with clients whose identities may evoke moral discomfort or social condemnation. Understanding and recognising therapeutic bias is essential to developing resources and knowledge to strengthen the relationship between the Non-Offending MAPs client and the therapist. An informed therapist would aim to mitigate harm to the Non-Offending MAPs client and promote therapeutic growth. This would enable the therapy to be culturally responsive and avoid discriminatory practices to encourage and foster an inclusive approach. This study highlights therapeutic bias as a form of stigma. The decision to focus on therapeutic bias concerning adolescent Non-Offending MAPs reflects the developmental importance of this group, especially regarding access to care and therapeutic bias. Adolescence is a vital time for identity development, emotional regulation, and building trust in relationships which are areas that are highly influenced by therapeutic approach. Bias during this period can have enduring effects, impacting not only the therapeutic relationship but also the adolescent's

internalised stigma, self-image, and willingness to seek help later in life. An informed therapist, possessing reflexive awareness and stigma-sensitive training, is better positioned to minimise harm, uphold ethical boundaries, and support positive therapeutic progression.

#### ***1.4.10 The Importance of the Therapeutic Alliance In Counselling Psychology Practice***

The therapeutic alliance in counselling psychology is regarded as a crucial factor in therapy effectiveness (Norcross, 2010), irrespective of the therapeutic approach (Wampold, 2015), and plays a key role in enabling change (McLeod et al., 2014). Since many mental health issues begin during adolescence, establishing a strong alliance in therapy can enhance treatment outcomes (Oetzel & Scherer, 2003). In therapy, emphasising a relational framework is essential so clients feel valued and are actively engaged in their treatment (Horvath, 2000). Apostolopoulou and Giovazolias (2021) emphasise that the alliance is not static but a dynamic, co-created process that influences every stage of therapy. When working with stigmatised groups, the alliance can become delicate and may be undermined by the therapist's discomfort, moral judgements, and unconscious biases, which can reinforce internalised stigma.

### **1.5 Summary**

This introductory chapter provides an overview of the topic of Non-Offending MAPs. It acknowledges this is a sensitive and emotive topic, highlighting that Non-Offending MAPs are often adversely mislabelled with the negative connotations of 'Child Sex Abusers' and 'Paedophilic Disorder.' There appears to be a prominent controversy debated about in Non-Offending MAPs research as to whether the minor attraction is framed as a 'disorder' or as a 'sexual orientation'. With the exponential growth in online media and social media, it is apparent that there is widespread online dehumanising of this group of people who are sexually attracted to children but do not act on the attraction (Harper et al., 2018; Jahnke et al., 2014; Jahnke 2018a, 2018b).

There also appears to be little helpful support to those who may need psychologically informed therapeutic interventions. Collectively, this stigma and prejudice may result in an inability for someone to access therapy. They may become persecuted in the media, shunned by the public, and experience covert and/or overt discrimination through a lack of therapeutic support. There is an acknowledgement that therapeutic interventions for these individuals are an unmet need (Lievesley & Harper, 2022). This means there is a need for interventions and training for therapists to recognise their biases to improve access to therapy and mental health. The dehumanising societal attitudes towards Non-Offending MAPs contribute to declining mental health and function as barriers to accessing therapy. This highlights the urgent need for therapists to undergo further training. The lack of research on Adolescent Non-Offending MAPs calls for an innovative approach to therapy. Professionals need to develop empathy and resilience-based interventions to address societal stigma and bias.

## **Chapter Two: Literature Review**

### **2.1 Literature Search Strategy**

A search was conducted of the current and historical literature exploring theories of stigma, therapeutic factors, therapists' factors, and training interventions to reduce stigma perceptions towards Non-Offending MAPs. The literature review retrieved literature search engines such as Google Scholar, Open Athens, PsycINFO, CINAHL, and Psych books. Wiley, Soc INDEX, and articles retrieved from a research forum. Through the searches, the researcher compiled and categorised the literature, focusing on sub-themes related to the research topic. As this is a novel area of research, there is limited research in this area. To gain sufficient depth within the literature, a thematic approach was appropriate to extract literature to synthesise multiple themes (Cronin et al., 2008). Although an unsystematic approach may introduce interpretation biases (Green, 2006), in research on Non-Offending MAPs this approach can be justified given the current paucity of knowledge in the field. A thematic approach to literature is a way of understanding and integrating literature across disciplines with a theoretical connection (Parse, 2023). In relation to the present study, this approach was pertinent due to underlying tensions of stigma and how Non-Offending MAPs are conceptualised differently as a disorder or a sexuality through different research disciplines such as sexuality, criminology, social science and psychology. A thematic literature approach allowed for the combination of perspectives, mapping out themes, and recognising gaps in the literature (Snyder, 2019).

### **2.2 Aims And Objectives of the Literature Review**

This literature review adopts a thematic and reflexive approach, selecting sources from theoretical, empirical, and practice-based materials. By synthesising insights across disciplines, the review aims to critically engage with key concepts and interventions relevant

to theories of stigma, therapeutic factors, therapists' factors, and training interventions that shape therapeutic responses to Adolescent Non-Offending MAPs. It does not aim to exhaustively evaluate all available studies, but rather to critically engage with key concepts and interventions. Most literature broadly examines Non-Offending MAPs; however, research explicitly focused on Adolescent Non-Offending MAPs remains scarce.

### **2.3 Theories Of Stigma**

It is important to examine theoretical models of stigma, which might help elaborate on how stigma links to the therapeutic bias of Adolescent Non-Offending MAPs. Stigma research is abundant. Stigma is a universal term underpinned by negative constructs (labels, stereotypes, distancing, and discrimination) (Link & Phelan, 2001). Stigma emerges from social norms and expectations (Eriksson et al., 2021). If a person's behaviour or identity deviates from a suggested social norm or the unwritten assumptions of what should be the right action, then the individual may experience negative judgements from others and experience increased loneliness from social exclusion (Luhmann & Hawkey, 2016).

Goffman (1963) framed Stigma as a process underpinned by the social construction of identity and identified stigma as an attribute. Applying this theory would suggest that Non-Offending MAPs could be negatively attributed to the undesirable stereotype of a predatory paedophile. Allport's (1954) theory was further applied to the identity of Non-Offending MAPs, meaning prejudice would be experienced through others' negative beliefs and attitudes. Building upon Goffman's (1963) original stigma observations, Aranda et al. (2023) argues that Goffman's (1963) Theory focused on relational individual stigma but needed to understand stigma collectively. Goffman's (1963) theory suggests stigma arises from people's deeply rooted beliefs evoking negative judgements. Reviewing Goffman's theory, Aranda et al. (2023) further indicate that refocusing on the relational aspect of stigma enables an

understanding of its implications. It is essential to explore the implications of stigma to improve the barriers to Non-Offending MAPs' access to services. Broader stigma research from Addison (2023) explored experiences of addiction in treatment recovery services. The qualitative findings suggest that stigma impacts mental health, prevents access to services, exacerbates loneliness and dehumanises and lowers self-worth. In relation to Non-Offending MAPs, this collective prejudice may result in an inability to access therapy, experience being persecuted in the media, being shunned by the public and experiencing covert discrimination through a lack of therapeutic support (Jahnke et al., 2015a).

People who experience prejudiced attitudes towards minor attraction may talk adversely about this group, fuelled by preconceptions on social media and in the public media linking minor attraction and committing child sexual offences to non-offenders (Jara & Jeglic 2021). This may result in social distancing from avoidance of this group. Jimenez-Arista and Caldera's (2024) Content Analysis explored online blogs analysing public attitudes toward 'teenagers with paedophilia' and the likelihood of accessing Psychological 'treatment'. The findings suggested four reactions of 'Rejection,' 'Cognitive Distortions' (rationalisation, normalisation, and victim-blaming), 'Pity' (sympathy), and 'Responsiveness' (acknowledgement, therapy /support, public awareness). There was recognition that attraction can be non-offending, but also harmful beliefs that both offending and non-offending are equally punishable, implying the attraction was linked to the offending behaviour. The authors acknowledge pity as adverse, but it could also increase support; they further noted "feelings of sympathy from survivors" as a way of validation, which may also be perceived as condescending. As Brown (2012) stated, empathy fosters connection and sympathy leads to separation. So, this understanding could further stigmatise. The findings are limited as there may be bias from the sources of the blogs. However, the research adds to the scarcity of

existing Non-Offending MAPs adolescent literature and the prejudiced attitudes prevalent towards adolescents.

According to social constructionism, prejudiced attitudes are socially constructed from interactions with others and co-constructed through social interactions (Ankers et al., 2023). Herek et al. (2009) recognise stigma as being socially constructed as inferiority and powerlessness, which society imposes on those who belong to discredited groups and labels someone as different (Link & Phelan, 2001). Societal inequalities may perpetuate negative perceptions, and individuals become further marginalised (Herek et al., 2009).

In relation to Non-Offending MAPs, another relevant theory is the Minority Stress Model (Meyer, 1995), which builds upon the stigma theory (Allport, 1954; Goffman, 1963; Lazarus, 1993). The model includes external (discrimination, victimisation) and internal stressors (rejection, internalised negative attitudes), which impact the individual, resulting in stigma, mental health decline, substance use, suicidality, and inflexible thinking (Weeks et al., 2021). The model integrates identity theory and social psychological theories of stress to explain the negative impact of prejudice on mental health (Meyer, 1995). The minority stress model was conceptualised initially for LGBTQ+ populations (Meyer, 2003) but has been applied to other populations and has been highlighted in adolescent populations (Weeks et al., 2021). As marginalised groups experience potential rejection, they may become more hypervigilant for threats (Mendoza-Denton et al., 2002). This then may result in distress and overactivation of stress responses, mental health decline and attempts to conceal their identity (Goffman, 1963). In terms of Non-Offending MAPs, this stigma may be experienced over a long duration through public hatred (Jahnke et al., 2015), which then may result in Non-Offending MAPs needing to hide their attraction from negative experiences and leads to further stress as the minority stress model suggests resulting in suppression of identity and concealed internalised stigma (Meyer, 2003).

### *2.3.1 Impact of Concealed Internalised Stigma*

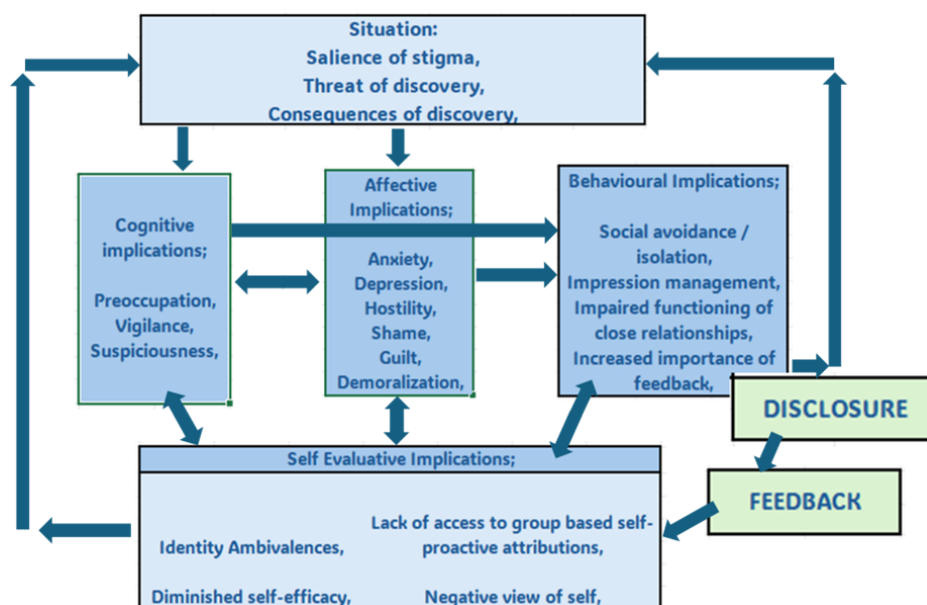
It is essential to consider the impact of concealing stigma. Jahnke and Hoyer (2013) noted that Non-Offending MAPs can choose to disclose or not show their sexual attraction to children. However, Pachankis (2007) suggests this decision may result in further stress because they need to foresee that their minor attraction may be outed constantly, and they become incongruent with their self-identity. Managing stigma may result in Non-Offending MAPs' concealment of their sexual attraction towards children, which may then result in further distress and internalising stigma and damage to their self-construct. This may result in depression, anxiety, and mental health decline. Those individuals who experience 'Concealed Stigma' may face additional challenges in disclosing their stigma (Greene et al., 2003). Pachankis (2007) further theorised how an individual who experiences concealed stigma must appraise new situations and individuals are faced with additional psychological challenges as stressors. Pachankis's (2007) Cognitive-Affective behavioural process framework model (see Figure 1) conceptualises the psychological impact of concealing a stigmatised identity. This cyclical model suggests how the process of concealing a stigma requires:

- Cognitive processes monitoring of others and self for signs of failure to conceal, which in turn requires more cognitive attention, which can impair performance and become exhausting (Rimes, 2023)
- Affective processes which are the fear of being discovered, which exacerbates prolonged anxiety and stress, which results in mental health decline (Pachankis, 2007)
- Behavioural Processes alter the behaviour (avoiding situations) to avoid being discovered.

The model further allows for points of intervention (coping strategies, managing anxiety, improving low self-worth) to support the management of stressors associated with concealed stigma.

**Figure 1**

*A Process Model of the Psychological Implications of Concealing a Stigmatised Identity (adapted from Pachankis, 2007)*



In relation to Non-Offending MAPs, Pachankis's (2007) process model may be relevant in examining the stigma associated with Non-Offending MAPs. If Non-Offending MAPs fear they will be discovered without choosing to disclose freely, then this may result in vigilance. Their thoughts may be overly suspicious towards others, and they may become preoccupied with thinking about someone else finding out. This could increase feelings of low mood, anxiety, shame, and guilt and may result in feeling unworthy. The person may then behave differently through either masking or concealing their attraction through impression management, avoiding, and isolating. There may be more need for validation from others, which has an impact on their relationships with not being able to live

authentically. This then leads to increased feelings of guilt, or they may then disclose to someone about their minor attraction. Psychological self-evaluations may lead to ambivalence in their identity as they internalise a negative self and low self-worth. This may be exacerbated by feeling alone due to a fear of being discovered (Pachankis et al., 2018; Stuber et al., 2008). Amongst a Non-Offending MAPs community-based wellness programme, there was a fear of vigilantism (Jackson et al., 2022). Similarly, from a public perception study on sex offending, there were experiences of being outed and repercussions of losing friendships, being harassed, losing employment and being assaulted (Levenson et al., 2017).

Lievesley et al. (2020) aimed to build upon existing stigma research by exploring how internalised self-stigma manifests through thought suppression. This maladaptive coping strategy may contribute to avoidance behaviours and a decline in psychological well-being. Lievesley et al. (2020) suggested this avoidance impacts the Non-Offending MAP's ability to seek help and become child-avoidant. In a sample of white male adult Non-Offending MAPs, Lievesley et al. (2020) found that thought suppression and well-being decline were associated with future hope and feelings of shame and guilt regarding their sexual attraction to children. This may mean that Non-Offending MAPs experience an increase in guilt and shame about their attraction. Still, they are not able to self-accept their own identity, reinforcing the stigma they experience and reinforced by therapists' biased judgements. This would imply that Non-Offending MAPs who suppress thoughts may still seek support but not disclose their attraction to children and instead use strategies of avoiding children. Lievesley et al. (2020) findings suggest psychological well-being was associated with reduced hope for the future. Non-Offending MAPs may experience an increase in guilt and shame following being attracted to children, but found the opposite for wellbeing, implying stigma may also be internalised. Lievesley et al.'s (2020) findings concur that internalised stigma is reinforced as

Non-Offending MAPs may employ a defensive strategy to avoid children to prevent any potential loss of close friendships in case they are subsequently discovered. This then serves as a way of protecting them from having their attraction to children uncovered and then potentially being shunned and treated like sex offenders. In relation to the present study, this may imply that Non-Offending MAPs may avoid talking about children, and they will fear being exposed if the therapeutic alliance and core conditions do not promote acceptance. Jurcevic et al. (2021) further highlight that concealed stigma has long-term and short-term effects, such as negative emotions, behavioural changes, and impedes mental well-being. Non-Offending MAPs may then appraise whether someone may suspect their minor attraction or whether they feel in a threat mode that someone may discover their attraction. Concealed stigma may be experienced as a safer way to avoid any consequences of disclosing to unknown individuals and results in internalised stigma.

### ***2.3.2 Self Stigma vs Social Stigma***

Mantovani et al. (2016), Corrigan and Watson (2002), Henderson et al. (2014) and Javed et al. (2021) identify stigma as either interpersonal (person to person), intrapersonal (self-stigma) or structural stigma. Self-stigma is identified as an internalised perception of feeling discriminated which results in shame, embarrassment, and disempowerment because of their attraction to children. The individual avoids therapy and support. At the same time, societal stigma is held collectively with negative beliefs towards Non-Offending MAPs and becomes expressed as discrimination. Baumann (2007) further suggests that this results from a lack of information and social distancing among discriminated people. In the context of Non-Offending MAPs, this stigma is not only internalised by individuals but also reflected in the attitudes of health professionals, creating additional barriers to accessing mental health services (Ahmedani, 2011). In terms of therapists, stigma can have an impact indirectly and lead to low self-esteem and reduced self-efficacy (Corrigan, 2007). However, Crocker and

Major (1999) also suggest this varies and considering individual coping styles and resilience may mitigate indirect stigma. Although their research focused on social work professionals, so its application to Non-Offending MAPs remains tentative.

### ***2.3.3 Discreditable Stigma***

Another important theorist, Goffman (1963), outlines that discredited people are those who experience stigma. People who experience discreditable stigma is when the stigma is concealed and not apparent. Chaudoir et al. (2016) further suggest that discreditable stigma socially devalues a person. Relating this to the identity of Non-Offending MAPs may suggest they may experience discreditable stigma which the person could also conceal from others by distancing themselves from the stigmatising attitudes of others. An individual who hides their attraction may have increased feelings of shame and attempt to hide their attraction through impression management and not wanting to be rejected (Pachankis & Goldfried, 2006) resulting in further self-monitoring behaviours.

Jones et al. (1984) established a six-dimensional approach towards stigma for clinical conditions in line with a diagnostic viewpoint. Corrigan et al. (2001) added three new dimensions. In relation to Non-Offending MAPs, this may be transferable to thinking about stigma and minor attraction. Looking at the model, it is important to note separate dimensions can exist simultaneously, resulting in stigma.

The first area of Jones et al. (1984) approach explores *Concealability*, which refers to whether “minor attraction” is visible to others. In relation to Non-Offending MAPs, the minor attraction is not visible to others unless there has been a disclosure made. It may be suggested that many Non-Offending MAPs conceal their attraction; the course of the attraction typically relates to most Non-Offending MAPs who disclose their attraction, which remains static and does not change over the lifespan. *Course and stability dimensions* relate to how someone is

likely to recover or find benefit from treatment (Corrigan et al., 2001). The *Disruptiveness dimensions* explore how the mental health disorder may impact upon relational functioning and social mobility (Jones et al., 1984). In relation to Non-Offending MAPs Disruptiveness, it may relate to how communication with others may be hindered due to not being able to be open and trust others for fear of stigma. Thinking about *Aesthetic Qualities* this may reflect how Non-Offending MAPs internally experience their attraction shaping their self-perception, their interpretation of how others may react in disgust towards them, and the emotional distress they may internalise as a result. These aesthetic dimensions may represent deeper psychological processes, including identity negotiation and the tension between private experiences and public stigma. Relating to Non-Offending MAPs the term Origin could be related to when the onset of the attraction started and whether they internalise responsibility for their attraction. *Peril* (dangerousness) considers the extent of harm towards others. Lundberg et al. (2007) highlight that disorders are perceived as frightening and unpredictable, resulting in fear. The public perceives Non-Offending MAPs as dangerous (Imhoff, 2015) and believes this group will commit sexual offences against children. There appears to be a widely held belief that we must fear and punish this group within society. This is fuelled by social media and tabloid media worldwide. In a comparable way to how sex offenders who perpetrate abuse are seen. There appear to be deep-rooted beliefs that these people are predatory and societal misinformation (Lundberg et al., 2007). Perceiving Non-Offending MAPs as dangerous may be reinforced because Non-Offending MAPs are not perceived as conforming to social norms, which leads to public generalisations that Non-Offending MAPs are predatory. This may then evoke fear and uncomfortable feelings and perpetuate beliefs Non-Offending MAPs cannot control their sexual attraction and will harm a child. Imhoff (2015) and Imhoff and Jahnke (2018) suggest that the term Paedophilia increases punitive attitudes and increases perceived dangerousness towards Non-Offending

MAPs. Jones et al. (1984) highlighted that a less stigmatising disorder would be one that could be concealed, short-lived, not disruptive to the individual, not disgusting, not the individual's fault and not put others in danger. Jones et al. (1984) highlight the Aesthetics dimension as disgust and displeasure from disorder, which results in discomfort as social norms are not adhered to. Furthermore, generalisations are often made, which can add to the stigma. Three further dimensions were added by Corrigan et al. (2001): *Stability, Pity and Controllability*. *Controllability* is linked to how individuals are perceived as being able to control their own conditions and are responsible for their behaviour (Corrigan et al., 2001). In relation to Non-Offending MAPs, Feldman and Crandall (2007) highlight that paedophilia is viewed as being more controllable. This reflects the *pity dimension*. If Non-Offending MAPs are perceived with pity, then there is often less stigma (Corrigan et al., 2001).

#### ***2.3.4 Experiences of Stigma: Accessing Support or Seeking Help***

It is important to recognise the role of stigma in relation to Non-Offending MAPs experiences, as it is thought to contribute to the avoidance of seeking help (Brenner et al., 2020). Mental health concerns amongst Non-Offending MAPs are believed to be an increasing concern. Stevens and Wood (2019) suggest that a third of Non-Offending MAPs may experience severe mental health issues due to experiencing stigma and a lack of perceived social desirability. Non-Offending MAPs may experience elevated levels of psychological distress and experience shame, fear, anxiety, depression, and hopelessness, leading to suicidal thoughts, self-harm and substance misuse and disassociation (Jahnke, 2018a; Levenson & Grady, 2019). Then, subsequently, they cannot cope with the stigma and struggle with a lack of self-acceptance. Non-offending MAPs may experience stigmatic shaming from how they are excluded from society in a comparable way to those who commit sexual offences, and this may also extend to their wider families as secondary stigma (Furst

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& Evans, 2014), leading to a domino effect. It is also noted that Grady et al. (2019) research suggested over 50% of MAPs did not seek treatment because they felt able to control their sexual attraction, so it must not be assumed that Non-Offending MAPs need support to not act on their thoughts. Furthermore, Levenson and Grady (2019) identified that the challenges faced by Non-Offending MAPs may stem from feelings of shame and guilt, as well as the inability to express their sexual interests or form intimate relationships (Cash, 2016).

Parr and Pearson (2019) explored the main barriers to Non-Offending MAPs accessing treatment. An Inductive Thematic Analysis explored 20 therapists (males and females ranging from 25 years to 65+) working in specialist organisations. Participants answered 11 open-ended survey questions, which focused on a vignette case of a Male Non-Offending MAP and how he coped with his minor attraction. The findings focused on how Non-Offending MAPs may experience barriers in seeking and receiving help, how these barriers could be reduced and how Non-Offending MAPs could be supported to remain non-offending. It was further suggested that Non-Offending MAPs face treatment barriers and experience an increased perceived risk of disclosing as potential difficulties. Findings highlighted that these barriers could be addressed through public education, improving publicity and specialist professional training.

Parr and Pearson's (2019) research used a critical realist lens to address the prevention of Child Sexual Abuse (CSA) and help Non-Offending MAPs manage their attraction in a pro-social way. Their work adds evidence to limited qualitative research data by understanding how stigma prevents Non-Offending MAPs from seeking support. This highlights the potential reluctance that professionals may have towards working with Non-Offending MAPs. It is noted that the sample of professionals were less likely to hold negative attitudes towards Non-Offending MAPs due to working in a specialist organisation, and there may have been potential sampling bias. However, the research highlights the importance of

understanding these barriers and dispelling misconceptions around the stigma this group experiences. Parr and Pearson's (2019) research expanded on the existing literature as it recognised that therapists may misunderstand reporting laws. However, the research does not explore the underlying reasoning and contextual factors or individual nuances of why professionals misunderstand paedophilia. It may have been beneficial to use a semi structured interview as a tool to be able to elaborate this further to elicit a deeper level of data and glean the non-verbal communication and understand the complexity of working in this group. In relation to the present study, it may be useful to explore the experiences of professionals working within this group to understand their lived experiences.

However, Parr and Pearson (2019) did highlight a need for professional specialised training courses and why there is a lack of available services for Non-Offending MAP clients. The analysis findings suggested a perceived risk of disclosure and a need for training professionals and education to increase the publicity of Non-Offending MAPs. This indicates it may also be useful to explore how a training intervention manages therapist tensions around disclosure and reporting. Concluding there is a need for further research to highlight training to meet future service provision needs. The research recognises that most Non-Offending MAPs do not seek support for their minor attraction, but instead for other mental health issues related to the minor attraction, which is noted in Steven and Wood's (2019) research.

Stevens and Wood's (2019) Thematic Analysis found themes related to mental health issues, such as self-hatred from their minor attraction leading to feelings of guilt, shame, increased suicidal feelings, depression, anxiety, and addiction to substances. Participants highlighted coping mechanisms of managing attraction and risk by avoidance of triggers, trying to distract their attention from their thoughts, seeking professional help or peer support and wanting to remain non-offending. Participants expressed fear of being labelled as

offenders; however, the Thematic Analysis was based on self-reported data from 5,210 posts retrieved from the online forum 'Virtuous Paedophiles'. This reliance on self-reported data introduces potential bias and limits the generalisability of the findings. It did include some comparisons to offending minor-attracted persons as well, which needs to be taken tentatively with caution because there is no evidence that Non-Offending MAPs will act on their attraction. It has highlighted the challenges experienced by Non-Offending MAPs, such as suppressing thoughts and avoidance of children as ways of managing risk and highlighted an unmet need for increased therapy services to work with this group. It may be implied that therapists working with this group could help reduce self-hatred by normalising experiences and creating an alternative narrative to support Non-Offending MAPs to improve coping strategies. If therapists encourage self-compassion and foster supportive alliances, so Non-Offending MAPs are more able to manage situations and face adverse societal stigma, this could reduce anxiety and increase well-being. Although this population experiences severe mental health conditions, it is not known who seeks psychological support, but it is possible that increased social stigma—fuelled by societal and media perceptions—acts as a significant deterrent. The public may perceive minor attraction as child sexual abuse resulting in discrimination and reducing the likelihood of individuals seeking therapy (Jahnke & Hoyer, 2013).

Schaefer et al.'s (2022) thematic analysis explored Non-Offending MAPs' experiences of mental health and public perceptions. Overall themes suggested that paedophilia is not a choice and suggest instead it is a sexual orientation. Those feelings did not lead to acting on feelings and engaging in child sexual abuse, and there was control over their behaviour.

Participants expressed attitudes of not wanting to be attracted to children and experiences of shame and guilt. Additionally, participants reported attraction to have begun in

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adolescence and mentioned negative perceptions of themselves such as feeling outcasted and demonised. Participants experienced dehumanisation from society and experienced a psychological burden. As they recognised that they would not have an emotional/ relational connection and suppressed their sexual attraction. It was noted that some participants found ways of coping through alternatives such as pornography, some viewing child images, and some were able to engage in mindful activities such as yoga. They further identified themes that they wanted professional support but also experienced mistrust and felt alienated.

Due to the risks associated with stigmatising attitudes Non-Offending MAPs may isolate themselves so they do not reveal their attraction. Schaefer et al (2022) suggested that some Non-Offending MAPs experienced feelings of being afraid to ask for help due to concerns of repercussions, as they feared professionals would report them regarding their sexual orientation. Non-Offending MAPs experienced the help offered was inadequate and subsequently increased feelings of hopelessness due to a lack of support. Leading to further isolation and experiences of loneliness (Grady et al., 2019).

Further research by Levenson et al. (2017) explored male adults convicted of child sex offending to establish help-seeking behaviours of individuals prior to being arrested. Results suggest that 20% tried to access formal help prior to sex offending. Participants experienced challenges in finding therapists who were helpful or competent to support them. Cohen et al. (2018) further suggested there was more offending minor attracted people who endorsed a history of experiencing psychotherapy. It may be implied that there were negative experiences from therapists, which were believed to be a contributing factor to offending.

These results suggested the importance of accessing appropriate therapy from an early age in adolescence to prevent offending, but may be limited in application to Non-Offending MAPs. Other research outside of Non-Offending MAP populations suggests adolescents often only experience therapy following parental input and then often drop out of sessions (de

Haan et al., 2013) and do not seek help because of stigma and embarrassment (Gulliver et al., 2010). Adolescents may also prefer self-reliance when experiencing difficulties and negative perceptions of professionals (Radez et al., 2021). This is supported by research from a minor attraction support group, B4U Act (2011a), which surveyed 209 Non-Offending MAPs, finding over 50% wanted access to mental health services but did not seek support due to apprehensions of negative reactions from professionals. B4U Act (2011a) highlight a high number of Non-Offending MAPs have tried to seek professional help but feared professionals would report them or lacked knowledge of how to support them. B4U Act (2011a) suggest that when Non-Offending MAPs sought help from therapists, they were often met with unjustified assumptions based on DSM-5 criteria that Paedophilia is a 'mental disorder'. These assumptions frequently implied a link between attraction and child sexual abuse, despite the absence of offending behaviour (Feelgood & Hoyer, 2008) (See Chapter 1). Furthermore, Non-Offending MAPs experience elevated levels of stigma and discrimination (Imhoff, 2015; Jahnke, 2018a), lack of counselling and increased levels of emotional distress, which could potentially lead to sexual offending. Indicating it is important to explore professionals' attitudes and experiences towards Non-Offending MAPs.

#### **2.4 Literature Theme: Therapeutic Factors in Relation to Working with Non-Offending MAPs**

It is essential to consider therapeutic factors in relation to working with Non-Offending MAPs. When Non-Offending MAPs seek mental health support through therapy, they face several barriers: lack of accessibility to treatment services, the perceived risk of disclosing their attraction (Parr & Pearson, 2019), and the therapist's lack of knowledge and judgemental attitudes. This subsequently may hinder any meaningful empathic therapeutic change, resulting in Non-Offending MAPs not receiving adequate support (Levenson et al.,

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2017). There appears to be no research exploring therapists' experiences of working with adolescent Non-Offending MAPs. As this is a niche area of research, therapists may lack knowledge about working with adolescent Non-Offending MAPs. This lack of research highlights the need for more targeted studies to better understand the dynamics and potential biases that may arise in therapeutic settings. Addressing this gap could lead to improved training programmes and support systems for therapists, benefiting adolescent Non-Offending MAPs seeking help. The research indicates therapists may lack knowledge when working with Non-Offending MAPs, often focusing on risk, which results in therapeutic bias.

If therapy is framed from a risk perspective, this could lead to therapeutic bias. The therapy may then concentrate on the therapist's perceived potentially harmful behaviour of the client and neglect to understand other aspects of the client's mental health. If a client is viewed through a risk-focused lens, then this could also reinforce stigma. Subsequently, the individual would then experience feelings of being misunderstood or judged. This therapeutic bias may then impact the client-therapist relationship, and the client may feel scrutinised, judged and mistrusted. The Non-Offending MAPs' needs may be unmet. By acknowledging and addressing these biases, therapy can shift towards a more supportive therapeutic environment that considers individual needs and dignity.

Lawrence and Willis (2024) emphasise there may be a misunderstanding in distinguishing between Non-Offending MAPs and those who act on their attraction, as the focus tends to be on the risk and perceived actions instead. Then, therapy may become risk-averse, similar to how probation and prison forensic services function. The therapist may subsequently focus on managing the risk rather than exploring the person's therapy needs. Therapy may then become dominated by the focus on sexual interest in children and their sexuality (Grady et al., 2017), rather than addressing the individual's needs and reasons for seeking therapy. Non-Offending MAP clients may face barriers to attending therapy due to

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perceived stigma from the public (Hinshaw & Stier, 2008) and therapists. This may lead to increased isolation, reduced acceptance, and a higher likelihood of experiencing a negative self-worth and emotional distress. This could lead to significant stigmatisation stress, negatively affecting Non-Offending MAP's willingness to seek support (Grady et al., 2019).

Chronos and Jahnke (2024) conducted a systematic review which explored the treatment needs and experiences of 'Pedohebephiles'. Their findings indicated that 'treatment' needs remain unaddressed. Community samples reported both positive and negative experiences. Mental health improvements were observed when therapists were non-judgemental, while negative experiences occurred when therapists were risk-focused rather than goal-focused. This risk-focused approach can lead to therapeutic bias and hinder effective treatment. The research indicates a shortage of mixed-methodology research, with only two of 40 studies using this approach (Jahnke et al., 2023; Mitchell & Galupo, 2018). These findings are generalised to predominantly online community samples from Western English-speaking populations.

Chronos and Jahnke's (2024) research recognised the importance of a supportive and empathetic therapeutic environment. When therapists focus on understanding and addressing the individual's broader mental health needs, rather than solely on managing perceived risks, it can lead to more positive outcomes for the client.

This was also observed in Schaefer et al. (2022) thematic analysis that highlighted the importance of considering therapeutic factors when working with Non-Offending MAPs. Findings suggested that shifting the focus from risk management to the client's personal goals and well-being can lead to more positive therapy outcomes. Addressing the individual's broader mental health needs, rather than solely focusing on their minor attraction, ensures a more holistic and effective treatment. Therapists who approach their clients without judgement help create a safe and supportive environment, which can significantly improve

mental health outcomes. Demonstrating empathy and a genuine understanding of the client's experiences fosters a stronger therapeutic alliance and encourages openness. It is important to acknowledge there are therapeutic factors and conflicting tensions which impact Non-Offending MAPs therapy. These factors align with the findings of Chronos and Jahnke (2024), highlighting the need for a balanced and empathetic approach in therapy. By emphasising these therapeutic factors, therapists can better support Non-Offending MAPs and address their unique mental health needs.

Inexperienced therapists who lack training may focus on discussing the attraction towards children and view therapy primarily as a way of preventing future offending. However, Non-Offending MAP clients may simply want to feel better about their minor attraction. If the Non-Offending MAP client experiences feeling rejected due to the therapist's disgust or uncertainty, the therapist may inadvertently increase and reinforce the client's existing shame. This rejection is further exacerbated if the therapist refuses to work with this group (Levenson & Grady, 2019a).

This was also found in Schmidt and Niehaus's (2022) work, which researched perspectives of Swiss outpatient therapists working with offending MAPs and Non-Offending MAPs. Participants were asked to rate 17 psychological issues they might experience. Exploratory factor analysis found that outpatient therapists were unwilling to provide therapy (45% for Non-Offending MAPs vs. 63% for offending MAPs). The quantitative study showed negative attitudes towards Non-Offending MAPs, with a high percentage of therapists agreeing that Non-Offending MAPs should not be allowed to work with children and should be forced to have therapy. However, the findings suggested therapists felt unable to provide therapy due to not perceiving themselves as competent. Additionally, therapists with previous experience were more likely to offer therapy. This appeared underpinned by therapists recognising their lack of adequate qualifications and concerns that therapy errors

may result in child abuse, liability for therapy mistakes, and discomfort working with these clients. This research indicates that anti-stigma interventions can only partially increase therapists' willingness to work with Non-Offending MAPs. Some participants held strong beliefs against providing professional support. According to Schmidt and Niehaus (2022), this stemmed from biased beliefs that the psychotherapeutic needs of Non-Offending MAPs are different from those of other clients due to their sexual orientation. This suggests that the issue may not solely be about the therapist's competency but also about the therapists not addressing their own biases towards Non-Offending MAPs. Levenson and Grady (2019a) also suggest that these clients seek out therapy for similar problems as other clients, such as anxiety, depression, and loneliness. They propose that competence in therapy could be increased by becoming familiar with Non-Offending MAPs therapy needs, which are often unrelated to their minor attraction.

Nováková et al. (2023) surveyed 61 mental health and social work practitioners in the Czech Republic anonymously online, exploring perspectives on engaging with individuals seeking help in relation to paraphilic interests. The findings suggested practitioners perceived limited capacity to support with paraphilic concerns and barriers included lack of experience and training. Gender differences were noted with males feeling more confident than females in treating people with paraphilic interests. However, the researchers were unable to explore this further due to the imbalance of gender (male = 18 and female = 33) and low reliability of the data. More female than male practitioners also felt hindered by a lack of professional training. Previous research has also found uncertainty in how to work with Non-Offending MAPs (Jahnke et al., 2014; Jahnke, 2018a; Schmit & Niehaus, 2022), but this was not directly related to gender.

Nováková et al. (2023) used a self-report cross-sectional design, so it is unclear whether participants' perceptions would change over time. Self-perception may have led to

overestimates or underestimates of their capabilities due to social desirability bias. However, the study did indicate a need for more training in Non-Offending MAPs' therapy needs. This is supported by Heinonen et al. (2012), who found that higher therapy confidence improves therapeutic outcomes. This further highlights the importance of professional training when working with Non-Offending MAPs (Lievesley & Harper, 2022; Parr & Pearson, 2019; Stephens et al., 2021). This may indicate bias may be addressed through increased knowledge of Non-Offending MAPs' needs and by working on personal stigma biases. This further highlights a need for staff support.

Predominantly, Non-Offending MAPs are first viewed through a CSA lens, which can reinforce perceived public stigma and hinder their ability to seek support. This was further supported by Schmidt and Niehaus (2022), who researched therapists' perspectives and minor attraction. They found that therapy, based on a sample from Swiss community prevention in a non-forensic setting, is needed; however, therapists were often unwilling to support these clients. The substantial difference in mean ages between groups may suggest that willingness to seek or provide support is influenced by life experience.

The authors also noted that male participants had more experience than females. It was observed males were more likely to work as medical professionals, and females were more likely to be psychologists. This suggests that the issue may be related to philosophical underpinnings of the individual's professional alignment rather than experience, age, or gender. The authors highlight a lack of knowledge and skills among Swiss outpatient therapists to explore the concerns related to minor-attracted people. They also emphasise a perceived lack of training as an obstacle to receiving counselling services.

In comparison, training for professionals working with people who have committed sex offences has demonstrated changes in attitudes (Farrenkopt, 1992). Farrenkopf found therapists working with sex offenders experienced several changes in attitudes over time.

Therapists felt an initial shock of fear and vulnerability when they first started working with sex offenders. They subsequently developed empathy, non-judgemental work ethics, and hope for effectiveness. Therapists became intolerant of offending behaviour and lost some of their professional idealism. Therapists noted feelings of resentment, futility, exhaustion, and depression. This led to burnout or a more detached attitude and lowered expectations. These changes highlight the emotional and professional impact of working with sex offenders and accentuate the importance of support systems and coping strategies for therapists.

#### ***2.4.1. Therapy Barriers: Attitudes, Bias, Beliefs, Values***

Research is limited in how therapists' personal beliefs and values may impact their therapeutic work with Non-Offending MAPs. Lievesley et al. (2022) conducted an online survey with a sample of 220 non-specialists who may encounter Non-Offending MAPs seeking help. Compared to other mental health professionals, primary medical professionals were more likely to view those with minor attraction as dangerous, unable to control their attractions and that the attraction was a choice. However, both groups emphasised the importance of focusing on mental health, though there was still a secondary element of wanting to control the attraction. The findings highlighted the need for willingness and professional training to support those working with this group and identified gaps in service provisions for Non-Offending MAPs.

There are several barriers that therapists face when working with Non-Offending MAPs, including displaying a lack of empathy (B4U Act, 2011a, Van Horn et al., 2015), being risk-averse, focusing on the prevention of sexual activities, experiencing mental health issues, low resilience, feeling incompetent, not addressing the 'elephant in the room' and facing ethical dilemmas. It is well-researched that therapists' negative attitudes towards sex

offenders may result in service users' disengagement and impact service delivery (Ward et al., 2013). This can lead to a lack of services for Non-Offending MAPs.

Dymond and Duff (2020) conducted qualitative research interviews exploring barriers to receiving help by interviewing minor-attracted people from the UK. Participants highlighted their apprehension that therapists would be judgemental, lack empathy, and be unwilling to support them. Similar findings were reported by Levenson and Grady (2019), who found that less than 50% of participants had useful therapy and encountered judgement and a lack of empathy. Research with therapists has shown that those without experience working with Non-Offending MAPs tend to hold more negative attitudes compared to those with experience (Levenson & Grady, 2019). It is not only empathy in the Non-Offending MAPs client alliance but also how the therapist copes with negative feelings, highlighting a need for reflective supervision and personal therapy.

Therapeutic change may be hindered by preconceived bias, resulting in avoidance of working with this group. It is not known how therapists' attitudes are informed and shaped by their own histories, working experience, culture, and gender differences. Research may indicate that therapists working with sex offenders which may be transferable towards working with Non-Offending MAPs, demonstrate different attitude styles. Polson and McCullom (1995) identified four therapist themes which could be reframed in terms of counselling psychology:

- Constructing a Positive view of the person.
- Working with maladaptive beliefs and behaviours.
- Recognising the therapist's response.
- Counselling intervention limitations.

In the specific context of Non-Offending MAPs, it is crucial to consider both individual and systemic contexts. Societal norms, cultural beliefs, policies, and community attitudes can either perpetuate stigma or help mitigate it. If Non-Offending MAPs continue to face stigma, isolation, and withdrawal, the effectiveness of therapeutic interventions may be limited, particularly if the external environment remains punitive. Forensic samples are not always directly comparable to Non-Offending MAP samples, as therapy interventions in forensic populations may be motivated by the desire for freedom or court orders (Chronos & Jahnke, 2024). These considerations highlight the complexity of addressing stigma and the need for a multi-faceted approach that encompasses both individual and systemic changes.

Jahnke et al. (2023) have identified several barriers to effective therapy, including:

- *Concerns about Being Reported.* Individuals might fear that disclosing their thoughts or behaviours could lead to legal consequences or mandatory reporting, which creates a significant barrier to open and honest communication in therapy.
- *Risk-Focused Therapy:* There is a concern that therapy may prioritise risk prevention and the prevention of offending over the individual's broader mental health needs. This can lead to a narrow focus that may not fully address the person's overall well-being.
- *Stigmatising Therapeutic Bias.* The framing of therapy with an underlying bias toward preventing offending can contribute to a stigmatising atmosphere. This bias can inadvertently reinforce negative stereotypes and further stigmatise individuals seeking help.

These barriers highlight the need for a more compassionate and holistic approach to therapy that recognises and addresses the stigma and challenges faced by individuals.

### *2.4.2 Factors Contributing Towards Therapist Bias*

Therapists may encounter challenges when working with Non-Offending MAPs due to a lack of knowledge, leading them to focus primarily on the risk aspect, which results in therapeutic bias. To address this bias in therapy, it is essential for therapists to receive education and training so they can provide effective care to Non-Offending MAPs.

It is well established that the therapeutic relationship in counselling psychology is crucial for promoting change (Orlans & van Scoyoc, 2008) alongside Rogers' (1951) core conditions of empathy, congruence, and unconditional positive regard. Working with service users who discuss their attraction towards children may challenge therapists' ability to empathise with this group. Therapists may become incongruent depending on their age, experience, and resilience.

Levenson and Grady (2019) highlighted that the prevention of child sexual abuse should include counselling that precedes any offending. Their pilot project evaluated an intervention workshop conducted at four different clinical therapy conferences over a 14-month period. The results suggested significant changes in attitudes towards Non-Offending MAPs related to therapy goals and knowledge of mandatory reporting laws. Participants who had not previously worked with minor attraction showed a notable increase in therapeutic willingness to work with this group. The willingness to work with Non-Offending MAPs may be underpinned by the feeling of being unqualified (Lasher & Stinson, 2017) or lacking confidence in the effectiveness of therapy (Jahnke et al., 2015a). Levenson and Grady (2019) found a reduction in the belief that counselling Non-Offending MAPs was solely to prevent child abuse, indicating an unexpected humanisation consequence of attending the workshop. They further highlighted that professionals working with this group should recognise the dual facets of client wellbeing and child protection/prevention of sexual offences.

However, the findings also recognised that the participants' attitudes were not overall negative at baseline, which was attributed to many of the participants (social worker/ ATSA professionals) self-selecting to attend the training and already being familiar working with sex offending. This may have biased the findings.

### ***2.4.3 Therapist Gender***

Baum and Moyal (2020) highlight that there is an abundance of research noting the distressed therapist's experience when working with sex offenders but less is known about whether the therapist's gender has an impact on the therapy. There appears to be limited research regarding Non-Offending MAPs and therapist gender. Craig (2005) found male therapists demonstrated more positive attitudes towards sex offenders than female therapists following a two-day training workshop, which was to support understanding of theory and education around sexual offending and to challenge myths and understand risk and relapse prevention. Craig (2005) measured the attitudes of professionals working with sex offenders versus attitudes to non-sex offender prisoners. Post-training findings suggested male therapists were found to be more confident working with sex offenders, whilst females were more concerned with their own safety and demonstrated more negative attitudes than male therapists. Similarly, in Farrenkopf's (1992) research which examined the attitudes of therapists working with sex offenders found female therapists highlighted experiences of feeling paranoid, vulnerability, and increased vigilance associated towards their own safety and their children. Craig (2005) suggests training should emphasise therapeutic alliance and those who work with sexual offenders should consider the impact of age and gender of the professional as this may impact on the client.

Exploring the limited Non-Offending MAP research similarly, Schmidt and Niehaus (2022) found female therapists to hold more stigmatising attitudes towards Non-Offending

MAPs than males in relation to a Swiss outpatient setting. Iffland and Schmidt (2023) replicated Schmidt and Niehaus's (2022) gender difference in therapy, with findings demonstrating females had higher social distancing scores than males. Although Iffland and Schmidt (2023) reported a small effect size, the findings from their small sample should be considered tentative. However, if females were more concerned and preoccupied with their own safety, then this may imply female therapists may be more preoccupied in therapy when there are any perceived risk indicators around safety and socially distanced.

Baum and Moyal's systematic review (2020) recognised that males and females cope differently with traumatic details, with males being more emotionally exhausted, which challenges Farrenkopf's (1992) research that females may be more prone to burnout than males. Baum and Moyal (2020) found 10 papers compared gender in mental health in response to sex offenders. Findings were inconsistent with two papers finding significant differences in distress (Ennis & Horne, 2003) and burnout (Sheehy et al., 2009). All the other studies found gender differences, with males working with sex offenders reporting more adverse effects than females. Research by Way et al. (2004, 2007) and VanDeusen and Way (2006) found male therapists had higher scores for avoidance and intrusion and disrupted cognitions than female therapists. However, if there are disrupted cognitions, these could impede a therapeutic relationship if there is a lack of commonality and negatively impact the client/therapist relationship (Blasko & Jeglic, 2016). Having a negative attitude toward Non-Offending MAPs may also be a block towards empathy, which then impedes the therapeutic relationship (Blasko & Jeglic, 2016). This is important because if therapists exhibit negative qualities, such as hostility, or reject the client, the client may disengage from the therapist (Hudson, 2005; Yates, 2013). This highlights the importance of recognising potential therapist bias when working with non-offending MAPs.

Research has demonstrated that empathy can be enhanced through training focused on understanding clients' concerns and experiences (Ruiz-Moral et al., 2017). However, some studies found no significant difference in affective empathy between training and non-training groups (Epstein & Street, 2011; Riess et al., 2012). Nonetheless, the overall research consistently supports that training interventions are a viable tool for reducing stigma.

#### ***2.4.4 Therapist Empathy Stigma: Affective and Cognitive Empathy***

Empathy is a multidimensional construct. Research consistently demonstrates that therapist empathy is one of the most influential factors in predicting client progress in psychotherapy, regardless of the therapeutic approach (Norcross & Wampold, 2011). Rogers (1951) defined empathy as the ability to accurately perceive the internal frames of reference of others. His definition highlights empathy as both an emotional and a cognitive process. Therapist empathy towards Non-Offending MAPs can be influenced by affective and cognitive reactions which include both affective (emotional) responses and cognitive empathy.

**2.4.4.1 Affective Empathy.** Involves mirroring the emotions of another person (Lamm et al., 2007) and referring to the immediate feelings a therapist might have when working with Non-Offending MAPs, such as discomfort or judgement. Cognitive empathy, alternatively, involves understanding the Non-Offending MAPs' perspective and experiences without necessarily sharing their feelings (Baron-Cohen & Wheelwright, 2004).

Addressing these factors is crucial for providing effective and unbiased therapy. There is evidence even those people who report prejudice are still more likely to respond aversely to stereotyped groups (Allport, 1954), such as Non-Offending MAPs, which may conflict with their own help beliefs and the unconditional positive regard therapists strive towards. Allport (1954) noted that people who intentionally rejected their biased opinions and did not perceive

themselves as discriminatory still reacted negatively unintentionally. This is important because as Allport (1954) theorised any conflict between how a person believes they should respond to someone and how they actually do would lead to affective responses of shame and self-criticism.

The emotional response therapists may feel towards Non-Offending MAPs can be framed as an affective reaction on a continuum, ranging from sympathy to anger. Freimond's (2013) qualitative work explored the experiences of nine male Non-Offending MAPs to understand the stigma surrounding their identity. The findings suggest that Non-Offending MAPs encountered both negative and positive reactions when disclosing their attraction to others. Reactions varied from acceptance to discrimination, highlighting the need for new interventions to promote anti-discriminatory practice and enhance empathy through educational measures. It should be acknowledged that this study is limited to a Canadian sample. Cultural context is important to recognise, as stigma endorsement may differ based on cultural norms (Yang et al., 2007).

**2.4.4.2 Cognitive Empathy.** Also known as perspective-taking, involves understanding and considering another person's thoughts, feelings, and perspectives without necessarily sharing their emotions (Hatfield et al., 2011). This form of empathy is crucial for therapists as it allows them to comprehend their client's experiences and challenges more deeply. Incorporating cognitive empathy into therapy with Non-Offending MAPs can significantly reduce biases and enhance therapeutic effectiveness. Therapists should practice active listening, where they fully concentrate, understand, and respond to the client's communication. This helps in accurately understanding the client's perspective, and considering situations from their client's point of view can enhance cognitive empathy. Therapists can use reflective dialogue to confirm their understanding of the client's thoughts and feelings, ensuring they accurately grasp the client's perspective. Learning about the

specific experiences and challenges faced by Non-Offending MAPs can help therapists better understand and empathise with their clients. Regular supervision and feedback from peers and mentors can help therapists identify areas where they may need to improve their cognitive empathy. By integrating cognitive empathy into practice, therapists can create a more supportive and effective therapeutic environment for Non-Offending MAPs, addressing their needs with greater understanding and reducing potential biases.

Exploring these themes in relation to this work may hinder a therapist if they cannot construct a positive view of their client, which implies lower levels of empathy. This was noted in Mivshek and Schiver's (2022) research, which delved into the impact of empathy bias on forensic practitioners' objectivity. Their study used a multivariate analysis of covariance to explore differences in burnout and empathy in sex offender versus non-sex offender treatment settings. The findings revealed professionals with lower levels of empathy and negative attitudes towards the intervention experienced higher levels of burnout. Although these results may be tentatively applied to Non-Offending MAPs, this is due to their comparison with an offending population, which limits direct generalisability. There was also no significant difference noted between therapists who worked with sex offenders and those working with non-sex offenders in terms of empathy. Their study highlighted that empathy bias can adversely impact forensics practitioners' objectivity, suggesting that personal biases can influence judgement and interactions with clients. However, psychotherapists' empathy can also be associated with strong treatment outcomes (Moyers et al., 2016). As Moyers et al. (2016) RCT looked at higher levels of therapist empathy and treatment context of addictive behaviours using audio-recorded psychotherapy sessions (38 therapists and 700 clients). These sessions were assessed for coping skills and relational components (empathy level of the therapist). This study did suggest the importance of

empathy in achieving positive treatment outcomes and 11% of the variance was accounted for by therapists.

In therapy, it is essential to practice empathy, non-judgement, and acceptance, particularly for individuals facing significant stigma and shame (Wagner et al., 2016). Providing a safe and nurturing environment is key to effective therapy. Therapists must understand and validate their clients' unique experiences, creating a space where they can express themselves without fear of judgement. Therapists must prioritise seeing the person first, understanding and working with their beliefs and behaviours around non-offending minor attraction. This may involve navigating the client's unique frame of reference, which could differ significantly from the therapist's own. Effective therapy in this context hinges on the therapist's ability to maintain curiosity about the client's thinking and to highlight listening, empathy, and rapport as foundations for therapeutic growth. If therapists anticipate hearing potentially distressing events, this expectation could create a barrier, hindering the development of relational depth and a non-judgemental therapeutic alliance. It is imperative for therapists to overcome these barriers to really connect with their clients and support their growth.

Building relational depth is important in any therapeutic context. In research outside of Non-Offending MAPs, Knox and Cooper (2010) researched the qualities of a therapeutic relationship from a client experience. Therapists who experienced relational depth were perceived as trustworthy, caring, and wanting to understand the client. In contrast, in therapy relationships where the client experienced a lack of relational depth and perceived the therapist as powerful, remote, and prone to misinterpreting what was said with no meaning, rendering the therapy ineffective. Once a client and therapist form a non-judgemental unconditional alliance, this will promote and foster a client's sense of self-acceptance and start to increase self-compassion. Knox and Cooper (2010) advocate for a shift towards

client-centred approaches. This emphasises the importance of a strong therapeutic alliance, a factor consistently shown to significantly improve therapy outcomes (Martin et al., 2000). In relation to Non-Offending MAPs, the therapist who is client-centred would not focus on changing the minor attraction behaviour but instead understand the person and their sexual attraction. Any behavioural change is ultimately the client being able to become more accepting of their minor attraction and develop a more positive self-view. The therapist must address their own unconscious biases to fully accept the Non-Offending MAP client. Reflective practice and personal therapy can help therapists recognise and address these biases, promoting a more effective and empathetic relationship. As Norcross (2002) suggests reflective practice in therapeutic work underpins the therapist's responsiveness in their interventions. Experienced therapists can adapt their relational approach intuitively and flexibly, demonstrating an ability to effectively engage with their client's unique needs and experiences.

When working with Non-Offending MAPs, therapists need to be aware of the potential impact their therapeutic work may have on themselves. It is important that therapists reflect on situations where their personal values might conflict with those of their clients. This can create tensions, especially regarding the therapist's accountability to maintain client confidentiality and navigate what is disclosed in therapy. Consequently, therapeutic boundaries may need to be more rigid to manage these challenges effectively.

Friedrich and Leiper's (2006) study suggest that therapists who experienced more negative emotions when working with sex offenders often felt controlled or deceived. However, this research was conducted from a forensic risk perspective, so the prominence of negative countertransference might be higher in that context. Consequently, these findings may not be generalisable to the Non-Offending MAPs population. Furthermore, the study

does not address how to manage negative feelings arising from countertransference, which can impede empathy.

When therapists experience intense negative emotions, Knoll (2009) highlights that in forensic settings, clinicians may encounter morally objectionable clients, leading to negative countertransference reactions. Therapists can struggle with the tension between wanting to help the person and feeling anger, fear, or disgust. This internal discomfort may manifest in a rejecting manner, with therapists using 'isolation of affect' to manage their emotional discomfort. Psychodynamic theory suggests that this defense mechanism allows therapists to unconsciously compartmentalize their emotions, causing them to lose connection with the associated feelings (Di Giuseppe & Perry, 2021). This can create an emotional distance that hinders the therapeutic process.

In practice therapists should address the 'elephant in the room', (i.e., the 'minor attraction' from the onset of therapy). This may be helpful in contributing to the therapeutic alliance as Individuals may be reluctant to access support due to concerns of perceived therapist stigmatisation (Schmidt & Niehaus, 2022). However, it may also not be apparent there is minor attraction until later down the therapeutic journey. If faced with this scenario in therapy, it may be that the therapist perceives the relationship was not sufficiently safe enough for the client to disclose. Jahnke et al.'s. (2023) conducted a mixed-method study that explored secret keeping in therapy, identifying four themes in their qualitative findings:

- Disclosure experiences were marked by emotional turmoil and a desperate need to disclose.
- Reluctance to disclose was due to previous negative therapy experiences or fear of negative reactions from the therapist.

- Participants mainly sought out therapists with experience or awareness of minor attraction.
- The impact of disclosure varied, with trusting relationships being crucial, but negative reactions sometimes led to therapy discontinuation.

Furthermore, Hart et al. (2024) found that client withholding in therapy was associated with lower therapeutic outcomes. In order to deal with this problem, they recommend reflexivity and supervision along with maintaining a non-judgemental approach and clear boundaries to foster open dialogue (Farber, 2020).

#### ***2.4.5 Therapeutic Factors: Offering Therapy and Psychological Coping Strategies***

The therapeutic alliance is fundamental in psychotherapy (Orlinsky et al., 1994). Extensive research has shown that a strong relational alliance leads to positive therapy outcomes (Horvath & Greenberg, 1994; Jahnke et al., 2023).

In a mixed-methods study, Jahnke et al. (2023) investigated reasons why ‘paedophilic’ clients disclosed their sexual attraction towards children in therapy compared to those who did not. They recruited 136 male and female pedohebephiles online using forums such as B4UACT and Virtuous Paedophiles. The study found differences in client improvement and alliance between the non-disclosure and disclosure groups. The results noted client improvement in those who disclosed their attraction and stronger therapeutic alliance, as the act of disclosure was believed to have built a foundation of trust and openness. Clients who disclosed often did so because they were in significant distress and sought relief. This willingness to be vulnerable and open may have contributed to better therapeutic outcomes. Qualitative analysis revealed that disclosing often arose from emotional turmoil and desperation, while reluctance to disclose stemmed from previous negative therapy experiences and fears of the disclosing process. Further themes indicated

clients sought out therapists experienced in minor attraction. Therapy was perceived as beneficial when clients felt able to disclose, but negative reactions often led to therapy termination by the client. Jahnke et al. (2023) emphasised the importance of supportive therapist reactions for a stronger alliance and better therapy outcomes. However, the study's findings were based on self-report and correlational data, which may introduce bias, as some participants reported on therapy sessions from many years ago. It remains unclear whether therapy disclosure resulted from the strength of the therapeutic alliance or other factors such as therapist training. The implications of the research further evidence the importance of the therapeutic alliance (Bachelor, 2013). Jahnke et al. (2023) recommended therapists must monitor the reactions of their clients and bring more understanding to clients about breaching confidentiality through reporting obligations which may differ globally. By understanding these dynamics, therapists can be more mindful of the barriers and motivations their clients may have regarding disclosure to provide more effective support.

Christofferson (2019) similarly found that reporting information could act as a barrier, with 14% of therapists considering reporting clients who disclosed minor attraction. The study, conducted in New Zealand, involved 112 qualified health professionals using an anonymous online self-report survey. The findings indicated that health professionals felt confident in managing a client seeking help for sexual attraction towards children. Participants rated their knowledge of legal and ethical aspects as adequate, but there were inaccuracies in their understanding of disclosure thresholds. Although the sample was predominantly female (81%) and included a mix of medical and psychological professionals, the researcher found no differences in bias related to age or profession. These findings highlight the need for targeted training to improve knowledge and ensure clear, accessible service guidelines regarding reporting obligations.

Other factors, such as gender, may influence the therapeutic relationship and how therapists perceive their roles. Working with sex offenders is particularly challenging, as therapists often experience loneliness from hiding their roles and vicarious trauma responses due to exposure to abuse experiences (Way et al., 2007). This can negatively impact therapists' mental and physical health (Friedrich & Leiper, 2006).

Therapists may feel anxious, confused, helpless, angry, or protective, which can lead to avoiding difficult discussions about sexual issues. These reactions should be addressed through personal therapy, supervision, and training to ensure therapists can effectively support their clients (Chassman et al., 2010).

In counselling psychology, acknowledging the 'felt sense' during therapy and bringing awareness to the therapist's reactions is essential for enabling therapeutic understanding and movement (Gendlin, 2012). Self-awareness in therapy can allow therapists to understand their responses, become more aware of emotional responses, and become more attuned to a client's needs. For example, if a therapist experiences discomfort in a session this may be worth discussing with the client as it may be the client is experiencing a similar feeling, and this may be related to disclosure.

Qualitative research by Elias and Haj-Yahia (2019) explored the intrapersonal consequences therapists face when treating sex offenders and how they cope. The study highlighted impacts on intimate and parenting relationships, attitudes toward others, perceived quality of life loss, and some positive outcomes. This research was underpinned by Lazarus and Folkman's (1984) Transactional Theory of Stress and Coping, which views stress and coping as a cognitive appraisal process. Research also suggests positive experiences in working with sex offenders. Scheela (2001) and Elias and Haj-Yahia (2017) found significant levels of compassion satisfaction among therapists. However, it remains unclear how

therapists experience compassion satisfaction or coping strategies when working with Non-Offending MAPs.

#### ***2.4.6. Therapist Coping and Resilience***

Professionals working with sexual offenders require heightened self-care due to the risk of burnout, compassion fatigue, and vicarious trauma (Hardeberg-Bach & Demuth, 2018; Levenson, 2014). Tyagi (2006) suggests that empathy may be diminished because of negative countertransference responses to clients, necessitating increased supervision to foster resilience. Resilient therapists are better equipped to work with this group, implementing coping strategies to prevent burnout and maintain low levels of stress (Elias & Haj-Yahia, 2017; Evans et al., 2019).

Farrenkopf (1992) surveyed therapists working with sexual offenders and found that some needed to change roles or became burnt out. Therapists who continued working with this client group employed coping strategies such as minimizing their caseloads. Similarly, Woodward et al. (2006) suggest that Non-Offending MAP therapists may limit the number of clients to prevent burnout and feeling overwhelmed, as clients tend to have better therapy outcomes when caseloads are low.

Despite the potential for vicarious trauma from exposure to traumatic narratives (Levenson, 2014), some therapists experience elevated levels of compassion fulfilment (Scheela, 2001). The literature indicates mixed experiences for Non-Offending MAP clients, with both positive (Cacciatori & Xuereb, 2017; Cash, 2016; Houtepen et al., 2016) and negative (Cash, 2016; Levenson & Grady, 2019) outcomes reported. Discussing Non-Offending MAPs sexual preferences may require increased resilience, as Levenson and Grady (2019) acknowledge that many therapists feel repulsion, anxiety, and disbelief around 'paedophilia,' which can lead to rejection of this group.

Dreier and Wright's (2011) qualitative research explored the impact of counselling sex offenders on counsellors' wellbeing. Semi-structured interviews with five counsellors revealed both positive and negative themes, including feelings of competence, support from co-workers and supervision, belief in safety, experiencing intrusive thoughts related to traumatic material, feeling suspicious of others, and feeling disconnected. The research suggested that working with sex offenders might instil a sense of pride in therapists as they contribute to community safety. Therapists working with Non-Offending MAPs might hold similar beliefs. Dreier and Wright (2011) also identified that feeling competent and supported in supervision were positive experiences, but exposure to traumatic information led to intrusive thoughts, societal disconnection, and burnout.

Effective therapeutic relationships require a strong therapeutic alliance, cohesion, empathy, and collaboration between therapist and client (Norcross & Wampold, 2011). A non-judgemental attitude must underpin this relationship, as aversive responses can damage the foundation of therapy (Jahnke et al., 2015b). Therapists may struggle with the complexities of working with this group and must adapt to the client's needs, incorporating cultural identity and differences.

Therapists' coping strategies include conversations with colleagues, supervision, training, and monitoring well-being (Chassman et al., 2010). Research with a sample of 18 American and Australian therapists working with adolescents with sexual behaviours identified themes around counsellors' feelings about sexual information, their sexual abuse history, responses to clients, and the need for self-awareness and self-care. Therapists with sexual abuse histories may have different perspectives. The study emphasised the importance of listening to recounts of sexual deviant experiences and managing emotional immunity to trauma stories. Supervision, ethical and legal concerns, self-reflection, and self-care are essential for those working with adolescent Non-Offending MAPs.

Maladaptive coping strategies due to the therapeutic heaviness have also been identified. Elias and Haj (2016) highlighted that therapists using defense mechanisms, avoidance, denial, emotional detachment, and fragmentation (Farrenkopf, 1992) might distance themselves from their emotions. Sandhu et al. (2012) noted that humour could help manage negative emotions. Resilient therapists who employ adaptive coping mechanisms, such as personal therapy, exercise, and self-care, maybe more empathetic.

Therapists may also face mismatches in coping styles with clients. Lievesley et al. (2023) used data from an online forum project exploring help-seeking behaviours and motivations. The sample of 150 participants completed measures on treatment priorities and psychological measures (mental well-being, coping styles, hope, self-compassion, and perceived stigma). Correlational analyses found that higher levels of avoidance emotional coping were associated with higher levels of thought suppression. Professionals' focus was on treatment outcomes, while Non-Offending MAPs concentrate on mental health issues related to societal stigma. The research highlighted the importance of considering individual coping styles in therapy. Therapy for Non-Offending MAPs should address societal stigma and manage conflicts in social relationships, tailored to their reliance on social support.

### **2.5 Literature Theme- Video Training Interventions as Ways of Improving Therapy for Non-Offending MAPs**

Therapy interventions for adolescent Non-Offending MAPs are not extensively researched, leading to limitations in understanding their effectiveness. There is an abundance of literature which informs the use of training interventions as a way of improving therapy outcomes. Waqas et al. (2020) conducted a systematic review of interventions aimed at reducing stigma towards mental illness. They found approaches, including psychoeducation, case vignettes, contact-based interventions, and bespoke multimodal stigma reduction

strategies, were effective in reducing both public and self-stigma. However, more research is needed to understand the long-term effectiveness of these interventions.

Regarding Non-Offending MAPs, there is increasing evidence supporting the usefulness of interventions to inform therapists' work. Jackson et al. (2022) suggest that current therapeutic training courses framed by professional philosophies such as social work, clinical psychology, and counselling psychology offer inadequate educational experiential training in minor attraction and its relation to CSA. The research notes that only forensic curriculums offer relevant courses, typically from a risk reduction rather than a mental health support perspective.

Reducing stigma towards adolescent Non-Offending MAPs may then enable more access to therapy interventions and subsequently prevent child sex abuse. Training interventions are designed to reduce stigma and increase understanding of minor attraction. Exploring the literature, interventions appear to use combinations of approaches (education, humanisation /narrative and contact).

- Educational Interventions aim to provide factual information and clarify myths through lectures, presentations, printed material, and workshops, focusing on increasing knowledge and correcting misconceptions.
- Humanisation / Narrative Interventions use personal narratives to humanise individuals and their experiences. By focusing on their emotions, challenges, and strengths, these interventions aim to shift perceptions and reduce dehumanising attitudes. This helps create a more compassionate and understanding environment, reducing stigma and fostering empathy.
- Contact Interventions can involve direct contact or video contact involving direct interactions between the public and the stigmatised group. By facilitating personal

connections, these interventions aim to break down prejudices and build mutual respect.

### ***2.5.1 Narrative Humanisation Using Video Contact And Education***

Narrative humanisation has played a significant role in Non-Offending MAPs research, as seen in various studies (Boardman & Bartels, 2018; Lawrence & Willis, 2022 & 2023; Harper et al., 2018, 2021 & 2022; Jahnke et al., 2015a).

Lawrence and Willis (2022) compared two stigma-reducing interventions: a narrative video that humanised the experiences of a male attracted to children and an education-style video presenting factual information. They hypothesised that the narrative video would be more effective in reducing stigma. The study involved 694 participants recruited via an online survey, randomly assigned to one of the two groups. Baseline measures assessed attitudes towards people with sexual attraction towards minors, including affective reactions, social distancing, supportive attitudes, dangerousness perceptions, and deviance perceptions. Both interventions resulted in a small reduction in stigma attitudes. The psychoeducation intervention specifically reduced perceptions of dangerousness and increased understanding that sexual attraction is not a choice. However, participants still struggled with the concept that Non-Offending MAPs can control their attraction. The narrative video had a greater emotional impact on participants than the psychoeducation intervention, suggesting that personal lived experiences can be valuable in training interventions to change attitudes and increase therapist empathy. Lawrence and Willis (2022) noted that the distrust of the minor-attracted male in the humanising video may have contributed to participants experiencing the intervention as confrontational, reinforcing inherent societal stigma. The study's validity might have been affected by the use of an actor, potentially reducing the video's impact if

participants perceived it as dramatized. Using a real Non-Offending MAP could have increased the ecological validity of the intervention.

Supporting ecological validity of the intervention Harper et al. (2018) used footage from a real Non-Offending MAPs in their study, which explored stigma and attitudes through a narrative humanisation intervention compared to an expert intervention. They found that both interventions reduced self-reported stigmatising attitudes, but the narrative intervention notably reduced stigma at an implicit unconscious level. This finding has significant implications for stigma training interventions for therapists, suggesting that personal lived experiences can be more effective in changing attitudes and increasing empathy. Harper et al.'s (2018) research aligns with the 'Contact Hypothesis,' which suggests that interacting with a minority group can reduce stigma. According to Allport (1954), contact with diverse groups fosters positive attitudes towards those groups. This principle has effectively reduced stigma which is supported by the Moral Disengagement theory (Bandura et al., 1996), highlighting marginalised groups' dehumanisation and social distancing (Heron et al., 2021).

Harper et al. (2021) explored two interventions to see if they reduced stigma towards Non-Offending MAPs. Using a large longitudinal sample ( $N = 950$  initial sample;  $N = 539$  Follow up). Findings implied narrative humanisation (presented information from a lived perspective) had a positive effect on reducing stigma compared to the educational information which may have increased perceptions of deviance. Evidence supports longer-term positive outcomes, which were still present after four months. The findings suggested that both narrative humanisation and educational interventions can both be effective in reducing stigma. In this study, Dr. Cantor discussed the neurobiological underpinnings of paedophilia. The findings were mixed: while levels of perceived deviance increased following the intervention, there was a notable reduction in perceived dangerousness and

intention, which remained for four months after the intervention indicating some longevity of the intervention.

Harper et al. (2022) replicated their earlier work (Harper et al., 2018) using a larger sample ( $N = 539$  general public) with an equal gender sample. They used a longitudinal design over 4 months finding stigma was reduced in both conditions (narrative humanisation-using 5-minute video clips from the TV documentary -The Paedophile Next Door) and using expert Dr. James Cantor (information condition) talking about the neurobiological basis of minor attraction as a sexual orientation to understand Non-Offending MAPs as a sexual orientation and highlight a further need for them to be able to access support services. Participants completed the ATS-21 (Attitude to Sex Offenders Scale), the 30-item Stigma and Punitive Scale (SPS) developed by Imhoff in 2015, and Single-Target Implicit Association Tests (ST-IAT). However, they omitted baseline data, which meant comparisons could not be made. The researchers appear to frame the study from a forensic risk-focused perspective. There is mixed evidence regarding differences between forensic therapists and other sexology-trained professionals. Cantor (2014) suggests that sexology-trained professionals may focus more on the presenting issue, while forensic therapists may concentrate on risk. It is also recommended that forensic therapists, due to their greater exposure to sexual offending, may have reduced stigma towards Non-Offending MAPs (Bandura et al., 2018) and be more readily able to offer therapy. The SPS scale is a self-report measure which has been widely used to measure stereotypes and affective responses (Harper et al., 2022; Harper et al., 2018; Heron et al., 2021; Imhoff, 2015; Imhoff & Jahnke, 2018). Although stigma was reduced, the research did not reveal differences in participants' perceptions of Non-Offending MAPs' ability to refrain from acting on their attraction. The research did show that both narrative and educational interventions had a comparable impact on stigma reduction.

Boardman and Bartel's (2018) experimental research explored video stimulus ( $N = 89$ ) using control vs video condition (Offending or Non-Offending MAP). Participants watched two short video interventions (Older male, 47 years old, and younger male, 15 years old). In the control offending condition, the video was focused on an offending male. The study measured self-reported judgements about the male in the video and attitudes as to whether participants would differ in how they judged the offending paedophile compared to the Non-Offending MAP. They also compared adolescent and older Non-Offending MAPs to see if adolescents were judged less harshly. The intervention used the same 30-second video extract from 'Project Dunkelfeld', which was a television advert encouraging Non-Offending MAPs to reach out for support. Similar to previous studies, they used male actors to create the conditions, using identical scripts. The actors' faces were pixelated. Measures used in the study were SPS- 30 item scale (Imhoff, 2015) measuring stigma ATS-21 item (Hogue & Harper, 2018) to measure attitudes towards sexual offenders by using a newly created Judgement Questionnaire, an 11-item questionnaire measured perception of the male in the video. Findings partially supported that Non-Offending MAPs were judged less deserving of punishment than offending MAPs. This may have been attributed to the humanising video clips, which may have been effective in the reduction of stigmatising attitudes. However, it cannot be confirmed whether the video intervention reduced stigma towards Non-Offending MAPs as no baseline measures were recorded.

Boardman and Bartels (2018) also emphasised the importance of humanising individuals with minor attractions to combat stigma. However, it is important to note that much of this research has involved student samples of unqualified professionals whose experiences may differ significantly from those of trained therapists like Lasher and Stinson (2017) suggest a reluctance to work with this group due to a lack of knowledge. This highlights a need for further research involving trained therapists. Addressing these gaps

could help develop more effective, empathetic, and stigma-reducing interventions for Non-Offending MAPs.

Lawrence and Willis (2023) mixed-method approach used content and thematic analysis to explore the cognitive and emotional impact of interventions to reduce the stigma of Non-Offending MAPs using a previous video intervention (see above Lawrence & Willis, 2022). A sample of  $N = 460$  New Zealand participants explored using an online survey, answering questions on whether the video challenged their views on minor attraction (Cognitive) or elicited an emotional impact (Affective). Nine themes emphasised positive and negative views and emotional responses. Notably, these findings contrasted with Lawrence and Willis (2024), which reported no significant changes in participant attitudes, whereas the 2023 study suggested a positive shift in perceptions.

The content analysis noted that the emotional effect was similar in the humanising condition, but the informative conditions noted increased negative emotional reactions. However, there was no context around this. The authors address the limitations of bias, sample demographics of mainly higher educated females from New Zealand, data may be skewed to positive answers as the views were not discussed about why they had not changed. The research highlighted a need to consider interventions for cognitive bias due to the apparent cognitive and emotional disconnect and a need for combined interventions.

Heron et al. (2021) pilot training intervention underpinned by the Contact hypothesis appears to be the first study to explore whether contact directly with a Non-Offending MAP would reduce stigma. The research used mixed methods, qualitative and quantitative, to strengthen the evidence by allowing a richer, deeper experience. The study explored explicit punitive attitudes towards people with Paedophilia. The intervention was delivered via a 45-minute PowerPoint lecture with a 50-minute face-to-face presentation with a Non-Offending MAPs exploring childhood, sexual attraction onset and conflicts of identity and coping

mechanisms, followed by a question-and-answer session. Both pre- and post-measures were used (Stigma and Punitive Attitudes Towards Paedophiles Scale) (Imhoff, 2015) and self-evaluation. The intervention included both theory and psychoeducation around the difference between child sex offending and Non-Offending MAPs. The evaluation used a thematic analysis and an inductive approach. Findings suggested meeting a Non-Offending MAP was a positive experience, the topic was of interest, and there appeared to be a degree of humanisation of Non-Offending MAPs, with some participants seeing Non-Offending MAPs as normal people, and some people were able to perceive a less stigmatising perspective. Heron et al. (2021) found that students tended to hold punitive attitudes towards Non-Offending MAPs. As the intervention elements were combined it is not sure what element was the agent of change. While it may have been a combination of factors, the effect could also relate to the length of the intervention or the inclusion of direct contact with someone with lived experience.

There may have been sampling bias as inexperienced psychology students will lack knowledge and experience in working with Non-Offending MAPs in line with how Chronos and Jahnke (2024) suggest inexperienced students/trainees may lack training and focus on the attraction. As research demonstrates therapist effectiveness for newly qualified psychologists emphasising a relationship between experience and client outcome (Beutler, 2004). Subsequently, this may lead to therapists avoiding this group if they do not feel knowledgeable about Non-Offending MAPs. As Harper et al. (2022) highlight, stigma can be reduced by coming into contact with a minority group such as Non-Offending MAPs. It may be that if the intervention involves lived experience with a Non-Offending MAPs this may further reduce stigma bias.

Levenson and Grady's (2019) pilot project evaluated a short training workshop and highlighted the importance of including counselling therapy in pre-emptive efforts to prevent

sexual abuse. The findings suggested that even a brief training intervention could significantly increase professional self-reported knowledge about Non-Offending MAPs and support therapists' perceived competence in working with this group. While the study noted a greater knowledge change than attitude, it still indicated improved self-reported competency in working with Non-Offending MAPs. This outcome might be influenced by the participants' lower baseline negative attitudes towards paedophilic sexual interests and fewer stereotypical assumptions.

Jahnke et al. (2014) demonstrated that short interventions can effectively reduce stigma. They developed a 10-minute online anti-stigma video intervention focusing on paedophilia, using education and a Non-Offending MAPs story to decrease stigma and promote collaboration with this client group. The study involved a large sample ( $N = 134$ ), primarily female participants aged 24-53, who completed pre- and post-tests using the Stigma Inventory and Therapy Motivation scales. The video intervention included extracts from an Austrian documentary where an individual discussed their sexual attraction to children, mental health concerns, and therapy. The intervention group showed significant reductions in stereotypes about controllability and dangerousness, affective reactions, and social distance, although the motivation to work with this group remained unchanged.

Jahnke et al. (2015a) researched two anti-stigma video interventions (Psychoeducation vs. Narrative Humanisation). Participants were shown one of the two videos to challenge stigma-related attitudes. The psychoeducation video provided scientific information to address stereotypes and discussed the negative impacts and social benefits of a supportive service. The narrative video presented the life experiences of a New Zealand male actor with a sexual interest towards children, emphasising the need for support services. It is unclear if participants knew the person in the narrative video was an actor, which may have introduced bias in the intervention's internal validity. Both videos used the same actor, and

there were differences in length (12.17 minutes for the narrative condition vs. 8.46 minutes for the psychoeducation condition). Results showed that both conditions prompted participants to question their beliefs, challenged the stereotype conflating sexual interest and behaviour, and reduced stigma measures, except for perceived stigma controllability, suggesting the intervention may not be effective in changing perceptions that individuals can control their sexual interests. The sample consisted of the general population, so the findings may not be generalisable to professionals working in the field of minor attraction, and the real-world effectiveness is unknown. The study highlighted the need for supportive services for Non-Offending MAPs and suggested that findings could inform future training interventions.

Levenson and Grady (2019) emphasised that professionals working with this population should recognise the significance of both prevention and client well-being. Their research, conducted via online support forums for individuals with attraction to children, used descriptive analyses with a predominantly male sample to understand informal and formal help-seeking experiences, barriers to help-seeking, and treatment perspectives from both offending and Non-Offending MAPs. One limitation of descriptive analysis is its lack of depth and potential influence from survey questions, as it does not test a hypothesis. Although descriptive analysis enables the exploration of patterns and understanding of past behaviour, its recommendations are often limited without further analysis. Additionally, sporadic missing data from the survey may introduce bias.

Levenson and Grady (2019) and Jahnke et al. (2014) emphasised that short interventions can be cost-effective and beneficial in reducing stigma. Jahnke et al. (2014) observed changes in affective responses, such as anger and sympathy, and reduced social distance towards the person in the intervention. However, the sample consisted

predominantly of female Trainee CBT Psychotherapists in Germany, and the follow-up assessment occurred later, which could influence the results.

Both Jahnke et al. (2015b) and Jara and Jeglic (2021) incorporated the use of video and psychoeducational content in their studies. Jara and Jeglic (2021) specifically explored public attitudes towards Non-Offending MAPs through an intervention involving psychoeducational reading materials about minor attraction myths and facts. The aim was to ascertain if attitudes towards Non-Offending MAPs would be negative among participants in the psychoeducational intervention group. The participants were crowdsourced, consisting of 205 individuals (133 males and 70 females) aged between 18 and 69 years old. The psychoeducation text highlighted misconceptions surrounding minor attraction and was developed following an extensive literature review. It included statistics and research findings related to minor attraction. While the intervention led to negative attitude associations, it is also noted that training interventions could inadvertently reinforce stigma. Jara and Jeglic (2021) acknowledged that their psychoeducation intervention might have reinforced stigma myths around minor attraction. This concern is supported by Glina et al.'s (2022) systematic review, which collated studies on myths surrounding paedophilia and child sexual abuse (CSA). Glina et al. (2022) found increased negative attitudes towards Non-Offending MAPs, who were perceived as more of a threat than individuals with antisocial personality disorder, despite having no criminal activity.

Efforts to reduce stigma toward Non-Offending MAPs have focused on educational and training-based interventions across clinical and public populations. Christophersen and Brotto (2024) conducted a meta-analysis examining the effectiveness of educational interventions in reducing stigmatisation among mental health professionals towards individuals with paedophilic interests. Their findings highlight persistent negative attitudes within clinical settings and emphasise the potential of targeted education to foster more

compassionate, evidence-informed practice. Notably, the review emphasises the scarcity of robust empirical studies, particularly those involving adolescent Non-Offending MAPs, pointing to ethical and methodological barriers that limit research in this area.

Complementing these findings McKillop and Price (2023) replicated and expanded on Jara and Jeglic's (2021) earlier work, using a randomised controlled design to assess the impact of public anti-stigma interventions. They found that educational messages, whether delivered via text or video, significantly reduced negative attitudes across various conditions. Their results highlight the potential for public-facing interventions to promote healthier social environments and lessen barriers to seeking help. However, despite these promising outcomes, both studies emphasise the enduring nature of stigma and call for more nuanced, developmentally appropriate approaches, particularly in contexts involving adolescents, where ethical sensitivities and limited empirical access continue to pose challenges.

Beyond formal training, therapists' emotional responses and implicit biases notably influence engagement with Non-Offending MAPs. Research shows that feelings of discomfort, moral judgement, or fear of reputational damage can lead to clinical gatekeeping where practitioners avoid, refer out, or subtly disengage from MAP clients (e.g., Levenson & Grady, 2019). These emotional barriers can be especially prominent when working with adolescents, due to increased societal sensitivities and the clinician's dual role in safeguarding and therapeutic care. The limited research on adolescent Non-Offending MAPs further worsens this issue, leaving practitioners with few empirically grounded frameworks for ethical and compassionate responses. Addressing therapists' emotions through supervision, reflexivity, and values-based training may be vital in reducing therapeutic avoidance and fostering trust within this highly stigmatised group.

The reviewed literature highlights the ongoing stigma, the limited research focused on adolescents, and the wide differences in responses to Non-Offending MAPs. While

educational interventions show promise in reducing bias (Christophersen & Brotto, 2024; McKillop & Price, 2023), therapist affect and clinical gatekeeping continue to hinder engagement, especially in adolescent settings where ethical tensions are higher and empirical guidance is scarce. These gaps emphasise the need for research that extends beyond attitudinal measures to explore how therapists understand and manage therapeutic relationships with Non-Offending MAPs.

### ***2.5.2 Effectiveness of Interventions in Reducing Stigma***

There appears no consensus regarding the methodology of the design aside from using self-reported measures, and most studies have combined strategies and variability in the intentions. Jahnke et al. (2014) highlighted that combining narrative and educational strategies can effectively address stigma across multiple dimensions. There is little known about the long-term impact of interventions aside from Harper (2021, 2022), which showed both narrative and educational interventions noted stigma reduction for four months. Training workshops enhanced therapist knowledge but less effectively influenced attitudes (Levenson & Grady, 2019):

Jahnke et al. (2014) found that a 10-minute educational video intervention featuring Non-Offending MAPs experiences increased professionals' empathy towards Non-Offending MAPs and their ability to work therapeutically with them. Consistent findings across various studies (Boardman & Bartels, 2018; Harper et al., 2021; Jahnke et al., 2015a; Levenson & Grady, 2019) indicate that video interventions improve stigma reduction.

## **2.6 Summary and Rationale of the Present Study**

Current literature has extensively examined how adult Non-Offending MAPs experience stigma and ongoing difficulties related to their sexual attraction towards children (Elchuk et al., 2021; Jahnke et al., 2015a; Levenson & Grady, 2019). Most research is based

on qualitative samples from forensic populations (Seto & Eke, 2017) and online self-selecting participants from forums, exploring male experiences. Studies have drawn from both community (Cacciatori, 2017; Houtepen et al., 2016; Stephens & McPhail, 2023) and forensic populations (Drapeau et al., 2004; Seto & Eke, 2017), potentially introducing sampling bias. Although these studies provide a comprehensive understanding of how societal perceptions impact adult Non-Offending MAPs, their findings may not fully capture the diversity of experiences across age, gender, cultural contexts, and those who do not engage with online communities.

However, there is a notable lack of research exploring the therapeutic experiences and challenges faced by adolescent Non-Offending MAPs.

There was also confusion regarding what constitutes CSA, such as activities like spending time with a child, hugging, and contact (McCartan, 2010). Imhoff (2015) suggested that participants often connected CSA with paedophilia. Landgren et al. (2022) indicated that there might be misunderstandings about best therapeutic practices. In relation to the present study, these confusions could be addressed in training workshops.

This gap in the literature highlights the need for further investigation into this specific population particularly regarding therapists' experiences working with this group. Research highlights adolescence as the age when sexual attraction first becomes apparent (B4U-ACT, 2011a). As sexual attraction is believed to be static throughout the lifespan, adolescents seeking support often face challenges navigating systems that require parental consent, exacerbated by therapeutic stigma bias. This may result in rejection due to their age or attraction.

### ***2.6.1 Need for Mixed Methods Study***

There is a paucity of mixed-methodology research addressing adolescent Non-Offending MAPs, particularly studies that integrate both attitudinal data and experiences. The

existing literature tends to focus on either quantitative assessment of stigma or qualitative explorations of therapeutic engagement, with few studies bridging these two domains. This methodological gap may limit our understanding of how societal perceptions intersect with clinical realities, particularly in relation to therapeutic bias, resilience, ethical framing, and practitioner meaning making. The current study addresses this gap by employing a sequential mixed-methods design, capturing both lay attitudes and professional experiences to inform a more nuanced, multilevel understanding of stigma in line with Henderson et al. (2014) theory and current therapeutic practice.

Therapy interventions for Non-Offending MAPs are not extensively researched. This thesis acknowledges the need for future research focusing on female Non-Offending MAPs but will concentrate on male adolescent Non-Offending MAPs due to the difficulty in obtaining training material for the female population. To date, little research has focused on adolescent Non-Offending MAPs, as most studies have included participants over 18 years old. The NHS's five-year forward long-term plan for children and young people's services, supporting transitions up to the age of twenty-five, emphasises the importance of supporting adolescents, especially during the 16-18 age range when mental health issues may be exacerbated.

Research indicates that therapists may lack knowledge of working with Non-Offending MAPs, often focusing from a risk perspective, which can lead to therapeutic bias. Jackson et al. (2022) found existing therapist training inadequate for addressing minor attraction. Forensic curriculums focused on risk rather than mental health support (Jackson et al., 2022). Trained therapists may have more positive attitudes, set aside their biases, and display empathy more readily than those without specific training (Marshall et al., 2003). In counselling psychology practice, it is essential to be inclusive and provide appropriate counselling to marginalised groups, such as Non-Offending MAPs.

Therapists must be aware of their own incongruence and unconscious dynamics in therapy to contain the client's discrimination and felt stigma without disgust or rejection. According to the HCPC (2023) standards of proficiency, Counselling Psychologists should critically reflect on their practice to enhance their practice. However, some Counselling Psychologists may avoid working with Non-Offending MAPs due to a lack of training and support, which can increase stigmatisation.

Further research is needed to understand the long-term efficacy of interventions to reduce bias/stigma, as there is no longitudinal data available. Different intervention delivery methods, such as video education and lived experiences in lectures, highlight the need for varied approaches. Lievesley et al. (2022) emphasised the ongoing need for professional training and identified gaps in service provisions for minor attraction.

Jahnke et al. (2014) suggest using video extracts from individuals with lived experiences of minor attraction to improve real-world validity. Combining psychoeducation and narrative conditions may be more beneficial in the present study, using a population of therapists. Using non-actors and videos of similar lengths would improve the internal validity of the intervention.

## **2.7 Research Question and Aims**

The literature review directly informs the two research questions. First, empirical studies on therapist attitudes toward MAPs (e.g., Jahnke et al., 2015; McKillop & Price, 2023) and emerging training interventions (Christophersen & Brotto, 2024) highlight the potential for education to reduce therapeutic stigma bias, directly informing the question: Will a training intervention using a real Adolescent Non-Offending MAPs narrative reduce therapeutic stigma bias?

Whilst attitudinal change appears possible, the literature also reveals a gap in understanding how therapists develop their own relational competence with adolescent Non-

Offending MAPs. Secondly, the theoretical framework, including minority stress, labelling theory, and stigma by association, alongside findings on therapist affect, gatekeeping, and developmental sensitivity of adolescence, informs the question: How do therapists understand and manage therapeutic relationships with adolescent Non-Offending MAPs?

The literature points to significant gaps in adolescent-specific guidance, ethical clarity, and relational practice, underpinning the need for qualitative exploration into how therapists navigate therapeutic engagement with adolescent Non-Offending MAPs. Together, these strands justify a mixed-methods approach that examines both the impact of training and the lived complexity of therapeutic work with adolescent Non-Offending MAPs.

Therefore, the thesis investigates how stigma, training, and emotional reactions influence the therapeutic alliance and clinical decisions, particularly in adolescent contexts. The research questions together aim to explore how a training intervention may reduce therapeutic bias and if this manifests in the practice of professionals working with adolescent Non-Offending MAPs. This would help to support further training and identify opportunities for more inclusive, developmentally appropriate therapeutic approaches.

In relation to the present study, it would be useful to understand how professionals work with adolescent Non-Offending MAPs in therapy and if a training intervention using contact with real adolescent Non-Offending MAPs can be a way of reducing stigma.

## Chapter Three: Mixed Methodology

### 3.1 Chapter Overview

This chapter provides an overview of the methodological framework used in the present study. It outlines the rationale for adopting a mixed methodology alongside the theoretical underpinnings. The methodology for the quantitative and qualitative empirical studies will be addressed individually in Chapters Four and Five.

### 3.2 Research Design

This study uses a Transformative Explanatory Sequential Mixed methodology (Cresswell, 2014), which uses two distinct phases. The first phase (quantitative) (see Chapter Four) informs the second phase (qualitative) (see Chapter Five), followed by interpretation as depicted in Figure 2.

#### Figure 2

*Explanatory Sequential Mixed Methods (adapted from Cresswell, 2014, p. 220)*



The quantitative approach initially gathered experimental data on whether there were differences in pre- and post-stigma scores following a training intervention manipulation. Then, the qualitative approach was selected to bring depth to the research scarcity and give insight into participants' lived experiences. The results of both parts are integrated into an overall discussion.

### 3.3 Methodological Rationale

A mixed methods study examines both the measurable effects of the training intervention and the experiences of therapeutic engagement with adolescent Non-Offending MAPs. Quantitative data assesses whether a contact-based intervention can reduce therapeutic bias and stigma among support professionals by increasing knowledge for working therapeutically with Non-Offending MAPs. Meanwhile, qualitative data provides insights into how therapists interpret their work with adolescent Non-Offending MAPs. The two approaches inform each other, as increased knowledge of therapeutic practices with Non-Offending MAPs, achieved through attitude changes via training, may influence future relational practice. Exploring therapists' experiences also highlights how they navigate therapeutic bias, resilience, empathy, and perceptions, including any negative attitudes towards Non-Offending MAPs. This could help more adolescent Non-Offending MAPs access specialised counselling services.

The quantitative study recruited participants from an undergraduate population, aiming to engage individuals who may lack professional experience or formal training, in order to capture attitudes and reactions uninfluenced by clinical exposure, thereby providing insight into broader societal perceptions. As Chronos and Jahnke (2024) suggest inexperienced students may lack training and focus on the attraction. and avoid this group if they do not feel knowledgeable about Non-Offending MAPs.

Interview questions in the qualitative phase were informed by findings from the quantitative study, a literature review, and observations in guest lectures. In contrast, the second study focused on professionals working with adolescent Non-Offending MAPs, aiming to explore their lived experiences and therapeutic perspectives.

A Transformative Mixed Methods Approach aligns with the underpinning philosophy of counselling psychology. This recognises the philosophical paradigm a transformative

worldview maintains regarding political change to confront social injustice of marginalised groups, such as Non-Offending MAPs by collaboration and being change-orientated. (Creswell, 2014; Mertens, 2010). A mixed-method approach recognises the importance of an integrative approach to include subjective experiences alongside the scientific rigour of data (Plano-Clark et al., 2010). There is limited research which uses a mixed-method approach to provide an in-depth exploration of experiences of working in therapy with adolescent Non-Offending MAPs, which could subsequently inform a training intervention.

Johnson and Onweuegbuzie (2004) suggest a mixed-method approach involves synthesising two forms of data to connect the data. This enables further understanding of a research problem (Creswell, 2014) with the rationale that both separate methods of quantitative and qualitative are adequate, but when combined, the analysis is enhanced (Greene et al., 1989) increasing validity and reliability. In qualitative research, a researcher develops understanding through understanding and interpretation of participants' perceptions and values of their worlds and can be positioned from the researchers' own values and underpinning philosophy and allows for the research to be centred around the participant (Jamieson et al., 2022). The interpretivist/constructivist approach posits that understanding can only be achieved through individual perspectives, with values and meanings being socially constructed (Pervin & Mokhtar, 2022). From a relativist standpoint, there is a belief in the existence of multiple realities (Hudson & Ozanne, 1988).

Conversely, quantitative research adopts a value-free position, exploring a Positivist position from a realist perspective that relies on statistical data and explores relationships, variables, and objective measurements (Bryman, 2006). This can often be perceived as more detached from the reflexivity that qualitative research assumes. However, there is room for reflexivity in all research (Jamieson et al., 2022).

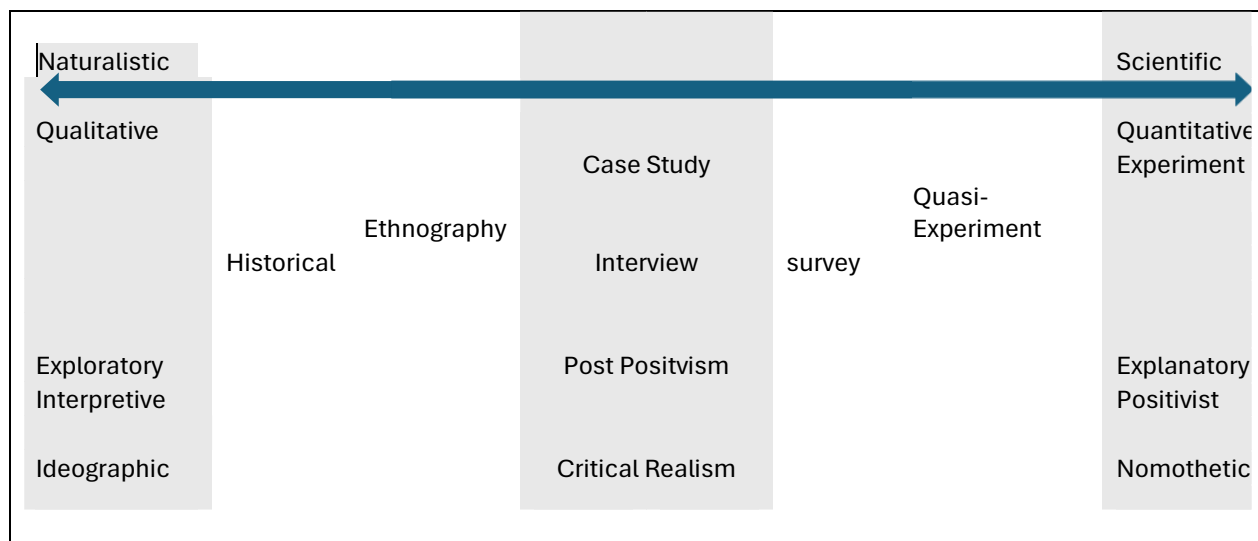
In relation to Non-Offending MAPs, this suggests that stigma is constructed through social interactions and cultural norms. Exploration of experiences can support an understanding of how this can differ widely and how there is no universal truth, allowing for a more nuanced understanding. Combining approaches can help understand the challenges faced by therapists and reduce the negative impact of stigma through interventions and training.

### ***3.3.1 Theoretical Standpoint- Critical Realism***

The methods selected are underpinned by theory and philosophy and, as Creswell and Poth (2017) suggest, influenced by the researcher's view on the axiology (nature of values), ontology (nature of reality) and epistemology (nature of knowledge) (Mertens & Wilson, 2012). A mixed methodology aligns with the researcher's philosophy as a Critical Realist. Critical Realism can be perceived as an all-encompassing philosophy as it assumes reality is multi-layered; the Real, the actual and the Empirical. It suggests that the world exists independently of our perceptions and there is a multidimensional system with underlying causal structures that may remain hidden until a particular experience reveals them (McEvoy & Richards, 2003). Critical Realism fits with the identity within the core of counselling psychology of understanding and welcoming 'the other' (Cooper, 2009) and wanting to highlight and challenge social inequalities Douglas et al. (2016). It aligns with the PTMF (Johnstone & Boyle, 2018), but also due to the limited amount of research in this area and the need to be flexible to understand research areas. Bisman (2010) suggests a complex research topic can be explored through frameworks of post-positivism and interpretivism by interlinking quantitative and qualitative data (see Figure 3). Poth and Munce (2020) suggest integrating and synthesising to enhance research.

**Figure 3**

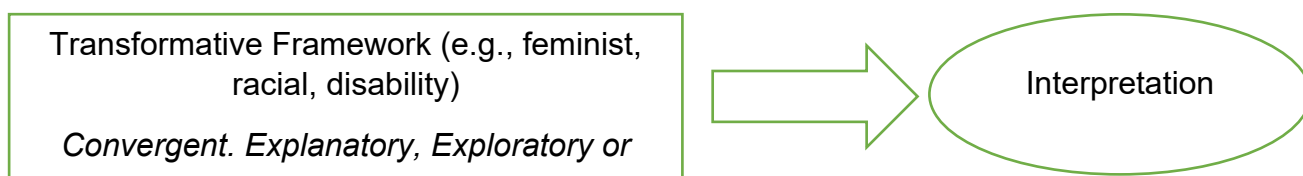
*Qualitative – Quantitative Research Continuum adapted from Bisman (2010)*



By adopting a mixed-method approach, the research avoids dichotomies and one-sided methods, thus sidestepping the “paradigm wars” (Feilzer, 2010, p.7) between post-positivism and interpretive research. A Critical Realism approach involves both theory and data, allowing the study to recognise the importance of both quantitative and qualitative methods, thereby providing balanced and informed results (Johnson & Onwuegbuzie, 2004). Critical Realism is often viewed as transformative because it challenges perceptions and advocates a deeper understanding of the world.

**Figure 4**

*Transformative Mixed Methods (adapted from Cresswell, 2014 pg. 221)*



The Transformative Mixed Method (see Figure 4) was selected as the research is framed by the social injustice in society and a shared sense of responsibility in the field of

counselling psychology to ensure therapy strives to recognise inequalities within marginalised groups (Mertens, 2020). Creswell (2014) highlights using a transformative framework, quantitative data is collected, analysed, and followed up with Qualitative data collection, analysis, and followed by interpretation. An important part of transformative mixed methods is an awareness of the power imbalance throughout the research process. Mertens (2020) suggests that, in research involving social justice issues it may be problematic for the researchers to align their values with the research method. The Transformative mixed methods approach is a framework focusing on ethics, power differences, and building trust, to impart social change. The research was underpinned by stigma theory to encapsulate the experiences that therapists working with marginalised adolescent Non-Offending MAPs encounter. The research comprehends the societal structures of stigma present in therapy and understands the individual phenomena and their impact and how this could be changed through interventions.

The Transformative mixed method approach has key assumptions knowledge is influenced by the world around us and reflects the societal positionality and knowledge is socially constructed to improve society (Sweetman et al., 2010). As an approach Mertens et al. (2020) suggest this would fit with a culturally diverse community. As the research focus surrounds Adolescent Non-Offending MAPs with the focus of the research to increase social equality in improving access to therapy through a training intervention, then, this approach was deemed appropriate to the research.

Furthermore, mixed methods can provide deeper insights than using a single approach. Research has debated the effectiveness of combining qualitative and quantitative methods. There are tensions between these approaches due to differences in their underpinning philosophical positions, with mixed methods not being perceived as a distinct unique methodology. Adopting a research paradigm as suggested by Alele and Malau-Aduli

(2023) (see Figure 5) bridges the divide between the quantitative and qualitative epistemologies of positivists and interpretivists (Howe, 1988; Onwuegbuzie & Johnson, 2004).

### Figure 5

*The Research Paradigm adapted from (Malau-Aduli & Alele, 2023)*



Methodology- The strategy and justification in constructing a specific type of knowledge.

Ontology- The nature of reality and of what really exists.

Axiology- What we value: the ultimate worth of research.

Epistemology -The relationship between the inquirer and what is known.

### 3.3.2 Philosophical Position

The research is grounded in a Critical Realist perspective, as articulated by Bhaskar (1979). This perspective is particularly relevant given the focus on stigma and a socially marginalised group. Critical Realism acknowledges that experiences of reality are unique and exist independently of our perceptions (Pilgrim, 2014). This reality can only be understood "imperfectly and probabilistically" (Guba & Lincoln, 2005, p.195). The research framework combines both humanistic and medicalised perspectives, reflecting the complexity of the

topic. The researcher adopts a solution-focused approach, emphasising interventions that can transform therapeutic practice. This is particularly relevant given that the therapeutic relationship is widely recognised as a key driver of change.

The researcher's epistemological stance is positioned between constructionist and realist perspectives. Constructionist perspectives assert that knowledge is socially constructed (Madill et al., 2000), while realist perspectives maintain that knowledge exists and can be understood through objective approaches.

### **3.3.3 *Ontology***

As a researcher, transparency throughout the research process is essential, including uncovering an epistemological stance and its relation to an ontological position.

Ontologically, this research aims to explore therapists' experiences with Adolescent Non-Offending MAPs. From a Critical Realist perspective, there is no single objective reality; instead, the research must also encompass a phenomenological interpretation from a subjective reality. Bhaskar highlights three ontological levels: the Empirical (observed or experienced), the Actual (not always observed), and the Real. Critical Realism is positioned between positivism and social constructionism (Clarke & Braun, 2017). Social constructionism suggests that participants' experiences of Non-Offending MAPs result from their interpretations based on their contextual world (Willig, 2013), but it does not consider influences beyond individual perception. Positivism, in contrast, largely focuses on epistemology. Although Critical Realism is often critiqued for being susceptible to bias, it is also recognised that personal values underpin all research (Guba & Lincoln, 2005).

This research fits within a Critical Realist paradigm. The three key concepts of Critical Realism of experiences, events, and causes align with how Non-Offending MAPs experience judgement, shame, and lack of access to therapy. Critical Realism includes more of what contributes to these experiences, such as therapeutic bias, lack of knowledge,

training, societal systems, and power. Critical Realism recognises that social structures and individual agency exist relationally. As a Counselling Psychologist, there is a need for a theoretical approach that allows for complexity to explore phenomena holistically.

### ***3.3.4 Epistemology***

This study utilises a mixed-method design that incorporates both post-positivist and interpretivist epistemologies. According to Bryman (2016), positivism posits that scientific inquiry can be conducted without bias, highlighting the significance of hypothesis testing through statistical analysis. The mixed-method approach is chosen to explore a therapeutic humanisation intervention to reduce therapeutic bias towards adolescent Non-Offending MAPs quantitatively, while also exploring therapist perceptions related to the therapy of adolescent Non-Offending MAPs.

The qualitative aspect is essential for capturing the depth of participant perspectives, which can be challenging to quantify (Bryman, 2006). Therefore, an interpretivist epistemology is employed to delve into the socially constructed meanings surrounding therapy experiences of working with Adolescent Non-Offending MAPs. This framework facilitates a comprehensive understanding of the social stigma faced by Non-Offending MAPs, aiming to enhance their access to therapeutic support and developing future pathways and policies.

### **3.4 Ethical Considerations – Respect, Competence, Responsibility and Integrity**

The research was ethically approved by the University of Wolverhampton Ethics Committee (See Appendix B) The research is underpinned by the ethical principles of respect, competence, integrity and responsibility were addressed by the BPS (2021) Code of Ethics and Conduct and HCPC (2016) Conduct and Ethics for students and HCPC (2023) Standards of Proficiency. Adhering to the BPS code of ethics (2021), all the interviews were

transcribed using a pseudonym to ensure participants' anonymity, and the study did not collect any identifiable information. The participants were informed during the research study the information will be collected, and the results will be presented and written up as part of a Doctorate dissertation which may be published or presented at a conference. The participants would not be identifiable in any report. All data was kept securely.

Ethical Competence in therapy ensures Counselling Psychologists act within their client's best interests to support practice standards, work within their competency limits and ensure ethical integrity is supported on a personal level. As a Trainee Counselling Psychologist, at times, supervision is used as a tool to advance clinical skills in assessing and developing complex formulations and using evidence-based interventions. During the research supervision has been used to maintain a high standard of research competence. Understanding meta competencies (Roth & Pilling, 2008) is useful for understanding psychological interventions and being able to adapt interventions to fit the client's needs and feedback and use this to grow research knowledge. Throughout the research, the principle of responsibility was observed during interviews. The researcher employed skills acquired from Doctorate training to maintain reflexivity on the real-world consequences of the research.

Clinical judgement was applied during interviews to ensure safe practice and prevent any harm to the participants. In the quantitative study, as the participants were reading, watching, and listening to audio of scenarios involving Non-Offending MAPs, they were clearly warned about this in the invitation and the information sheet prior to starting; they were cautioned not to take part if they were likely to be upset by this content. A participant could skip any questions they did not feel comfortable answering or withdraw without giving a reason. However, if a participant was upset by taking part in the study, there was information included in the participant information and debrief sheet which offered support

from a web-based charity. Throughout the research process, the researcher accessed personal therapy and received regular academic and clinical supervision to ensure they were adequately supported.

In the qualitative study, participants were clearly warned about the sensitive topic of Non-Offending MAPs in the invitation and information sheet prior to starting. They were cautioned not to participate if they were likely to be upset by the content. Participants were emailed the questions in advance of the interview to ensure they were fully informed and able to prepare. The researcher was mindful throughout the interviews to ensure participants were not distressed. The emotional well-being of therapist participants was assumed, as they were expected to participate in a manner comparable to their therapeutic practice, indicating they were emotionally well. This was further addressed at the end of each interview with a debrief, during which participants expressed no concerns and found the interview to be a helpful and supportive process.

During the analysis of the qualitative data, the researcher made efforts to bracket their own assumptions and maintained a reflective stance throughout the research process. This self-reflection was crucial in upholding the integrity principle. The researcher engaged in peer discussions and clinical supervision to identify and reflect on blind spots, biases, and emotional reactions. This approach allowed the researcher to manage their responses effectively, considering their roles as a researcher, trainee counselling psychologist, and parent, and to bracket their own emotional responses.

## **Chapter Four Quantitative Report - Exploring Therapeutic Bias Towards Non-Offending Minor Attracted People Using Online Humanisation Training**

### **4.1 Aim Of the Present Study**

The present study aimed to explore the effectiveness of a training intervention to reduce therapeutic bias/stigma to support professionals by increasing knowledge to working therapeutically with Non-Offending MAPs. This, in turn, could mean more adolescent Non-Offending MAPs gain access to specialist counselling services. This study highlights an original contribution to the field of Counselling Psychologists by bringing recognition to Non-Offending MAPs and potentially leading to increased therapy input following humanisation training which is preventative rather than reactive in reducing Non-Offending MAPs who may offend.

#### ***4.1.1 Rationale***

People with Paedophilic Sexual Interests, also referred to as MAPs, often prefer to be known as Non-Offending MAPs. These individuals are attracted towards children but suppress this attraction and do not commit criminal sexual offences.

#### ***4.1.2 Stigma and Dehumanisation***

It is not known who seeks psychological support due to stigma influenced by societal perceptions. Often perceived as 'Predatory Child Sex Offenders' this dehumanisation results in lower therapeutic alliances and unsuccessful therapeutic outcomes (Beech & Hamilton-Giachritsis, 2005). Stigma may be internalised by the individual and expressed through thought suppression- an avoidant coping mechanism. This process is associated with increased avoidance behaviours and diminished psychological well-being (Lievesley et al., 2020). Those Non-Offending MAPs who sought help found therapists made unjustified

assumptions in line with the DSM-5 diagnostics that Paedophilia is a ‘mental disorder’ and implied links to child sexual abuse (Feelgood & Hoyer, 2008).

#### ***4.1.3 Resilience, Empathy and Competence***

Professionals require increased self-care when working with sexual offences. Resilient therapists can work with this group and implement coping strategies to prevent burnout (Evans et al., 2019). Similarly, talking about Non-Offending MAP's sexual preferences may require increased resilience as Levenson et al. (2019) accept many therapists feel repulsion, anxiety, and disbelief around ‘paedophilia’ and reject this group. Effective therapeutic relationships require an alliance, cohesion, empathy and collaboration between therapist and client (Norcross & Wampold, 2011). To enable this relationship there must be a non-judgemental attitude towards the client. A negative attitude towards male Non-Offending MAPs may be a block towards empathy impeding the alliance (Blasko & Jeglic, 2016). If therapists display rejection, the client disengages (Yates, 2013), highlighting the importance of recognising therapist bias when working with Non-Offending MAPs.

#### ***4.1.4 The Research Question***

Will an online humanisation training intervention reduce Stigma (therapeutic bias) towards Non-Offending MAPs amongst those who work, or aspire to work, within psychological professions?

#### ***4.1.5 Expected Outcome***

Therapists who take part in humanisation training may be able to set aside their biases and display empathy more readily than those who have no training (Marshall, 2005). Harper et al. (2019) found a significant effect of narrative humanisation to positively change attitudes towards Non-Offending MAPs. Elias and Haj-Yahia (2016) found that participants who were able to perceive the person as ‘damaged’ could empathise and move forward in therapy.

The following hypotheses are proposed:

H1: Participants who participate in the humanisation training intervention will have significantly lower post-stigma scores (Cognitive Belief, Affective Reaction and Social Distancing) than those who do not complete the training intervention, accounting for Empathy and Resilience.

H2: The Participants who participate in the humanisation vignette intervention will have significantly lower post-stigma scores (Cognitive Belief, Affective Reaction and Social Distancing) than those who do not complete the training intervention, accounting for Empathy and Resilience.

## **4.2 Method**

### ***4.2.1 Research Design***

The mixed method approach explores therapeutic bias in relation to adolescent Non-Offending MAPs. The quantitative phase analysed data using a 2 (Condition: Humanisation Video Training Vs Control- between groups) X 2 (Client Type Vignette: Humanisation Adolescent Vs Non- humanised) X 2 (Time: Pre vs. Post stigma scores: within groups examining the three DVs Stigma Inventory Scale (SIS) factors: Cognitive Belief Stereotypes, Affective Reaction and Social Distancing). Additionally, the analysis included QCAE Total Empathy scores and CDRISC Total Resilience as fixed covariates. The methodological and theoretical underpinnings of quantitative research are discussed in Chapter Three.

### ***4.2.2 Sampling and Participants***

A priori power analysis using G\*Power version 3.1.9.7 (Faul et al., 2009) to determine the minimum sample size to test the study hypotheses indicated that the required sample size to achieve a 95% power to find a medium effect size when using an alpha of  $p < .05$ . was  $N = 279$  for MANOVA (Faul at al., 2009). Thus, 300 Participants were sought using

a non-probability sample using Convenience Sampling; participants were self-selected on their willingness and availability to take part. Those working within or aspiring to work in psychological professions in the UK were recruited using University of Wolverhampton Participant Pool and Psychology Students and from adverts distributed via social media inviting participants to sign up for the online research using Qualtrics. A total of 140 participants were recruited. After checking for missing data, 49 participants were removed due to missing or incomplete data or withdrawing from the study part-way, and outliers were removed from the dataset, leaving 92 participants. The 92 participants (17 male, 74 female, 1 non-binary) ranged in age from 18 to 51 years ( $M = 28.57$  years,  $SD = 8.36$ ). The sample characteristics consisted of psychology status, age, ethnicity, qualifications, and gender (see Table 1, 2 & 3).

**Table 1***Demographics By Group*

Sample Characteristics	Control ( <i>n</i> = 44)	Training ( <i>n</i> = 48)
Age	28.02 ( <i>M</i> ) 8.19 ( <i>SD</i> )	28.02 ( <i>M</i> ) 8.57 ( <i>SD</i> )
Gender		
Male	7	10
Female	36	38
Non-Binary	1	0
Parental Carer		
Yes	12	16
No	32	32
Ethnicity		
White	32	40
Black	3	2
Asian	6	4
Mixed Asian	1	0
Mixed Other	2	1
No Answer	0	1

**Table 2***Therapy/ Education Characteristics by Group*

Sample Characteristics	Control ( <i>n</i> = 44)	Training ( <i>n</i> = 48)
<b>Psychology Status</b>		
Undergraduate	30	36
Postgraduate	1	2
Counsellor	2	3
Psychotherapist	1	0
Trainee Psychologist	6	6
Qualified Psychologist	2	0
Not Answered	1	0
Assistant Psychologist	1	1
<b>Highest Educational Level</b>		
CSE, GCSEs	7	1
AS Levels	0	2
A Levels	14	19
L5 Diploma	1	8
Undergraduate (BSc, BA)	8	7
Postgraduate Certificate	1	0
Postgraduate Masters (MSc, MA)	5	8
Postgraduate PhD Doctorate	3	1
Postgraduate Diploma	1	1
Access Course	2	1
Not Answered	1	0
<b>Therapy Experience</b>		
< 1 year	26	28
1 year	5	6
2 years	2	2
3 years	1	7
4 years	4	1
5 years +	4	3

**Table 3***Experience Characteristics by Group*

Sample Characteristics	Control ( <i>n</i> = 44)	Training ( <i>n</i> = 48)
Worked with Offenders		
Yes	5	6
No	39	42
Heard of Non-Offending MAPs		
Yes	9	11
No	39	36
No Answer	0	1
Worked with Non-Offending MAPs		
Yes	1	2
No	43	46

There was insufficient power from 92 participants and not adequate to test the hypotheses of the study for MANOVA; therefore, a repeated measure ANOVA was performed instead. A post hoc analysis using G\*Power version 3.1.9.7 (Faul et al., 2009) to determine the minimum sample size to test the study hypotheses indicated that the required sample size to achieve a 99% power to find a medium effect size when using an alpha of  $p < .05$ . was  $N = 96$  for a repeated measures ANOVA (Faul et al., 2009).

#### 4.2.3 Materials

**4.2.3.1 Stigma Inventory Scale (SIS) (Jahnke et al., 2014).** This 15-item self-report scale measures subscales of stigma stereotypes- Cognitive Beliefs (controllability and dangerousness), Affective Reactions (sympathy and anger) and Social Distance. There was good internal reliability for the SIS (Cronbach's Alpha = .82) (See Appendix C for measures).

**4.2.3.2 Questionnaire of Cognitive and Affective Empathy (QCAE) (Reniers et al., 2011).** This 31-item self-report scale measures two broad aspects of empathy (cognitive and affective) on a four-point Likert Scale. The scale comprises of five subscales, with the subscales of perspective taking, online simulation measuring cognitive empathy, and the subscales of emotional contagion, peripheral response, and proximal responsivity measuring affective empathy. The scale has good internal reliability (Cronbach's Alphas = .88). Total empathy scores range from 0-124 with higher scores reflecting greater empathy.

**4.2.3.3 Questionnaire of Connor-Davidson Resilience Scale (CD-RISC-25) (Connor & Davidson, 2003).** This 25-item self-report scale measures six subscales, with the subscales of tenacity, competence, trusting instincts, accepting of change, control, and spirituality. The scale has good internal reliability (Cronbach's Alpha = .80). Total resilience scores range from 0-100 with higher scores reflecting greater resilience.

**4.2.3.4 Training Intervention.** Participants watched one eight-minute humanisation video training presentation using documentary extracts and additional information on working therapeutically with an Adolescent Non-Offending MAP. This includes narrative facts presented in an online mediated video/narrative using extracts from a television documentary video of an Adolescent Non-Offending MAP talking to an interviewer about their sexual attraction and interviews with expert professionals (BBC, 2017).

**4.2.3.5 Non-Intervention Group.** Participants watched a similar in length video to the Training intervention group but on an unrelated topic about the brain and central nervous system extracted from a YouTube video: Crash Course Anatomy & Physiology The Nervous System, Part 1: Crash Course Anatomy & Physiology #8 - YouTube.

**4.2.3.6 Vignettes.** Two Vignettes were designed by the researcher to manipulate whether a Humanised Adolescent Non-Offending MAP who was referred to by the name (Adam) to humanise him or a Client Adolescent Non-Offending MAP referred to as (Client)

and whether there would be any statistical differences with those participants who completed the humanisation training intervention. The vignette stated Client/Adam aged 14 has been referred to you with anxiety and low mood. He is currently struggling to manage this. The referral informs Client/Adam has previously reported sexual interest towards young children and now feels this is what is contributing to recent distress and would like to explore this further with you. It is noted although Client/Adam has spoken about interest in children, they have no offence history of sexual offences.

#### **4.3 Rationale for the Choice of Independent Variables**

The independent variables selected for this study, a humanisation video and a clinical vignette, were chosen to examine how targeted interventions might influence therapists' attitudes and emotional responses toward adolescent Non-Offending MAPs. The humanisation video was designed to evoke empathy, reduce moral distancing, and challenge dehumanising stereotypes by presenting Non-Offending MAPs within a context that highlights lived experience, ethical boundaries, and psychological distress. This approach draws on stigma reduction literature, which highlights the impact of affective priming and narrative exposure in shifting perceptions of marginalised groups (Henderson, 2023; Jahnke et al., 2015). By emphasising intrapersonal and interpersonal dimensions of stigma, the video simulates a therapeutic encounter intended to foster reflexivity and emotional engagement.

The clinical vignette, a familiar and validated tool in psychological research, was employed to simulate therapeutic decision-making in a controlled scenario. Its inclusion allowed participants to apply clinical reasoning while engaging with ethically sensitive content. While videos and vignettes have been used separately in prior studies, their combined use in this design enables a preliminary exploration of how emotional priming and contextual framing may interact to influence therapist responses.

#### **4.4 Procedure**

Data was collected using the online software Qualtrics. Participants were recruited via a study advertisement on social media (see Appendix D). The study advertisement clearly warned about the study's focus on Non-Offending MAPs and a direct invitation link, which took them to the Qualtrics website. There was another clear warning of the Non-Offending MAPs nature on Qualtrics where participants read the participant information sheet (see Appendix E) and read the informed consent form (see Appendix F). They were asked to create a unique ID. Online consent was obtained, and participants were again warned of the Non-Offending MAPs theme and the possibility of watching a video of a sensitive nature with audio sound. Upon consenting to take part, participants first completed the demographic questionnaire (See Appendix G) before completing the pre-intervention Stigma Inventory Scale (SIS). Participants were then randomly allocated to either the intervention group or the non-intervention group video condition. The Intervention group watched an online humanisation video training of an adolescent Non-Offending MAP, and the non-intervention group watched a similar-length video about the brain and central nervous system. All participants then read one of the two vignettes and were asked to think about the information in the vignette. All participants then completed the SIS scale followed by completing the baseline measures QCAE and CD-RISC-25. At the end of the study the participants read the debrief sheet (see Appendix H). Participation in the study took no longer than 45 minutes.

#### **4.5 Analysis**

The data was downloaded from Qualtrics, the online question platform, and was imported directly into IBM SPSS Statistics Software version 29. As Field (2024) suggested, data was cleaned to remove partially completed questionnaires, those who did not complete the consent questions were excluded from the data set, and data was examined for outliers,

which were removed. As there was no linear relationship between the dependent variables, as assessed by a scatterplot. There was evidence of multicollinearity, as assessed by Pearson correlation ( $|r| > 0.9$ ). The data did not meet the assumptions for MANOVA; therefore, a repeated measures ANOVA was performed. The data was analysed using a 2 (Condition: Humanisation Video Vs Control- between groups) X 2 (Client Type Vignette: Humanisation Adolescent Vs Non- humanised) X 2 (Time: Pre vs. Post stigma scores: within groups examining the 3 SIS factors: Cognitive Beliefs, Affective Reaction and Social Distancing). Additionally, the analysis included QCAE Total Empathy scores and CDRISC Total Resilience as fixed covariates. The QCAE Total Empathy score had a range of 66 to 112 ( $M = 85.96, SD = 7.28$ ). The CD RISC resilience score ranged from 21 to 97 ( $M = 66.02, SD = 16.79$ ). The QCAE Total Affective Empathy score ranged from 22 to 40 ( $M = 32.16, SD = 3.22$ ), and the QCAE Total Cognitive Empathy score ranged from 39 to 73 ( $M = 53.79, SD = 5.31$ ).

## **4.6 Results**

### ***4.6.1 Stigma Cognitive Belief Stereotypes (Dangerousness and Controllability)***

Descriptive statistics are presented in Table 4 for the two IVs (Intervention Group and Client Type), showing the mean and standard deviations for Stigma Cognitive Beliefs pre and post-scores.

**Table 4**

*Pre and Post Mean Scores and Standard Deviations for DV Stigma Cognitive Beliefs Stereotypes (Dangerousness & Controllability) and IV Intervention Group and Client Vignette Type.*

Group	Vignette	Pre		Post	
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Control	Client	15.55	6.68	14.76	5.38
Training	Client	18.87	6.62	15.57	5.00
Control	Humanised	16.24	4.25	14.98	3.79
Training	Humanised	17.90	5.70	14.52	4.66

A repeated measures ANOVA was performed to understand the effects of time (pre- and post-scores), group (training vs control), and vignette (client type) on Stigma Cognitive Belief scores. The Cognitive Belief scores were non-normally distributed, as assessed by Shapiro-Wilk's test ( $p < .05$ ). There was homogeneity of variances for both pre-Cognitive Belief scores ( $p = .168$ ) and post-Cognitive Belief scores ( $p = .690$ ), as assessed by Levene's test for equality of variances. Mauchly's test of sphericity indicated the assumption of sphericity was not violated, as there are only two levels of the within-subjects factor so there is only one paired difference, meeting the assumption automatically.

The results showed no significant main effects for pre and post-times,  $F(1, 86) = .002$ ,  $p = .965$ , partial  $\eta^2 < .001$ , training type  $F(1, 86) = 1.876$ ,  $p = .174$ , partial  $\eta^2 = .021$ , vignette type  $F(1, 86) = .079$ ,  $p = .780$ , partial  $\eta^2 = .001$ .

Partially in line with Hypothesis 1 there was a significant two-way interaction for pre and post times and training type  $F(1, 86) = 6.079$ ,  $p = .016$ , partial  $\eta^2 = .066$  (see figure 6).

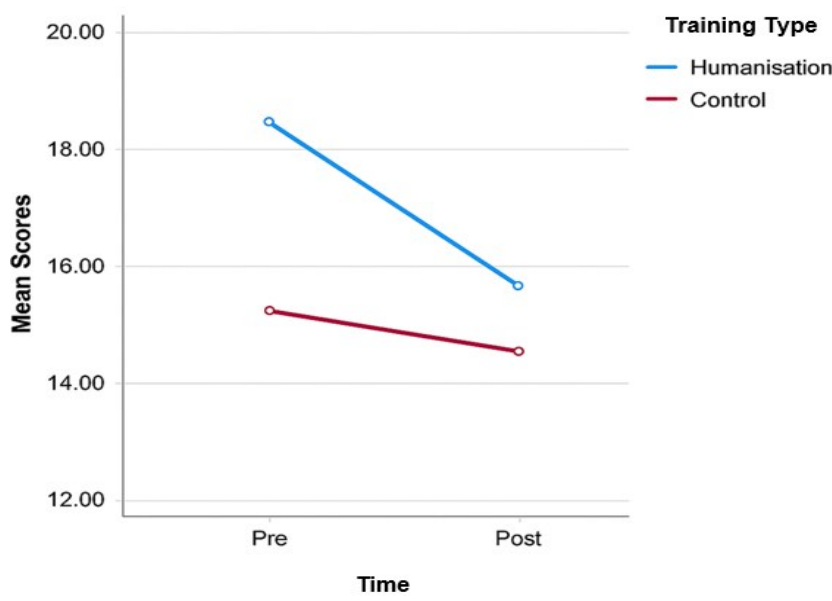
Post mean scores were significantly lower across the humanisation group compared to the pre mean scores of the humanisation group.

There were no other significant two-way interactions between pre and post times and vignette type  $F(1, 86) = 1.01, p = .752$ , partial  $\eta^2 = .001$ . There was no statistically significant three-way interaction between pre and post times, group and vignette on Stigma Cognitive Belief,  $F(1, 86) = .001, p = .982$ , partial  $\eta^2 < .001$ .

A post hoc paired samples t-test was conducted to evaluate the impact of the humanisation intervention on Cognitive Belief scores. Results indicated a statistically significant decrease in scores from pre-intervention ( $M = 17.25, SD = 5.92$ ) to post-intervention ( $M = 15.01, SD = 4.65$ ),  $t(91) = 4.86, p < .001, d = 0.51$ , reflecting a moderate effect size. Within the humanisation condition, significant reductions were observed for both the client vignette,  $t(26) = 3.60, p = .001$ , and the humanised vignette,  $t(20) = 2.75, p = .012$ , with mean decreases of 3.30 and 3.38 points, respectively. In the control condition, only the humanised vignette produced a significant reduction in scores,  $t(924) = 2.27, p = .032$ , whereas the client vignette did not yield a significant change,  $t(18) = 0.91, p = .377$ . These findings suggest that the humanisation intervention had a more robust and consistent effect on reducing cognitive belief scores across both vignette types compared to control conditions.

**Figure 6**

*Pre and Post mean scores for DV Stigma Cognitive Beliefs and Training Group*



#### **4.6.2 Stigma Affective Reaction**

Descriptive statistics are presented in Table 5 for the two IVs (intervention Group and Client Type), showing the mean and standard deviations for Stigma Affective Reaction pre- and post-scores. There was no significant difference between the pre- and post-group, meaning the training intervention and the non-training intervention were similar regardless of the manipulation of the vignette type. Pre- and post-mean scores were similar across both groups and vignette types.

**Table 5**

*Pre and Post Mean Scores and Standard Deviations for Stigma Affective Reaction and IV Intervention Group and Client Vignette Type.*

Group	Vignette	Pre		Post	
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Control	Client	6.42	2.01	6.32	2.19
Training	Client	6.11	1.15	5.44	1.89
Control	Humanised	6.08	1.78	6.08	1.82
Training	Humanised	5.61	1.63	5.52	1.63

A repeated measures ANOVA was performed to understand the effects of time (pre vs post), training group, and vignette type on Stigma Affective Reaction scores. Affective Reaction scores were normally distributed, as assessed by Shapiro-Wilk's test ( $p > .05$ ). There was homogeneity of variances for both pre–Affective Reaction scores ( $p = .588$ ) and post-affective Reaction scores ( $p = .510$ ), as assessed by Levene's test for equality of variances. Mauchly's test of sphericity indicated the assumption of sphericity had not been violated as there are only two levels of the within-subjects factor so there is only one paired difference, so the assumption is met automatically.

There were no significant main effects for pre and post-times,  $F(1, 86) = 1.501, p = .224$ , partial  $\eta^2 = .017$ , training type  $F(1, 86) = 2.234, p = .139$ , partial  $\eta^2 = .025$ , Vignette type  $F(1, 86) = .192, p = .662$ , partial  $\eta^2 = .002$ . All two-way interactions were not statistically significant ( $p > .05$ ). Total Empathy and Resilience were included as fixed covariates. Covariate analyses revealed that Total Empathy was significantly associated with Stigma Affective Reaction  $F(1, 86) = 13.721, p < .001$ , partial  $\eta^2 = .138$ . Total Resilience was significantly associated with Stigma Affective Reaction  $F(1, 86) = 5.447, p = .022$ ,

partial  $\eta^2 = .060$ . Covariates analyses highlighted the role of resilience and empathy. There was no statistically significant three-way interaction between pre and post-times, group and vignette on Stigma Affectiveness,  $F(1, 86) = .458, p = .501$ , partial  $\eta^2 = .005$ .

#### 4.6.3 *Stigma Social Distance*

Descriptive statistics are presented in Table 6 for the two IVs (intervention Group and Client Type), showing the mean and standard deviations for Stigma Social Distancing pre- and post-scores. There was no significant difference between the pre and post-means of the training intervention and the non-training intervention. Both were similar regardless of the manipulation of the vignette type. However, across all groups and vignette types showed a post-test score increase in stigma social distancing score.

**Table 6**

*Pre and Post Mean Scores and Standard Deviations for Stigma Social Distancing and IV Intervention Group and Client Vignette Type.*

Group	Vignette	Pre		Post	
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Control	Client	12.05	6.32	13.16	6.21
Training	Client	10.44	7.13	12.93	5.39
Control	Humanised	11.24	5.14	12.52	5.19
Training	Humanised	10.67	4.43	12.61	5.63

A repeated measures ANOVA was run to understand the effects of time (pre vs post), training group, and vignette type on Stigma Social Distancing scores. Social distance scores were normally distributed, as assessed by Shapiro-Wilk's test ( $p > .05$ ). There was homogeneity of variances for pre-Stigma social distance scores ( $p = .359$ ) and post-Stigma social distance scores ( $p = .772$ ), as assessed by Levene's test for equality of variances.

Mauchly's test of sphericity indicated the assumption of sphericity had not been violated as there are only two levels of the within-subjects factor so there is only one paired difference, so the assumption is met automatically.

There were no significant main effects for pre and post-times,  $F(1, 86) = .206$   $p = .651$ , partial  $\eta^2 = .002$ , training type  $F(1, 86) = 2.02$ ,  $p = .654$ , partial  $\eta^2 = .002$ , Vignette type  $F(1, 86) = .009$ ,  $p = .925$ , partial  $\eta^2 = .001$ . All two-way interactions were not statistically significant ( $p > .05$ ). There was no statistically significant three-way interaction between pre- and post-times, group and vignette on Stigma social distancing,  $F(1, 86) = .236$ ,  $p = .629$ , partial  $\eta^2 = .003$ . Covariate analysis revealed that higher Total Empathy scores were significantly associated with lower stigma social distancing scores,  $F(1, 86) = 4.46$ ,  $p = .037$ , partial  $\eta^2 = .050$ , indicating that individuals with greater empathic capacity tended to exhibit reduced social distancing toward stigmatised clients.

#### 4.7 Discussion

The quantitative phase examined whether there were differences in stigma attitudes towards Non-Offending MAPs following a stigma intervention on participants aspiring to work in psychological professions. The literature review in Chapter Two suggested that a humanisation intervention combining educational video using an adolescent Non-Offending MAP with humanised vignettes could reduce stigma bias. The results agree partially with previous research that humanisation interventions can play a role in reducing stigma (Harper et al., 2018; Jahnke et al., 2014; Jahnke & Hoyer, 2015a; Lawrence & Willis, 2022).

The results showed one significant two-way interaction between time and training group on Stigma Cognitive Belief Stereotypes indicating some impact from the intervention suggesting participants' attitudes in relation to perceptions of sub themes of dangerousness and controllability were less stigmatising following the intervention. The within-group results

are promising that a short intervention in agreement with Jahnke et al. (2014) may improve attitudes towards Non-Offending MAPs and reduce these negative stereotype perceptions towards adolescent Non-Offending MAPs which could be effective in challenging harmful stereotypes and promoting more understanding therapy attitudes. The statistically significant effect ( $p = .016$ ) with a partial  $\eta^2$  of .066, indicated that 6.6% of the variance in the dependent variable is explained by the independent variable with a moderate to large effect size.

However, in comparison to previous research the effect size is comparable and so it does add some meaningful impact to the results.

This reduction in Stigma Cognitive Beliefs following the intervention implies that stereotypes were reduced. It may also suggest that participants may be able to cognitively engage with and understand adolescent Non-Offending MAPs experiences without sharing their affective feelings (Hatfield et al., 2011). It may be that a change in cognitive beliefs may lead to therapists not believing counselling interventions are solely to prevent child abuse as Levenson and Grady (2019) workshop highlighted and support therapists to change attitudes towards supportive therapeutic relationships (Blasko & Jeglic, 2016). One possible explanation of why only Stigma Cognitive Beliefs showed a significant interaction, while Stigma Affective Reactions or Social Distancing did not have any impact between training and non-training groups concurring which has been recognised in other research (Epstein & Street, 2011; Riess et al., 2012). This may be related to the role of Cognitive Empathy as Perez-Fuentes et al. (2020) found a positive correlation between high cognitive empathy scores and humanisation scores. However, as there was no observed impact for affective reactions. This suggests that cognitive empathy may promote understanding, while Affective Empathy may act as a protective factor. This may then allow individuals to emotional distance themselves from what they perceive as morally conflicting values and hinders therapy as Giuseppe and Perry (2024) suggest. This emotional distance might then

unconsciously shield participants from discomfort explaining why there was a lack of significant findings for Stigma Affective reaction and Stigma Social Distancing.

These findings perhaps suggest that future humanisation interventions should focus on understanding and increasing Cognitive Empathy to reduce stigmatising cognitive beliefs, with additional focus on therapeutic bias through mandatory personal therapy in line with counselling psychologists' standards (HCPC, 2023) to uncover conflicting values and further understanding of morals and empathy.

It is also recognised that heightened Cognitive Empathy has also been found to be associated with improvements in emotional regulation (Thompson et al., 2021) whereas higher Affective Empathy scores may be associated with problems such as burnout which Maslach and Jackson (1981) suggest leads to helplessness and low self-concept and negative work attitudes. Furthermore Thompson et al. (2021) also suggest Cognitive Empathy has also been related to difficulties with emotional awareness than affective empathy which suggests those participants with higher cognitive empathy scores would experience less problems in relation to emotion regulation. Research suggests that empathy can occur implicitly (Singer & Lamm, 2009). In relation to these findings this would suggest that increasing cognitive empathy would support emotional regulation.

There was a statistically significant covariate two-way effect between Total Empathy and Stigma Affective Reaction, suggesting that affective reactions (such as sympathy and anger) were lessened following the intervention when participants' Total Empathy scores were higher. It may have been more imperative to have split the covariate scores as Cognitive and Empathy scores. However, previous research has shown empathy can be increased through training (Ruiz-Moral et al., 2017). This would imply that if interventions can increase empathy, then, in turn humanisation training would also reduce Stigma Cognitive Belief

stereotypes. This may then mean therapists may be more willing to work with this group, and therapy becomes more accessible.

There was also a statistically significant covariate interaction between Total Resilience and Stigma Affective Reaction in line with implying affective reactions (such as sympathy and anger) were lessened following the intervention when Total Resilience was higher. There was a covariate interaction between Total Empathy and Stigma Social Distancing, implying an interaction between empathy scores and participants socially wanting to discriminate by distancing themselves from the Non-Offending MAPs. It may also be that those with less empathy used social distancing as a defence mechanism more often (Elias & Haj, 2017). This suggested participants with higher levels of Total Empathy would be more willing to work with Non-Offending MAPs, reflecting a more positive attitude. In agreement with Hecht et al. (2021), findings show that higher empathy scores led to more positive attitudes and a reduction of stigma. Although Hecht's research examined mental health stigma, these results indicate a comparable trend within the context of this research.

Additionally, this aligns with Aranda et al. (2023), who perceive stigma as relational, and that empathy fosters connection (Brown, 2012). However, the present study's findings still imply that those with lower levels of Total Empathy may still reject this group. This is in line with Link's (1982) theory of social exclusion, leading to further experiences of stigma towards Non-Offending MAPs and the further reluctance of professionals to work with this group (Schmidt & Niehaus, 2022). It may have been useful to have analysed and separated the Affective and Cognitive Empathy scores to see if there were any significant differences, instead of solely the Total Empathy score. As with Affective Empathy scores, there may be differences in how emotional states are mirrored (such as through shared neural activations) (Lamm et al., 2007). This may influence how empathy is perceived by Non-Offending

MAPs, which could be especially relevant for assessing ecological validity in therapeutic settings.

The QCAE Total Affective Empathy score and the QCAE Total Cognitive Empathy score were comparable with previous research (Reniers et al., 2011). There was less variability in Affective Empathy which may reflect the high proportion of female participants. There are Gender differences in Affective Empathy, as females show higher Affective Empathy scores than males (Lam et al., 2012).

The Total Empathy Score was consistent with other studies which used the QCAE. However, the CD-RISC Resilience Scores were lower compared to the general population. In a study by Connor and Davidson (2003), the mean CD-RISC score for the general population was ( $M = 80.4$ ,  $SD = 12.8$ ). In the present study ( $M = 66.02$ ,  $SD = 16.79$ ), resilience was lower. This suggests that the resilience levels in the present study are lower compared to the general population. This may reflect the sample demographic age was the late 20s as the CD-RISC focuses on individual, social and environmental resources to cope and adapt to stressful situations (Hobfoll, 2011).

Previous research also suggests there may be fewer stigmatising perceptions towards sexual minorities from participants who have a higher educated background (Lambert et al., 2006), and similarly, professionals are less likely to hold negative attitudes towards Non-Offending MAPs (Parr & Pearson, 2019). The present study exhibited high levels of empathy. Additionally, resilience played a significant role, suggesting that participants with higher resilience maybe less likely to experience burnout in future practice. This emphasises the importance of understanding how therapists cope, particularly when working with non-offending MAPs.

There is research evidence that those who report prejudice may still respond adversely (Allport, 1954). Although these findings align with the Contact Hypothesis, suggesting that

interaction with diverse groups can foster positive attitudes, they also support Heron et al. (2021) and Ankers et al. (2021), who argue that beliefs are co-constructed through social interactions.

Gaining a clearer comprehension of the challenges adolescent Non-Offending MAPs experience through therapeutic bias would allow for future support to be provided in training to those who work in services. A further consideration is that lower cognitive empathy may predict stigma bias towards adolescent Non-Offending MAPs. Measuring stigma presents several challenges due to its subjective nature and the complexity of the factors involved. Developing reliable and valid tools to assess stigma accurately is crucial for understanding and addressing these biases effectively.

#### **4.8 Practical and Theoretical Implication of Findings**

It is important to reduce cognitive belief stereotypes to reduce judgemental attitudes so the foundation to therapy is not damaged (Jahnke et al., 2015). The current study builds upon recent research focused on adult Non-Offending MAPs. The results contribute to a broader understanding of therapeutic bias and its impact on Non-Offending MAPs. By embedding and addressing stigma bias within university training doctorate programmes, this intervention could be integrated into a therapeutic bias workshop to help uncover the biases of trainees and professionals through discussion and addressing stigma stereotypes of Non-Offending MAPs. However, the video intervention may need further development to understand its effectiveness in reducing biases. By uncovering biases process encourages trainees and professionals to think critically about how they can offer therapy and foster a more inclusive response. Additionally, it would enable them to work on their own biases, which may otherwise act as barriers to successful therapeutic work. There may be future uses

of a humanisation intervention to promote self-reflection and uncover bias so individuals can then work towards a more inclusive practice.

#### **4.9 Strengths and Limitations**

The results did not support the hypotheses for Stigma Affective Reaction and Social Distancing. This may have been because of a methodological issue with the study design and the training intervention video, but this was based on evidence from an extensive literature search. The study faced issues with a lack of power and not being able to perform a MANOVA, which may have subsequently increased the risk of type 1 errors.

In the present study, the vignettes may not have been explicit enough. Although vignettes are useful in research as they can reveal beliefs and attitudes (Schoenberg & Ravdal, 2000). The clarity and content validity of vignettes are crucial in research. Pilot testing of the vignettes could have helped refine and improve their content validity. Additionally adding photos to the humanised vignettes could also be beneficial. Visual elements could create a stronger first impression, which is known to impact judgements and potentially change therapeutic outcomes, as noted by Bowker et al. (2024). Incorporating these enhancements could improve the study's overall validity and reliability, leading to more robust findings and insights.

The results in the present study aligned with those of Jahnke et al. (2014) in relation to Stigma Dangerousness. In Jahnke et al.'s research, the intervention group showed significantly reduced scores on Stigma Controllability and Dangerousness, Stigma Affective Reaction, and Stigma Social Distance. In contrast, the present study faced potential confounding variables, particularly due to the handling of missing data by removing it, which affected the sample's power. A more effective approach might have been to remodel the data as Jahnke et al. (2014) did, potentially yielding different results.

The study's limitations include a significant percentage of female participants and the lack of exploration of gender differences among therapists toward Non-Offending MAPs. This leaves it unclear whether gender had any effect on the findings. Females may have more stigmatising attitudes as Schmidt and Niehaus (2022) suggested, and females also had higher social distancing scores in Iffland and Schmidt's (2023) research.

It is acknowledged that the participant group is White and westernised which introduces a cultural bias in that this research leans towards a Western perspective (Henrich et al., 2010). There may be cultural differences in relation to therapeutic bias and Non-Offending MAPs. Future research should aim to include a more diverse population of therapists to understand any cultural impacts. Additionally, social desirability bias may have influenced participants' responses, as they might have answered in ways that reflected the perceived societal norms of a therapist hiding their true feelings. However, addressing these biases is crucial for enhancing the validity and reliability of future research. By recognising and mitigating biases, researchers may achieve a more nuanced understanding of therapists' attitudes and experiences working with Non-Offending MAPs.

There may have been a limitation in how the video intervention described an attraction towards babies and toddlers. The video clip in this study example may have increased and reinforced the stigma, in line with that societal stigma is perpetuated by CSA (Schmidt & Niehaus, 2022) and agreeing non-specialists were more likely to perceive Non-Offending MAPs as more dangerous than trained professionals (Lievesley et al., 2022). The Length of video training may have been too short as it only lasted approximately eight minutes so it this could be increased. The narrative used during the video was a computer voice, so it may have been perceived as unempathetic, and in hindsight, it would have been better to have used the researcher's voice. It is important to acknowledge the stigma intervention video may have also perpetuated or increased stigma due to the representation of

the cartoon graphic. During a university lecture, the video prompted initial thoughts about existing preconceived biases, helping the researcher reflect on their own biases and awareness of the risk-focused lens of the research. The video may further support as an intervention tool to uncover therapeutic bias towards Non-Offending MAPs, which may be beneficial for therapists in understanding and addressing their own biases.

#### **4.10 Research Gaps for Future Recommendations**

As there is a lack of longitudinal studies, future research could examine a longer-term intervention. Levenson and Grady (2019) did a longer study over four consecutive workshop sessions over 14 months which did show attitudes were not changed but did suggest an intervention increased awareness and improved competence in working with this population and reduced belief the primary objective of counselling was to stop child abuse. Findings did suggest the importance of therapists working person-centred and putting the client at the centre of their therapy but recognising both prevention and client well-being needs. This may provide insight into the effectiveness of support over an extended period and assess any changes in mental health.

It is recognised this is an under-researched area, and it is easier to access professionals' experiences than lived experiences by involving Non-Offending MAPs. The author acknowledges research should include the hidden voice, but if therapists refuse to work with this group, then this is a good place to start to establish what would help to improve access to therapy by reducing therapeutic stigma bias. It may be beneficial in future research to explore different genders within those that work with Non-Offending MAPs as this sample may have been impacted by homogeneity.

The quantitative phase of allowed for exploring unqualified participants who held potentially stigmatising biases that are also reflected in society. The second part of this study will expand upon this using qualitative data.

## Chapter Five Qualitative Report

### 5.1 Introduction

There appears to be increasing interest in research into Non-Offending MAPs and stigma reduction. The research in the introduction (see Chapter One) and literature review (see Chapter Two) has predominantly focused on adult Non-Offending MAPs and stigma. There is a scarcity of research exploring therapy experiences with adolescent Non-Offending MAPs. Chapter Four revealed a significant interaction between time and training group on Stigma Cognitive Belief Stereotypes, indicating the intervention reduced perceptions of dangerousness and controllability. This suggests participants developed less stereotyped views and could cognitively engage with adolescent Non-Offending MAPs without sharing affective responses (Hatfield et al., 2011). These findings perhaps suggest that future humanisation interventions should focus on understanding and increasing Cognitive Empathy to reduce stigmatising cognitive beliefs, with additional focus on therapeutic bias through mandatory personal therapy in line with counselling psychologists' standards (HCPC, 2023) to uncover conflicting values and more understanding of morals and empathy. It was not known how therapists experience stigma. Therefore, a qualitative phase, by using semi-structured interviews, attempted to add meaning to the quantitative data by exploring experiences by interviewing professionals who work with adolescent Non-Offending MAPs. Interpretative Phenomenological Analysis explores experiences of working with this group, exploring therapists' own resilience, empathy, and perceptions to see if there were any negative attitudes towards Non-Offending MAPs.

The qualitative aspect was intentionally shaped by the preceding quantitative study, creating a coherent mixed-methods design. During supervisory discussions, qualitative questions were developed based on gaps and patterns identified in the literature review and quantitative findings, allowing for a deeper exploration of therapists' reasoning, emotional

responses, and ethical tensions. This integration improves the ecological validity of the study and supports a layered understanding of therapeutic bias, progressing from statistical trends to rich, contextualised narratives that reflect the complexity of clinical engagement with Non-Offending MAP clients.

## **5.2 Aim**

The aim is to explore therapists' experiences of working with adolescent Non-Offending MAPs which in turn could help inform a training intervention to reduce stigma bias and support professionals to competently work therapeutically with Non-Offending MAPs. This could mean more adolescent Non-Offending MAPs gain access to specialist counselling services, or those who may go on to offend and become child sex offenders may be able to manage their attraction in a pro-social way.

## **5.3 Research Question**

How do trained therapists/ psychologists make meaning of working with adolescent Non-Offending Minor Attracted Persons?

## **5.4 Research Design**

To explore trained therapists / Psychologists' experiences of adolescent Non-Offending MAPs. The interview data was analysed using Interpretive Phenomenological Analysis (IPA). Using a qualitative method, it was hoped to reach an in-depth understanding of the experiences of therapists working with adolescent Non-Offending MAPs, which would add to the quantitative study in Chapter Four to feed forward into a future training intervention on working with Non-Offending MAPs. Adding the second part of the study with IPA would add richer detail to highlight the subjectivity of Psychologists' and Therapists' experiences working with adolescent Non-Offending MAPs.

### 5.5 Qualitative Rationale

Interpretative Phenomenological Analysis (Smith et al., 2022) was selected as an approach because it would help support understanding the phenomenological experiences of those working with adolescent Non-Offending MAPs. IPA is a recognised approach in the field of Psychology. As an understudied area, Smith et al. (2022) highlight the usefulness of this approach when looking at making sense of the self. It was chosen in this thesis as it would allow for the participant's own experiences to emerge, to add further knowledge in an area lacking in research. Although IPA is not rooted in any theoretical model or establishes universal findings, it does acknowledge the transferability to connect and add to the literature or propose new models (Lincoln & Guba, 1985). IPA was selected because its theoretical underpinning is premised on Hermeneutics, ideography, and symbolic interactionism (Smith et al., 2022). IPA explores in-depth how the participants are the experts of their experiences (Smith et al., 2022) and make sense of their own phenomenon. IPA explored participants' experiences in working with adolescent Non-Offending MAPs.

This methodology provides a flexible approach to developing new ideas. Smith and Osborn (2004) note that IPA is especially effective for exploring novel areas. The research recognised the meaning-making process and understood the emotions that therapists and psychologists experience when working with Non-Offending MAPs. IPA recognises that although the researcher may have awareness of biases, they may also not be fully aware and bracketing during the research is useful. IPA adopts that the researcher also becomes part of the research. IPA is not seen as a method and has flexibility as a way of exploring the participant's experiences and links more in alignment with Counselling Psychologists' philosophy and the research aims. However, by also using mixed methods this enabled different approaches to bridge a broader understanding to inform future knowledge.

### ***5.5.1 IPA Over Other Qualitative Approaches***

The researcher initially considered using Grounded Theory and Thematic Analysis for the study. Grounded Theory was discounted because it does not focus on theory-making (Creswell & Poth, 2018). Since stigma theory already exists, it was not aligned with the research aims. Thematic Analysis was deemed unsuitable, as it entails a broader exploration of experiences that did not fit the specific focus of this research, and it would not have analysed individuals experience individually (Smith et al.2009).

Therefore, IPA was chosen to gain insights into how individuals perceive and make sense of their experiences within a therapy context. This method allows for a dynamic interaction between the participant and the researcher, emphasising the co-construction of meaning (Smith et al, 2022).

To address potential biases, the researcher employed the concept of ‘Epoche,’ as discussed by Emery and Andeman (2020). This involved suspending personal judgements and consciously acknowledging the researcher’s own experiences prior to the interviews through a bracketing interview. While bracketing helps to clarify the researcher’s perspective, it is acknowledged that completely removing personal biases is impossible. Therefore, IPA was deemed the most appropriate approach for exploring participants’ experiences, as it aligns with the researcher’s philosophical stance and recognises that the researcher’s insights will inevitably influence the interpretation of the data.

### ***5.5.2 Theoretical Underpinning of IPA***

IPA draws on three areas- Phenomenology, Hermeneutics and Ideography. IPA is Influenced by Husserl (1927), Heidegger (1962), Merleau-Ponty (1962) and Satre (Smith et al.,2022). IPA aims to explore how someone makes sense of life and provides a detailed interpretation to help understand experiences (Smith et al., 2022). These areas are not

exclusive to IPA, but when combined in an approach are aligned to IPA as a distinct approach in the field of phenomenological enquiry.

### ***5.5.3 Phenomenology***

Phenomenology, rooted in the works of Husserl and Heidegger, is an approach aimed at understanding lived experiences and how individuals perceive the world (Finlay, 2011 & 2013). The philosophy of IPA is grounded in both phenomenology and the interpretative framework of hermeneutics (Smith et al., 1999). According to Smith et al. (2022), IPA emphasises the convergence and divergence of experiences, allowing for a rich exploration of subtle details within a small participant sample. IPA is an inductive approach that delves into the complexities of individuals' worlds, consciously distancing itself from measurable quantitative methods (Smith et al., 2022). This focus on depth rather than breadth makes IPA particularly suitable for capturing the nuanced experiences of participants.

### ***5.5.4 Double Hermeneutic***

Smith and Osborn (2004) highlight that IPA is underpinned by a double hermeneutic as the participant tries to understand their experiences. Similarly, the researcher attempts to understand and interpret the participant understanding their experiences to gain a richer understanding of the interview through meaning-making by uncovering the underlying subtle differences through interpretation. The 'Double Hermeneutic' is a way of capturing the essence of the participant's experiences (Finlay, 2011). During the research, it is important for the researcher to understand and bracket their dual role in how they interpret the information and make sense of the participant making sense of their experiences (Smith et al., 2022). It is important to be reflexive (Barrett et al., 2020), so the researcher kept a reflexive diary.

### ***5.5.5 Idiography***

IPA allowed the researcher to engage with the research question at an idiographic level, with the participants positioned as the experts in their own phenomenological experiences (Smith et al., 2009). As IPA is an inductive approach which allows for a bottom-up approach as opposed to a top-down approach (Reid et al., 2005), this supports a transdiagnostic approach considering the notion of power (see Chapter Three).

### ***5.5.6 Trustworthiness, Transparency, and Integration of Methods***

To ensure the trustworthiness of the qualitative data, this study adhered to established criteria for rigour in psychological research, including credibility, transparency, and dependability (Morrow, 2005; Yardley, 2000).

Transparency was upheld through detailed documentation of analytical decisions, iterative coding, and reflexive journaling, while reliability was enhanced by regular supervision, which fostered critical dialogue around emerging themes and the researcher's assumptions. The researcher's positionality as someone involved in stigma reduction and ethically sensitive scholarship was explicitly acknowledged and reflexively scrutinised throughout the analytic process. This was particularly important given the emotionally and morally charged nature of the topic, where interpretive nuance and ethical clarity were crucial.

As a researcher working within a highly stigmatised and ethically complex domain I approached this study with a commitment to transparency, compassion, and methodological rigour. My positionality is shaped by prior engagement with stigma reduction and therapeutic ethics, which was continuously reflected upon through supervision, journaling, and critical dialogue. To mitigate bias and emotional entanglement, I used strategies to ensure

trustworthiness, including supervisory consultation, peer feedback, and iterative coding grounded in participants' voices.

These practices align with Morrow's (2005) emphasis on dependability and reflexivity, as well as Yardley's (2000) criteria for transparency and sensitivity to context.

Importantly, the qualitative strand was not developed in isolation but emerged directly from the quantitative findings and literature synthesis. As discussed in supervision, the qualitative questions were designed to probe the emotional and ethical dimensions that statistical data alone could not capture. This layered approach reflects a commitment to ecological validity, allowing the research to move beyond abstract measures and into the lived realities of therapeutic engagement with Non-Offending MAP clients.

## **5.6 Methods**

### ***5.6.1 Participants***

Four Participants were recruited using a non-probability sample utilising purposive sampling. Participants were selected on their willingness and availability to take part. Psychologists and therapists in the UK were recruited from adverts distributed via social media inviting participants to sign up for qualitative semi-structured interview research using online audio-recorded interviews using Microsoft Teams. Smith et al. (2022) suggest when choosing an IPA sample, it should reflect a homogenous sample meaning demographic characteristics should be similar. However, due to the specific niche area of Non-Offending MAPs it must be acknowledged the population sample is limited. The consistent demographic is that participants have insight through their personal experience in working with this niche population. Due to the small number of people who currently work in this area, there were no exclusion criteria in terms of demographic characteristics, and the research was open worldwide. The inclusion criteria required all participants to have worked

with Adolescent Non-Offending MAPs to support a deeper understanding of this area, which the literature search in Chapter Two recognised as limited. Due to the idiographic nature of IPA even a small sample of four participants would be sufficient due to the quality focus and depth of interpretation (Smith et al., 2022). The emphasis is on the richness of the interview in exploring the participant's lived experience of the phenomenon. Table 7 below shows the sample of four participants created a homogenous sample (Smith et al., 2022) as all participants had experience as a professional working in therapy with adolescent Non-Offending MAPs.

**Table 7**

*Participants Demographics*

Participant	1	2	3	4
Pseudonym	Ann	Sam	Christian	Zarah
Gender	Female	Female	Male	Female
Age	40-50	50-60	40-50	30-40
Ethnicity	White European	White	White	White
Nationality		Canadian	British	European
Therapy Experience	13 years	5 years	9-10 years	8 years
Profession	Psychotherapist	Psychotherapist	Psychologist	Psychologist
Sex Offender Experience	Yes	No	Yes	Yes
Non-Offending MAPs Experience	5 years	1 year	3 years	8 years
Adolescent Non-Offending MAPs Experience	5 years	1 year	1 year	8 years

**5.6.2. Materials and Procedure**

The interview schedule consisted of demographic questions, followed by 10 semi-structured questions (Appendix I). The interview aimed to gain an in-depth understanding of participants' experiences working with adolescent Non-Offending MAPs. Participants were told the researcher was interested in their thoughts, feelings, and understanding of their

experiences and to be open and honest, as there were no right or wrong answers. Using semi-structured interview questions enabled the researcher to provide further elaboration as needed through clarification and probing to elicit more in-depth and detailed answers. The interview questions were developed following a bracketing interview of the researcher, highlighting gaps in the current literature search of adolescent Non-Offending MAPs and further enquiry of quantitative study findings of experience resilience and empathy to further explore participants' experiences of working with adolescent Non-Offending MAPs. The interview questions explored how it feels to work with adolescent Non-Offending MAPs, exploring what impact working with this group has on the participant, uncovering therapists' empathy and how they empathise within their therapeutic work to explore affective and cognitive empathy. The questions further explored resilience and how this may have changed through participants' experiences and identified ways therapists managed to be resilient. Finally, it asked about therapists' reasons for working with this group to uncover what motivates or demotivates them, to uncover more of what participants' own therapeutic practice entails, and what they think is necessary to achieve in therapy (to see if this is from a therapist centred approach or a Non-Offending MAPs centred approach).

Potential participants were recruited via a study advertisement on social media (Appendix J). The study advertisement had clear warnings of the study's focus on a Non-Offending MAP. Participants were emailed a participant information sheet (Appendix K) and consent form (Appendix L) and were able to discuss the project before commencing an interview. Participants were invited to an approximately one-hour, one-to-one semi-structured interview with the researcher using an informal open-ended conversational style interview that allowed for elaboration when needed. The participants were told the online interview would be audio recorded using Microsoft Teams, any identifying information would be removed, and a pseudonym would be used when the data was transcribed verbatim.

Participants were given a debrief following the interview and further support information.

After the semi-structured interviews, the four participants all highlighted through a following verbal debrief (Appendix M) that they felt they were able to manage after the interview without any need for further intervention, and all were able to access support if needed.

All data was stored in line with Ethics and GDPR guidelines and data protection Acts. All data was anonymised at the earliest opportunity, and recordings were deleted. Participants were given code numbers and were not identified by name. All participants were given the opportunity to withdraw their data up until two weeks after the interview prior to the transcribing of the data.

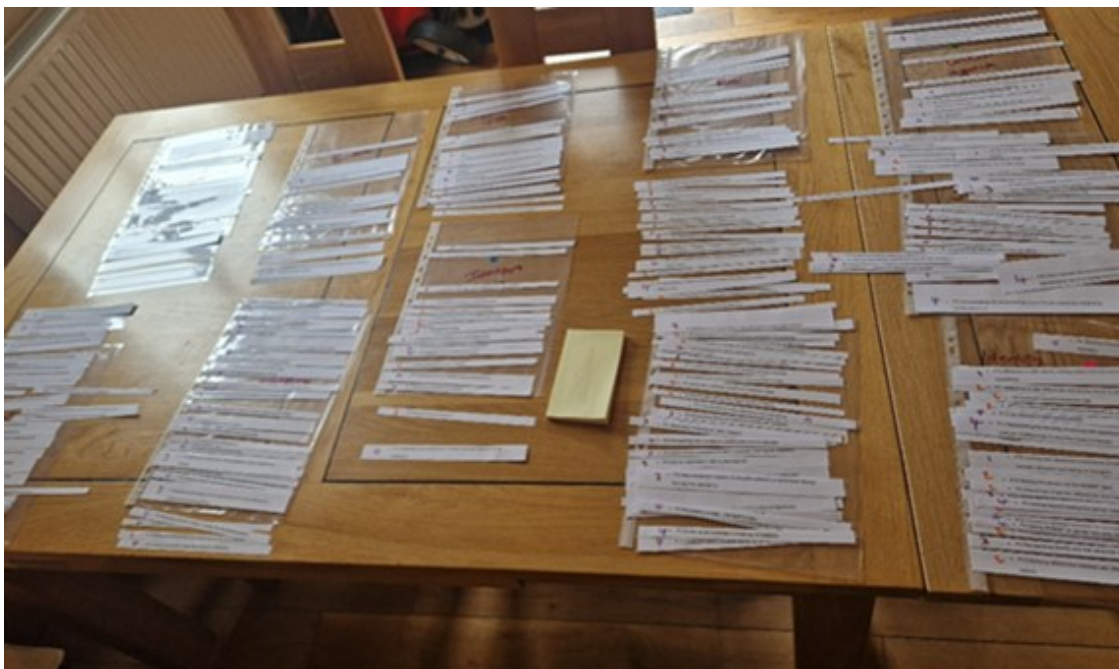
The data was analysed using Smith et al. (2009) and adopted the newer terminology in Smith et al. (2022). The data analysis stages are outlined below:

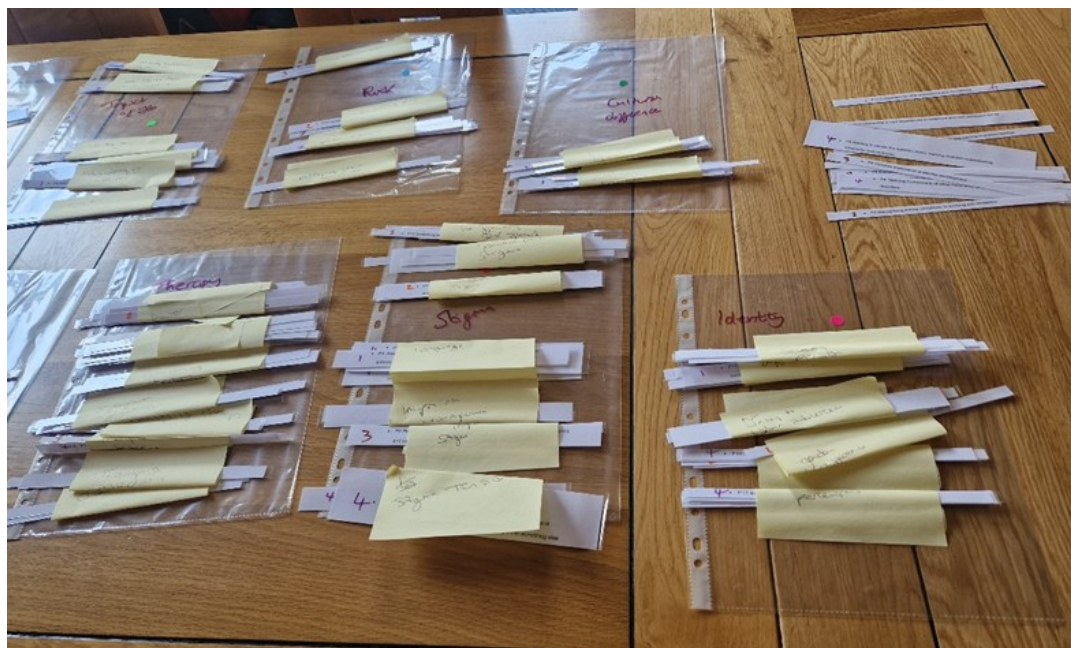
- Stage One-Reading & Re-reading: Audio recordings were repeatedly listened to and transcribed verbatim. Transcripts were re-read to immerse in participants' experiences.
- Stage Two: Exploratory Noting: Initial manual notes captured observations and experiential insights, applying the double hermeneutic to interpret participants' meaning.
- Stage Three: Developing Experiential Statements: Notes were analysed to create experiential statements, offering a phenomenological account of participants' lived experiences (Reid et al., 2005).
- Stage Four: Connecting Statements: Statements were printed, cut out, and physically arranged to identify patterns and deeper thematic links (figure 7).

- Stage Five: Naming PETs: Personal Experiential Themes (PETs) were titled, refined, and organised into a table. This stage involved making titles to describe the PETS and refining them (figure 8).
- Stage Six: Moving to the Next Case. Steps were repeated for all participants, bracketing previous PETs to preserve idiosyncrasy.
- Stage Seven: Looking for Patterns across Participants: PETs were colour-coded and compared across cases to identify GETs. Themes would often overlap, and this was a time-consuming stage

### Figure 7

*Photo of Stage Four*



**Figure 8***Photo of Stage Five*

### 5.7 IPA Reflexivity

IPA is a flexible, iterative process requiring movement between stages to uncover deeper interpretative themes. Qualitative analysis is inherently subjective, so the researcher considered the double hermeneutic of making sense of participants making sense of their world (Golsworthy & Coyle, 2001). Reflexivity involved acknowledging personal perspectives on adolescent Non-Offending MAPs and tuning into felt responses when reading transcripts and listening to interviews. Similar to Gendlin's (2012) concept of 'focusing,' the researcher aimed to remain non-judgemental, hold open space, and attend to internal reactions for insight.

Interview questions were adapted as participants' experiences shaped discussion. Post-interview reflections informed technique and highlighted the researcher's influence. Therapeutic skills supported rapport, though tension existed between listening and reflecting. Assumptions were bracketed to avoid bias, aided by a reflexive journal (Tufford & Newman,

2012) to enhance validity. Using IPA enabled the researcher to detach from the research to focus on the experiences of the participants.

### **5.8 Findings- IPA**

Four participants are included in this IPA study, where interviews ranged from 55 minutes to 68 minutes. Table 8 presents Five Group Experiential Themes (GETS): Stigma and Societal Narratives surrounding Adolescent Non-Offending MAPs, Constructing Non-Offending MAPs Identity, Therapeutic Engagement and Boundaries, Therapist factors- Emotional impact of working with Adolescent Non-Offending MAPs and Systemic Barriers and Professional Issues.

Each theme is illustrated with anonymised quotes extracted from each participant's transcripts, serving as supporting evidence of the interpretation of the interviews. allowing for a personalised understanding of their experiences. Where data has been omitted from the quotes, this is indicated using '...'. The experiences highlighted reflect the insights gained from the interviews, offering a glimpse into each participant's journey.

**Table 8***Summary of Group and Sub-Themes*

Group Experiential Themes	Sub-Themes
5.8.1: Stigma and Societal Narratives	5.8.1.1 Comparing Adolescent Non-Offending MAPs to Sex Offenders and Recognising the Impact of Societal Fear. 5.8.1.2 Therapists' Use of Language.
5.9.1: Constructing Non-Offending MAPs Identity	5.9.1.1 Seeing the Person First. 5.9.1.2 Navigating individual differences and support needs.
5.10.1: Therapeutic Engagement and Boundaries	5.10.1.1 Managing Therapeutic Boundaries, Risk Management and Decision Making. 5.10.1.2 Power Dynamics. 5.10.1.3 Emotional Containment and Engagement.
5.11.1: Therapist Factors – Emotional Impact of Working With Adolescent Non-Offending MAPs	5.11.1.1 Therapeutic Heaviness and Emotional Responses. 5.11.1.2 Navigating Emotional Reactions and Relational Depth. 5.11.1.3 Holding Hope and Navigating Safety Needs.
5.12.1: Systemic Barriers and Professional Issues	5.12.1.1 Policy and Funding as an Unmet Need 5.12.1.2 Building Resilience and Addressing Personal Bias.

***5.8.1 Stigma and Societal Narratives***

In this theme, stigma is observed by therapists as a detrimental impact of discrimination stemming from societal comparisons made between adolescent Non-Offending MAPs and sex offenders. Such comparisons appear to not only amplify shame but also deter Non-Offending MAPs from seeking crucial support due to the fear of being labelled similarly to offenders. This association was believed to increase their sense of shame and feelings of isolation, making it challenging for them to form connections with others, often as they live in fear of judgement. This theme was underpinned by forensic contexts

when discussing adolescent Non-Offending MAPs. Adolescent Non-Offending MAPs were frequently compared to sex offenders, identifying this comparison as a source of stigma. A notable impact of societal fear was observed. Societal fear was experienced as contributing to the stigmatisation of adolescent Non-Offending MAPs, affecting their social interactions and well-being. In this theme, there were elements of therapists needing to conceal their therapeutic work due to experiencing fear and stigma by association. Therapeutic interventions for adolescent Non-Offending MAPs were often conducted in secrecy and led to isolation as a therapist. In line with the DSM-5, the use of negative stigmatising language framed adolescent Non-Offending MAPs as ‘disordered’ was a common issue. This theme highlighted the multifaceted nature of stigma and its consequences on individuals and therapeutic practices.

**5.8.1.1 Comparing Adolescent Non-Offending MAPs to Sex Offenders and Recognising the Impact of Societal Fear.** Therapists described how societal stereotypes frequently conflate adolescent Non-Offending MAPs with sex offenders, reinforcing stigma through media, cultural narratives, and dominant social norms. This conflation was seen to amplify shame, hinder help-seeking, and contribute to both client and therapist isolation. Across narratives, participants reflected on the emotional and relational toll of working within these fear-driven frameworks and called for greater compassion and understanding.

Christian noted that adolescent Non-Offending MAPs are often perceived by society as unable to resist temptation, linking this to public misunderstanding and his own early career assumptions: “It’s too hard to access support... but largely, I don’t think they do offend” (p. 10). Zarah viewed minor attraction on a continuum, stating: “There’s no difference to me... whether they have offended or haven’t offended” (p. 7). These perspectives highlight the difficulty adolescent Non-Offending MAPs face in being seen beyond the label of potential offender.

Societal fear was also described as shaping therapists' emotional responses and sense of safety. Christian expressed a protective instinct toward adolescent Non-Offending MAPs "They don't want to harm a child... it felt like I was the parent... They were very much alone" (p. 5). Convergently, Zarah described how stigma affected her personally, leading to hypervigilance in public spaces: "It's not very fun to go to the playground... it's taken away a bit of my naivety" (p. 10).

Therapists also described stigma by association, noting that therapeutic work with adolescent Non-Offending MAPs was often concealed due to fear of judgement. Ann shared her experience of receiving threats: "I've had people say, 'I'm gonna find you and kill you'... I've become more careful about who I engage with" (p. 13). Sam reflected on the anxiety of secrecy: "You're always keeping secrets... anyone who has a secret experiences a bit of anxiety" (p. 5). Christian expressed concern about professional rejection: "There's a huge taboo... you can't just talk about working with these people" (p. 7/8). Zarah, however, saw therapy as a potential safety refuge: "Therapy sessions offer a platform... to explore more safely" (p. 5).

Ann's longing to create safe spaces for adolescent Non-Offending MAPs was tempered by fear of public backlash: "I dream of setting up a group... but I don't know how to do it safely... I think we'd have Molotov cocktails and picket lines" (p. 18). Her statement captured the emotional weight of stigma and the sense of powerlessness it can impose on therapists committed to compassionate care.

This theme illustrates how societal fear not only shapes public perception of Non-Offending MAPs, but also influences therapists emotionally, relationally, and impacts their professional identity. It highlights the need for stigma-informed practice, safer therapeutic spaces, and a reframing of adolescent Non-Offending MAPs' identity beyond risk-based narratives.

**5.8.1.2 Therapists' Use of Language.** Therapists expressed concern about the use of stigmatising language that frames adolescent Non-Offending MAPs as 'disordered,' particularly in reference to diagnostic labels. Ann reflected on the tension between language and acceptance and confusion from others: "...training... emphasised the difference between sex offender, child sex abuser, and a paedophile. And I thought, yeah, but isn't it obvious?" (p. 4).

Zarah advocated for deconstructing language, viewing minor attraction as a sexuality rather than a 'disorder'. She was especially cautious about labelling adolescents, noting: "...they are so young... in search of identity. It's a really strong label" (p. 31). She acknowledged the difficulty of finding appropriate terminology and use of words such as paedophile or disorder: "...they're already very stigmatised... it's a very hard wording" (p. 33) and expressed ambivalence about open dialogue: "...there can be some sort of danger in allowing conversations... there's a risk of it becoming something" (p. 26).

Sam echoed this developmental age, emphasising that adolescents may not yet understand their sexuality: "It's not till you're getting much older... adolescents haven't really identified it yet" (p. 17). Zarah also aligned with this view, stressing the importance of allowing young people to explore without being prematurely labelled: "...it's very hard to feel like they're allowed to make mistakes... without being instantly labelled" (p. 12). She also valued the adaptability and individual differences required when working with adolescent Non-Offending MAPs: "The flexibility of working with young people... I find nuance very important" (p. 13).

This sub-theme emphasises the ethical and emotional intricacies of language use in therapy and stresses the importance of avoiding reductive labels that could reinforce stigma and obstruct identity development.

### ***5.9.1 Constructing Non-Offending MAPs Identity***

This theme examines how therapists conceptualise Non-Offending MAPs' identities, especially during adolescence, as a complex and developing aspect of sexuality rather than a fixed disorder. Participants challenged DSM-framed ideas of pathology, instead viewing minor attraction as part of a wider spectrum of human experience. Therapists demonstrated efforts to understand adolescent Non-Offending MAPs' perspectives with empathy, recognising their emotional struggles, identity development, and need for relational safety.

**5.9.1.1 Seeing the Person First.** Sam and Zarah highlighted the importance of viewing Non-Offending MAPs holistically, beyond just their attraction. Sam described this as a process of deep acceptance: “They're human beings... deep, deep, deep pain! ... acceptance of the whole person and not just focus on the minor attraction” (p. 10). The repetition emphasised the emotional intensity and the suffering caused by being reduced to a label.

Zarah echoed this, advocating for connection rather than categorisation: “By always realising the similarities are greater than the differences... it doesn't matter really what your sexual orientation” (p. 21). She also acknowledged the additional challenges faced by those expressing gender diversity: “It gets very confusing for people... they are still faced with a lot of backlash or stigma” (p. 3). Her reflections highlighted the need for greater understanding of both sexual and gender identity, especially in therapeutic contexts.

Ann brought a developmental lens to Non-Offending MAPs identity, contrasting younger clients' flexibility with older clients' entrenched self-hatred: “We got to him finding a sense of this is acceptable... but never accepting himself” (p. 15). She noted cognitive rigidity in older clients and described adolescents as more open to change. Her role with adolescent Non-Offending MAPs often felt parental: “You're a role model... I have a bit of mummy role in those cases” (p. 15). This protective stance reflected both empathy and

emotional investment, as she recognised the heavy burden adolescent Non-Offending MAPs carry.

Ann's narrative revealed the tension between hope and exhaustion, between guiding young people and witnessing the long-term effects of stigma and secrecy. Her reflections illustrated how therapists navigate the emotional complexity of supporting adolescent Non-Offending MAPs through identity formation, self-acceptance, and relational trust.

**5.9.1.2. Navigating Individual Differences and Support Needs.** This sub-theme examines how therapists recognised the developmental, cognitive, and gender-related differences among adolescent Non-Offending MAPs, particularly in relation to identity formation and therapeutic engagement. Both Sam and Zarah emphasised that adolescents are often still in the process of discovering who they are and may not yet fully comprehend their minor attraction.

Sam's earlier quote (see p. 154) highlighted the fluidity of identity during adolescence and the vulnerability that comes with navigating emerging sexuality. His observations highlight the importance of a stigma-informed therapeutic environment that fosters exploration without fear or judgement.

Zarah echoed this developmental sensitivity, noting that younger clients tend to be more cognitively flexible and open to self-exploration: "Young people... are in full search of who they are... which brings an openness... harder in working with adults... they already have a clear sense of who they are" (p. 12). She expressed a preference for working with adolescents, recognising the potential for growth and change: "... easier to do with young people who are still trying to figure it out" (p. 14).

Zarah also noted that some adolescent Non-Offending MAPs lack insight into why their attractions may be upsetting to others: "... they don't have a lot of insight into why this is troubling... or why others are concerned" (p. 4). This highlights the importance of

therapeutic approaches that promote self-awareness and contextual understanding without reinforcing shame.

Gender differences were also observed. Sam noted that while most Non-Offending MAP clients are male, it is mainly females who seek therapy: “Mostly females come to therapy, but most of the MAP clients are male” (p. 5). This discrepancy points to possible gendered dynamics in help-seeking behaviour and stigma perception, although the exact reasons remain unclear.

Both Sam and Zarah discussed Non-Offending MAPs attraction within the context of sexuality rather than as a form of pathology. Sam expressed confusion regarding diagnostic framing, referencing a case involving relational conflict: “Was it his MAP orientation, or was it the porn addiction?” (p. 11). Zarah found it helpful to conceptualise Non-Offending MAPs attraction as a type of sexuality: “... I find these different perspectives very helpful in working with binary attracted persons” (p. 18).

Together, these reflections emphasise the importance of recognising individual differences in identity development, self-awareness, and therapeutic needs. They highlight the value of flexible, developmentally sensitive approaches that avoid pathologising and instead assist adolescents in managing complex aspects of their emerging identity.

### ***5.10.1 Therapeutic Engagement and Boundaries***

All participants discussed the therapeutic process of working with adolescent Non-Offending MAPs, while also recognising individual differences. Common themes included power dynamics, management, and containment within the therapy context. This GET theme focused on therapeutic issues and barriers, including sub-themes of managing boundaries and emotional distance in therapy. Emotional overload can lead to burnout, highlighting the importance of balancing empathy with self-care. Therapists emphasised the importance of

maintaining professional boundaries and to emotionally distancing themselves to avoid burnout. The challenge of shared decision-making was also noted, with participants acknowledging the difficulties in providing adequate support while navigating complex ethical considerations.

**5.10.1.1 Managing Therapeutic Boundaries, Risk Management and Decision Making.** Therapists described the importance of maintaining professional boundaries and emotional distance when working with adolescent Non-Offending MAPs. This was seen as ethically necessary and protective against burnout and vicarious trauma. Boundary-setting varied by therapist, shaped by emotional responses, past experiences, and case intensity.

Ann described distancing during difficult disclosures: “Brace myself and don’t listen to the detail” (p. 9). She used dissociation and avoidance to cope while prioritising clients, reflecting tension between presence and self-protection. Her narrative reflected an internal struggle between maintaining therapeutic presence and safeguarding her emotional well-being.

Sam also emphasised “switching off,” noting thoughts about clients outside work were reflective, not distressing: “Oh,that’d be good for so and so, you know...” (p. 16). She appeared confident in maintaining a clear separation between her professional and personal life.

Christian echoed this, describing his ability to detach as a skill developed during his previous work in prisons: “Uh I’m a little bit kind of detached from my work” (p. 7). He used physical activity as a means of emotional regulation and boundary reinforcement.

Ann also asserted boundaries shaped by prior experiences: “...it’s never shaming... but I’m not a sex worker” (p. 14). Both Ann and Zarah stressed physical and emotional separation. Ann, who publicly identified as “paedophilia friendly,” felt compelled to clarify her own sexual identity to protect herself and her clients: “I’m definitely in my age group...

my age of attraction” (p. 4). Zarah relied on her commute and routine to decompress: “Travel time gives me time to... be present for my family” (p. 30). She avoided minor attraction related content privately and acknowledged emotional depletion: “Support is very, very, very important in my job!” (p. 18).

Across accounts, therapists expressed a common need for boundaries, not as a means of avoidance, but to sustain empathy, safeguard their own well-being, and maintain ethical clarity in emotionally demanding work.

Therapists described the emotional and ethical weight of working with adolescent Non-Offending MAPs, highlighting the need for robust support systems and shared decision-making. Across narratives, participants expressed tensions in accessing supervision, navigating risk, and managing the burden of secrecy and stigma.

Support systems and supervision were vital yet inconsistent. Ann contrasted supervisors as one was experienced in forensic work and the other supportive, but unfamiliar with MAP risk: “Talking about risk... can be really hard because people go immediately to the risk to children” (p. 5). She emphasised the importance of transparency.

Zarah echoed the need for specialised support, preferring to consult colleagues familiar with Non-Offending MAPs work: “Colleagues who work with the same group... really recognise the struggles you're going through” (p. 18). Her preference for consulting peers with shared experience reflects a need for safety and validation in ethically complex work. She described feeling overwhelmed by complex decisions and the fear of working in isolation: “I really need the help and support of the team and a shared vision on where we're going with this client” (p. 18). She valued second opinions and collaborative planning.

Christian and Sam also emphasised the importance of peer support and supervision. Christian valued honest, non-avoidant supervision and recognised the need to seek help when feeling depleted: “I seek support from colleagues and other psychologists” (p. 10). He

described peer supervision as essential, although acknowledged hesitations around discussing risk: “The main thing is talking about it in supervision... and there's also a peer supervision group” (p. 7).

Zarah also sought support outside of work, relying on her partner while remaining mindful not to overburden him: “I have a very understanding and loving spouse... but I don't want to burden him” (p. 17). Her emphasis on the word “very” when describing the importance of support highlighted the emotional intensity of her role: “Support is very, very, very important in my job!” (p. 18).

Across accounts, therapists conveyed a shared need for safe, informed, and collaborative spaces to process the emotional and ethical complexities of working with adolescent Non-Offending MAPs. The burden of decision-making, secrecy, and stigma was mitigated, though not eliminated, by supervision, peer dialogue, and relational support.

Therapists described the complexity of managing perceived risk when working with adolescent Non-Offending MAPs, highlighting tensions between safeguarding, stigma, and therapeutic empathy. Risk was not framed as static or binary, but rather as a relational and developmental concern that requires nuanced judgement and collaborative dialogue.

Managing perceived risk was complex and relational. Risk was framed as dynamic, requiring nuanced judgement. Christian viewed therapy as protective: “Coming to therapy is protective... they don't want to harm a child” (p. 4–5). He acknowledged ethical weight when clients resisted change: “If they're unwilling to change, there will be very real consequences” (p. 17).

Ann and Zarah both described the tension between recognising risk and avoiding unnecessary pathologisation. Ann spoke of a “balancing act” between protecting children and respecting Non-Offending MAPs' self-perception: “Not every person with paedophilia wants to be sad... they see themselves as definitely not ever being the risk” (p. 11). She emphasised

the importance of co-creating risk conversations with clients, particularly during intake: “If you feel I’m hammering on too much... we can talk together about what it’s about” (p. 11).

Zarah shared similar concerns, noting the challenge of maintaining a non-judgemental stance while addressing risk. She described her clients’ internalised stigma: “They understand society’s viewpoint... but society has a problem with me” (p. 17). Her approach moved beyond risk management toward a strengths-based model, focusing on quality of life and holistic wellbeing: “What a good life to them looks like... more than just how do you deal with sexual interests” (p. 15).

Ann also observed challenges in supervision, where risk discussions often defaulted to child protection concerns: “Talking about risk... people go immediately to the risk to children” (p. 6). This reflected broader societal anxieties that can permeate clinical environments, making nuanced therapeutic engagement more difficult.

Together, these narratives reveal how therapists navigate risk not as a fixed threat, but as a dynamic process shaped by stigma, developmental context, and relational ethics. Their reflections highlight the importance of supervision, collaborative dialogue, and therapeutic environments that balance caution with compassion.

**5.10.1.2 Power dynamics.** The challenges of providing adequate support, shared decision-making, and the burden of making complex decisions were highlighted. Ann and Zarah both discussed that therapy supervision was both formal and informal. They both experienced tensions across different forms of support from colleagues and supervision. Overall, Ann perceived both supportive and negative reactions towards adolescent Non-Offending MAP client group from others, and she observed both sides of this in supervision.

They're scared and I'm like, but I need people who can talk about this, and I have two supervisors who are wonderful, and one actually has a lot of experience, but mainly in the offending... So, he is not afraid of talking about anything, so to speak. But my

other supervisor...she's very supportive, but she doesn't know anything about it. (p. 5).

In addition, Ann felt the burden of holding secrets and then needing to share them in supervision. Here she perceived herself as,

Strongly on the prevention side and whatever I do is about, and I do always keep risk in the back of my head, but it's not always necessary to explicitly talk about it.

Frequently, but I will always bring a client like this immediately to supervision. I will let both my supervisors know I've taken on another one just to make sure it never becomes a secret. Because they have so many secrets and the risk of a parallel process of secrets is really big and I feel I've maybe done something clumsy, or even wrong. And then because I've never introduced them, I can't speak about it (p. 12).

Zarah's earlier quote (see p. 160) noticed differences in support with her colleagues preferring to share with other therapists who work with Non-Offending MAPs. Zarah experienced feeling burdened with decision-making when working with adolescent Non-Offending MAPs and needing to share the burden with others as a way of making the right professional decisions. She highlighted that she needed ongoing support from her Multi-Disciplinary Team to share plans and interventions, and she feared being alone in her decision-making. This insinuated how the work can be complex and lonely at times. She previously illustrated this (see p. 161). Zarah highlighted experiencing a lack of support working with adolescent Non-Offending MAPs and not being able to share her work with others due to the stigmatising connotations attached to the work. Additionally, Zarah acknowledged her conflict between supportive but also experiencing strong subjective opinions from others, rather than professional opinions and managing this tension appeared difficult for her. She illustrated this here, "... we have a very strong shared purpose and shared vision in how we want to help people.... people have very strong or really very quick

to resort to their own personal opinions... and which sometimes hinders my job” (p.19).

Zarah experienced that she was able to challenge and confront her team and be part of something bigger. She felt included and empowered during therapy. This sense of inclusion and agency may have been reinforced by her linguistic shift from “client” to “people,” subtly reframing therapeutic work as relational and humanised rather than clinical or transactional. The repetition of “shared vision” (see p.160 & p.164) across contexts suggests a deepening of connection and alignment, both with her team and with the broader goals of therapy. She also valued feeling a shared purpose as a form of support, suggesting that she did not want to work alone and emphasising the importance of a wider community.

Sam and Christian both focused on supporting their peers. While they shared a need to support others, they had different views on supervision. Ann recognised that supervision and informal meetings with colleagues serve as a form of support through connection and relating to peers and in contrast Sam's earlier quote sought support from both internal and external sources and aimed to be prepared (see p.162). Zarah valued gaining support through frank conversations with her peers, saying, “And I was also more dependent on the help and the advice of my colleagues because those are very hard cases to work with” (p. 17). Zarah’s earlier quote (see p. 161) highlighted how she looked for support outside of work from her partner too. This perhaps highlights how therapists often carry the emotional residue of clinical encounters into their home environments, blurring the lines between therapy provision and personal wellbeing.

There was a commonality shared by Ann, Christian and Zarah. Ann needed to find support and network with forensic experience from specialist supervision and from external sources.

Christian also needed external support through supervision and noted the importance of transparency in sharing the risk with others.

I really uh think it helped in in supervision having a supervisor was kind of frank and honest and able to you know not be scared to talk about this group and I uh think you know some of my peers I've worked with avoid working with this group because of the risk and they don't know is an unknown factor (p. 4).

Christian prioritised his need to create space to talk about this in supervision and peer support, emphasising the importance to him. In an earlier quote, there was hesitation in his voice and words as he spoke about peer supervision (see p. 162), this may have been related to the tensions with how he experienced risk. Christian later noted being able to see support and recognition of needing help. "... recognise when I need more support or I'm feeling like I need a boost" (p. 10). Christian recognised the need for his supervisor to be helpful and open, rather than avoidant and unable to talk about risk and his feelings.

Therapists reflected on the changing power dynamics within therapeutic relationships with adolescent Non-Offending MAPs, emphasising tensions between autonomy, responsibility, and relational influence. These dynamics were influenced by client readiness, societal stigma, and therapists' own emotional stance.

Sam described adolescent Non-Offending MAPs as often entering therapy under external pressure, which limited their sense of agency: "They don't really want to be there... parents or schools told them they got a problem" (p. 5). She acknowledged the challenge of working with clients who felt disempowered, and the need to balance therapeutic pacing with accountability: "There will come a point... I've got to turn the heat up a little bit" (p. 6). Her approach emphasised collaboration and choice: "...choose with anybody what we talk about" (p. 11), while also recognising the risks of imposing direction: "If I get in there and start deciding where we go, I can mess things up" (p. 12).

Christian described moments of emotional transference, where clients' isolation and sadness affected his own sense of efficacy, "They felt so isolated and alone... I could only do

so much” (p. 5). He used pauses and supervision to recalibrate, maintaining therapeutic presence while respecting his limits. His flexible, transparent approach, such as adjusting fees and scheduling, reflected a commitment to fairness and client autonomy: “If they are struggling... we can either pause therapy or do it once a month” (p. 9).

Zarah viewed her therapeutic role as a source of strength for clients, emphasising resilience-building as central to her practice: “Help them recognise they are stronger than they believe” (p. 24). She reflected on her own growth, noting how working with Non-Offending MAPs enhanced her awareness of therapeutic influence: “It’s made me more aware of my own powers as a therapist” (p. 23). Her narrative highlighted curiosity, presence, and the transformative potential of even brief interactions: “I just have one moment, one conversation... and then they’re gone” (p. 7).

Ann focused on relational repair and transparency, describing how acknowledging mistakes and apologising fostered trust: “I reflected... I think I got it totally wrong... it’s important I say sorry and learn from it” (p. 22). Her openness created space for clients to feel heard and respected, reinforcing a collaborative and empowering therapeutic alliance.

Across narratives, therapists highlighted the importance of authenticity, humility, and shared exploration. Sam’s willingness to sit with uncertainty, “There’s no magic pills over here... I got nothing” (p. 6), and Zarah’s focus on values and dreams, “What a good life looks like... more than just sexual interests” (p. 14), demonstrated how power can be rebalanced through relational depth and meaning-making. Therapists also recognised that empowerment is not always linear or sustained. Zarah noted that not all interactions were overtly therapeutic yet still held meaning: “People... are very thankful... it can be really cathartic” (p. 6). Her reflections highlight the importance of presence, attunement, and the capacity to hold space for clients navigating complex identities and societal judgement.

This theme reveals how therapists navigate power not as control, but as relational influence shaped by empathy, reflexivity, and a commitment to fostering autonomy within ethically charged and emotionally demanding contexts

**5.10.1.3 Emotional Containment and Engagement.** Therapists described the dual challenge of containing their own emotional responses while encouraging clients to move beyond superficial engagement. This balance was seen as essential for building trust, fostering insight, and navigating the stigma and complexity surrounding minor attraction.

Christian emphasised the importance of relational safety and acceptance, noting that many Non-Offending MAPs clients felt disgusted by their thoughts but were committed to non-offending: “They are attracted to children, but they were adamant they wouldn’t do anything... you can offer some hope and some acceptance for their identity too” (p. 3). His approach reflected principles of Acceptance and Commitment Therapy, guiding clients toward self-acceptance without judgement.

Zarah described oscillating between emotional containment and exploration, recognising that clients often struggled to understand their own experiences: “Sometimes they have questions... they don’t understand what’s gotten to this place” (p. 5). She acknowledged the difficulty of confronting sexual feelings and the need to scaffold emotional readiness: “They were really unwilling to think about their own sexual feelings... or why people were concerned” (p. 16).

Sam and Christian both noted barriers to deeper engagement. Sam observed that adolescents often entered therapy under external pressure, which limited their investment: “They’re not paying... so they have less skin in the game” (p. 4). She addressed this directly in sessions, challenging clients to reflect on their presence: “What had you show up today?”

(p. 6). Her willingness to confront avoidance promoted emotional depth and therapeutic momentum.

Christian also described logistical challenges, particularly in remote therapy settings: “Sometimes it just feels... quite superficial and trying to build trust” (p. 6). These barriers highlight the importance of presence and attunement in fostering meaningful engagement.

Zarah offered a strengths-based counterpoint, focusing on envisioning a good life as a way to bypass avoidance and build hope: “I find it really important to discover what a good life looks like... especially for young people confronted with very hard feelings” (p. 15). She recognised that emotional readiness often emerged gradually, and that resilience could be cultivated through curiosity and relational safety: “When people are finally overcoming their insecurities... it’s a very stigmatised topic” (p. 20).

Across narratives, therapists described emotional containment not as detachment, but as a deliberate stance that allowed them to hold space for clients’ discomfort, shame, and uncertainty. Engagement was framed as a process sometimes slow, sometimes fragile, but always rooted in empathy, authenticity, and the belief that even stigmatised identities deserve relational depth and therapeutic care.

### ***5.11.1 Therapist Factors – Emotional Impact and Relational Responses in Non-Offending MAPs Therapy***

All participants described experiencing a significant emotional burden in their work with adolescent Non-Offending MAPs. This burden was expressed through language that conveyed both deep empathy and psychological strain. While individual experiences varied, there was a shared recognition of therapeutic heaviness, emotional reactions, fear, and the importance of holding hope. These reflections revealed how therapists internalise and navigate the emotional complexity of supporting stigmatised youth, often in the absence of societal understanding or institutional support.

**5.11.1.1 Therapeutic Heaviness and Emotional Responses.** Ann, Sam, and Christian all described the weight of working with adolescent Non-Offending MAPs clients as emotionally intense and, at times, overwhelming. Ann spoke of intrusive thoughts that lingered beyond sessions: “Clients keep popping up in my head whilst I’m chopping the onions... it’s hard to let go of them” (p. 21). She described a sense of helplessness, particularly with clients who felt their desires were “unsolvable”: “Grief can be incredibly heavy” (p. 5) and noted that suicidal ideation added a layer of fear and emotional intensity: “It can be very heavy... and feel scary” (p. 8).

Sam previously echoed this heaviness, describing the profound pain and isolation her clients experienced (see p. 163). She related to her clients as equals, expressing heartbreak over the risks they faced if exposed: “You can lose your job... your family... your whole world can get blown up” (p. 10). Christian described the transference of sadness and the need to limit his caseload to maintain emotional capacity: “Immense, immense sadness... I park it in the session and then talk to my supervisor” (p. 6). His reflections highlighted the importance of collaborative meaning-making as a counterbalance to despair.

Zarah, while acknowledging the emotional intensity, described her coping mechanisms with confidence. She noted that the work was manageable and not intrusive: “It doesn’t take over my life... it’s not very intrusive” (p. 10). Her narrative reflected a sense of control and resilience, supported by boundaries and emotional regulation.

**5.11.1.2 Navigating Emotional Reactions and Relational Depth.** Therapists described a wide range of emotional reactions in their work with adolescent Non-Offending MAPs, spanning discomfort, fear, empathy, and relational fulfilment. While negative responses were common, particularly in early encounters or moments of disclosure, all participants also reflected on the importance of acceptance, curiosity, and emotional attunement as core conditions for effective therapy.

Ann described initial feelings of shock and disgust when clients disclosed their attraction, noting how she had to regulate her internal response: “Oh, I didn’t expect this coming” (p. 9). She relied on breathing and containment strategies to remain present, while recognising transference: “The parallel process can be very similar” (p. 8). Her fear of “horrendous responses” from others contributed to a sense of isolation: “It’s difficult to talk to other people” (p. 5).

Sam experienced tension between her personal values and societal stigma, describing the intrusion of intolerance into her therapeutic space: “Bigotry or intolerance... therapists should be beacons of openness” (p. 10). She expressed sadness when clients terminated therapy prematurely: “They gotten uncomfortable... the therapist in me goes, oh you were so close!” (p. 6), revealing her emotional investment in facilitating change.

Christian acknowledged fear in managing risk and described moments of internal triggering: “If something triggers something in me... I deal with it at the time” (p. 6). He relied on supervision to process these reactions and drew on his prison experience to maintain emotional detachment when needed.

Zarah earlier quote (see p.167) described the pressure of brief therapeutic encounters, where she had one chance to make an impact. She acknowledged the uncertainty and emotional weight of these interactions, especially when clients remained anonymous or disengaged.

Despite these challenges, all participants described moments of empathy, acceptance, and emotional connection. Ann reflected on the importance of repairing mistakes and becoming more reflective over time: “There can be a lot of good in repairing mistakes” (p. 22). Sam described a turning point in her confidence: “I felt like I had the capacity to work with the group... not being triggered” (p. 9), and expressed genuine care: “I care about you... I want it as best as I can” (p. 18).

Christian emphasised the bravery of adolescent Non-Offending MAPs and the importance of building trust: “These young people are scared... demonised... trying to make sense of shame and hatred” (p. 10). His reflections highlighted the need for relational safety and therapeutic containment.

Zarah described her work as meaningful and rewarding, grounded in curiosity and inclusivity. She viewed adolescent Non-Offending MAPs through a sexuality lens and valued the “grey areas” of identity: “The humanity behind it is so similar... it really helps me to empathise” (p. 22). She expressed pride in her role and gratitude for client feedback: “They often expressed a lot of gratitude... which I take pride in” (p. 7) and found motivation in making a difference even if only for one person: “If it’s just one person in a whole year... you’ve made a difference” (p. 8).

Across narratives, emotional reactions were not static but evolved through reflection, supervision, and relational engagement. Therapists described the emotional labour of holding space for stigmatised youth, and the transformative potential of empathy, humility, and human connection. Their accounts highlight the need for stigma-informed supervision, emotional containment, and relational depth in therapeutic work with adolescent Non-Offending MAPs.

**5.11.1.3 Holding Hope and Navigating Emotional Safety.** Therapists described holding hope as a vital component of their work with adolescent Non-Offending MAPs, beneficial not only for clients, but also for sustaining their own emotional resilience. Hope was framed as a counterbalance to stigma, shame, and despair, and as a therapeutic tool for fostering self-acceptance, future orientation, and relational trust. At the same time, participants reflected on the emotional toll of working with stigmatised material, revealing how therapeutic exposure can reshape perceptions of safety in both professional and personal contexts.

Ann described adolescent Non-Offending MAPs as her “most successful client group,” emphasising that self-acceptance was the most meaningful outcome: “The chances of acting on them go down massively... they can have fulfilling lives” (p. 7). She focused on helping clients envision alternative, meaningful futures: “What can I do with my life that is fulfilling?” (p. 16) and expressed deep empathy for the grief and fear they carried: “It’s not difficult for me to empathise with the hopelessness... and the fear of telling someone” (p. 9).

Zarah echoed this future-focused stance, describing hope as a professional duty: “I think it’s my professional duty... to keep hope alive” (p. 25). She guided clients to explore their values and life goals: “Getting people to actually look at their own life and the hard feelings” (p. 15) and found transformation most evident when clients internalised therapeutic insights: “Seeing them actually do something with the things you discussed in therapy” (p. 6).

Sam’s earlier quote also held hope as a core therapeutic value, describing pride and satisfaction when witnessing client growth, and expressing genuine care (see p. 174). Her narrative suggested that hope was not abstract, but relational built through trust, presence, and belief in the possibility of change.

Yet alongside this hopeful stance, therapists also described the emotional toll of working with taboo and distressing material. Zarah offered a divergent account of emotional intrusion and hypervigilance. She reflected on how therapeutic exposure had reshaped her perception of public space and eroded a sense of innocence.

I think it takes away part of your naivety. It it and I am a mother, and I am very aware of the surroundings and the people surrounding my child, so it it does have an impact on the way you view society item. I’ve always been very conscious of privacy and public spaces...But it it's it's this job has certainly

made me feel made, made even more more aware of when I go to public playgrounds or swimming pools. (p. 9).

She described a heightened sensitivity to potential risks, particularly in environments involving children. This hypervigilance extended beyond professional boundaries, suggesting that the emotional residue of her work had permeated her personal life.

Her reflections highlighted the need for protective strategies and emotional boundaries, especially when working with high-stakes topics. While other participants described emotional containment within therapy, Zarah's account suggests that for some therapists, the impact of working with Non-Offending MAPs may extend into their lived experience, shaping how they navigate public and familial spaces.

Together, these narratives illustrate how therapists balance hope and caution using future-focused engagement to resist dehumanisation and foster resilience, while also recognising the emotional cost of proximity to stigma and risk. Holding hope emerges as both a therapeutic strategy and a protective stance, sustained through ethical care, emotional attunement, and the ongoing negotiation of emotional safety.

### ***5.12.1 Systemic Barriers and Professional Issues***

This theme captures therapists' recognition of systemic gaps in training, funding, and policy, alongside their personal journeys of growth, awareness of bias, and resilience. Participants described the absence of formal pathways for working with adolescent Non-Offending MAPs, the emotional labour of navigating stigma, and the transformative potential of reflexive practice.

**5.12.1.1 Policy and Funding as an Unmet Need.** Ann and Zarah both highlighted the lack of specialist training and institutional support for adolescent Non-Offending MAP focused therapy. Ann expressed a sense of professional isolation, noting the absence of

formal guidance: “I can't call myself a specialist because there is no specialism... there is no training in this” (p. 17). Her reflections suggested a burden of responsibility and fear of mistakes in a field with no clear guidance.

Zarah emphasised the political and societal reluctance to invest in Non-Offending MAPs-related services, noting that media attention occasionally shifted public and funding priorities: “This media case... made a really big difference in funding, in willingness” (p. 28). She also acknowledged the broader societal avoidance and discomfort surrounding minor attraction, which complicates policy development and public discourse.

Together, these accounts highlight the need for systemic reform specialist pathways, funding structures, and stigma-informed training to support ethical and effective therapeutic provision.

**5.12.1.2 Building Resilience by Preparing and Working on Personal Bias.** Sam, Christian, and Zarah described how working with adolescent Non-Offending MAPs prompted deep personal reflection and growth. Resilience was framed not only as emotional endurance but as a product of confronting bias, processing discomfort, and expanding empathy.

Christian drew on his prison experience to contextualise his emotional resilience: “Working with people minor attracted... they haven't done anything” (p. 7). He described becoming sensitised through exposure, learning to bracket emotional responses and maintain therapeutic presence.

Zarah reframed desensitisation as strength: “I've been desensitised... but I think it's powerful to view it as resilience” (p. 22). She described how repeated exposure to difficult narratives expanded her capacity for empathy: “People don't really blow me away anymore” (p. 20). Her reflections revealed a shift from overwhelming to grounded confidence.

Sam attributed her resilience to personal therapy and self-work: “I’ve had to work through decades of interpersonal trauma” (p. 16). She described how exposure to Non-Offending MAPs helped dismantle stereotypes: “You only have the stereotypes... that’s why I go to those meetings” (p. 14). Her narrative illustrated how intentional exposure, and reflection can challenge cultural conditioning and foster inclusive practice.

All three therapists described moments of emotional intensity and self-awareness. Sam recounted a visceral experience of cultural bias surfacing unexpectedly: “I was making the bed... really surprised by the intensity of the bigotry or intolerance” (p. 9).

Earlier (see p.168), Zarah reflected on her evolving sense of power and responsibility as a therapist. She recognised that families surrounding Non-Offending MAPs often struggle with acceptance, and that her own growth enabled her to support both clients and their wider systems.

Across narratives, resilience was not innate it was cultivated through discomfort, reflection, and relational engagement. Therapists described becoming more self-aware, more ethically attuned, and more capable of holding space for stigmatised identities. Their insights point to the need for systemic support not only in service provision, but in therapist development training that fosters reflexivity, emotional regulation, and bias awareness.

### **5.13 Discussion**

The IPA aimed to understand the lived experiences of trained therapists/psychologists as they make meaning of working with adolescent Non-Offending MAPs, uncovering therapists’ empathy, therapeutic bias and resilience within their therapeutic work. This section will discuss and interpret the findings by applying theory and previous research from the literature review in Chapter Two. It will offer further recommendations for future research and practical research implications. The findings are dominated by five GETS made

up of subthemes which emerged through the analysis. The themes can be understood through social psychological theory in relation to Stigma as an individual and relationally to the client. Each theme will be discussed below.

### ***5.13.1 Navigating Stigma and Societal Fear***

The findings illustrated that therapists consistently grappled with societal narratives that conflate adolescent Non-Offending MAPs with sex offenders, reinforcing stigma through media and cultural discourse. This aligns with Henderson's (2014) model of stigma, particularly at the structural and interpersonal levels, where adolescent Non-Offending MAPs are framed as inherently dangerous and morally deviant. Therapists described the emotional toll of working within these narratives, noting how societal fear obstructed empathy and contributed to both client and therapist isolation. This theme illustrated how all participants experienced a felt sense of how deeply rooted the societal discourse of the prevalence of stigma is embedded into the narrative of their therapeutic work. It captured how the participants experienced stigma not only towards themselves but there was an additional impact of stigma on the role towards family and an apparent tension to defend or hide. Previous research has suggested managing stigma may result in Non-Offending MAPs concealing their sexual attraction which may contribute to internalising stigma and mental health decline (Greene et al., 2003). The findings further confirm therapists also experience a wider impact from this stigma and experience a lack of understanding from others. The need to conceal their work to avoid societal taboos can be distressing for therapists. This concealment leads to self-censorship and creates tension between destigmatising Non-Offending MAPs while avoiding further controversy. Additionally, seeking support networks becomes crucial in navigating these challenges. The finding suggests this need for therapist concealment was an unexpected aspect of the research highlights a critical facet of working

with adolescent Non-Offending MAPs, which may significantly impact therapeutic work. This dynamic may significantly impact therapeutic work and recognising it can inform future research and practice. This emphasises the importance of support systems for therapists and the need for stigma-free environments that allow for effective and empathetic therapeutic interventions.

This finding should be seen as a facet of working with adolescent Non-Offending MAPs, and the implications may impact therapy work. This finding suggested the participants experienced a sense of feeling powerless and fearing repercussions. This appeared to be exacerbated by the socially constructed societal fear surrounding adolescent Non-Offending MAPs. Participants made references to the comparison of adolescent Non-Offending MAPs with offending MAPS. This indicated that deeply embedded stigma can be held implicitly (Nematy et al., 2024). There also appears to be tensions in how adolescent Non-Offending MAPs are perceived on a 'Continuum' of sex offending and direct comparisons made to sex offenders. This may be reinforced by the therapist's previous experiences or interactions with sex offenders.

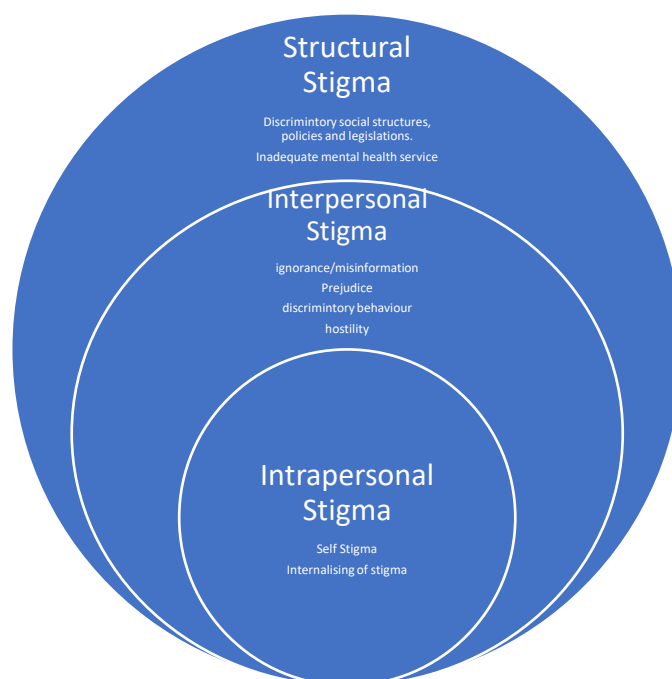
Overall participants recognised vast differences from offending. Ankers et al. (2023) findings concur prejudiced attitudes are socially constructed through interactions with others. The present study concurs with Pachanki's (2007) process model. Some participants concealed their work through impression management. This duly impacts on therapists as they become more hypervigilant towards threat (Mendoza-Denton et al., 2002) resulting in overactivation of stress responses, mental health issues and concealing their identity (Goffman, 1963). It is acknowledged three out of the four participants were female. It is not known if there was any influence from gender. In line with Schmidt (2023) who suggested that female therapists held more stigmatising attitudes towards Non-Offending MAPs than male counterparts. It may also mean female therapists may be more preoccupied with safety

and risk. In relation to the present study there was some focus on being more aware of risk in agreement with Baum and Moyal (2020).

Stigma plays an important part in therapeutic work with this group. There appears to be stigma by association (Goffman, 1963) and an impact of stigma outside of work (self, social and structural stigma). The findings support how stigma exists on three levels structurally within self (intrapersonal), social (interpersonal) and structural (Henderson et al., 2014) (Figure 9).

### Figure 9

*Multiple levels of stigmatisation of mental health adapted from Henderson et al. (2014)*



In Chapter Two, it was highlighted that societal stigma is prevalent in mental health and can be attributed to professionals (Ahmedani, 2011). The findings further conveyed adolescent Non-Offending MAPs are still considered an abstract concept and there is a lack of understanding of the constraints they experience. It is perceived as additionally harder for adolescents since they are physically and emotionally still developing. The findings harboured tensions about how the language used is stigmatising. Therapists wanted to use

deconstructing language, which does not reinforce stigma. Therapists recognised that adolescents are still in the process of identity formation; however, they also acknowledge the absence of any widely accepted alternatives.

However, the present study's findings further suggest that stigma can also be experienced by the professional. This aligns with Ostman and Kjellin (2002), who concur that professionals close to stigmatised individuals could also experience associative stigma due to social stigma and perceptions from others working with individuals who are 'socially unacceptable' (Vogel et al., 2006). The findings of the present study also support those of Parr and Pearson (2019), who suggest there is a perceived professional risk of supporting Non-Offending MAP clients with associative stigma, which they suggest could deter therapists from supporting this client group. The perceived prejudice and discrimination increased by the fear of the therapist's negative consequences. Therapists may then experience '*roadblocks*' from offering support (Cantor & McPhail, 2016). This is evidenced by Ahuja and Tenbergen (2022) who suggest a fear of repercussion, which could further hinder support. Similarly, the review by Aranda et al. (2023), which highlighted Goffman's (1963) theory, appeared to frame stigma as relational rather than an attribute. This perspective suggests a need to refocus on the relational dimensions of stigma to deepen understanding of its implications. Relationally, stigma appears to be experienced by both the adolescent Non-Offending MAP client and the therapist, and this is something that needs acknowledging in the relationship as '*the elephant in the room*'.

### ***5.13.2 Constructing Non-Offending MAPs Identity***

This theme represents a felt sense of understanding and acceptance towards adolescent Non-Offending MAPs. Therapists perceived themselves as 'Protectors'. This understanding and acceptance are constructed from being able to see the person holistically

and not from a reductionist perspective, but seeing the attraction as an innate sexual orientation, as suggested by Seto (2012). The findings suggested most participants were resistant to pathologising adolescent Non-Offending MAPs, similar to research which has focused on acceptance (Dymond & Duff, 2020; Lievesley et al., 2020). There was a shared narrative of wanting to see beyond the label of disorder, which is in tension with how many Non-Offending MAPs report judgemental attitudes in therapy (Cacciatori, 2017). Although the present study cannot be generalised to other therapists outside the participants of the present study, it suggests therapists can empathise with and accept adolescent Non-Offending MAPs. The present study findings agreed with existing literature, such as Lievesley et al. (2023), that therapy should be focused on facilitating inner peace and encouraging self-acceptance. The participants depicted experiences of instilling hope by highlighting the differences between attraction and acting on thoughts in line with the Good Lives Model (Ward & Brown, 2004).

The interviews highlighted how participants experienced differences between adolescent and adult clients. The findings suggested adolescent Non-Offending MAPs are perceived as not holding deeply rooted beliefs, and the therapist's role was being able to be a role model to influence the plasticity of brain development, and there was more willingness to explore beliefs in therapy. Participants experienced some confusion and frustration around age and not wanting to label adolescents as Non-Offending MAPs. Instead, perceiving the attraction as a sexual orientation which is not changeable in agreement with Seto (2012) and Schaefer et al. (2022). Recognising minor attraction does not mean the client will act on their thoughts and therapy should be focused on the client's distress. In line with Tozdan et al. (2020) that attraction remains stable throughout the life span. Adolescent Non-Offending MAPs were perceived as holding deeply rooted, rigid beliefs, low self-acceptance, and self-hatred. These findings agree with research that the development of sexual orientation occurs

during childhood and adolescence. This is consistent with Houtepen et al.'s (2016) observation that Non-Offending MAPs face significant challenges during puberty in accepting their sexual attraction. The tension and struggle for acceptance during this critical developmental period are key points highlighted in both sources. Therapists recognised the tension of labelling, but foremost, they wanted to support adolescent Non-Offending MAPs.

### ***5.13.3 Therapeutic Engagement and Boundaries***

This theme highlights how therapists manage risk, power and containment in the therapeutic relationship, which is often shaped by stigma at multiple levels. This is consistent with the existing literature (Chronos & Jahnke, 2024; Schmidt & Niehaus, 2022). Participants described how being a therapist of adolescent Non-Offending MAPs required increased emotional support, and being part of a wider community was important for all participants. Participants expanded 'support' was often missing, or they experienced tension in the types of experiences of support. Connections with peers and supervisors appeared imperative. It seemed social acceptance was important within therapy for both the therapist and their clients. Participants were able to foster a sense of being in a collective with other like-minded therapists to feel supported.

There is research that suggests the importance of peer support as a coping mechanism, indicating a need for Psychological Safety within the team (Edmondson, 1999). In relation to the Power Threat Meaning Framework (Johnstone & Boyle, 2018), this theme highlights how participants made sense of this as a threat to their own safety and well-being and used their own internal resources. This may have led to a narrative of experiencing tension of not wanting to be a burden to partners about their work.

The findings suggest their experiences related to enforcing boundaries in therapy, needing to physically distance themselves, and needing to switch off from client work.

Therapists were not always able to distance themselves in their work, and sometimes there was emotional distress in the role and an impact outside of their professional work.

Professional boundaries were apparent as participants highlighted informed consent and underlying ethics of not wanting to cause harm to clients and tensions in consent.

Findings suggested that coping was experienced through the implementation of 'boundaries. There were idiosyncratic differences in how participants would use different ways, such as 'switching, distancing, blocking, avoidance and dissociation'. When any details were perceived as distressing, these techniques appeared to be used. In line with Elias and Haj (2016), therapists employed maladaptive coping techniques from a psychodynamic frame. There were no experiences of using humour as Sandhu et al. (2012) suggested. Despite research suggesting therapists may then lack empathy, it appears in the present study therapists were able to centre the client in the work and be client-focused, but they still experience tensions where their own mental health had been impacted and why boundaries were imperative in therapy.

Some participants described the importance of implementing boundaries and switching off using distancing and appeared to feel confident in switching between therapist and home life as a way of decompressing. There was an impact at times on family, needing support and wanting space to reflect on the role, wanting separation between home and work life as crucial factors. This was framed by some participants as something previously learnt from forensic clients. Distancing at times was related to feeling emotionally depleted, and some described feeling emotionally empty.

Lower levels of empathy have been associated with burnout (Mivshek & Schiver, 2022). There were experiences of detachment from work, which may have indicated how participants experienced vicarious trauma associated with the therapeutic work, which Hatcher and Noakes (2010) imply may be a negative consequence of caring. Di-Giuseppe and

Perry (2021) suggest that isolation of affect as a defence mechanism is an unconscious way of allowing the therapist to separate themselves from the emotional feeling until they can process it in supervision or personal therapy. This suggests a need to be able to make sense of their own narratives through reflexive practice, which would support the participants in understanding their strengths and resources (Johnstone & Boyle, 2018).

Participants did appear to keep an open mind and therapeutic curiosity but acknowledged a need for boundaries. One participant conveyed how she had reinforced her boundaries due to past experiences of other clients objectifying women and instigating feelings of disgust, perhaps increasing therapeutic bias. This highlighted perhaps how unresolved issues from participants' histories may play out in the therapeutic relationship (Hayes et al.,2018), which may lead to adolescent Non-Offending MAPs experiencing further stigma.

There was tension across different forms of support, with supportive and horrendous negative reactions to the adolescent Non-Offending MAPs client group from others and seeing both sides of this in supervision. Supervision was perceived as risk-focused and predominantly a preference for sharing with colleagues. There was a need to share the burden with others to be able to make the right professional decisions. There was a highlighted need for ongoing support from her Multi-Disciplinary Team to share plans and interventions, and fearing being alone in her decision-making, insinuating how the work can be complex and lonely at times.

There were experiences of a lack of support working with adolescent Non-Offending MAPs and not being able to share their work with others due to the stigmatising connotations attached to the work, and finding subjective opinions would encroach on the professional workplace. Participants reported being unable to share their work meaningfully with others due to the perceived stigma and professional tensions, which often introduced biases into the

workplace. The present study agrees with Levenson et al. (2007) that therapists also experience fear of being outed as an adolescent Non-Offending MAPs therapist and repercussions from this of losing friendships, being harassed, losing employment and being assaulted (Levenson et al., 2017). Agreeing with similarities of how therapists who work with sex offenders experience loneliness from hiding their role (Way et al., 2007), which could lead to helplessness (Chassman et al., 2010).

Clinical Research has recognised that supervision is a major component of the development of clinicians (Kühne et al., 2019). It has been well-researched that the ability of therapists to maintain a therapeutic relationship is imperative to the well-being of clients and the outcome of therapy (Steindl et al., 2023). Supervisors also need to develop their own competencies to provide emotional support to supervisees (Kühne et al., 2019). In relation to practice involving adolescent Non-Offending MAPs, supervisors need to be able to foster psychological safety and feelings of security to the supervisee and offer emotional support and understanding of the nuances of working with this group and not framing from an offending perspective. As Lasher and Stinson (2017) recognised, if professionals lack knowledge, they may become more risk-focused. This implies a need for recognised training for professionals.

The present study findings suggest the importance of using supervision and meeting up informally with colleagues as a form of support through connection and relating to peers. The latter may have been beneficial due to the shared understanding of this client group, offering insight and exploration safely in line with Chassman et al. (2020) to improve wellbeing. Hawkins and Shohet (2020) advocate the benefits of peer supervision, offering an alternative perspective and resonating with peers. Furthermore, peer support can alleviate emotional stress and prevent burnout (Vallance, 2004). This may have been deemed as more useful, as there was a common theme of needing supervision to be helpful and being openly

able to talk about risk and feelings, indicating a need for experienced supervisors. This suggests there is a lack of supervisors who are experienced with adolescent Non-Offending MAPs therapy. If the supervisor is not experienced, this may result in felt tensions surrounding risk. Based on the findings of the present study, participants recognise they can also become risk-averse and use supervision to explore and acknowledge the need to recognise and reduce risk, but also the importance of co-creating risk and allowing clients to discuss how they perceive themselves at times as the problem and a need to move beyond the riskiness therapy. This highlights the importance of collaboration in fostering acceptance-based approaches, as previously identified in the research by Lievesley et al. (2022).

During therapy sessions, participants noted there were apparent experiences of common themes of power, managing and containing therapy, superficial engagement, delivery of therapy, managing emotions in therapy, and client avoidance. All participants noted power dynamics in therapy and compared adolescent Non-Offending MAPs to mandated clients. There was a narrative of wanting responsibility in therapy for the depth of therapy, and therapists encountered adolescents as being less empowered in therapy. Lago (2011) highlights an imbalance of power as the therapist, and the adolescent Non-Offending MAPs were perceived to assume different social positions. Therapists may also be perceived as authority figures, which may also link to why some participants found themselves becoming 'Parents' to adolescent Non-Offending MAPs. Cook and Monk (2020) suggest that person-centred therapy may empower adolescent clients. One participant described empowering clients by instilling autonomy, which may promote self-acceptance and feeling valued.

The findings suggest an awareness of power imbalances which may have been framed by training and why there was a felt responsibility to empower. This may also have reflected a need for her clients to be listened to and be collaborative. A divergent theme was wanting

clients to take responsibility in therapy for the depth of therapy and encountering adolescent Non-Offending MAPs as being less empowered in therapy, reflecting the wider systems around them, such as parents and school. There was awareness of how power imbalances may have been framed by training and therapists having a responsibility to empower clients. This may also have reflected a need for clients to be listened to and collaborated with, indicating the positive aspects of therapy.

Some themes showed how participants felt useful in therapy to their clients. Therapy emphasised other aspects aside from their sexuality and avoided becoming solely focused on the minor attraction. This suggests that therapy was not intended to suppress sexual orientation. Winder et al. (2019) emphasised that using medications to suppress sexual attraction was ineffective and highlighted the importance of therapy to address other mental health issues. Participants expressed the importance of collaboratively setting therapy goals in line with adolescent Non-Offending MAPs, aiming to support clients without shaming them for their unchosen sexuality (Grady et al., 2019).

Participants highlighted the value of containing clients through the core therapeutic conditions and fostering relational engagement. They acknowledged that these individuals cannot alter their minor-attraction feelings and therefore require acceptance. There was, at times, perceived superficial engagement, which perhaps highlighted the powerlessness of adolescent clients in general (not just adolescent Non-Offending MAPs) who were often deemed reluctant to engage in therapy. This may have been because most psychotherapy interventions have been based on adult populations (Oetzel & Scherer, 2003), and more research is needed to highlight what may be more useful to adolescent Non-Offending MAPs. One participant experienced frustration in therapy when adolescent Non-Offending MAPs were not able to access a deeper level of emotions but did address this in sessions by challenging the client. Indicating the most important part of therapy was being open and

building a strong therapeutic alliance (Greenberg, 2008). This is imperative in therapy, which is further supported by adolescent Non-Offending MAPs experiences, whilst respecting autonomy (Wilmots et al., 2020), alongside therapists not being passive in therapy (O’Keeffe et al., 2020) or this may lead to non-engagement. A divergent theme noted by one participant was how both therapists and clients might become avoidant in talking about minor attraction, and it may be beneficial to address this avoidance rather than sit in silence. The findings suggested a therapeutic narrative characterised by reflection, facilitating exploration of unmet needs and identifying what was useful. This process appeared to reflect participants’ curiosity and engagement in collaborative therapeutic discovery.

#### ***5.13.4 Therapist Factors- The Emotional Impact Of Working With Adolescent Non-Offending MAPs.***

This theme encapsulated the emotional impact of working with adolescent Non-Offending MAPs. The findings were in agreement with Cohen et al. (2018) that suicidal ideation was prevalent among adolescent Non-Offending MAPs, highlighting a darker, heavier side of therapy. Participants discussed the emotional impact of working in therapy with adolescent Non-Offending MAPs. If therapists are predominantly focused on their own threat zones of regulation, this may manifest as anxiety or anger, which as Bach and Demuth (2018) suggested leading to further burnout. Reflexive practice and adopting the principles from Compassion Focused Therapy (Gilbert, 2014) may support therapists in achieving a sense of balance in their therapeutic work.

The participants' narratives highlighted how therapeutic heaviness was a prominent theme when working with adolescent Non-Offending MAPs, and participants experienced intrusive thoughts and countertransference of loss and grief, as clients recognised. They noticed the danger clients encountered but also felt isolated and needed to emotionally

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distance themselves by limiting the clients again highlighting a need for boundaries. To counteract this heaviness, therapists would limit adolescent Non-Offending MAP clients as suggested by Woodward et al. (2006); especially if they perceived the risk of suicidal clients wanting to act upon their thoughts. Supervision was used to manage the therapeutic heaviness and promote wellbeing as Chassman et al. (2020) suggested. Therapists highlighted that they would use strategies like ‘bracketing’ and becoming ‘detached’ during therapy. A divergent theme was how one therapist experienced trying to conceal feelings of disgust and shock by using their own internal resources through breathing but becoming more hypervigilant outside of the role. There was a parallel process of therapists experiencing loneliness, uncertainty and despair and becoming desensitised as a way of building resilience. There were worries about other people’s reactions to being able to share their work with others outside due to fears of negative responses. At the interpersonal level, stigma was experienced through professional relationships. Participants described feeling unable to share their work openly due to fear of judgement, misunderstanding, or reputational harm. Some noted tensions in supervision, where subjective opinions or risk-focused frameworks overshadowed therapeutic nuance. This aligns with Henderson et al. (2014) emphasis on how stigma is enacted through relational dynamics, often compromising psychological safety and collaborative decision-making.

The findings further suggested the positives of the therapeutic interactions with adolescent Non-Offending MAPs were being able to remain emotionally attuned, foster acceptance, empathy and experience attachment. This reiterates again the importance of the core conditions for an effective therapeutic alliance.

Some therapists felt rewarded for the meaningful work, which is emphasised by previous research (Lysova et al., 2019), as making a difference also suggests the importance of social change and reducing the social injustice experiences of adolescent Non-Offending

MAPs. This acknowledges how clients experience distress clients due to the power structures within society which then perpetuate marginalisation (Amari, 2021). This highlighted compassion-focused therapies as a way of promoting inclusiveness.

There was a unanimous discourse in line with all participants who experienced mixed feelings as therapists from being unable to solve their client's problems, feeling hopeless and sad, but paradoxically also wanting to maintain hope for clients and find alternative narratives of self-acceptance. The Paradoxical Theory of Change (Beisser, 1970) suggests that change occurs not from an effort to impose change, but as an invitation to engage wholly with the person as they are in the present. This theory suggests that the most helpful way of change is by becoming more self-accepting. In terms of adolescent Non-Offending MAPs, the client is seeking change through therapy from what they perceive they should be and what they think they are and never fully identifying with either. There may be benefits of Gestalt therapy, which focuses on the here and now. Feltham and Dryden (1993) highlight four theoretical pillars of the importance of the client's own phenomenology, the dialogical relationship between the client and therapist as needing to be authentic and validating, field theory considering the social environment and experimentation' where clients can try out new behaviours safely which may promote confidence. Stripling (2021) further indicated that research supports emotional well-being, conflict resolution, improves low mood and self-esteem.

#### ***5.13.5 Systemic Barriers and Professional Issues of Therapy Services***

This theme emerged from the research. Participants felt that, during the journey of becoming therapists for adolescents with Non-Offending MAPs, they had become more self-aware of their biases as part of their need to develop as therapists. They discovered that self-

reflection on their biases was important. Lemma (2016) further highlights that therapists must be able to reflect on their own experiences during and after therapy.

However, the findings further suggest that exploration of one's own biases is useful before working with clients. It was recognised that exposure to adolescent Non-Offending MAPs helped therapist address their biases, and therapists identified learning from their clients as a way of seeing differences and embracing holistic learning. There were also experiences of the need to develop a therapist's Internal resilience, which could be developed through personal therapy growth. It was important to acknowledge space to process negative emotions to address the therapists' own bias. There was a recognition of building resilience through self-awareness and recognising one's own insecurities and potential power dynamics in therapy and addressing bias was important. This preparation was seen as important to prepare for therapy by addressing biases, researching online before commencing working with adolescent Non-Offending MAPs and putting adequate support in place.

There was self-awareness among therapists, who recognised their own biases through training. They recognised their own journey as a therapist in training and became self-aware of their blind spots, which then led to self-growth. At the intrapersonal level of Henderson Stigma Model (2014), therapists described confronting internalised stigma, discomfort, and bias. These reflections were not static but evolved through exposure, supervision, and relational engagement. The emotional labour of working with adolescent Non-Offending MAPs required therapists to process their own reactions, challenge assumptions, and cultivate reflexivity, especially when societal narratives framed attraction as inherently deviant. This further highlighted the importance of personal therapy which is mandatory in Counselling Psychologists' training compared to other therapists and psychologists' training.

At the structural level, the absence of specialist pathways, formal training, and national guidelines was described as a significant barrier. Participants expressed frustration at

the lack of NICE guidance and NHS pathways for adolescents who identify as being attracted to children. Without formal recognition, adolescent Non-Offending MAPs are often routed through forensic or risk-based services, such as the NSPCC Harmful Sexual Behaviours pathway, which may pathologise rather than support. As Lawrence and Wills (2024) suggest, this framing can lead therapy to become overly risk-focused, missing opportunities for identity development and emotional support. The interviewees acknowledged a lack of specialist pathways in services as an unmet need. Participants appeared to seek something formal. Without a specialist pathway in services, this was something perceived as difficult to navigate, as there was no training, and participants indicated self-reliance, relying on the expert and experiencing loneliness or fear of not getting it right for adolescent Non-Offending MAPs, as there are no current guidelines. Although private organisations such as STOP it Now and STOP SO and minor attraction-led forums also offer some support.

Within the interviews, the importance of a need for a societal change in policies was recognised, and the impact of a lack of funding. One narrative noted that societal awareness was increased through the media, which brought attention to the topic. This may have generated interest in awareness and willingness to listen, and media coverage played a crucial role in fostering awareness and potentially shifting societal attitudes. However, despite this increased awareness, the lack of specialised pathways and funding remains a significant barrier to effectively supporting adolescents' Non-Offending MAPs. These experiences emphasise the need for continued advocacy and policy reform to ensure these individuals receive the necessary support.

#### **5.14 Summary**

The IPA outlines convergent and divergent themes identified among the four participants. Henderson et al. (2014) stigma model offers a valuable lens for interpreting

these dynamics. At the interpersonal level, therapists described how stigma shaped their relationships with colleagues, supervisors, and clients. Support systems were often compromised by judgemental attitudes, risk-focused supervision, and discomfort discussing adolescent Non-Offending MAPs related work. Participants experienced both supportive and “horrendous” reactions to their client group, reinforcing the need for psychological safety and stigma-informed supervision.

At the structural level, the absence of recognised training, policy guidance, and institutional support for adolescent Non-Offending MAP therapy created a climate of professional isolation. Therapists feared being misunderstood, harassed, or professionally penalised for their work, echoing findings from Levenson et al. (2007, 2017) and Way et al. (2007) on stigma by association. These fears contributed to secrecy, emotional strain, and a reluctance to share openly, even within clinical teams.

At the intrapersonal level, therapists navigated their own emotional responses, biases, and coping strategies. Participants described enforcing boundaries through switching off, distancing, blocking, avoidance, and dissociation, particularly when therapeutic material was distressing. These techniques, while protective, also reflected the internalisation of stigma and the emotional toll of working with taboo content. These pressures shaped how adolescent Non-Offending MAPs identity was constructed in therapy not only by clients, but through the relational stance therapists adopted in response to societal fear and institutional neglect. Participants described a parallel process of experiencing stigma by association in their work, akin to the experiences of adolescent Non-Offending MAPs themselves. This stigma often leads to concealing their work agreeing with Furst and Evans (2014) who suggest a domino effect of secondary stigma to the therapist and/or family. This appears to mirror how adolescent Non-Offending MAPs are hidden, isolated, and experiencing shame. This parallel process highlights the profound impact of societal stigma, not only on adolescent Non-

Offending MAPs but also on professionals working with them. This underpins the need for broader societal change to reduce stigma and create a more supportive environment for both adolescent Non-Offending MAPs and those who provide therapeutic support. During the analysis, there was a sense of participants needing connection and support in their role, and participants outlined how they sought connection through colleagues, supervisors and outside of professional work to improve wellbeing. There was familiarity between participants as there was awareness of therapeutic heaviness, compassion fatigue and lived experience of vicarious trauma (Beaumont et al., 2016) which may also lead to avoidance and emotional detachment in line with Elias and Haj (2016). There was a tendency for professionals to frame adolescent Non-Offending MAPs from a sexual identity perspective. Subsequently, practice appeared to facilitate acceptance, and therapists were able to empathise. This appeared to be underpinned by previous forensic experiences and the recognition of addressing one's own biases before working with adolescent Non-Offending MAPs. Professionals, at times, were risk-averse and were self-aware of the risk tension and needed to co-create risk. The voices of adolescent Non-Offending MAPs were heard through the professionals' experiences, and adolescents were seen as too young to be labelled but still needing therapy support.

The therapy narrative was related to managing the emotional distress, therapeutic heaviness and, at times, superficial engagement. There were therapeutic issues associated with not wanting to feel alone with the risk and burden of decision-making and seeking out peer supervision. There is a need for experienced supervisors to foster a safe space for therapists and not to become solely focused on the risk aspects.

Overall, the themes outlined in this chapter should feed forward to training programmes and interventions within the university. Participants developed self-care

strategies through implementing boundaries; in line with other research (Parr & Pearson, 2018), there was a recognised need for training.

### **5.15 Strengths and Limitations**

Counselling psychology is distinguished from other branches of psychology with a focus on lived experience and meaning. This study facilitated the lived experience of therapists working with adolescent Non-Offending MAPs. Using interviews in research may increase validity as McNeeley (2013) suggests survey data can be problematic if any questions are perceived as sensitive. The interview questions were developed from the literature search to be open-ended to elicit participants' experiences (Powell et al., 2014) as a way of being objective (Baumbusch, 2010).

The interviews were conducted by an experienced, qualified Psychotherapist and Trainee Psychologist nearing the end of their training. The interviewer was able to contain, probe, clarify, elaborate, validate, and empathise with the participants. Compared to a novice interviewer the interviewer would have enhanced the quality of the data collection. Robinson (2023) suggests that probing in interviews is useful for eliciting deep and meaningful data from participants.

As highlighted by Braun and Clarke (2021), there is a lack of generalisability from the IPA, and the findings reflect the researcher's interpretation of the participant's phenomenology. The Research was dependent on participants identifying as Psychological Therapists / Psychologists working with adolescent Non-Offending MAPs. It may have been difficult to find participants due to the stigma and therapists wishing to conceal their identity or fear of repercussions from what is perceived as normalising sexual attraction. A strength of the findings was the inclusion of ideographic accounts from each participant, which contributed to the larger themes. It is acknowledged that the research attempted to highlight the strengths and difficulties experienced and offer an indirect voice to the hidden population

of adolescent Non-Offending MAPs but further acknowledges that further intervention would benefit from being informed from an adolescent Non-Offending MAPs perspective.

It is acknowledged that the researchers' personal bias and previous forensic training may have influenced the research interviews. This was mitigated by being reflexive during the interviews and using personal supervision to discuss.

The quality of qualitative research was assessed using Tong et al. (2007) Consolidated Criteria for Reporting Qualitative Research (COREQ), a 32-item checklist for interviews and focus groups. This checklist serves as a guideline for three domains: 'Research Team and Reflexivity,' 'Study Design,' and 'Analysis and Findings,' to ensure that the methods, data collection, and validation were adequately robust. The checklist highlighted several areas in the study design that could have improved validity. For instance, there was no pilot study, data saturation was not discussed, and transcripts were not returned to participants for their comments. Additionally, the analysis had limitations, such as the fact that there was only one data coder and participants were not allowed to provide feedback on their individual findings, which might have offered further insight into their phenomenological experiences.

The IPA study had one male participant, which may have meant the homogeneity of the sample was impacted as there was a divergence between genders. The participant sample was comprised of experienced therapists and psychologists, and this may have meant they were more likely to have framed adolescent Non-Offending MAPs with a positive frame as they may have been desensitised towards sex offenders.

The IPA findings were similar to the research by Levenson and Grady (2019) and Parr and Pearson (2019), which revealed that therapists often compared clients with minor attraction to sex offenders, influenced by their forensic backgrounds. This tendency highlights the need for specialised training to help therapists distinguish between minor attraction and criminal behaviours. Such training is essential for creating a supportive

therapeutic environment that promotes understanding and effective treatment rather than reinforcing stigma.

As the present study used a Critical Realist lens, it is important to acknowledge that the findings do not directly represent reality (Fletcher, 2017) as the questions influence the research asked, the interview structure and the constructed inferences made during the interview from the interviewer frame of reference will shape the findings (Bohnsack, 2014; Silverman, 2017). During the interview, the researcher attempted to bracket their assumptions. Although at times, the researcher may have been more focused on asking the interview questions. However, after each interview, each interviewee was asked if they thought they needed to cover any other topics. This enabled the participants to add in anything they deemed important.

### **5.16 Conclusion**

In summary, this IPA has achieved its aim of exploring therapists' experiences when working with adolescent Non-Offending MAPs and the role of stigma within this context. The findings reveal a complex interplay between interpersonal, structural, and intrapersonal factors that shape professional practice and wellbeing. These findings illustrate the pervasive influence of stigma in undermining professional relationships, constraining organisational support, and shaping coping mechanisms, thereby fostering a complex and often challenging context for therapeutic work.

The use of IPA was appropriate for capturing rich, ideographic accounts of lived experience, consistent with counselling psychologists' emphasis on meaning-making. Although the sample size was small, this aligns with IPA's focus on depth rather than breadth. However, this limits generalisability, and findings should be understood as

exploratory. Recruitment challenges were likely influenced by stigma and fear of professional repercussions which further underpin the hidden nature of this work.

Researcher reflexivity and supervision were employed to mitigate bias, though the influence of prior forensic experience cannot be fully excluded.

The findings emphasise the need for stigma-informed supervision, specialist training, and organisational frameworks that promote psychological safety. Addressing stigma at societal and institutional levels has significant implications for policy, clinical intervention, and therapist wellbeing. Future research should incorporate adolescent Non-Offending MAP perspectives and examine the impact of stigma-informed practices across diverse contexts.

This study contributes to an emerging evidence base advocating for systemic change to reduce stigma and create supportive environments for both adolescent Non-Offending MAPs and the professionals committed to their care.

## **Chapter Six: Overall Discussion**

This discussion chapter outlines the theoretical implications of the mixed method study, which was underpinned by therapeutic bias in relation to stigma theories. This chapter will bridge the significance of findings and implications, address the overall limitations of the two studies, and acknowledge constraints, potential bias and methodological issues and shortcomings. It will provide suggestions for future research and proposed directions with how other research studies could build on this mixed methods study. This will be followed by practical and theoretical implications of findings and conclusions. The study has contributed to the current literature, adding research on adolescent Non-Offending MAPs from a therapist's perspective.

### **6.1 Integrating Findings and Results**

There was some impact from the humanisation intervention training. It may also be that higher levels of empathy and resilience in therapists may mean therapists are less likely to socially distance from adolescent Non-Offending MAPs. This then would indicate a greater willingness to work with this marginalised group. The qualitative findings did explore how therapists working with adolescent Non-Offending MAPs can support them to develop a positive self-identity. Therapists found it important to engage collaboratively with peers and teams, ensuring they had supportive supervision, and addressing their personal biases through reflective practice to effectively support adolescent Non-Offending MAPs.

Combining the results and findings creates a holistic understanding of the challenges faced by therapists working with adolescent Non-Offending MAPs and an understanding of the application of embedding therapeutic humanisation interventions into training courses. This insight suggests a dual approach that addresses societal stigma while providing a robust support system for therapists, including niche training. An integrated perspective can inform

the future development of more effective therapeutic interventions and therapist support tools.

This study suggests that therapeutic interventions should be developed to reduce stigma and foster empathy to address the unique challenges that Adolescent Non-Offending MAPs experience. Current professional training concerning understanding Non-Offending MAPs appears lacking. The study suggests that therapists who work with this group need to be equipped with the skills and knowledge to effectively support adolescent Non-Offending MAPs, including strategies for building resilience and managing their emotional well-being. This suggests there is a need for professional training to uncover their own bias through mandatory personal therapy in line with counselling psychology courses, which have a mandatory 40 hours of personal therapy. There is a further need for experienced supervisors through further training for supervision outside of solely forensic risk perspective. There is a requirement for university doctorate training to include training embedded into course programme. There is a recognition of concealed stigma for therapists. Therapists also experience fear too, similar to Non-Offending MAPs. Currently, there is no recognised funding or NHS pathways to support therapeutic services for adolescent Non-Offending MAPs. This thesis highlights the need of a framework model to understand and demonstrate the change needed to improve practice and reduce social inequalities.

There are future Policy Implications for services as there is a lack of current NHS clinical pathways. The literature review highlighted there is no current clinical pathway in the United Kingdom, and there are no current NICE guidelines to advised psychological interventions with Non-Offending MAPs, nor NHS guidelines or established treatment pathways. The focus has been on sex offending and Tenbergen et al. (2021) highlight that these are mainly offered in forensic settings and aimed at reducing the risk post offending with little being offered prior to offending. There are various organisations throughout the

World, such as STOP it Now- Stop SO, Lucy Faithfull Foundation, B4uACT, and Virtuous Paedophiles who support Non-Offending MAPs. However, in America, there is the Global Prevention Project based treatment (TGPP) programme for Non-Offending MAPs, The Berlin Prevention Project Dunkelfeld (PPD), which aims to prevent CSA by supporting individuals who identify as Non-Offending MAPs. In Germany, the Research Consortium is exploring Neurobiological mechanisms underlying Paedophilia and CSA. The TGPP pathway comprises psychoeducational sessions addressing Non-Offending MAPs experiences (distress, depression and Suicide) and improving psychological wellbeing. The pathway aims to promote self-acceptance and self-compassion alongside an exploration of sexual orientation and emotional management and resilience.

## **6.2 Clinical Implications**

Participants were able to voice their experiences in an area that is often concealed. It is recognised that the use of labels in therapy is fraught with tensions and the language used must reflect the individual's preference and be person-first.

It is recognised that therapists do experience stigma from their work alongside adolescent Non-Offending MAPs. By incorporating phenomenological experiences into a future training intervention will help develop doctorate training programmes for Clinical and Counselling Psychologists. As these do not currently include any training workshops on adolescent Non-Offending MAPs and by offering training in this area, then this can be disseminated, in the future, to adolescent Non-Offending MAPs who may experience more support and less stigma by upskilling trainee Psychologists.

Doctorate courses and psychotherapy courses should include sessions on working with our unconscious biases and discuss how trainees feel about working with adolescent Non-Offending MAP clients, and if they feel unable to, then where they could either

empower the adolescent Non-Offending MAP client to self-refer to support or provide alternative therapy support. Those who feel able to work with this client group should be able to centre the therapy on what the client needs, provide acceptance, and explore the attraction if the client wishes to but for it not to become the sole focus of the sessions. The therapist would receive help from having additional reflective specialised supervisors with experience in either working with Non-Offending MAP clients or previously supervising those who have worked with Non-Offending MAPs otherwise the supervision may become risk-averse and not be focused on the client's needs. Future curriculum on courses could offer workshops on uncovering biases and discussing ways in which trainees can recognise their biases to working with Non-Offending MAP clients and keeping their self-care. It may also be beneficial to include lived experience and give a voice to Non-Offending MAPs either via the video intervention and further longer workshop discussions. An idiographic approach allows for training to recognise that Non-Offending MAPs are individuals and therapists need to be self-aware of the underlying stigma they may also bring through power dynamics in therapy.

### **6.3 Recommendations for Future Research Practice**

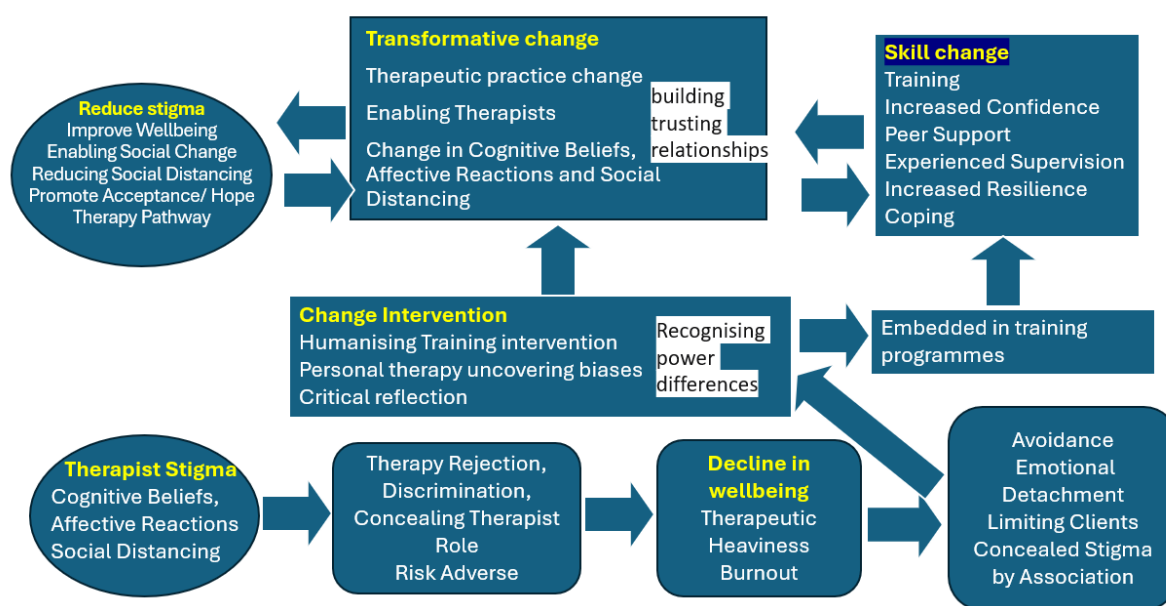
As this study has given therapists a chance to share their voice and insight into working with adolescent Non-Offending MAPs and support understanding how therapists also experience stigma. The clinical implications discussed above led to these recommendations for therapeutic practice and future research.

This thesis develops a preliminary model to understand therapeutic bias towards adolescent Non-Offending MAPs, using stigma theory and the concept of the therapeutic alliance. The findings support the idea that stigma exists on three levels: within the self (intrapersonal), social (interpersonal), and structural (Henderson et al., 2014) levels, both within and outside clinical environments, including stigma by association (Goffman, 1963).

It is recognised that stigma plays an important role in therapeutic work with this group. There appears to be stigma by association (Goffman, 1963) and an impact of stigma outside of work. These insights inform the research questions about how stigma affects practitioner attitudes and therapeutic engagement.

**Figure 10**

*Ball's (2025) Therapist Stigma Bias Development Framework*



Ball (2025) Therapist Development Framework

As a direct impact of this research this Study preliminary proposes Ball's (2025) Therapist Stigma Bias Development Framework (see figure 10) which recognises how Therapist Stigma (Cognitive Beliefs, Affective reactions and Social Distancing) in therapy practice can lead to Therapy Rejection of adolescent Non-Offending MAPs, discrimination and concealing therapist role through fear of negative judgements and framing therapy from a risk averse perspective. This may lead to a Decline in Wellbeing resulting in distress, therapeutic heaviness and burnout. Therapist may use avoidance, emotional detachment, limit clients and experience concealed stigma by association. This therapist stigma may be changed through a Change Intervention (humanisation training, personal therapy to uncover

biases and reflection), which needs to become embedded in training courses. This would then lead to a Skill Change to build resources/ resilience in therapists and supervisors, improving wellbeing, confidence and empowering therapists to reduce stigma through addressing therapist bias. By implementing these recommendations this leads to a Transformative Change in therapeutic practice enabling therapists to build trusting relationships, increased cognitive belief empathy, affective reactions and social distancing to then lead to Reducing Stigma to enable social change, foster acceptance, hope in therapy, challenging inequality and improving access to therapy pathways for adolescent Non-Offending MAPs.

### ***6.3.1 Implications for Future Research***

This thesis provides a preliminary conceptual and thematic foundation for understanding therapeutic bias toward adolescent Non-Offending MAPs. Future research could build on these findings by:

- Empirically testing how Henderson's stigma dimensions manifest in clinical decision-making and alliance formation.
- Developing and evaluating training interventions that explicitly address intrapersonal, interpersonal, and collective stigma.
- Expanding research focused on adolescents through ethically sensitive designs that examine developmental needs, therapeutic engagement, and safeguarding challenges.
- Investigating institutional cultures and supervisory practices that may reinforce or challenge collective stigma in clinical settings.

### **6.4 Conclusion**

Finally, this thesis attempts to bridge the gap between research on adult and adolescent Non-Offending MAPs, providing a more nuanced and comprehensive understanding of the stigma and therapeutic challenges faced by this population. By

integrating the findings from both studies into a framework model, it allows for a more effective and empathetic approach to support adolescent Non-Offending MAPs and the professionals who work with them. Future research should continue to explore these areas, focusing on developing tailored therapeutic approaches and interventions that reduce stigma and foster empathy to address the unique challenges that adolescent Non-Offending MAPs experience. Professional training would equip therapists with the skills and knowledge to effectively support adolescent Non-Offending MAPs. This would include strategies for building resilience and managing their own emotional well-being. There is a need for a provision of ongoing training for therapists to uncover their own bias through mandatory personal therapy in line with counselling psychology courses. There is a need to develop supervisors through further training that goes beyond solely risk-focused forensic perspectives. University doctoral programmes should embed this training into their course structure. It is important to recognise the concealed stigma experienced by therapists and address their associated fears. Future Policy should consider the suggested framework model to understand and demonstrate the changes needed to improve practice and reduce social inequalities. This thesis further suggests exploration of funding pathways to support therapeutic services for adolescent Non-Offending MAPs.

This expanded approach provides a detailed synthesis of the findings, highlighting the importance of addressing both individual and systemic challenges in supporting adolescent Non-Offending MAPs. The study highlights the stigma experienced by therapists working with adolescent Non-Offending MAPs. The research has addressed the gap in the literature surrounding adolescent Non-Offending MAPs and a need for person first therapy through own self development. This research provides a glimpse into therapist's experience. Although the findings cannot be generalised, they provide a starting point for further research and inform future training. The present study adds to mixed methods research alongside Jahnke et

al. (2023) and Mitchell and Galupo (2018). Lastly, implementing these changes could have a positive impact on adolescent Non-Offending MAPs. Adolescent Non-offending MAPs may be more likely to access therapy from trained clinicians who have addressed their own biases. Trained clinicians will have built internal and external resources/resilience to reduce stigma and ultimately there may be an improvement in access to therapy pathways for adolescent Non-Offending MAPs. Furthermore, there needs to be a collaborative approach involving policymakers and service commissioners to improve therapy for adolescent Non-Offending MAPs and ultimately reduce stigma.

## Chapter Seven: Critical Reflexivity of the Research

### 7.1 Chapter Overview

This concluding chapter highlights my reflections on the research process. It will outline my own background, my reasoning behind the choice of research topic, and the role of myself in the research. Reflective practice is essential in the field of counselling psychology as this enables (Donati, 2016). Using Driscoll (1994) model of reflection based upon Borton (1970) model. This model provides a framework asking *What? So What?* and *Now What?* This model is often used in everyday reflective practice as part of my role. This model allows for the identification of feelings and facts of an experience and enables meaning to be made, and then allows for future action, which allows for change. This chapter will reflect on my growth as both a researcher and a Scientific Practitioner as a Counselling Psychologist in training over the last six years, who strives to be inclusive and facilitates therapy to include marginalised groups.

### 7.2 Researcher Background

As the researcher of this thesis my background has been studying healthcare from a nursing perspective for two years and subsequently 10 years studying Psychology from BSc undergraduate level to Postgraduate MSc and doctorate level. Working alongside studying in a variety of mental health roles, from Support Worker, Assistant Psychologist, Trainee Psychologist and Applied Psychologist in a variety of settings, including NHS services within prisons, probation, courts, CAMHS and secure children's care. Additionally, supporting academically as a university visiting lecturer on undergraduate and master's Psychology courses. Developing resilience in my own life has been pivotal through personal therapy, self-reflection, and journaling. During my Doctorate, I experienced losses and changes due to ongoing personal therapy and life events. I developed my self-awareness and thinking as a

reflective Scientific Practitioner in line with the BPS core values, recognising social injustice and working with diversity in a holistic way.

### **7.3 Developing a Research Idea**

This research topic was chosen following attending a university conference and a presentation on different ‘philiias,’ some of which were unknown to me. I recall being surprised by the many different terms for something I had just amalgamated as one issue. At this time, I was working within a prison and had been working with numerous offences, including sex offenders and had no idea at all about non-offending minor attraction. I recall researching the DSM-5 for Paedophilia with a very much stigmatising attitude of the people who had perpetrated these offences. I had previously researched unwanted sexual behaviour in relation to public transport (Ball & Wesson, 2017) and peer-perpetrated child sexual abuse and had worked with perpetrators of harmful sexual abuse as well as victims of child sex abuse (CSA) and child sex exploitation (CSE). I was starting to develop a critical view of working from both victim and offending perspectives.

When I started to research areas for my doctorate, I became more interested in minor attraction and the group of people then did not go on to offend. I started reading about the topic and found there was little literature on minor attraction, and it included research from forensic populations. There was little research on adolescents, and this was the area I felt drawn to explore following on from my work experiences with forensic services and recently working in children’s services and experiences of marginalised clients and social injustice. I recognised this would be an area of contention from underlying stigma and whether adolescents should be labelled as Non-Offending MAPs in a comparable way to personality disorders are not diagnosed in under 25s. However, I also was aware from my reading that lived experiences suggested this was the age when individuals started to realise, they were

attracted to children and there was no support readily available. I started to think about how I ethically would be able to research this area and what I would be able to do, and whether exploring lived experiences or therapist experiences would be of research interest. I decided due to the abundance of literature on stigma and previous studies highlighting how Non-Offending MAPs perceived barriers to accessing therapy. This highlighted a gap in the research of exploration of therapists' experience of those who currently work with adolescent Non-Offending MAPs, with the aim that I could use an intervention training video to help reduce stigma of adolescent Non-Offending MAPs. I decided I would design the intervention training video first and then see what my results showed.

#### **7.4 Choosing a Methodology Reflexivity**

During my previous research, I had used quantitative methods and felt more swayed to use them than qualitative methods. However, in line with counselling psychologists' underpinning philosophy (Wertz, 2005), I found myself being drawn to wanting to explore phenomenology approaches and understand the lived experience as a therapist working with these individuals. Pluralistic methods have been valued as counselling psychology emphasises humanistic, relational, and integrative approaches, valuing multiple perspectives rather than rigid adherence to one model (Wertz, 2005). Subsequently I decided a mixed methods approach would best represent my research. The quantitative phase explored a training intervention but showed there were some stigma differences and some influence of empathy and resilience. In the second part, I wanted to include therapists' experiences to understand and be able to inform a future intervention. I would interview qualified therapists working with this group and then use IPA as a framework to understand the lived experience. I started to explore IPA and its philosophical underpinnings and felt this would fit with my own personal philosophy.

During the interviews, I found they were all unique, and because I was new to IPA semi-structured interviews, I found myself drawing upon my therapeutic skills to attempt to build rapport during the interviews. I felt mainly comfortable during the interviews but also had to remind myself that the interview did not have to answer the set questions and to let the participants guide the interview. By the last interview, I found familiarisation and linking topics, and there seemed to be more fluidity in the interview process. This enabled a greater depth of understanding of the phenomenon. This may be because of only an exceedingly small number of interviewees, some interviews were much richer in detail, but I only managed to interview four people. According to Smith and Eatough (2006), there is no correct sample size, but a consensus of four to ten is a sufficient sample. I also gave participants the choice to have the camera on or off and all chose to have the camera on. This gave me the opportunity to be in the same room as the interviewee, and as the audio was recorded, I was able to transcribe it. At times, the interviews felt clumsy when we went off topic. Although I tried to frame this as a topic of importance for the interviewee to address, the extent to which this emphasis influenced their responses remains unclear.

During interviews, I needed to use immediacy and empathy. I was open and non-directive in my interviews. I actively listened to ensure I captured the interviewees from their experiences as I wanted to capture their phenomenon.

I started interviewing in July and completed the last interview in November. I reflected shortly after each interview. This was to provide insight into my thinking and feelings during each interview, which was also a way to recognise my own biases. I started transcribing the interview a few weeks after each interview so the interview would be fresh in my mind. I initially listened and relistened to each interview so I could start to capture my felt sense alongside each interviewee's experiences.

I tried to bracket my own phenomenon between each interview so as not to influence the interviews from the previous participant's experience. However, it is inevitable as the researcher interviewer, I am very much part of the research process, and it is difficult to be objective. When I started the analysis process, I read and reread the transcripts and started to extract quotes fitting with themes. During the analysis, this was not a linear process. It felt exceedingly difficult at times to try and capture what was being said in the narrative without making assumptions. I found it was useful to create an Excel datasheet so I could create themes, find supporting evidence for themes and be able to move the themes as needed. But also, able to identify each participant and start to highlight similar themes and different themes to be able to start to group these into main themes.

### **7.5 Overcoming Difficulties Through the Research Process**

During the research, it was essential to recognise any power imbalances. When planning the thesis that not involving adolescent Non-Offending MAPs in the research created tension between involving experts by experience in the research. Due to ethics and the research question, it was decided that the research would focus on the therapist's side.

During the research process, I kept reflective research journal notes. This highlighted my initial experiences of annoyance and frustration when I needed to keep resubmitting ethics. On reflection, I could understand it was needed as my study was convoluted and over-ambitious. This is highlighted as one of my flaws. I do go into excessive detail and above what is required and struggle to limit myself. Perhaps as a way of demonstrating my capabilities, instead of showcasing what I can do well.

I experienced a sense of relief once the ethics process was completed and approved. However, I continued to feel overwhelmed throughout the subsequent stages due to numerous

requirements and suggestions to address. On reflection I could see it was mainly rewording and felt proud to have passed another hurdle.

I did reflect on how I manage criticism. I do take it personally but need to see it as a way of challenging the areas I am struggling with. And through criticism, I can develop a more rounded scientific reflective practitioner too.

Qualtrics seemed to take me ages with lots of trial and error and watching Youtube videos on how to do things. Similarly, I designed my video training and researched what software to use. I chose Moovly software but then I had to learn how to use it, again with lots of self-exploration and learning as I went. I had only paid for a month's access usage, so I felt pressured to complete it in the time span.

I felt proud to have designed a research poster and a sense of achievement showcasing this at the BPS Counselling conference. There was a shift here to feeling like an equal to other academics and moving away from feeling like an imposter.

Using a Gantt chart helped me keep on track but I still needed to focus and remember the Annual Progress Reviews would need evidence would also attempt to keep me on track but at times the anxiety increased and also from external life factors which were time-consuming and battles in themselves (my father's passing, implications of covid, son's health) often justified the avoidance not to write the literature search and analyse the data. Although I managed to remain on track, I occasionally questioned whether my avoidance functioned as a defence mechanism, enabling me to attribute delays to external factors rather than assume full accountability. Ultimately, I was able to reorient my focus and re-engage with the thesis process.

In the second study, I struggled to get anyone interested after I found one person who agreed to an interview. This motivated me to try and find others. The first interview appeared to be insightful, and I could see many similarities between myself and the person, so I was

aware during the interview not to lead and just try to reflect and be curious. However, at times, because I wasn't sure, I may have come across as not validating enough, and I needed to remind myself this was not a therapy session, just an interview, and put on a researcher persona instead.

During my journey as a psychologist, critical self-reflection has been imperative to my own development and to becoming aligned with my profession. I have become more self-aware of my own impact on the research process through both the quantitative and qualitative parts of my mixed-method research. This thesis has been a vast undertaking and when I set out on my journey to become a Counselling Psychologist, I did not envision the enormity of this research and how progress was not going to be linear and instead would be an intense and difficult process, and one I also knew would be important. I envisaged this research would feed forward into training interventions and workshops around non-offending minor attraction and create new knowledge in the field of counselling Psychologists, leading to future work which was more holistic and integrating therapeutic experiences to shape an intervention.

During the interviews I reflected on my own experiences and working previously in forensics and how this had impacted on me. I believe working with sex offenders increased my own resilience and, at times, my own need for increased self-care and moved me to be able to find empathy when perhaps others struggled. I questioned whether my own interpretations had influenced my interview. I was aware I would paraphrase and reflect themes in interviews and found it hard to switch off my therapist persona and be purely academic. I reflected this may also have enhanced the interviews and built rapport. One interviewee highlighted to me how this was the first interview she had felt truly listened to. I reflected on this and thought this was how my clients felt, and it was a strength a secondary outcome of my interviews was to validate the interviewee.

During data analysis, I thought more about how I had changed my original positionality on perceiving adolescent Non-Offending MAPs as disordered and moved towards this as something innate and unchangeable and had moved towards perceiving this as a sexual orientation. Some aspects of my findings I noted feeling surprised. I had not been aware of how others may have experienced stigma as a therapist as I had not experienced this myself in therapy. However, as a researcher, I experienced stigma indirectly through explaining my research area to be met with personal opinions, 'These people should be imprisoned, and why was I researching this field?'. I noticed social media has already hounded people for researching Non-Offending MAPs. When I posted my study into the ethos, I felt I had distanced myself from my study a little due to this as I used the non-offending terminology as a way of showing I was not looking at offending people.

Having completed both parts of the study, on reflection, I felt I should have completed the interviews first to inform the second study, and this maybe would have developed more of an insightful intervention. I delivered a lecture on Adolescent Non-Offending MAPs to undergraduate university students I started to see from the Q & A session I had perhaps created more of a tool to uncover therapeutic bias and start discussions around why people experience difficulties. The interviews revealed some therapists had taken to dealing with their own parts in relation to working with adolescent Non-Offending MAPs as recognised they may experience disgust and fear and avoid working with this group.

Procrastination was my biggest enemy, and I underestimated how much I would avoid, especially around literature reviewing and data analysis and then justifying those other parts of the course where more important because of deadlines. I found myself procrastinating around the literature review as such a large amount of reading and writing. I reflected on how unorganised I had become, whether this was always there, and how I could accomplish such a mammoth task successfully. At this point, I resorted back to labels and

medicalising and reflected on my neurodiversity. I adapted my own strategy. I had read somewhere about thinking about the literature review as a dinner table and how the subtopics were all guests, and when the guests were together, what would be discussed, contemplated, laughed at, revoked, and agreed upon. What learning would come from the discussion? What was the consensus of the guests? Did any guests have less to say? My metaphoric dinner table of guests helped me to formulate my ideas and synthesise and explore what my metaphoric guests were discussing. This helped me for a brief period of time to start formulating and breaking down my extensive literature into smaller manageable chunks which I could carry around and read.

## **7.6 Analysis**

I had issues downloading data from Qualtrics, panicked, and could not see which participants had done which intervention. I thought I would need to do the whole study again. After reading around, there were further options I could select to download, and my grouping categories were then visible. I felt a bit clunky recoding data, especially around the questionnaire values, as I had not saved them as the same in the psychometric measures. So, I had to rectify this before recoding variables. I learnt a lot from my research process through trial and error. This highlighted how I use avoidance rather than asking others. I found the quantitative data confusing and repetitive. As my study was exploratory, it did not fit neatly into study parameters, and due to time constraints, I felt pressured to analyse the data. In essence, this was done several times as I became familiar with the data and methodically used SPSS.

## **7.7 Self-Care**

At times, I experienced feeling burnt out with the research topic. In supervision with other professionals, I was reminded because this topic is laden with tensions and stigma. It

was useful to be aware of my own coping mechanisms and to take regular breaks when transcribing and the interpretation of the analysis and discussion sections. During this doctorate, I have been aware of potential vicarious trauma and ensuring alongside my full-time work I am able to take care of myself and engage with personal therapy and supervision to protect myself from becoming burnt out and recognise my limits.,

### **7.8 Reflexivity**

It was difficult during the IPA approach to distance myself from the verbatim quotes as I wanted to capture each participant's voice accurately and fully. I was able to develop my skills in perceiving this as an iterative process. As expected, the research process was slow and unpredictable. At times, I felt more connected to my research, and at other times, I felt more distance, which I perceive as my own initial tensions with the underpinning theory of sexuality vs disorder. During my research, there was continued self-awareness of my own biases and thinking from my own curious bias to seeing the person behind the label. During the analysis, I created the interpretations and themes without participant input. However, by using IPA, I attempted to keep the participants' voices by using direct quotes. My interpretations were very much like my therapy sessions where I uncovered hidden meanings.

I was able to draw upon subjective experiences and build rapport. I reflected in action and on action and this enabled learning from each interview. I valued the uniqueness of each interview dynamic as its own ethos and the impact of interpretation and reflection in each interview. During transcription, it was noted how hard it was to separate the dual identity as a Counselling Psychologist and a researcher and how the researcher automatically reflected, paraphrased, listened and validated during the interviews. Paralleling in some ways how a therapeutic session contains and reflects so the client's voice is heard. This may have helped during the transcribing and interpreting part as by reflecting in action in the interview may

have helped bracket between interviews. This was reflected at the end of one interview when the participant said this was the first interview; they had felt their voice had been heard, and no one had asked them how they felt before.

During interviews, I used my clinical judgement when one participant wanted more information on the researcher's views. This was offered rather than dismissed as an attempt to validate the client's voice and needs, allowing the participants to feel safe and contained as they shared their unique experiences in relation to their own therapeutic narratives.

### **7.9 Growth as a Researcher and Professional**

Exploring my own beliefs. I started this research with the notion of supporting therapists to work with this group and design an intervention that may then support the unknown number who go on to offend. My underlying beliefs were framed from wanting to stop child abuse, and I held beliefs some of this client group do go on to abuse children, which made me feel disgusted. Addressing my own feelings through therapy and supervision enabled me to be able to understand more and be more self-aware about my own reactions which could be experienced as avoidance or rejection. I am very much aware now at the start of my own research I was unaware of my own biases, and these became more apparent after I developed the video intervention. I initially wanted to design an intervention to help reduce stigma and help support people working with these individuals, but I think I inadvertently created an intervention that was more useful in helping people recognise and bring new awareness to their own unconscious biases from watching the intervention by process of follow-on discussion. Throughout the Doctorate, I am able to be more authentic through my growth through personal and professional development, which Rizq (2010) suggested as an important part of self-development. I allowed myself to be vulnerable in sharing research.

Previously, I noted in the early start of the Doctorate training, I held more medicalised perspectives in line with positivists. During the training and in line with the stage of Psychologist self-development I started to hold more purist philosophies in line with humanistic counselling underpinning. However, I started to realise in practice, it was impossible to practice in this way due to time constraints, not always being able to follow up and needing to be more directive. As my therapy repertoire expanded, I was able to integrate therapies and theories to meet the needs of my clients. After reviewing back and comparing now I can see how I managed tensions in practice between medical and psychological models and have more of a critical realist perspective. The early literature review may have been more framed on the topic of non-offending minor attraction as a sexual orientation, so more balance was needed from a risk perspective

During my thesis study, I was able to deliver my training in several workshops and presentations, and the discussions after were especially useful in starting to highlight biases in therapy. It may be the intervention could be used as a discursive approach to unlocking and uncovering unconscious biases. It could then be developed and embedded in counselling and clinical trainee psychologist courses so when newly qualified Psychologists enter the workplace, they will be able to work with this group being more aware of their own biases. Which will mean they are subsequently better equipped to focus on the client's needs and not becoming absorbed into the narrative around risk and be more culturally competent recognising diversity and stigma.

My epistemological stance altered during my research. Initially, I found myself drawn towards a pragmatic stance based upon socially constructed beliefs. During my Doctorate, I became more aligned with Critical Realism due to the influence of power towards marginalised groups as I aligned myself with the empiricism of psychology drawing upon the subjectivity of counselling (Douglas et al., 2016) in line with the scientific-practitioner

model. In line with Cooper and McLeod (2012), at times, I can employ a pluralistic approach and recognise the individual experience as key to the therapeutic practice, bringing curiosity to my practice. I had previously only used Quantitative methods, and studying counselling psychology enabled me to become curious about a Qualitative approach. Using a mixed method approach fitted best with my own positioning.

There are no training programmes or accredited models to work with Non-Offending MAPs. During my thesis research, I have researched, interviewed, and reflected on my own ideas about working with Non-Offending MAPs and future ideas. There is no NHS pathway to working with adolescent Non-Offending MAPs, and the training could be developed from my thesis work. I reflected on how I feel about the diagnostic labels of Non-Offending MAPs and the tension this raises within the field of counselling psychologists. But also, how early on in my research I was driven by a belief there needs to be some recognition of risk, and this was perhaps my own therapeutic bias underpinning my research and how this changed during my research.

During practice placements, it was highlighted at times to me by Clinical and Forensic Psychologist that I place emphasis on working relationally with clients as a criticism. However, I can see how important it is to build therapy on a relational framework as this enables me to integrate modalities of psychological therapy as needed. I started out my psychology journey working with childhood trauma, and this enabled me to see the importance of the therapeutic relationship and why I hold it as a key requisite now in my beliefs as a counselling psychologist in training. I am mindful that my journey has been influenced by working within Forensic settings. I am influenced by my understanding of counselling psychology and how a relational framework can identify an evidence-based approach to support my clients and draw upon evidence-based practice and different models of counselling and psychotherapy such as person-centred and psychodynamic. Partaking in

personal therapy has enabled me to address my own unresolved parts, become more self-aware of my own bias and blind spots, and be able to relate this to my clients. The role of a Counselling Psychologist is one in which the self becomes very much part of the therapy. As the BPS suggests, counselling psychologists' use of self is imperative in therapy and the identity of the profession. During the research I used supervision and personal therapy to reflect on my own biases and personal values and what this meant in relation to adolescent Non-Offending MAPs.

### **7.10 Conclusion**

The chosen mixed methodology aligned with my philosophy as a Critical Realist of how individual experiences are important to gain lived information from how participants attribute different meanings. As a scientific practitioner, I tried to incorporate both quantitative and qualitative methods as a way of triangulating data and reflect the scientific underpinning of the field of counselling psychologists. This study provided an original contribution as there was no research exploring adolescent Non-Offending MAPs from a counselling psychologist lens. The study implored a mixed methodology to understand the differences between a humanisation intervention on stigma measures and the experiences of psychologists/ therapists working with adolescent Non-Offending MAPs.

The results from both studies bridged together, highlighting the practical implications of this research. Therapists need to work on their own unconscious biases through personal therapy to become self-aware. Humanisation interventions can be useful ways to generate conversation through reflexive practice alongside being developed further to reduce stigma so Psychologists can become more able to support this group. Supervision is important, and there is a growing need for competent supervisors in the area of adolescent Non-Offending

MAPs. Training should become embedded into university doctorate programmes around Stigma Intervention training.

Finally, if I were to summarise my doctoral experience, I would describe it as an immense challenge that has pushed me to persevere and develop my learning as both a scientific practitioner and psychologist. At times, I felt overwhelmed, and choosing a mixed method and seeing peers complete ahead made me question my elaborate design. However, my determination and resilience bestowed pride and I stuck with the research. Finally, my reflections for the future are to improve therapeutic outcomes to improve mental health and foster support for both therapists and adolescent Non-Offending MAPs clients. I would like to involve adolescent Non-Offending MAPs/carers in training programmes, develop supervisor support through workshops and reflexive practice, to develop workshops with Doctorate psychology training programmes.

### References

- Addison, M. (2023). Framing stigma as an avoidable social harm that widens inequality. *The Sociological Review*, 71(2), 296-314. <https://doi.org/10.1177/00380261221150080>
- Ahmedani, B. K. (2011). Mental health stigma: Society, individuals, and the profession. *Journal of Social Work Values and Ethics*, 8(2), 41-416.  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3248273/>
- Alele, F., & Malau-Aduli, B. (2023). *An introduction to research methods for undergraduate health profession students*. James Cook University. <https://jcu.pressbooks.pub/intro-res-methods-health>
- Allport, G. W. (1954). *The nature of prejudice* (p. 537). Addison-Wesley Publication
- Amari, N. (2021). Social justice in counselling psychology practice: Actualizing the ethics of compassion. *Journal of Humanistic Psychology*, 0(0).  
<https://doi.org/10.1177/00221678211039968>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi/book/10.1176/appi.books.9780890425596>
- American Psychological Association. (2008). *Understanding sexual orientation and homosexuality*. <https://www.apa.org/topics/lgbtq/orientation>
- Ankers, M. D., Barton, C. A., & Parry, Y. K. (2018). A phenomenological exploration of graduate nurse transition to professional practice within a transition to practice program. *Collegian*, 24(3), 319-325. <https://doi.org/10.1016/j.colegn.2017.09.002>
- Ankers, M., Parry, Y., Willis, E. (2023). *Social constructionism, power, and understanding the health needs of different groups engaged in a shared reality*. In: Liamputtong, P. (eds) *Handbook of Social Sciences and Global Public Health*. Springer, Cham.  
[https://doi.org/10.1007/978-3-030-96778-9\\_141-1](https://doi.org/10.1007/978-3-030-96778-9_141-1)

- Apostolopoulou, M., & Giovazolias, T. (2021). Therapeutic alliance as a dynamic process: Implications for clinical practice. *International Journal of Psychology and Counselling*, *13*(2), 45–58. <https://psycnet.apa.org/record/2022-31792-002>
- Arain, M., Haque, M., Johal, L., Mathur, P., Nel, W., Rais, A., Sandhu, R., & Sharma, S. (2013). Maturation of the adolescent brain. *Neuropsychiatric disease and treatment*, *9*, 449–461. <https://doi.org/10.2147/NDT.S39776>
- Aranda, A. M., Helms, W. S., Patterson, K. D. W., Roulet, T. J., & Hudson, B. A. (2023). Standing on the shoulders of Goffman: Advancing a relational research agenda on stigma. *Business & Society*, *62*(7), 1339-1377. <https://doi.org/10.1177/00076503221148441>
- B4U-ACT. (2011a). *Mental Health care and Professional literature*. B4U-ACT <https://www.b4uact.org/research/survey-results/spring-2011-survey/B4U-ACT>. (2011b). *Youth, suicidality and seeking care*. B4U-ACT <https://www.b4uact.org/research/survey-results/youth-suicidality-and-seeking-care/>
- B4U-ACT. (2011b). *Youth, Suicidality, and Seeking Care*. Retrieved from <https://www.b4uact.org/research/survey-results/youth-suicidality-and-seeking-care/>.
- Bachelor, A. (2013). Clients' and therapists' views of the therapeutic alliance: Similarities, differences and relationship to therapy outcome. *Clinical Psychology and Psychotherapy*, *20*(2), 118-135. <https://doi.org/10.1002/cpp.792>.
- Ball, K. S., & Wesson, C. J. (2017). Perceptions of unwanted sexual behaviour on public transport: Exploring transport density and behaviour severity. *Crime Prevention and Community Safety*, *19*, 199-210. <https://doi.org/10.1057/s41300-017-0026-3>
- Balmer, A. S., & Sandland, R. (2012). “Making monsters: The polygraph, the plethysmograph, and other practices for the performance of abnormal sexuality.” *Journal of Law and Society*, *39*(4), 593–615. <https://doi.org/10.1111/j.1467-6478.2012.00601.x>.

- Bandura, A., Barbaranelli, C., Caprara, G. V., & Pastorelli, C. (1996). Mechanisms of moral disengagement in the exercise of moral agency. *Journal of Personality and Social Psychology, 71*(2), 364–374. <https://doi.org/10.1037/0022-3514.71.2.364>.
- Baron-Cohen, S., & Wheelwright, S. (2004). The empathy quotient: An investigation of adults with Asperger syndrome or high functioning autism, and normal sex differences. *Journal of Autism and Developmental Disorders, 34*(2), 163–175. <https://doi.org/10.1023/b:jadd.0000022607.19833.00>
- Barrett, A., Kajamaa, A., & Johnston, J. (2020). How to be reflexive when conducting qualitative research. *The Clinical Teacher, 17*(1), 9–12. <https://doi.org/10.1111/tct.13133>
- Baum, N., & Moyal, S. (2020). Impact on therapists working with sex offenders: A systematic review of gender findings. *Trauma, Violence and Abuse, 21*(1), 193–205. <https://doi.org/10.1177/1524838018756120>
- Baumann A. E. (2007). Stigmatization, social distance and exclusion because of mental illness: The individual with mental illness as a 'stranger'. *International Review of Psychiatry, 19*(2), 131–135. <https://doi.org/10.1080/09540260701278739>
- Baumbusch, J. (2010). Semi-structured interviewing in practice-close research. *Journal for Specialists in Paediatric Nursing, 15*(3), 255–258. <https://doi.org/10.1111/j.1744-6155.2010.00243.x>
- Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016). Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: A quantitative survey. *Midwifery, 34*, 239–244.
- Beech, A. R., & Hamilton-Giachritsis, C. E. (2005). Relationship between therapeutic climate and treatment outcome in group-based sexual offender treatment programs. *Sexual Abuse : A*

*Journal of Research and Treatment*, 17(2), 127–140.

<https://doi.org/10.1177/107906320501700204>

- Beier, K. M., Ahlers, C. J., Goecker, D., Neutze, J., Mundt, I. A., Hupp, E., & Schaefer, G. A. (2009). Can paedophiles be reached for primary prevention of child sexual abuse? First results of the Berlin Prevention Project Dunkelfeld (PPD). *Journal of Forensic Psychiatry and Psychology*, 20(6), 851–867. <https://doi.org/10.1080/14789940903174188>
- Beier, K. M., Neutze, J., Mundt, I. A., Ahlers, C. J., Goecker, D., Konrad, A., & Schaefer, G. A. (2009). Encouraging self-identified paedophiles and hebephiles to seek professional help: First results of the Prevention Project Dunkelfeld (PPD). *Child Abuse and Neglect*, 33(8), 545-9. <https://doi:101016/j.chiabu.2009.04.002>.
- Beisser, A. (1970). The paradoxical theory of change. In: J. Fagan, J. & I. L. Shepherd (Eds.). *Gestalt Therapy Now* (pp.77-80). Harper & Row. <http://www.gestalttherapy.org>.
- Beutler, L. E., Malik, M. L., Alimohamed, S., Harwood, T. M., Talebi, H., Noble, S., & Wong, E. (2004). Therapist variables. In M. J. Lambert (Ed.), Bergin and Garfield's *Handbook of Psychotherapy and Behavior Change* (5th ed., pp. 227-306). Wiley.
- Bhaskar, R. (1979). *The possibility of naturalism: A philosophical critique of the contemporary human sciences*. The Harvester Press.
- Bisman, J. E. (2010). Post positivism and accounting research: A (personal) primer on critical realism. *The Australasian Accounting Business and Finance Journal*, 4, 3-25.
- Blanchard, R., Klassen, P., Dickey, R., Kuban, M. E., & Blak, T. (2001). Sensitivity and specificity of the phallometric test for paedophilia in nonadmitting sex offenders. *Psychological Assessment*, 13, 118–126. <https://doi.org/10.1037/1040-3590.13.1.118>
- Blasko, B. L., & Jeglic, E. L. (2016). Sexual offenders' perceptions of the client-therapist relationship: The role of risk. *Sexual abuse: a journal of research and treatment*, 28(4), 271–290. <https://doi.org/10.1177/1079063214529802>

- Boardman, K. A., & Bartels, R. M. (2018). Using video stimuli to examine judgements of nonoffending and offending pedophiles: A brief communication. *Journal of Sex & Marital Therapy, 44*(4), 333–342. <https://doi.org/10.1080/0092623X.2017.1405300>
- Bohnsack, R. (2014). Documentary method. In: U. Flick (Eds.). *The SAGE handbook of Qualitative Data Analysis*. (pp.217–233). Sage.
- Børseth Barca, T., Strandbu, A., & Øverlien, C. (2020). The nature of youth in the eyes of mental-health care workers: Therapists' conceptualization of adolescents coming to therapy at others' initiative. *International Journal of Mental Health Systems, 14*(1), 1–10. <https://doi.org/10.1186/s13033-020-00363-w>
- Borton. T. (1970). *Reach touch and teach: Student concerns and process education*. McGraw-Hill.
- Bowker, H., Saxon, D., & Delgadillo, J. (2024). First impressions matter: The influence of initial assessments on psychological treatment initiation and subsequent dropout. *Psychotherapy Research, 35*(3), 368–378. <https://doi.org/10.1080/10503307.2024.23081641>
- Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research, 21*(1), 37-47. <https://doi.org/10.1002/capr.12360>
- Brenner, R. E., Cornish, M. A., Heath, P. J., Lannin, D. G., & Losby, M. M. (2020). Seeking help despite the stigma: Experiential avoidance as a moderated mediator. *Journal of Counseling Psychology, 67*(1), 132–140. <https://doi.org/10.1037/cou0000365>
- British Psychological Society (2021). *Code of ethics and conduct*. The British Psychological Society.
- Brown, B (2012). *Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead*. Penguin Publishing Group
- Bryman, A. (2006). Paradigm peace and the implications for quality. *International Journal of Social Research Methodology, 9*(2), 111–126. <https://doi.org/10.1080/13645570600595280>

Cacciatori, H., & Xuereb, S. (2017). The lived experiences of men attracted to minors and their therapy-seeking behaviors.

[https://www.researchgate.net/publication/319435083\\_The\\_Lived\\_Experiences\\_of\\_Men\\_Attracted\\_to\\_Minors\\_and\\_Their\\_Therapy-Seeking\\_Behaviors](https://www.researchgate.net/publication/319435083_The_Lived_Experiences_of_Men_Attracted_to_Minors_and_Their_Therapy-Seeking_Behaviors)

Cantor, J. M. (2014). "Gold-Star Pedophiles" in general sex therapy practice. In Y. Binik & K. Hall (Eds.). *Principles and practice of sex therapy* (pp. 277-313). The Guilford Press.

Cantor, J.M., & McPhail, I. V. (2016). Non-offending pedophiles. *Current Sexual Health Reports*, 8, 121–128. <https://doi.org/10.1007/s11930-016-0076-z>.

Cash, B. M. (2016). *Self-identifications, sexual development, and wellbeing in minor attracted people: An exploratory study* (Unpublished master's thesis). Cornell University.

Challa, M., Hajirnis, A., Khan, C. T., & Cagande, C. C. (2025). Addressing implicit bias in child and adolescent psychiatry. *Journal of the American Academy of Child and Adolescent Psychiatry*, 9(2), 1-17. <https://jaacapconnect.org/article/92240.pdf>

Chapman, E. N., Kaatz, A., & Carnes, M. (2013). Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. *Journal of general internal medicine*, 28(11), 1504–1510. <https://doi.org/10.1007/s11606-013-2441-1>

Chassman L., Kottler J., & Madison J. (2010). An exploration of counselor experiences of adolescents with sexual behavior problems. *Journal of Counseling and Development*, 88, 269–276. <https://doi.org/10.1002/j.1556-6678.2010.tb00022.x>

Chaudoir, S. R., Earnshaw, V. A., & Andel, S. (2013). "Discredited" versus "Discreditable": understanding how shared and unique stigma mechanisms affect psychological and physical health disparities. *Basic and Applied Social Psychology*, 35(1), 75–87.

<https://doi.org/10.1080/01973533.2012.746612>

- Chaudoir, S.R., Francis, A. and Earnshaw, V.A. (2016). Discreditable stigma. In: G. Ritzer (Eds.). *In The Blackwell Encyclopedia of Sociology*, Wiley  
<https://doi.org/10.1002/9781405165518.wbeos0643>
- Christofferson, S. M. B. (2019). Is preventive treatment for individuals with sexual interest in children viable in a discretionary reporting context? *Journal of Interpersonal Violence*, 34(20), 4254-4280. <https://doi.org/10.1177/0886260519869236>
- Christophersen, L., & Brotto, G. (2024). The effectiveness of educational interventions for mental health professionals in reducing stigmatization toward people with pedophilia: A Meta-Analysis. *Trauma, Violence, & Abuse*, 25(5), 3796-3813.  
<https://doi.org/10.1177/15248380241262286>
- Chronos, A., Jahnke, S., & Blagden, N. (2024). The treatment needs and experiences of pedohebephiles: A systematic review. *Archives of Sexual Behavior*, 53, 3329–3346.  
<https://doi.org/10.1007/s10508-024-02943-0>
- Clarke, V., & Braun, V. (2017). Thematic analysis. *The Journal of Positive Psychology*, 12(3), 297–298. <https://doi.org/10.1080/17439760.2016.1262613>,
- Cohen, L. J., Ndukwe, N., Siegfried, R., Kopeykina, I., Yaseen, Z. S., & Galynker, I. (2018). Attraction versus action in pedophilic desire: The role of personality traits and childhood experience. *Journal of Psychiatric Practice*, 24(6), 374–387.  
<https://doi.org/10.1097/PRA.0000000000000348>
- Cohen, L., Ndukwe, N., Yaseen, Z., & Galynker, I. (2018). Comparison of self-identified minor-attracted persons who have and have not successfully refrained from sexual activity with children. *Journal of Sex and Marital Therapy*, 44(3), 217–230.  
<https://doi.org/10.1080/0092623X.2017.1377129>

- Connor, K. M., & Davidson, J. R. (2003). Development of a new resilience scale: the Connor-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety, 18*(2), 76–82.  
<https://doi.org/10.1002/da.10113>
- Cook, D., & Monk, L. (2020). ‘Being able to take mask off’: adolescent clients’ experiences of power in person-centered therapy relationships. *Person-Centered & Experiential Psychotherapies, 19*(2), 95–111. <https://doi.org/10.1080/14779757.2020.1717982>
- Cooper, M. (2009). Welcoming the other: Actualising the humanistic ethic at the core of counselling psychology practice. *Counselling Psychology Review, 24*(3-4), 119-129.  
<https://doi.org/10.53841/bpscpr.2009.24.3-4.119>
- Cooper, M., & McLeod, J. (2012). From either/or to both/and: Developing a pluralistic approach to counselling and psychotherapy. *European Journal of Psychotherapy & Counselling, 14*(17), 5. <https://doi.org/10.1080/13642537.2012.652389>
- Cooper, M., van Rijn, B., Chryssafidou, E., & Stiles, W. B. (2021). Activity preferences in psychotherapy: What do patients want and how does this relate to outcomes and alliance? *Counselling Psychology Quarterly, 35*, 505-526.  
<https://doi.org/10.1080/09515070.2021.1877620>
- Corrigan P. W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social work, 52*(1), 31–39. <https://doi.org/10.1093/sw/52.1.31>
- Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., Mathisen, J., Gagnon, C., Bergman, M., Goldstein, H., & Kubiak, M. A. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin, 27*(2), 187–195. <https://doi.org/10.1093/oxfordjournals.schbul.a006865>
- Cortoni, F. (2016). Treatment of female sex offenders. In: D.P. Boer (Eds.). *The Wiley Handbook on the Theories, Assessment and Treatment of Sexual Offending*  
<https://doi.org/10.1002/9781118574003.wattso058>

- Cortoni, F., & Gannon, T. (2016). The assessment of female sexual offenders. In: L. Craig & M. Rettenberger, (Eds.). *Assessment of Sexual Offenders*.  
<https://doi.org/10.1002/9781118574003.wattso046>.
- Craig, L. A. (2005). The impact of training on attitudes towards sex offenders. *Journal of Sexual Aggression*, 11(2), 197–207. <https://doi.org/10.1080/13552600500172103>
- Creswell, J. W. (2014). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches* (4th ed.). Sage Publications.
- Creswell, J. W., & Poth, C. N. (2017). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage Publications.
- Crocker, J. (1999). Social stigma and self-esteem: Situational construction of self-worth. *Journal of Experimental Social Psychology*, 35(1), 89–107. <https://doi.org/10.1006/jesp.1998.1369>
- Crocker, J., & Major, B. (1989). Social stigma and self-esteem: The self-protective properties of stigma. *Psychological Review*, 96(4), 608–630. <https://doi.org/10.1037/0033-295X.96.4.608>
- Cronin, P., Ryan, F., & Coughlan, M. (2008). Undertaking a literature review: a step-by-step approach. *British Journal of Nursing* 17(1), 38–43.  
<https://doi.org/10.12968/bjon.2008.17.1.28059>
- De Haan, E., Duckworth, A., Birch, D., & Jones, C. (2013). Executive coaching outcome research: The contribution of common factors such as relationship, personality match, and self-efficacy. *Consulting Psychology Journal: Practice and Research*, 65(1), 40–57.  
<https://doi.org/10.1037/a0031635>
- Denzin, N. K. (1978). *The Research Act*. McGraw-Hill Book Company.
- Di Giuseppe, M., & Perry, J. C. (2021). The hierarchy of defense mechanisms: Assessing defensive functioning with the defense mechanisms rating scales Q-Sort. *Frontiers in Psychology*, 12, 718440. <https://doi.org/10.3389/fpsyg.2021.718440>

- Dombert, B., Schmidt, A. F., Banse, R., Briken, P., Hoyer, J., Neutze, J., & Osterheider, M. (2016). How common is men's self-reported sexual interest in prepubescent children?. *Journal of Sex Research, 53*(2), 214–223. <https://doi.org/10.1080/00224499.2015.1020108>
- Donati, M. (2016). Becoming a reflective practitioner. In Douglas, B., Woolfe, R., Strawbridge, S., Kasket, E. & Galbraith, V (eds). *The Handbook of Counselling Psychology*. 4th Ed., p.55-73. SAGE Publications.
- Douglas, B., Woolfe, R., Strawbridge, S., Kasket, E., & Galbraith, V. (2016). *The handbook of counselling psychology* (4th ed.). SAGE Publications.
- Dovidio, J. F., & Fiske, S. T. (2012). Under the radar: how unexamined biases in decision-making processes in clinical interactions can contribute to health care disparities. *American Journal of Public Health, 102*(5), 945–952. <https://doi.org/10.2105/AJPH.2011.300601>
- Drapeau, M., Körner, A. C., & Brunet, L. (2004). When the goals of therapists and patients clash: A study of pedophiles in treatment. *Journal of Offender Rehabilitation, 38*(3), 69–80. [https://doi.org/10.1300/J076v38n03\\_05](https://doi.org/10.1300/J076v38n03_05)
- Dreier, A., & Wright, S. (2011). Helping society's outcasts: The impact of counseling sex offenders. *Journal of Mental Health Counseling, 33*, 359-376. [doi:10.17744/mehc.33.4.214t56448430872x](https://doi.org/10.17744/mehc.33.4.214t56448430872x)
- Driscoll J. (1994). Reflective practice for practise. *Senior Nurse, 13*, 47 –50.
- Dymond, H., & Duff, S. (2020). Understanding the lived experience of British non-offending paedophiles. *The Journal of Forensic Practice, 22*(2), 71-81. Article 22. <https://doi.org/10.1108/JFP-10-2019-0046>
- Edmondson, A. (1999). Psychological safety and learning behavior in work teams. *Administrative Science Quarterly, 44*(2), 350–383. <https://doi.org/10.2307/2666999>

- Elchuk, D. L., McPhail, I. V., & Olver, M. E. (2022). Stigma-related stress, complex correlates of disclosure, mental health, and loneliness in minor-attracted people. *Stigma and Health*, 7(1), 100–112. <https://doi.org/10.1037/sah0000317>
- Elder-Vass, D. (2022). Pragmatism, critical realism and the study of value. *Journal of Critical Realism*, 21(3), 261–287. <https://doi.org/10.1080/14767430.2022.2049088>
- Elias H., & Haj-Yahia M. (2017). Therapists' perceptions of their encounter with sex offenders. *International Journal of Offender Therapy and Comparative Criminology*, 61(10), 1151–1170. [10.1177/0306624X16629972](https://doi.org/10.1177/0306624X16629972)
- Elias, H., & Haj-Yahia, M. M. (2019). On the lived experience of sex offenders' therapists: their perceptions of intrapersonal and interpersonal consequences and patterns of coping. *Journal of Interpersonal Violence*, 34(4), 848–872. <https://doi.org/10.1177/0886260516646090>
- Emery, A, & Anderman, L. (2020). Using interpretive phenomenological analysis to advance theory and research in educational psychology. *Educational Psychologist*, 55,1-12. <https://doi.org/10.1080/00461520.2020.1787170>.
- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196(4286),129-36. <https://doi.org/10.1126/science.847460>. PMID: 847460.
- Ennis, L., & Horne, S. (2003). Predicting psychological distress in sex offender therapists. *Sexual Abuse: Journal of Research and Treatment*, 15(2), 149–157. <https://doi.org/10.1177/107906320301500205>
- Epstein, R. M., & Street, R. L. (2011). The values and value of patient-centered care. *Annals of family medicine*, 9(2), 100–103. <https://doi.org/10.1370/afm.1239>
- Eriksson, K., Strimling, P., Gelfand, M. (2021). Perceptions of the appropriate response to norm violation in 57 societies. *Nature Community*, 12, 1481. <https://doi.org/10.1038/s41467-021-21602-9>

- Evanoff, C. (2022). 10 years later: Revisiting Seto's (2012) conceptualization of orientation to sexual maturity among pedohebephilic persons. *The Canadian Journal of Human Sexuality*, 31(5). 443-457 <https://doi.org/10.3138/cjhs.2022-0006>.
- Evans, C. T., Ward, C., & Chan, H. C. (Oliver). (2019). Counseling sex offenders and the importance of counselor self-care. *Cogent Social Sciences*, 5(1). <https://doi.org/10.1080/23311886.2019.1595878>
- Farber, B. A. (2020). Disclosure, concealment, and dishonesty in psychotherapy: A clinically focused review. *Journal of Clinical Psychology*, 76, 251–257. <https://doi.org/10.1002/jclp.22891>
- Farmer, C., Salter, M., & Woodlock, D. (2024). A review of academic use of the term “minor attracted persons.” *Trauma, Violence, & Abuse*. Advance online publication. <https://doi.org/10.1177/15248380241270028>
- Farrenkopf, T. (1992). What happens to therapists who work with sex offenders? *Journal of Offender Rehabilitation*, 18, 217-224. [https://doi.org/10.1300/J076v18n03\\_16](https://doi.org/10.1300/J076v18n03_16)
- Faul, F., Erdfelder, E., Buchner, A., & Lang, A. G. (2009). Statistical power analyses using G\*Power 3.1: tests for correlation and regression analyses. *Behavior research methods*, 41(4), 1149–1160. <https://doi.org/10.3758/BRM.41.4.1149>
- Feelgood, S., & Hoyer, J. (2008). Child molester or paedophile? Sociolegal versus psychopathological classification of sexual offenders against children. *Journal of Sexual Aggression*, 14(1), 33–43. <https://doi.org/10.1080/13552600802133860>
- Feilzer, M. (2010). Doing mixed methods research pragmatically: Implications for the for the rediscovery of pragmatism as a research paradigm. *Journal of Mixed Methods Research*, 4(1),6-16. <https://doi.org/10.1177/1558689809349692>

- Feldman, D. B., & Crandall, C. S. (2007). Dimensions of mental illness stigma: What about mental illness causes social rejection? *Journal of Social and Clinical Psychology, 26*(2), 137–154. <https://doi.org/10.1521/jscp.2007.26.2.137>
- Feltham, C., & Dryden, W. (1993). *Dictionary of Counselling*. Whurr Publishers.
- Field, A. (2024). *Discovering Statistics Using IBM SPSS Statistics* (6<sup>th</sup> ed). Sage Publication.
- Finlay, L. (2011). *Phenomenology for Therapists: Researching the Lived World. Phenomenology for Therapists*: Wiley
- Finlay, L. (2013). Unfolding the Phenomenological Research Process: Iterative Stages of “Seeing Afresh”. *Journal of Humanistic Psychology, 53*(2), 172-201. <https://doi.org/10.1177/0022167812453877>
- Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology, 20*(2), 181-194. doi:10.1080/13645579.2016.1144401
- Freimond, C. (2013). *Navigating the stigma of pedophilia. The experiences of nine minor-attracted men in Canada* (Unpublished master’s dissertation). Simon Fraser University, British Columbia, Canada. Retrieved from <http://summit.sfu.ca/item/137-98>
- Friedrich, M., & Leiper, R. (2006). Countertransference reactions in therapeutic work with incestuous sexual abusers. *Journal of Child Sexual Abuse, 15*(1),51-68. [https://doi.org/10.1300/J070v15n01\\_03](https://doi.org/10.1300/J070v15n01_03). PMID: 16551585
- Furst, T. R., & Evans, D. (2014). An exploration of stigma in the lives of sex offenders and heroin abusers. *Deviant behaviour, 36*, 130-145. <https://doi.org/10.1080/01639625.2014.915673>
- Gendlin, E. T. (2012). *Focusing-oriented psychotherapy: A manual of the experiential method*. Guilford Press.
- Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology, 53*(1), 6-41. <https://doi.org/10.1111/bjc.12043>.

- Glina, F., Carvalho, J., Barroso, R., & Cardoso, D. (2022). Lay people's myths regarding pedophilia and child sexual abuse: A systematic review. *Sexual medicine reviews*, 10(4), 596–619. <https://doi.org/10.1016/j.sxmr.2022.06.010>
- Goffman, E (1963). *Stigma notes on the management of spoiled identity*. Prentice-Hall
- Golsworthy R., & Coyle A. (2001). Practitioners' accounts of religious and spiritual dimension in bereavement therapy. *Counselling Psychology Quarterly*, 14(3), 183–202. <https://doi.org/10.1080/0951507011003799309>
- Grady, M. D., Levenson, J. S., & Bolder, T. (2017). Linking adverse childhood effects and attachment: A theory of etiology for sexual offending. *Trauma, violence & abuse*, 18(4), 433–444. <https://doi.org/10.1177/1524838015627147>
- Grady, M. D., Levenson, J. S., Mesias, G., Kavanagh, S., & Charles, J. (2019). “I can't talk about that”: Stigma and fear as barriers to preventive services for minor-attracted persons. *Stigma and Health*, 4(4), 400–410. <https://doi.org/10.1037/sah0000154>
- Greenberg, L. (2008). Emotion and cognition in psychotherapy: The transforming power of affect. *Canadian Psychology / Psychologie canadienne*, 49(1), 49–59. <https://doi.org/10.1037/0708-5591.49.1.49>
- Greene, J.C. (2006). Toward a methodology of mixed methods social inquiry . *Research in the Schools*, 13(1), 93-99.
- Greene, J.C., Caracelli, V.J., & Graham, W.F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis*, 11(3), 255-27. [https://www.researchgate.net/publication/228968099\\_Toward\\_a\\_methodology\\_of\\_mixed\\_methods\\_social\\_inquiry](https://www.researchgate.net/publication/228968099_Toward_a_methodology_of_mixed_methods_social_inquiry)
- Greene, K., Derlega, V.J, Yep, G.A & Petronio, S. (2003). *Privacy and disclosure of HIV in interpersonal relationships: A sourcebook for researchers and practitioners*. Lawrence Erlbaum Associates Publishers.

- Grundmann, D., Krupp, J., Scherner, G., Amelung, T., & Beier, K. M. (2016). Stability of self-reported arousal to sexual fantasies involving children in a clinical sample of pedophiles and hebephiles. *Archives of Sexual Behavior*, *45*(5), 1153–1162. <https://doi.org/10.1007/s10508-016-0729-z>.
- Guba, E.G., & Lincoln, Y.S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In: Denzin, N.K. and Lincoln, Y.S., (Eds.). *The Sage Handbook of Qualitative Research* (3rd Edition) (pp191-215). Sage Publications.
- Gulliver, A., Griffiths, K.M. & Christensen, H. (2010) Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry* *10*, 113. <https://doi.org/10.1186/1471-244X-10-113>
- Hardeberg-Bach, M., & Demuth, C. (2018). Therapists' experiences in their work with sex offenders and people with pedophilia: A literature review. *Europe's journal of psychology*, *14*(2), 498–514. <https://doi.org/10.5964/ejop.v14i2.1493>
- Harper, C. A., Bartels, R. M., & Hogue, T. E. (2018). Reducing stigma and punitive attitudes toward pedophiles through narrative humanisation. *Sexual Abuse : A journal of research and treatment*, *30*(5), 533–555. <https://doi.org/10.1177/1079063216681561>
- Harper, C. A., Lievesley, R., Blagden, N. J., & Hocken, K. (2022). Humanising pedophilia as stigma reduction: A large-scale intervention study. *Archives of Sexual Behavior*, *51*(2), 945–960. <https://doi.org/10.1007/s10508-021-02057-x>
- Harper, C. A., Lievesley, R., Carpenter, T., Blagden, N., Hocken, K. (2019). Using personal narratives to humanize people with pedophilic sexual interests. Advance Online Publication. [10.31234/osf.io/9c3s2](https://doi.org/10.31234/osf.io/9c3s2)
- Hart, C. L., Barnett, M., & Curtis, D.A. (2024). Client deception in therapy is associated with worse therapeutic relationships and perceived therapeutic outcomes. *Counselling and Psychotherapy Research*, *24*, 1–7. <https://doi.org/10.1002/capr.12767>

- Hatcher, R., & Noakes, S. (2010). Working with sex offenders: The impact on Australian treatment providers. *Psychology, Crime & Law*, 16(1-2), 145–167.  
<https://doi.org/10.1080/10683160802622030>
- Hatfield, E., Luckhurst, C. L., & Rapson, R. L. (2011). Sexual motives: The impact of gender, personality and sexual motives on sexual behavior—especially risky sexual behavior. *An International Journal of Personal Relationships*, 5, 97-133.  
<http://interpersona.org/issues/interpersona-5-2-december-2011/> .
- Hawkins, P., & Shohet, R. (2020). *Supervision in the helping professions* (Fifth Edition). One University Press.
- Hayes, J. A., Gelso, C. J., Goldberg, S., & Kivlighan, D. M. (2018). Countertransference management and effective psychotherapy: Meta-analytic findings. *Psychotherapy*, 55(4), 496–507. <https://doi.org/10.1037/pst0000189>
- Health Care Professional Council. (2016). *Guidance on Conduct and Ethics for Students*.  
<https://www.hcpc-uk.org/globalassets/resources/guidance/guidance-on-conduct-and-ethics-for-students.pdf>.
- Health Care professions Council (HCPC). (2023) Standards of proficiency for practitioner psychologists. HCPC. <https://www.hcpc-uk.org/standards/standards-of-proficiency/practitioner-psychologists/>
- Hecht, M., Kloß, A., & Bartsch, A. (2021). Stopping the stigma. How empathy and reflectiveness can help reduce mental health stigma. *Media Psychology*, 25(3), 367–386.  
<https://doi.org/10.1080/15213269.2021.1963991>
- Heidegger M. (1962). *Being and time*. Harper.
- Heinonen, E., Lindfors, O., Laaksonen, M. A., & Knekt, P. (2012). Therapists' professional and personal characteristics as predictors of outcome in short- and long-term psychotherapy. *Journal of affective disorders*, 138(3), 301–312. <https://doi.org/10.1016/j.jad.2012.01.023>

- Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., Schulze, B., Druss, B., & Thornicroft, G. (2014). Mental health-related stigma in health care and mental health-care settings. *The Lancet. Psychiatry*, *1*(6), 467–482. [https://doi.org/10.1016/S2215-0366\(14\)00023-6](https://doi.org/10.1016/S2215-0366(14)00023-6)
- Herek, G. M., Gillis, J. R., & Cogan, J. C. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology*, *56*, 32-43. <https://doi.org/10.1037/a0014672>
- Heron, R.L., Schwiekert, L. & Karsten, J. (2021) Meeting a person with pedophilia: Attitudes towards pedophilia among psychology students: A pilot study. *Current Psychology*, *42*, 1-12 1022–1033. <https://doi.org/10.1007/s12144-021-01384-5>
- Hinshaw, S. P., & Stier, A. (2008). Stigma as related to mental disorders. *Annual review of Clinical Psychology*, *4*, 367–393. <https://doi.org/10.1146/annurev.clinpsy.4.022007.141245>
- Hobfoll, .S.E. (2011). Oxford Library of Psychology. Oxford University Press.
- Hogue, T., & Harper, C. (2018). Development of a 21-Item Short Form of the Attitudes to Sexual Offenders (ATS) Scale. *Law and Human Behavior*, *43*, <http://doi.org/10.1037/lhb0000308>.
- Horvath, A. O., & Greenberg, L. S.(1994). *The working alliance: Theory, research, and practice*. John Wiley & Sons.
- Horvath, A. O., & Bedi, R. P. (2002). *The alliance*. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37–69). Oxford University Press.
- Houtepen, J. A. B. M., Sijtsema, J. J., & Bogaerts, S. (2016). Being sexually attracted to minors: sexual development, coping with forbidden feelings, and relieving sexual arousal in self-identified pedophiles. *Journal of Sex & Marital Therapy*, *42*(1), 48–69. <http://doi.org/10.1080/0092623X.2015.1061077>

- Howe, K. R. (1988). Against the quantitative-qualitative incompatibility thesis or dogmas die hard. *Educational Researcher*, 17(8), 10-16. <https://doi.org/10.3102/0013189X017008010>
- Hudson, C. G. (2005). Socioeconomic status and mental illness: Tests of the social causation and selection hypotheses. *American Journal of Orthopsychiatry*, 75(1), 3–18.  
<https://doi.org/10.1037/0002-9432.75.1.3>
- Hudson, L. A., & Ozanne, J. L. (1988). Alternative ways of seeking knowledge in consumer research. *Journal of Consumer Research*, 14(4), 508–521. <https://doi.org/10.1086/209132>
- Iffland, J. A., & Schmidt, A. F. (2023). "Stigmatization and perceived dangerousness for intrafamilial child sexual abuse of fathers with a history of sexual offenses and paraphilic interests: Results from a survey of legal psychological experts". *Child Abuse & Neglect*, 144, 106348. <https://doi.org/10.1016/j.chiabu.2023.106348>
- Imhoff, R. (2015). Punitive attitudes against pedophiles or persons with sexual interest in children: does the label matter? *Archives of Sexual Behavior*, 44(1), 35–44.  
<https://doi.org/10.1007/s10508-014-0439-3>
- Imhoff, R., & Jahnke, S. (2018). Determinants of punitive attitudes toward people with pedophilia: Dissecting effects of the label and intentionality ascriptions. *Archives of Sexual Behavior*, 47(2), 353–361. <https://doi.org/10.1007/s10508-017-1048-8>
- Jackson, T., Ahuja, K., & Tenbergen, G. (2022). Challenges and solutions to implementing a community-based wellness program for non-offending minor attracted persons. *Journal of Child Sexual Abuse*, 31(3), 316-332. <https://doi.org/10.1080/10538712.2022.2056103>.
- Jahnke, & Hoyer, J. (2013). Stigmatization of people with pedophilia: A blind spot in stigma research. *International Journal of Sexual Health*, 25(3), 169–184.  
<https://doi.org/10.1080/19317611.2013.795921>

- Jahnke, S. (2018a). Emotions and cognitions associated with the stigma of non-offending pedophilia: A vignette experiment. *Archives of Sexual Behavior*, 47(2), 363–373.  
<https://doi.org/10.1007/s10508-017-1073-7>
- Jahnke, S. (2018b). The stigma of pedophilia: Clinical and forensic implications. *European Psychologist*, 23(2), 144–153. <https://doi.org/10.1027/1016-9040/a000325>
- Jahnke, S., Blagden, N. & Hill, L. (2022). Pedophile, child lover, or minor-attracted person? Attitudes toward labels among people who are sexually attracted to children. *Archives of Sexual Behavior*, 51, 4125–4139. <https://doi.org/10.1007/s10508-022-02331-6>
- Jahnke, S., Blagden, N., McPhail, I. V., & Antfolk, J. (2023). Secret keeping in therapy by clients who are sexually attracted to children. *Psychotherapy Research*, 1-16, DOI: <https://doi.org/10.1080/10503307.2023.2265047>
- Jahnke, S., Imhoff, R., & Hoyer, J. (2015a). Stigmatization of people with pedophilia: two comparative surveys. *Archives of sexual behavior*, 44(1), 21–34.  
<https://doi.org/10.1007/s10508-014-0312-4>
- Jahnke, S., Philipp, K., & Hoyer, J. (2014). Stigmatizing attitudes towards people with pedophilia and their malleability among psychotherapists in training. *Child Abuse and Neglect*, 40, 93-102. <https://doi.org/10.1016/j.chiabu.2014.07.008>
- Jahnke, Schmidt, A., Geradt, M., Hoyer, J., & Schmidt, A. F. (2015b). Stigma-Related Stress and Its Correlates Among Men with Pedophilic Sexual Interests. *Archives of Sexual Behavior*, 44(8), 2173–2187. <https://doi.org/10.1007/s10508-015-0503-7>
- Jamieson, M. K., Govaart, G. H., & Pownall, M. (2022). Reflexivity in quantitative Research: a rationale and beginner’s guide. *Social and Personality Psychology Compass*, 17(4), e12735  
<https://doi.org/10.1111/spc3.12735>

- Jara, G. A., & Jeglic, E. (2021). Changing public attitudes toward minor attracted persons: an evaluation of an anti-stigma intervention. *Journal of Sexual Aggression, 27*(3), 299–312. <https://doi.org/10.1080/13552600.2020.1863486>
- Javed, A., Lee, C., Zakaria, H., Buenaventura, R. D., Cetkovich-Bakmas, M., Duailibi, K., Ng, B., Ramy, H., Saha, G., Arifeen, S., Elorza, P. M., Ratnasingham, P., & Azeem, M. W. (2021). Reducing the stigma of mental health disorders with a focus on low- and middle-income countries. *Asian Journal of Psychiatry, 58*, 102601. <https://doi.org/10.1016/j.ajp.2021.102601>
- Jimenez-Arista, L. E & Caldera, K. (2024). Public attitudes toward teenagers with paedophilia: a qualitative examination, *Journal of Sexual Aggression, 30*(2), 211-225, <https://doi.org/10.1080/13552600.2023.2233552>
- Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher, 33*(7), 14-26. <https://doi.org/10.3102/0013189X033007014>
- Johnstone, L., & Boyle, M. (2018). The power threat meaning framework: An alternative nondiagnostic conceptual system. *Journal of Humanistic Psychology, 0*(0). <https://doi.org/10.1177/0022167818793289>
- Jones, E.E., Farina, A., Hastorf, A. H., Markus, H, Miller, D. T., & Scott, R.A. (1984). *Social stigma: The psychology of marked relationships*. Freeman.
- Jurcevic, Ines & Wong, Lauren & Schetter, Christine & Shapiro, Jenessa. (2021). Strategies for disclosing a concealable stigma: Facts and feelings?. *Journal of Experimental Social Psychology, 97*, 104187. <https://doi.org/10.1016/j.jesp.2021.104187>.
- Knoll, J. (2009). Treating the morally objectionable patient: Countertransference reactions. *Psychiatric times, 26*(4), 45-77. <https://www.psychiatristimes.com/view/treating-morally-objectionable-patient-countertransference-reactions>

- Knox, R. & Cooper, M. (2010). Relationship qualities are associated with moments of relational depth: the client's perspective. *Person-Centered and Experiential Psychotherapies*, 9(3), 236-256. <https://strathprints.strath.ac.uk/26790/>
- Kühne, F., Maas, J., Wiesenthal, S., & Weck, F. (2019). Empirical research in clinical supervision: a systematic review and suggestions for future studies. *BMC psychology*, 7(1), 54. <https://doi.org/10.1186/s40359-019-0327-7>
- Lago, C. (2011). Diversity, oppression, and society: Implications for person-centered therapists. *Person-Centered & Experiential Psychotherapies*, 10(4), 235–247. <https://doi.org/10.1080/14779757.2011.626621>
- Lam, C. B., Solmeyer, A. R., & McHale, S. M. (2012). Sibling relationships and empathy across the transition to adolescence. *Journal of Youth and Adolescence*, 41, 1657–1670. doi: 10.1007/s10964-012-9781-8
- Lambert, E. G., Ventura, L. A., Hall, D. E., & Cluse-Tolar, T. (2006). College students' views on gay and lesbian issues: Does education make a difference? *Journal of Homosexuality*, 50(4), 1–30. [https://doi.org/10.1300/J082v50n04\\_01](https://doi.org/10.1300/J082v50n04_01)
- Lamm, C., Batson, C. D., & Decety, J. (2007). The neural substrate of human empathy: effects of perspective-taking and cognitive appraisal. *Journal of Cognitive Neuroscience*, 19(1), 42–58. <https://doi.org/10.1162/jocn.2007.19.1.42>
- Landgren, V., Savard, J., Dhejne, C., Jokinen, J., Arver, S., Seto, M. C., & Rahm, C. (2022). Pharmacological treatment for pedophilic disorder and compulsive sexual behavior disorder: A review. *Drugs*, 82(6), 663–681. <https://doi.org/10.1007/s40265-022-01696-1>
- Lasher, M. P., & Stinson, J. D. (2017). Adults with pedophilic interests in the united states: Current practices and suggestions for future policy and research. *Archives of Sexual Behavior*, 46(3), 659–670. <https://doi.org/10.1007/s10508-016-0822-3>

- Lawrence, A. L. & Willis, G. M. (2023). Cognitive and affective Impacts of anti-stigma intervention surrounding people with a sexual interest in children. *Journal of Sex & Marital Therapy*, 49(8), 945-959, <https://doi.org/10.1080/0092623X.2023.2224323>
- Lawrence, A. L., & Willis, G. M. (2024). Facilitators and barriers to understanding and accepting people with a sexual interest in children: A thematic analysis. *Archives of sexual behavior*, 53(4), 1361–1375. <https://doi.org/10.1007/s10508-023-02757-6>
- Lazarus R. S. (1993). From psychological stress to the emotions: a history of changing outlooks. *Annual review of psychology*, 44, 1–21. <https://doi.org/10.1146/annurev.ps.44.020193.000245>
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. Springer.
- Lemma, A. (2016). *Introduction to the practice of psychoanalytic psychotherapy* (2nd ed.). Wiley Blackwell.
- Levenson, J (2014). Incorporating trauma-informed care into evidence-based sex offender treatment. *Journal of Sexual Aggression*, 20(1), 9-22, <https://doi.org/10.1080/13552600.2013.861523>
- Levenson, J. S., & Grady, M. D. (2019). Preventing sexual abuse: perspectives of minor-attracted persons about seeking help. *Sexual Abuse*, 31(8), 991-1013. <https://doi.org/10.1177/1079063218797713>
- Levenson, J. S., & Grady, M. D. (2019a). “I could never work with those people...”: Secondary prevention of child sexual abuse via a brief training for therapists about pedophilia. *Journal of Interpersonal Violence*, 34(20), 4281–4302. <https://doi.org/10.1177/0886260519869238>
- Levenson, J. S., Willis, G. M., & Vicencio, C. P. (2017). Obstacles to help-seeking for sexual offenders: Implications for prevention of sexual abuse. *Journal of Child Sexual Abuse*, 26, 99-120. doi:10.1080/10538712.2016.1276116

- Lievesley, Harper, C. A., & Elliott, H. (2020). The internalization of social stigma among minor-attracted persons: Implications for treatment. *Archives of Sexual Behavior*, *49*(4), 1291–1304. <https://doi.org/10.1007/s10508-019-01569-x>
- Lievesley, R., & Harper, C. A. (2022). Applying desistance principles to improve wellbeing and prevent child sexual abuse among minor-attracted persons. *Journal of Sexual Aggression*, *28*(1), 1–14. doi:10.1080/13552600.2021.1883754
- Lievesley, R., & Lapworth, R. (2022). "We do exist": The experiences of women living with a sexual interest in minors. *Archives of Sexual Behavior*, *51*(2), 879–896. <https://doi.org/10.1007/s10508-021-02160-z>
- Lievesley, R., Harper, C. A., Swaby, H., & Woodward, E. (2023). Identifying and working with appropriate treatment targets with people who are sexually attracted to children. *Journal of Sex & Marital Therapy*, *49*(5), 497–516. <https://doi.org/10.1080/0092623X.2022.2149437>
- Lievesley, R., Swaby, H., Harper, C. A., & Woodward, E. (2022). Primary health professionals' beliefs, experiences, and willingness to treat minor-attracted persons. *Archives of Sexual Behavior*, *51*(2), 923–943. <https://doi.org/10.1007/S10508-021-02271-7>
- Lincoln Y. S., Guba E. G. (1985). *Naturalistic inquiry*. Sage
- Link, B. (1982). Mental patient status, work, and income: An examination of the effects of a psychiatric label. *American Sociological Review*, *47*(2), 202-215.
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*, 363–385. <https://doi.org/10.1146/annurev.soc.27.1.363>
- Liu, Z., & Kuai, M. (2025). The global burden of depression in adolescents and young adults, 1990–2021: Systematic analysis of the global burden of disease study. *BMC Psychiatry*, *25*(767), 1–15. <https://doi.org/10.1186/s12888-025-07201-8>

- Luhmann, M., & Hawkley, L. C. (2016). Age differences in loneliness from late adolescence to oldest old age. *Developmental Psychology*, 52(6), 943–959.  
<https://doi.org/10.1037/dev0000117>
- Lundberg, B., Hansson, L., Wentz, E. and Bjorkman, T. (2007). Sociodemographic and clinical factors related to devaluation/discrimination and rejection experiences among users of mental health services. *Social Psychiatry and Psychiatric Epidemiology*, 42, 295-300.  
<http://dx.doi.org/10.1007/s00127-007-0160-9>
- Lundberg, C., & Schreiner, L., Hovaguimian, K., & Miller, S. (2007). First-Generation status and student race/ethnicity as distinct predictors of student involvement and learning. *Journal of Student Affairs Research and Practice*. 44(1) 57-83. 10.2202/1949-6605.1755.
- Lysova EI, Allan BA, Dik BJ, et al. (2019) Fostering meaningful work in organizations: A multi-level review and integration. *Journal of Vocational Behaviour*, 110(2), 374–389.  
<https://doi.org/10.1016/j.jvb.2018.07.004>
- Madill, A., Jordan, A. & Shirley, C. (2000) Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies, *British Journal of Psychology*, 91, 1-20
- Mandangu, C., Ramos, A. M., Sengupta, M., Bender, R., El-Hayani, R., Hasan, I., Okechukwu, H., Anas, S., & Havsteen-Franklin, D. (2025). Implicit bias in referrals to relational psychological therapies: Review and recommendations for mental health services. *Frontiers in Public Health*, 12, 1-15. <https://doi.org/10.3389/fpubh.2024.1469439>
- Mantovani, N., Pizzolati, M., & Edge, D. (2017). Exploring the relationship between stigma and help-seeking for mental illness in African-descended faith communities in the UK. *Health Expectations: An international journal of public participation in health care and health policy*, 20(3), 373–384. <https://doi.org/10.1111/hex.12464>

- Marshall, W. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse, 17*, 109-116. <https://doi.org/10.1177/1079063205017002>
- Marshall, W. L., Serran, G. A., Fernandez, Y. M., Mulloy, R., Mann, R. E., & Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behaviour change. *Journal of Sexual Aggression, 9*(1), 25–30. <https://doi.org/10.1080/355260031000137940>
- Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*(3), 438–450. <https://doi.org/10.1037/0022-006X.68.3.438>
- Maslach C., Jackson S. (1981) The measurement of experienced burnout. *Journal of Occupational Behavior, 2*, 90–113. <http://www.jstor.org/stable/300028>
- McCartan, K. F. (2010). Student/trainee-professional implicit theories of paedophilia. *Psychology, Crime & Law, 16*(4), 265–288. <https://doi.org/10.1080/10683160802614144>
- McEvoy, P., & Richards, D. (2003). Critical realism: a way forward for evaluation research in nursing? *Journal of advanced nursing, 43*(4), 411–420. <https://doi.org/10.1046/j.1365-2648.2003.02730.x>
- McKillop, N & Price, S (2023). The potential for anti-stigma interventions to change public attitudes toward minor-attracted persons: A replication and extension of Jara and Jeglic’s study. *Journal of Child Sexual Abuse, 32*(6), 694-714. <https://doi.org/10.1080/10538712.2023.2204864>
- McLeod B. D., Islam N. Y., Chiu A. W., Smith M. M., Chu B. C., Wood J. J. (2014). The relationship between alliance and client involvement in CBT for child anxiety disorders. *Journal of Clinical Child and Adolescent Psychology, 43*(5), 735–741. <https://doi.org/10.1080/15374416.2013.850699>

- McNeeley, S. (2012). Sensitive issues in surveys: Reducing refusals while increasing reliability and quality of responses to sensitive survey items. In: Gideon, L. (eds.). *Handbook of Survey Methodology for the Social Sciences*. Springer. [https://doi.org/10.1007/978-1-4614-3876-2\\_22](https://doi.org/10.1007/978-1-4614-3876-2_22)
- Mendoza-Denton, R., Downey, G., Purdie, V. J., Davis, A., & Pietrzak, J. (2002). Sensitivity to status-based rejection: implications for African American students' college experience. *Journal of personality and social psychology*, 83(4), 896–918. <https://doi.org/10.1037//0022-3514.83.4.896>
- Mertens D. M. (2020). *Research and evaluation in education and psychology* (5th ed.). Sage.
- Mertens D. M., & Wilson A. (2012). *Program evaluation theory and practice*. Guilford Press.
- Mertens, D. (2010). Transformative Mixed Methods Research. *Qualitative Inquiry*, 16(6), 469-474. <https://doi.org/10.1177/1077800410364612>
- Meyer I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697. <https://doi.org/10.1037/0033-2909.129.5.674>
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, 36(1), 38–56. <https://doi.org/10.2307/2137286>
- Mitchell, R. C, & Galupo, M. P. (2018) .The role of forensic factors and potential harm to the child in the decision not to act among men sexually attracted to children. *Journal of Interpersonal violence*, 33(14) 2159-2179, <https://doi.org/10.1177/0886260515624211>
- Mivshek, M. E., & Schriver, J. L. (2022). Attitudes toward treatment among sex offender treatment providers affect burnout and empathy. *Journal of Sexual Aggression*, 29(2), 256–267. <https://doi.org/10.1080/13552600.2022.2070293>

- Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250–260. <https://doi.org/10.1037/0022-0167.52.2.250>
- Moyers, T. B., Houck, J., Rice, S. L., Longabaugh, R., & Miller, W. R. (2016). Therapist empathy combined behavioral intervention, and alcohol outcomes in the COMBINE research project. *Journal of Consulting and Clinical Psychology, 84*(3), 221–229. doi:10.1037/ccp0000074
- Nematy, A., Flynn, S., & McCarthy-Jones, S. (2024). Perspectives, treatment goals and approaches of prevention-specialist mental health professionals in working with clients attracted to children. *Sexual Abuse, 0*(0) <https://doi.org/10.1177/10790632241268465>
- Norcross J. C. (2010). *The therapeutic relationship*. In *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 113–141). American Psychological Association. <https://doi.org/10.1037/12075-004>
- Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy, 48*(1), 98–102. <https://doi.org/10.1037/a0022161>
- Norcross, J.C. (2002). *Psychotherapy relationships work: Therapist contributions and responsiveness to patients*. Oxford University Press
- Nováková, L. M., Krejčová, L., Potyszová, K., & Klapilová, K. (2023). Held back by limited experience, training, and therapeutic confidence: self-perceptions of Czech mental health professionals about addressing paraphilic-related concerns. *Sexual and Relationship Therapy, 1–27*. <https://doi.org/10.1080/14681994.2023.2232318>
- Núñez, D., Moreno, M., Sepúlveda, R., & Araya, R. (2021). Interventions to reduce stigma towards mental disorders in young people: Protocol for a systematic review and meta-analysis. *BMJ Open, 11*(11), 1-5. <https://doi.org/10.1136/bmjopen-2020-045726>

O’Keeffe, S., Martin, P., & Midgley, N. (2020). When adolescents stop psychological therapy:

Rupture-repair in the therapeutic alliance and association with therapy ending.

*Psychotherapy*, 57(4), 471–490. <https://doi.org/10.1037/pst0000279>

Oetzel, K., & Scherer, D. G. (2003). Therapeutic engagement with adolescents in psychotherapy.

*Psychotherapy: Theory, Research, Practice, Training*, 40(3), 215–225.

<https://doi.org/10.1037/0033-3204.40.3.215>

Oosterhuis, H. (2012). Sexual modernity in the works of Richard von Krafft-Ebing and Albert Moll.

*Medical History*, 56(2), 133-155. <https://doi.org/10.1017/mdh.2011.30>

Orlans, V., & Van Scoyoc, S. (2008). *A Short Introduction to Counselling Psychology*. Sage.

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy: Noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270–376). John Wiley & Sons.

Pachankis, J. E. (2007). The psychological implications of concealing a stigma: a cognitive-affective-behavioral model. *Psychological Bulletin*, 133(2), 328–345.

<http://doi.org/10.1037/0033-2909.133.2.328>

Pachankis, J. E., & Goldfried, M. R. (2006). Social anxiety in young gay men. *Journal of Anxiety Disorders*, 20(8), 996–1015. <https://doi.org/10.1016/j.janxdis.2006.01.001>

Pachankis, J. E., Hatzenbuehler, M. L., Wang, K., Burton, C. L., Crawford, F. W., Phelan, J. C., & Link, B. G. (2018). The burden of stigma on health and well-Being: A taxonomy of concealment, course, disruptiveness, aesthetics, origin, and peril across 93 stigmas.

*Personality & Social Psychology Bulletin*, 44(4), 451–474.

<https://doi.org/10.1177/0146167217741313>

Parse, R. R. (2023). Thematic integrative literature reviews. *Nursing Science Quarterly*, 36 (4),321-322. <https://doi:10.1177/08943184221115132>

- Parr, J., & Pearson, D. (2019). Non-offending minor-attracted persons: Professional practitioners' views on the barriers to seeking and receiving their help. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders*, 28(8), 945–967. <https://doi.org/10.1080/10538712.2019.1663970>
- Pérez-Fuentes, M. C., Herrera-Peco, I., Molero Jurado, M. M., Oropesa Ruiz, N. F., Ayuso-Murillo, D., & Gázquez-Linares, J. J. (2016). The development and validation of the healthcare professional humanization Scale (HUMAS) for nursing. *International Journal of Environmental Research and Public Health*, 16(20), 3999. <https://doi.org/10.3390/ijerph16203999>
- Pervin, N., & Mokhtar, M. (2022). The interpretivist research paradigm: A subjective notion of a social context. *International Journal of Academic Research in Progressive Education and Development*, 11(2), 419–428.
- Pilgrim, D. (2014). *Understanding Mental Health: A critical realist exploration* (1st ed.). Routledge. <https://doi.org/10.4324/9781315756592>
- Plano-Clark, V., Garrett, A., & Leslie-Pelecky, D. (2010). *Applying three strategies for integrating quantitative and qualitative databases in a mixed methods study of a nontraditional graduate education program*. *Field Methods*, 22, 154-174. 10.1177/1525822X09357174.
- Polson, M., & McCullom, E. (1995). Therapist caring in the treatment of sexual abuse offenders: Perspectives from a qualitative case study of one sexual abuse treatment program. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders*, 4(1), 21–43. [https://doi.org/10.1300/J070v04n01\\_02](https://doi.org/10.1300/J070v04n01_02)
- Poth, C., & Munce, S. E. P. (2020). Commentary- preparing today's researchers for a yet unknown tomorrow: Promising practices for a synergistic and sustainable mentoring approach to mixed methods research learning. *International Journal of Multiple Research Approaches*, 12, 56-64. <https://doi.org/10.29034/ijmra.v12n1commentary>

- Powell, B. J., Proctor, E. K., & Glass, J. E. (2014). A systematic review of strategies for implementing empirically supported mental health interventions. *Research on Social Work Practice, 24*(2), 192–212. <https://doi.org/10.1177/10497315135057>
- Radez, J., Reardon, T., Creswell, C., Lawrence, P. J., Evdoka-Burton, G., & Waite, P. (2021). Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. *European child & adolescent psychiatry, 30*(2), 183–211. <https://doi.org/10.1007/s00787-019-01469-4>
- Rahman, M. S. (2016). The advantages and disadvantages of using qualitative and quantitative approaches and methods in language “Testing and Assessment” research: A literature review. *Journal of Education and Learning, 6*, 102-112. <https://doi.org/10.5539/jel.v6n1p102>
- Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist, 18*(1), 20–23.
- Reisman, J. A., & Strickland, G. B. (2011). B4U-Act's 2011 Symposium on pedophilia, minor-attracted persons and the DSM. *Ave Maria International Law Journal, 1*(2), 265-311. <https://www.avemarialaw.edu/wp-content/uploads/2022/02/Reisman.Strickland.pdf>
- Reniers, R. L. E. P., Corcoran, R., Drake, R., Shryane, N. M., & Völlm, B. A. (2011). The QCAE: A questionnaire of cognitive and affective empathy. *Journal of Personality Assessment, 93*(1), 84-95
- Riess, H., Kelley, J., Bailey, R., Dunn, E., & Phillips, M. (2012). Empathy training for resident physicians: A randomized controlled trial of a Neuroscience-Informed Curriculum. *Journal of General Internal Medicine, 27*(10), 1280-1286. <https://doi/10.1007/s11606-012-2063-z>
- Rizq, R. (2010). Training and disillusion in counselling psychology: a psychoanalytic perspective. *Psychology and Psychotherapy: Theory, Research and Practice, 79*, 613-627. <https://doi/10.1348/147608305x89964>

- Robinson, O. C. (2023). Probing in qualitative research interviews: Theory and practice. *Qualitative Research in Psychology, 20*(3), 382–397. <https://doi.org/10.1080/14780887.2023.2238625>
- Rogers, C. R. (1951). *On becoming a person: A psychotherapist's view of psychotherapy*. Houghton Mifflin.
- Rolfe, G., Freshwater, D., & Jasper, M. (2001). *Critical reflection in nursing and the helping professions: a user's guide*. Palgrave Macmillan.
- Roth, A. D., & Pilling, S. (2008). Using an evidence-based methodology to identify the competences required to deliver effective cognitive and behavioural therapy for depression and anxiety disorders. *Behavioural and Cognitive Psychotherapy, 36*(2), 129–147. <https://doi.org/10.1017/S1352465808004141>
- Ruiz-Moral, R., Pérula de Torres, L., Monge, D., García Leonardo, C., & Caballero, F. (2017). Teaching medical students to express empathy by exploring patient emotions and experiences in standardized medical encounters. *Patient Education and Counseling, 100*(9), 1694-1700. <https://doi.org/10.1016/j.pec.2017.04.018>
- Sandhu D. K., Rose J., Rostill-Brookes H. J., Thrift S. (2012). “It’s intense, to an extent”: A qualitative study of the emotional challenges faced by staff working on a treatment programme for intellectually disabled sex offenders. *Journal of Applied Research in Intellectual Disabilities, 25*, 308–318. <https://doi.org/10.1111/j.1468-3148.2011.00667.x>
- Saray, A. (2017). “Sexual Orientation and Choice”. *Journal of Social Ontology, 3*(2), 249-65. <https://journalofsocialontology.org/index.php/jso/article/view/6815>.
- Sawyer, S. M., Azzopardi, P. S., Wickremarathne, D., & Patton, G. C. (2018). The age of adolescence. *The Lancet Child & Adolescent Health, 2*(3), 223 – 228. [https://doi.org/10.1016/S2352-4642\(18\)30022-1](https://doi.org/10.1016/S2352-4642(18)30022-1)

- Schaefer, A., Wittenberg, A., Galynker, I.I., & Cohen, L.J. (2022). Qualitative analysis of minor attracted persons' subjective experience: Implications for treatment. *Journal of Sex & Marital Therapy, 49*, 391 - 411. <https://doi.org/10.1080/0092623X.2022.2126808>
- Scheela, R. A. (2001). Sex offender treatment: Therapists' experiences and perceptions. *Issues in mental health nursing, 22*, 749-767. <https://doi.org/10.1080/01612840152713009>
- Schmidt, A.F., Niehaus, S. (2022). Outpatient therapists' perspectives on working with persons who are sexually interested in minors. *Archives of Sexual Behavior, 51*, 4157–4178 (2022). <https://doi.org/10.1007/s10508-022-02377-6>
- Schoenberg, N. E., & Ravdal, H. (2000). Using vignettes in awareness and attitudinal research. *International Journal of Social Research Methodology, 3*(1), 63–74. <https://doi.org/10.1080/136455700294932>
- Seto, M. C. (2008). *Pedophilia and sexual offending against children: Theory, assessment, and intervention*. American Psychological Association. <https://doi.org/10.1037/11639>
- Seto, M. C. (2012). Is pedophilia a sexual orientation? *Archives of Sexual Behavior, 41*(1), 231– 58 236. <http://doi.org/10.1007/s10508-011-9882-6>
- Seto, M. C. (2012). Is pedophilia a sexual orientation?. *Archives of sexual behavior, 41*(1), 231–236. <https://doi.org/10.1007/s10508-011-9882-6>
- Seto, M. C., & Eke, A. W. (2017). Correlates of admitted sexual interest in children among individuals convicted of child pornography offenses. *Law and human behavior, 41*(3), 305– 313. <https://doi.org/10.1037/lhb0000240>
- Seto, M.C.(2017). The puzzle of male chronophilias. *Archives of Sexual Behavior. 46*(1), 3–22. <https://doi.org/10.1007/s10508-016-0799-y>.
- Sheehy, C. M. J., & Friedlander, M. L. (2009). The relation of secondary traumatization to therapists' perceptions of the working alliance with clients who commit sexual abuse. *Journal of Counselling Psychology, 56*(3), 461–467. <https://doi.org/10.1037/a0015422>

- Silverman D (2017) How was it for you? The interview society and the irresistible rise of the (poorly analyzed) interview. *Qualitative Research*, 17(2), 144–158.
- Singer, T., & Lamm, C. (2009). The social neuroscience of empathy. *Annals of the New York Academy of Sciences*, 1156, 81–96. <https://doi.org/10.1111/j.1749-6632.2009.04418.x>
- Skiest. H. E, Milliken. A. L, & Limbers. C. A. (2025). Therapeutic alliance within trauma-focused cognitive behavioral therapy: A systematic review. *Clinical Child Psychology and Psychiatry*, 30(2), 402-418. <https://doi:10.1177/13591045251318058>
- Smith, J. A., & Osborn, M. (2004). Interpretative phenomenological analysis. In G. M. Breakwell (Ed.), *Doing social psychology research* (pp. 229-254). Blackwell.
- Smith, J. A., Flowers., & Larkin, M. (2022). *Interpretative Phenomenological Analysis 2<sup>nd</sup> Edition* Sage.
- Smith, J.A., Jarman, M. & Osborn, M.(1999). Doing interpretative phenomenological analysis. In M Murray & K. Chamberlain (Eds.) *Qualitative health psychology: Theories and methods* (p.218–241). Sage.
- Snyder, H. (2019). Literature review as a research methodology: An overview and guidelines. *Journal of Business Research*, 104, 333-339. <https://doi.org/10.1016/j.jbusres.2019.07.039>
- Steindl, S. R., Matos, M., & Dimaggio, G. (2023). The interplay between therapeutic relationship and therapeutic technique: The whole is more than the sum of its parts *Journal of Clinical Psychology*, 79(7),1686-1692. <https://doi.org/10.1002/jclp.23519>
- Stephens S, & McPhail I.V. (2023). A preliminary examination of sexual interest in children in a non-representative community sample of females. *Journal Sex Marital Therapy*, 47(6), 591-604. <https://doi.org/10.1080/0092623X.2021.1928804>.
- Stephens, S., McPhail, I. V., Heasman, A., & Moss, S. (2021). Mandatory reporting and clinician decision-making when a client discloses sexual interest in children. *Canadian Journal of*

*Behavioural Science/Revue Canadienne Des Sciences Du Comportement*, 53(3), 263–273.

<https://doi.org/10.1037/cbs0000247>

Stevens, E., & Wood, J. (2019). “I despise myself for thinking about them” A thematic analysis of the mental health implications and employed coping mechanisms of self-reported non-offending minor attracted persons. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders*, 28(8), 968–989.

<https://doi.org/10.1080/10538712.2019.1657539>

Stiels-Glenn, M. (2010). The availability of outpatient psychotherapy for paedophiles in Germany. *Recht und Psychiatrie*, 28, 74-80.

Stripling, T. (2021). Gestalt interventions benefitting children and adolescents: A literature review. *Gestalt Review*, 25(2), 197–220. <https://doi.org/10.5325/gestaltreview.25.2.0197>

Stuber, J. P., Rocha, A., Christian, A., & Link, B. G. (2014). Conceptions of mental illness: attitudes of mental health professionals and the general public. *Psychiatric services*, 65(4), 490–497.

<https://doi.org/10.1176/appi.ps.201300136>

Stuber, J., Meyer, I., & Link, B. (2008). Stigma, prejudice, discrimination and health. *Social science & medicine*, 67(3), 351–357. <https://doi.org/10.1016/j.socscimed.2008.03>

Sweetman, D., Badiee, M., & Creswell, J. W. (2010). Use of the transformative framework in mixed methods studies. *Qualitative Inquiry*, 16(6), 441-454.

<https://doi.org/10.1177/1077800410364610> Silverman 2017

Tenbergen, G., Martinez-Dettamanti, M., & Christiansen, C. (2021). Can nonoffending pedophiles be reached for the primary prevention of child sexual abuse by addressing nonoffending individuals who are attracted to minors in the united states? New strategies with the global prevention project. *Journal of psychiatric practice*, 27(4), 265–272.

<https://doi.org/10.1097/PRA.0000000000000561>

- Thompson, N. M., van Reekum, C. M., & Chakrabarti, B. (2021). Cognitive and affective empathy relate differentially to emotion regulation. *Affective Science*, 3(1), 118–134.  
<https://doi.org/10.1007/s42761-021-00062-w>
- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Journal of the International Society for Quality in Health Care*, 19(6), 349–357. <https://doi.org/10.1093/intqhc/mzm042>
- Tozdan, S., Dekker, A., Neutze, J., Santtila, P., & Briken, P. (2020). Sexual interest in children among women in two nonclinical and nonrepresentative online samples. *Sexual Medicine*, 8(2), 251–264. <https://doi.org/10.1016/j.esxm.2020.01.007>
- Tozdan, S., Hübener, G., Briken, P., & Schröder, J. (2023). What do women with sexual interest in children tell us about the assumed cause of their sexual interest in children, (non-)disclosure, and professional help?- Results of a qualitative content analysis. *International Journal of Impotence Research*, 10.1038/s41443-023-00677-6. Advance online publication.  
<https://doi.org/10.1038/s41443-023-00677-6>
- Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative Social Work: Research and Practice*, 11(1), 80–96. <https://doi.org/10.1177/1473325010368316>
- Tyagi, S. V. (2006). Female counselors and male perpetrators of violence against women. *Women & Therapy*, 29(1–2), 1–22. [https://doi.org/10.1300/J015v29n01\\_01](https://doi.org/10.1300/J015v29n01_01)
- Vallance, K. (2004). Exploring counsellor perceptions of the impact of counselling supervision on clients. *British Journal of Guidance & Counselling*, 32(4), 559–574.  
<https://doi.org/10.1080/03069880412331303330>
- Van Horn, J., & Taris, T. W & Schaufeli, W. B & Schreurs, P. J. G (2004). The structure of occupational well-being: A study among Dutch teachers. *Journal of Occupational and Organizational Psychology*, 77. <https://doi.org/10.1348/0963179041752718>.

- VanDeusen, K. M., & Way, I. (2006). Vicarious trauma: An exploratory study of the impact of providing sexual abuse treatment on clinicians' trust and intimacy. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders*, 15(1), 69–85. [https://doi.org/10.1300/J070v15n01\\_04](https://doi.org/10.1300/J070v15n01_04)
- Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counselling Psychology*, 53(3), 325–337. <https://doi.org/10.1037/0022-0167.53.3.325>
- Vrangalova, Z., & Savin-Williams, R. C. (2012). Mostly heterosexual and mostly gay/lesbian: Evidence for new sexual orientation identities. *Archives of Sexual Behavior*, 41(1), 85–101. <http://doi.org/10.1007/s10508-012-9921-y>
- Wagner, S. L., Koehn, C., White, M. I., Harder, H. G., Schultz, I. Z., Williams-Whitt, K., Warje, O., Dionne, C. E., Koehoorn, M., Pasca, R., Hsu, V., McGuire, L., Schulz, W., Kube, D., & Wright, M. D. (2016). Mental health interventions in the workplace and work outcomes: A best-evidence synthesis of systematic reviews. *The international Journal of occupational and environmental medicine*, 7(1), 1–14. <https://doi.org/10.15171/ijoom.2016.607>
- Walker, A., & Panfil, V. R. (2017). Minor attraction: A queer criminological issue. *Critical Criminology*, 25(1), 37-53. <https://doi.org/10.1007/s10612-016-9342-7>
- Wampold B. E. (2015). How important are the common factors in psychotherapy? An Update. *World Psychiatry*, 14, 270–277. <https://doi.org/10.1002/wps.20238>.
- Waqas, A., Malik, S., Fida, A., Abbas, N., Mian, N., Miryala, S., Amray, A. N., Shah, Z., & Naveed, S. (2020). Interventions to reduce stigma related to mental illnesses in Educational Institutes: a Systematic Review. *The Psychiatric quarterly*, 91(3), 887–903. <https://doi.org/10.1007/s11126-020-09751-4>

- Ward, T.(2013). The dual relationship problem in forensic and correctional practice: Community protection or offender welfare? *Legal and Criminal Psychology, 19*, 35-39.  
<https://doi.org/10.1111/lcrp.12039>
- Ward, T., & Brown, M. (2004). The good lives model and conceptual issues in offender rehabilitation. *Psychology, Crime & Law, 10*(3), 243–257.  
<https://doi.org/10.1080/10683160410001662744>
- Way, I., VanDeusen, K. M., Martin, G., Applegate, B., & Jandle, D. (2004). Vicarious trauma: a comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of interpersonal violence, 19*(1), 49–71. <https://doi.org/10.1177/0886260503259050>
- Way, I., VanDeusen, K., & Cottrell, T. (2007). Vicarious trauma: Predictors of clinicians' disrupted cognitions about self-esteem and self-intimacy. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders, 16*(4), 81–98.  
[https://doi.org/10.1300/J070v16n04\\_05](https://doi.org/10.1300/J070v16n04_05)
- Weeks, S. N., Renshaw, T. L., & Vinal, S. A. (2021). Minority stress as a multidimensional predictor of LGB+ adolescents' mental health outcomes. *Journal of Homosexuality, 70*(5), 938–962.  
<https://doi.org/10.1080/00918369.2021.2006000>
- Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52*(2), 167–177. <https://doi.org/10.1037/0022-0167.52.2.167>
- Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Open University Press.
- Wilmots, E., Midgley, N., Thackeray, L., Reynolds, S., & Loades, M. (2020). The therapeutic relationship in cognitive behaviour therapy with depressed adolescents: A qualitative study of good-outcome cases. *Psychology and Psychotherapy Theory, Research and Practice, 93*(2), 276-291. <https://doi.org/10.1111/papt.12232>
- Winder, B., Fedoroff, J. P., Grubin, D., Klapilová, K., Kamenskov, M., Tucker, D., Basinskaya, I. A., & Vvedensky, G. E. (2019). The pharmacologic treatment of problematic sexual interests,

paraphilic disorders, and sexual preoccupation in adult men who have committed a sexual offence. *International review of psychiatry* 31(2), 159–168.

<https://doi.org/10.1080/09540261.2019.1577223>

Woodward, T. S., Moritz, S., Cuttler, C., & Whitman, J. C. (2006). The contribution of a cognitive bias against disconfirmatory evidence (BADE) to delusions in schizophrenia. *Journal of clinical and experimental neuropsychology*, 28(4), 605–617.

<https://doi.org/10.1080/13803390590949511>

World Health Organisation (2023) *Adolescent health age 10-19*. World Health Organization:

<https://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions>

World Health Organization (2001). *The world health report: Mental health: New understanding*. World Health Organisation.

World Health Organization, & UNICEF. (2021). *Helping adolescents thrive toolkit: Strategies to promote adolescent mental health and reduce self-harm and other risk behaviours*. World Health Organization.

Wurtele, S. K. (2008). Behavioral approaches to educating young children and their parents about child sexual abuse prevention. *The Journal of Behavior Analysis of Offender and Victim Treatment and Prevention*, 1(1), 52–64. <https://doi.org/10.1037/h0100434>

Yager, J., Greden, J. F., Riba, M. B., & Rasgon, N. L. (2021). Clinicians' cognitive and affective biases and the practice of psychotherapy. *American Journal of Psychotherapy*, 74(1), 1–8. <https://pubmed.ncbi.nlm.nih.gov/33445958/>

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, 15(2), 215–228. <https://doi.org/10.1080/08870440008400302>

Yang, L.H., Kleinman, A., Link, B. G., Phelan, J.C., Lee, S., & Good B. (2007). Culture and stigma: Adding moral experience to stigma theory. *Social Science & Medicine*, 64(7), 1524–1535. <https://doi.org/10.1016/j.socscimed.2006.11.013>

Yates, P. (2013). Treatment of sexual offenders: Research, best practices, and emerging models.

*International Journal of Behavioral Consultation and Therapy*. 8, 89-95.

<https://doi.org/10.1037/h0100989>.



## Appendix B

### Letters of Ethical Approval



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20<sup>th</sup> July 2023

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University of Wolverhampton  
FEHV

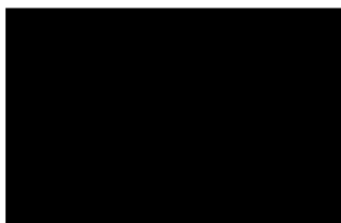
Dear Krista,

**Re: An IPA investigation into experiences of therapists working with Adolescent Non-Offending Minor Attracted People.** The psychology ethics Chair has considered and reviewed your submission. On review your Research Proposal was passed and the Chair believes that the ethical issues inherent in your study have been adequately considered and addressed. Therefore, the Chair is giving you full ethical approval for your study (**Code 1 - Approved**).

We wish you every success with your study

Yours sincerely





0921KBUOWPSY

18<sup>th</sup> October 2021

K. Ball  
University of Wolverhampton  
FEHW

Dear Krista,

**Re: Exploring Therapeutic Bias Towards Non-Offending Minor Attracted People Using Online Humanisation Training, 0921KBUOWPSY**

The Psychology Department Ethics Panel has considered and reviewed your submission. On review your Research Proposal was passed and given approval **2A-Supervisor to monitor**. Please address the amendments and clarification detailed below.

**Please list REQUIRED changes**

- Section 2.9: in the 'consent' section, it states that the participant can withdraw at any time but can't once the data has been analysed. You need to provide a timescale here within which the participant can withdraw following their completion of the study, as they will not know when the data is to be analysed. Please change section 2.9 and the consent form to match the 2-week withdrawal period stated on the information sheet.
- Section 2.10: Needs clearer information on the ethics form about right to withdraw - how long are participants given following their completion of the study within which they can withdraw? Are they allowed to skip any questions that they feel uncomfortable answering?
- Recruitment poster: This states that participants between the ages of 18 and 75 years are to be sought however it is unclear why a maximum age of 75 has been specified. The justification for this should be stated in participants section of the ethics form.
- Recruitment poster: the term 'non-offender minor attracted people' needs to be defined as some may not be aware of what this is referring to.
- Information Sheet: please expand the 'what will happen to me...' section to ensure it summarises everything, i.e. repeat the information about watching a video and add brief description of the other types of things that they will answer questionnaires on (resilience QCAE etc).
- Debrief form: 'due to the sexual nature of this study' should really read 'due to the sensitive nature of the survey'.
- Debrief form: remind participants again on this form to keep a record of their unique ID number and the time limit in which they can withdraw and how.

- Competency questions include questions asking for free-text responses but there is no mention of analysis of this data. If this is not going to be used, please remove the 'explain your score' parts of the question. If you are going to have free-text responses in your survey, please include some information in the ethics form about how you will deal with any sensitive data that you receive, e.g. if someone uses that free-text box to disclose personal knowledge/history of child sexual abuse. The information sheet and consent form do mention that if there is 'a reason for us to be worried about harm to yourself or someone else then in only those circumstance would any information be divulged,' but this doesn't explain who the information would be divulged to. If you remove the free-text box there is no chance of receiving any information about risk of harm, so you could remove this warning.
- Please ensure you discuss with supervisors and make a plan for safeguarding your own wellbeing as a researcher of a heavily stigmatised area; there is a possibility you will receive negative or confrontational emails/comments on social media which could be distressing.

**Please list SUGGESTED changes**

- Section 2.4: It is unclear why the baseline measures are collected after the 'intervention'... surely these should be measured at the start?
  - Please clarify whether the QCAE and resilience scale will be administered just once, or twice. I think it is just once (and this seems the most appropriate as they do not seem like scales designed for repeat administration within a 45 min timeframe) but the wording is slightly ambiguous.
- Information Sheet: under 'What is the Purpose of the Study', the definition of 'clients that may have an attraction to children' needs to be expanded on a little to make it clearer that these are clients that don't act on this attraction.
- We would recommend simplifying the title at least for the participant facing documents as it is a little confusing and unclear in terms what the study is exploring (i.e., particularly what non-offender minor attracted person is referring to).
- Recommend considering broadening your recruitment strategy; 300 is a high target, particularly to get people to take part in a 45 min study. You may wish to consider networks you have access to, such as participant pool / the counselling students at the University. You could consider simplifying your design to reduce the sample size required – a simpler design with adequate statistical power could be better than a very complex one that you end up unable to test if you fall short of the sample size you're aiming for.
- In the information sheet, the wording 'However, this may cause some emotional distress and you are able to withdraw from the study.' is a little blunt. Consider adding a little more detail, e.g. 'However, this may cause some emotional distress, and if you think it may be distressing to you, you are under no obligation to take part. If you decide to take part, you can stop the study at any time. Some support sites are also listed at the end of this information sheet and again at the end of the study.'

**Appendix C**

**Study 1 Measures REDACTED**













## Appendix D

### Study 1 Recruitment Poster for social media



#### **Participants Needed for Research**

**Are you aged 18 to 75 years? Working as a Trainee or Qualified - Psychologist, Psychotherapist, Counsellor or Psychology Student who is aspiring to work in therapy?**

#### **Exploring Perceptions Towards Non-Offending Minor Attracted People Using Online Humanisation Training**

Hello, my name is Krista I am a Counselling Psychology Doctorate student and am currently researching non-offending minor attracted people. I am looking for people aged 18 years to 75 years to complete an online study. Participation is entirely voluntary. This study is looking for those aspiring or working in psychological professions to explore perceptions of minor attracted people. You will be asked to read a specially designed case scenario, followed by questions about this scenario. You need to be willing to watch and listen to an 8-minute video presentation on a potentially sensitive topic. The study should take no longer than 45 minutes. Your responses are collected anonymously via Qualtrics survey software you are your data will remain confidential.

**Please be aware the content of this online study relates to a case scenario involves a minor attracted person. Given this content, I advise you to consider carefully whether or not you should progress onto the questionnaire.**

If you would like to take part, then please click on the Qualtrics link to find out more about the study.

Thanks for your time.

please contact

Krista Ball (Researcher) REDACTED

For more information about this study

## Appendix E

### Study 1 Participant Information Sheet



### Participant Information Sheet

Thank you for clicking on this study and considering taking part. You need to be willing to watch and listen to an 8-minute video on a sensitive topic. Please read the following information to make an informed decision about participating in this study. After reading this you will be asked to consent before beginning the study.

#### Study title

#### **Exploring Perceptions of Non-Offending Minor Attracted People Using Online Humanisation Training**

You are being invited to take part in a research study. Before you decide 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 if there is anything is not clear or if you would like more information. Please take the time to decide whether or not you wish to take part.

**Please be aware the content of this questionnaire relates to a case scenario involves minor (child) attraction. Given this content, we advise you to consider carefully whether or not you should progress onto the questionnaire.**

#### **What is the purpose of the study?**

This aim of the study is to look at perceptions of non-offending minor attracted people (Non-Offending MAPs ). The study will highlight potential ways of working with clients may have an attraction to children. Your information will help me understand the perceptions of people for a Doctorate qualification.

#### **Why have I been invited?**

You are between the ages of 18 and 75 years, and are either an aspiring to work in a psychological profession or already a professional

#### **What will happen to me if I take part?**

If you wish to participate you will be asked to create a unique ID. Then you will be asked to answer questions on your opinions on a case scenario includes reference to minor attracted

people. Then you will answer demographic questions (such as age, gender). Participating should take no longer than 45 minutes.

**Do I have to take part?**

No, there is no requirement to take part. I would, however, appreciate your participation. If you do decide to take part you will be asked in the next screen, to complete an online consent form. If you decide to take part, you are still free to withdraw at any time by clicking the withdraw button and without giving a reason. You do not have to participate if you do not wish to and if you decided to stop participation once beginning you can do without any consequence. However please note any data collected may still be used unless you use your unique ID to withdraw your data as Qualtrics is anonymous so once completed you will need to the unique number if you wish to withdraw your data up until the point the data has been analysed.

**What are the risks and benefits of taking part?**

It is hoped this study will provide insight into how training interventions could be used to assist professionals working with Non-Offending MAPs . The outcome of the study may show those who take part in the training maybe able to set aside their biases and display empathy more readily than those who have no training and inform future psychological service interventions.

There are no risks or physical harm to taking part in the study. The topic of minor attracted people will be used in the vignettes and video. The materials used will not be overly descriptive. However, this may cause some emotional distress and you are able to withdraw from the study.

**Will my taking part in the study be kept confidential?**

Yes, all the information collected from you will be kept confidential. The Qualtrics site will not ask for your name or any identifying information. The raw data will only identify you by a unique number (three letters followed by 2 digits). The raw data will be retained for at least five years following any resulting publication and will then be disposed of securely. Data may be viewed by supervisors and examiners. Data does not identify you may be presented at scientific meetings or in academic publications. It could also be used in future research studies approved by a Research Ethics Committee. However, if you tell us something which suggests there is a reason for us to be worried about harm to yourself or someone else then in these circumstances it is important the information is shared appropriately. Data will be held confidentially in line with General Data Protection Regulation (GDPR) and Data protection Act 2018

**What will happen if I don't want to carry on with the study?**

You can withdraw online at any time by clicking on the Withdraw button on each page of the Qualtrics site using your unique number. If you wish to withdraw after you have submitted the study questionnaires, then you will need the unique number you will be given if you wish to withdraw your data up until two weeks after submission. If you exit the study without withdrawing any data collected will still be used.

**What will happen to the results of the research study?**

At the end of the research study the information will be collected, and the results will be presented and written up as part of a Doctorate dissertation which may be published. You will not be identifiable in any report.

### **What if there is a problem?**

If you have any questions about, or if you have a concern about any aspects of this study, you can contact myself in the first instance as the Researcher via email: REDACTED

### **Who is organising and funding the research?**

The project is being conducted for course credit. No student or member of staff will benefit financially over and above their normal salary.

### **Who has reviewed the study?**

The University of Wolverhampton Research Ethics Committee have granted ethical approval for the study.

### **Contact for further information**

If you have any questions, please contact myself in the first instance Krista Ball (REDACTED) or my Supervisors Caroline Wesson (REDACTED) or Chelsea Slater (REDACTED) Please email if you wish to receive a summary of the results later after completion of the doctorate in 2025. If there are any problems, you wish to address with this research please contact the Director of Studies Caroline Wesson (REDACTED)

If you wish to raise concerns regarding research being undertaken by the University, you may wish to contact the research integrity leads in the first instance.

The senior lead for research integrity is the Dean of Research - Professor Silke Machold  
The administrative lead is the Research Integrity Manager - Miss Jill Morgan

Alternatively, the University of Wolverhampton has incorporated its policies and procedures for Anti-Bribery, Staff Interests, Fraud, and Whistleblowing into one Transparency Policy <https://www.wlv.ac.uk/about-us/governance/legal-information/corporate-compliance/transparency/>. Please report any concerns to REDACTED

### **Further Support**

Victim Support

08453030900

<http://www.victim support.org.uk/>

Survivors UK

Text 020 3322 1860

[www.survivors.uk.org](http://www.survivors.uk.org)

Confidential helpline for survivors of sexual abuse

01706 765200



**Appendix F****Study 1 Consent Form****CONSENT FORM****Title of Project: Exploring Perceptions Towards Non-Offending Minor Attracted People Using Online Humanisation Training**

1. I confirm I have read and understood the participant information sheet and have been given the opportunity to ask questions.
2. I understand my participation is voluntary and I am free to withdraw at any time/ up until the commencement of data analysis without giving any reason.
3. I understand the researcher may wish to publish the anonymised results of the study and/or presented at conferences or online. For which I give permission.
4. I understand my data will be stored securely and confidentially unless there is a reason for us to be worried about harm to yourself or someone else then in only those circumstance would any information be divulged. I will not be identifiable in any report or publication
5. I agree my data may be retained for future ethical approved research.
6. I Confirm I am over the age of 18 years.
7. I agree to take part in the above study and understand by continuing on to the questionnaire will be giving tacit consent for my data to be used in this study.

## Appendix G

### Demographic Questions

1. Which country do you live in?
2. How would you describe your gender? Male, Female, Non-binary, Other, prefer not to say
3. What is your ethnic background? White, Black, Asian, Other please state in the text box, Prefer not to say
4. How old are you? (*Sliding scale 18-75*)
5. Do you have any parental care duties? Yes, No, Prefer not to answer
6. What is your psychology status? Undergraduate Student, Postgraduate student, Counsellor, Accredited Counsellor, Psychotherapist, Trainee Psychologist, Qualified HCPC Psychologist, Other please state in the text box
7. How many years therapy experience? (*Sliding scale 0-10+*)
8. What is the highest level of education you have achieved? CSE, GSSE/O Levels, AS Level, A level, L5, Diploma, Undergraduate degree (BSC BA), Postgraduate Certificate, Postgraduate (MSC MA) Postgraduate PhD Doctorate, other please state in the text box
9. Have you heard of the term Non-Offending MAPs ? Yes, No, Prefer not to answer, Other please state in the text box.
10. Have you ever worked with sex offenders? Yes, No, please state what capacity in the text box
11. Have you ever worked with Non-Offending Minor Attracted People? Yes, No, please state what capacity in the text box

## Appendix H Study 1

### Debrief

**Debriefing for study on Exploring Perceptions Towards Non-Offending Minor Attracted People Using Online Humanisation Training.**

The aim of this study is to understand if therapeutic bias of therapists/ psychological professionals and those aspiring into this profession around towards non-offending minor attracted (Non-Offending MAPs ) people differs using online humanisation video training. Research shows adolescent Non-Offending MAPs are unlikely to be able to access therapy and this may be because of societal stereotypes and how therapists may experience concerns which result in turning away minor attracted persons.

Half of the participants watched a training intervention video, alongside reading a vignette, half just watched a video about the brain and read the vignette and completed the questions. To see if there was a training difference which may support future psychological services.

Please contact myself in the first instance as the Researcher Krista Ball (REDACTED) or the Director of Studies (REDACTED) if you have any concerns regarding this study.

Due to the sexual nature of this study, if this has led to any negative emotions then please seek further support by contacting Student services if you are current student or seek further support from your GP or Further organisations which are listed again below.

Thank you for taking the time to take part in this study.

#### **Further Support**

##### **Victim Support**

08453030900

<http://www.victim support.org.uk/>

##### **Survivors UK**

Text 020 3322 1860

[www.survivors.uk.org](http://www.survivors.uk.org)

##### **Confidential helpline for survivors of sexual abuse**

01706 765200

[www.supportline.org.uk](http://www.supportline.org.uk)

## Appendix I

### Demographics and Qualitative Interview Schedule

#### Demographics

Which country do you live in?

How would you describe your gender? Male, Female, Non-binary, Other, prefer not to say

What is your ethnic background? White, Black, Asian, Other please state in the text box, Prefer not to say

How old are you?

What is your job title?

How many years therapy experience?

How many years working with Non-Offending MAPs ? Working with adolescent Non-Offending MAPs ?

Have you ever worked with sex offenders? Yes, No, please state what capacity in the text box

IPA investigation into experiences of therapists working with Adolescent Non-Offending Minor Attracted People.

#### **What are the experiences of participants as they make meaning of working with Non-Offending Minor Attracted Persons.**

- Recap participant information sheet
- Obtain signed consent.
- Answer Demographics questions
- Explain the aim of the interview is to gain an in depth understanding of your experiences working with adolescent Non-Offending MAPs . I am interested in your personal thoughts, feelings, and understanding of your experience's. Please be open an honest and there are no right or wrong answers.

1. Tell me about your experiences working with adolescent Non-Offending MAPs ? (to explore experiences)

(Prompts- are there times when you feel positive about the work you do? tell me more about these? Are there parts of your work you enjoy?/ feel proud of?- tell me more about these? Are there times when you feel negative about the work you do? tell me more about these? Are there parts of your work you dislike, feel disappointed? - tell me more about these?)

2. What motivates you to work with adolescent Non-Offending MAPs ? (Prompts- How does impact on your work.) (to explore therapy)

3. Tell me more about your own therapeutic practice working with Adolescent Non-Offending MAPs ? (Prompts- What therapy do you/don't use? What do you feel is most/least important and how does this impact on your work?) (to explore therapy)

4. What do you think is necessary to achieve in therapy with adolescent Non-Offending MAPs ? to explore therapy)

5. Can you tell me about how you empathise in your therapeutic work with adolescent Non-Offending MAPs – (Prompts- can you tell me about how it feels, what thoughts, is this easy, difficult) (*to explore affective, cognitive empathy*)

6. What do you think other people think about the work you do to support adolescent Non-Offending MAPs (Prompts- other therapists, professionals, external agencies, other clients)- What do you think about ? How do you feel about ? Who values the work you do?) (*to explore stigma*)

7. From your experience what helps you work with adolescent Non-Offending MAPs ? (to explore positive support) (Prompts, internal, external, professional, family, training, What support do you receive to perform your role to work therapeutically with adolescent Non-Offending MAPs what support is most helpful? What is less helpful. How do you feel about the support?)

8. From your experience what hinders you to work with adolescent Non-Offending MAPs ? (*to explore negative support*) (*Prompts, internal, external, professional, family, training, What support do you need to perform your role to work therapeutically with adolescent Non-Offending MAPs what support is lacking? What is less helpful. How do you feel about the support?*)

9. What impact does working with adolescent Non-Offending MAPs have on you? (Prompts-How do you cope? What impact does have on your work? Outside of work?) (*to explore coping strategies*)

10. Tell me more about your own resilience? (Prompts- has this changed through your experiences of working with Adolescent Non-Offending MAPs , Tell me more about how you maintain your resilience? How does your resilience relate to your therapeutic work with adolescent Non-Offending MAPs ? (*to explore resilience e.g. boundaried, distancing, spiltting, desensitised, detachment*)

#### Additional Probes

(How, why, could you tell me more? What did it feel like? What do you mean? Can you expand? What do you think about in relation to working with adolescent Non-Offending

MAPs , what does mean for you when supporting adolescent Non-Offending MAPs . How does relate to the work you do with adolescent Non-Offending MAPs , How does impact on the work you do? What affect does have on the work you do? Is there anything else you think/ feel we should have talked about?)

## Appendix J

### Recruitment Poster for Social Media



#### Participants Needed for Research

**Are you a Qualified - Psychologist, Psychotherapist, Counsellor currently working in therapy with adolescent Non-Offending Minor Attracted People?**

#### **Exploring experiences Towards adolescent Non-Offending Minor Attracted People**

Hello, my name is Krista I am a Counselling Psychology Doctorate student and am currently researching non-offending minor attracted people. I am looking for people to complete a one-hour semi-structured interview which will be audio recorded using Microsoft Teams.

Participation is entirely voluntary. This study is looking for qualified Psychologists and therapists exploring experiences of working in therapy with adolescent non-offending minor attracted people (Non-Offending MAPs ). Non-Offending MAPs are individuals who are sexually attracted towards children but do not act on attraction and do not commit a criminal offence. Your responses will be transcribed anonymously so you and your data will remain confidential.

**Please be aware during the interview you will be asked about your experiences and perceptions of people are attracted to children. Given this content, we advise you to consider carefully whether or not you should progress to an interview.**

If you would like to take part, then please contact the researcher to find out more about the study.

Thanks for your time.

please contact

Krista Ball (Researcher) REDACTED

For more information about this study

## Appendix K

### Study 2 Participant Information Sheet



### Participant Information Sheet

**Thank you for reading the study poster and considering taking part. You need to be willing to take part in a one-hour face to face semi-structured interview on a sensitive topic. Please read the following information to make an informed decision about participating in this study. After reading this you will be asked to consent before beginning an interview**

#### **Study title**

**An IPA investigation into the experiences of therapists working with Adolescent Non-Offending Minor Attracted People.**

You are being invited to take part in a semi-structured research interview. Before you decide 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 if there is anything is not clear or if you would like more information. Please take the time to decide whether or not you wish to take part.

**Please be aware during the interview you will be asked about your experiences / perceptions of people are attracted to children. Given this content, we advise you to consider carefully whether or not you should progress to an interview.**

#### **What is the purpose of the study?**

This aim of the study is to look at perceptions of adolescent Non-Offending Minor Attracted People (Non-Offending MAPs ). Non-Offending MAPs are individuals who are sexually attracted towards children but do not act on attraction and do not commit a criminal offence. The study will highlight experiences of working with Non-Offending MAPs which may inform potential ways of working with individuals in therapy may have an attraction to children but do not act on this attraction. Your information will help me understand the perceptions of people for a Doctorate qualification.

#### **Why have I been invited?**

You are a qualified psychologist or therapist currently working with adolescent Non-Offending MAPs .

**What will happen to me if I take part?**

If you wish to participate at the start of the study, you will be asked to complete a brief demographic questionnaire before taking part in a semi-structured interview during which you will be asked some questions around your experience of working with adolescent Non-Offending MAPs . At the end of the interview, you will be provided with further support information. Interviews will be conducted online at a time of your convenience and are expected to take no more than one hour. All interviews will be recorded and transcribed. Your anonymity shall be protected during this process.

**Do I have to take part?**

No, there is no requirement to take part. I would, however, appreciate your participation. If you do decide to take part, you will be asked to complete an online consent form. If you decide to take part, you are still free to withdraw at any time by letting myself the researcher know and without giving a reason. You do not have to participate if you do not wish to and if you decided to stop participation once beginning you can do without any consequence.

**What are the risks and benefits of taking part?**

It is hoped this study will provide insight into how training interventions could be used to assist professionals working with Non-Offending MAPs .

There are no risks or physical harm to taking part in the study. The topic of minor attracted people will be discussed in the interview, but this will not be overly descriptive. However, if this may cause some emotional distress, and if you think it may be distressing to you, you are under no obligation to take part. If you decide to take part, you can stop the interview at any time. Some support sites are also listed at the end of this information sheet and again at the end of the interview.

**Will my taking part in the study be kept confidential?**

Yes, all the information collected from you will be kept confidential. The raw data will only identify you by a unique number. You will need to remember this number. The raw data will be retained for at least two years following any resulting publication and will then be disposed of securely. Anonymised interview transcripts may be viewed by supervisors and examiners. Anonymised extracts from the interviews may be presented at scientific meetings or in academic publications. Data will be held confidentially in line with General Data Protection Regulation (GDPR) and Data protection Act 2018

**What will happen if I don't want to carry on with the study?**

You can withdraw at any time by letting the researcher know during the interview. If you wish to withdraw after you have finished your interview, then you will need to email the researcher (REDACTED) your unique number you created and request to withdraw your data. Please note you can only withdraw your data up until two weeks after the interview as after this date transcription and anonymization of data will have commenced.

**What will happen to the results of the research study?**

At the end of the research study the information will be collected, and the results will be presented and written up as part of a Doctorate dissertation which may be published. You will not be identifiable in any report.

**What if there is a problem?**

If you have any questions about, or if you have a concern about any aspects of this study, you can contact myself in the first instance as the Researcher via email: REDACTED

**Who is organising and funding the research?**

The project is being conducted for course credit. No student or member of staff will benefit financially over and above their normal salary.

**Who has reviewed the study?**

The University of Wolverhampton Research Ethics Committee have granted ethical approval for the study.

**Contact for further information.**

If you have any questions, please contact myself in the first instance Krista Ball (REDACTED) or my Supervisors Caroline Wesson (REDACTED) or Chelsea Slater (REDACTED) Please email if you wish to receive a summary of the results later after completion of the doctorate in 2025. If there are any problems, you wish to address with this research please contact the Director of Studies Caroline Wesson (REDACTED)

If you wish to raise concerns regarding research being undertaken by the university, you may wish to contact the research integrity leads in the first instance.

Research Integrity Manager — Miss Jill Morgan (REDACTED).

For more information regarding research integrity at the University please visit <https://www.wlv.ac.uk/research/research-policies-procedures—guidelines/research-integrity/>

**Further Support**

Mental Health Helpline  
Saneline 03003047000  
Stop it Now 0808 1000 900

Victim Support  
08453030900  
<http://www.victim support.org.uk/>

Survivors UK  
Text 020 3322 1860  
[www.survivors.uk.org](http://www.survivors.uk.org)

Confidential helpline for survivors of sexual abuse  
01706 765200

## Appendix L

### Study 2 Consent Form

**Title of Project:** An IPA investigation into experiences of therapists working with Adolescent Non-Offending Minor Attracted People.

1. I confirm I have read and understood the participant information sheet and have been given the opportunity to ask questions prior to my interview
2. I understand my participation is voluntary and I am free to withdraw up until 2 weeks after completion of the interview without giving any reason.
3. I understand the researcher may wish to publish the anonymised results of the study and/or presented at conferences or online.
4. I understand my data will be stored securely and confidentially.
5. I will not be identifiable in any report or publication
6. I confirm I am 18 years or over.
7. I understand I will be audio recorded.
8. I give my consent for my data to be used in this study.
9. I agree to take part in the above study.

## Appendix M

### Study 2 Debrief

#### **Debriefing for interview on An IPA Investigation into the experiences of therapist working with Adolescent Non-Offending Minor Attracted People.**

The aim of this study is to understand experiences of qualified psychologists / therapists towards non-offending minor attracted (Non-Offending MAPs ). This study will help inform a training intervention designed to support working with Non-Offending MAPs .

Research shows adolescent Non-Offending MAPs are unlikely to be able to access therapy and this may be because of societal stereotypes and how therapists may experience concerns which result in turning away minor attracted persons.

Please keep a record of your unique ID number you created, and you have 2 weeks to withdraw your data if you change your mind. You can withdraw by emailing the 'unique ID number and Withdraw' to myself (REDACTED)

Please contact myself in the first instance as the Researcher Krista Ball (REDACTED) or the Director of Studies (REDACTED) if you have any concerns regarding this study.

Due to the sensitive nature of this study, if this has led to any negative emotions then please seek further support by contacting Student services if you are current student or seek further support from your GP or further organisations which are listed again below.

Thank you for taking the time to take part in this study.

#### **Further Support**

##### **Mental Health Helpline**

**Saneline** 03003047000

**Stop it Now** 0808 1000 900

##### **Victim Support**

08081689111

<http://www.victimsupport.org.uk/>

##### **Survivors UK**

02035983898

[www.survivors.uk.org](http://www.survivors.uk.org)

[@help@survivorsuk.org](mailto:@help@survivorsuk.org)

##### **Confidential helpline for survivors of sexual abuse**

01706 765200

[www.supportline.org.uk](http://www.supportline.org.uk)