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REVIEW ARTICLE

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Preventing child sexual abuse before it occurs: examining the scale and nature of secondary public health prevention approaches

Stephanie Kewley [a], Rosemary Mhlanga-Gunda [b] and Marie-Claire Van Hout [c]

[a]School of Psychology, Liverpool John Moores University, Liverpool, UK; [b]Faculty of Health and Medical Sciences, Family Medicine, Global and Public Health Unit, University of Zimbabwe, Harare, Zimbabwe; [c]Public Health Institute, Liverpool John Moore's University, Liverpool, UK

ABSTRACT

Preventing child sexual abuse (CSA) requires comprehensive multi-agency criminal justice and public health approaches. Yet, marginal attention has been given to secondary prevention strategies that target "at risk" populations. Thus, we carried out a scoping review examining secondary prevention interventions for people at risk of sexual offending by considering their effectiveness, challenges and barriers. We identified $N = 43$ sources and completed a qualitative analysis. Our appraisal found five themes: (a) essential features needed for secondary prevention programmes (plus summary of interventions); (b) barriers to examining, implementing and accessing secondary prevention programmes; (c) methodological limitations; (d) the ethical justification; and (e) economic benefits for preventing abuse before it occurs. Over the last two decades, sources report greater public tolerance to the notion of tackling CSA using public health prevention approaches. Thus, we call for policy makers to embrace this positive shift and invest resources to further examine this area.

Practice impact statement

Advancing clinicians' and therapists' practice is critical for those working with people at risk of harm. This review aims to strengthen current knowledge and inform practice. Further, policy makers and funders are essential to the development and progression of prevention strategies; by providing this contemporary review, we hope to assist the decision-making process for allocating resources and strengthening confidence in advancing policy that builds comprehensive prevention approaches.

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Introduction

The consequences of CSA are far-reaching (Dube et al., 2005) with rates estimated at 1 in 4 (girls) and 1 in 13 (boys) (Pereda et al., 2009). The World Health Organisation (WHO, 2016) reports harms to children across the life course, including increasing rates of mental health conditions (Asante & Andoh-Arthur, 2015; Mandelli et al., 2015); sexual and reproductive problems (Bertone-Johnson et al., 2014); communicable diseases (Norman et al., 2012); harmful risky sexual behaviours (Homma et al., 2012); and drug

CONTACT Stephanie Kewley s.kewley@ljmu.ac.uk School of Psychology, Liverpool John Moores University, Liverpool, L33AF, UK

This article has been corrected with minor changes. These changes do not impact the academic content of the article.

and alcohol use (McCarthy-Jones & McCarthy-Jones, 2014; Yuan et al., 2014). Social and behavioural problems include poor attachment (Tardif-Williams et al., 2017); emotional dis-function (Lanier et al., 2015); sex work (Norman et al., 2012); poor quality of life (Weber et al., 2016); cognitive impairment, poor language functioning (Kavanaugh et al., 2015); academic performance (Lanier et al., 2015); and economic problems including a greater risk of gambling (Zhu et al., 2015), unemployment (Barrett et al., 2014), welfare dependency (Horan & Widom, 2015) and housing instability (Lake et al., 2015). Children who experience CSA are most at risk from injury, death and disease (WHO, 2010) thus, carry the greatest burden. Understanding how to prevent CSA is of significant concern (WHO, 2016).

CSA is complex, not one single factor explains the phenomenon (Ward & Beech, 2016). Instead, like all behaviours, CSA exists within a socioecological structure (Bronfenbrenner, 1977) whereupon at least four levels or contexts interact to inform human behaviour. These include the *individual, interpersonal, community and societal level*. Individual-level factors known to influence people to commit CSA include emotional dysregulation (Gillespie & Beech, 2016); sexual motivation (Seto, 2019); distorted thinking (Ó Ciardha & Ward, 2013); mental disorders (Serin et al., 2001); childhood experiences of abuse (Jespersen et al., 2009); poor attachments (Smallbone & McCabe, 2003); and genetic predisposition (Quinsey & Lalumière, 1995). Interpersonal level factors include inadequate adult relationships, intimacy deficits (Marshall, 2010); loneliness (Schulz et al., 2017); witnessing a fathers' sexual or domestic abuse (Sitney & Kaufman, 2020); being exposed to a sexually inappropriate family environment and use of pornography/deviant sexual fantasy during childhood (Beauregard et al., 2004). Community-level factors include anti-social peers (Jordaan & Hesselink, 2018) and social isolation (Miner et al., 2016). Societal level factors include patriarchal cultures (Purvis & Ward, 2006); the normalisation of pornography (Foubert et al., 2019); online sexualised cultures (Moore & Reynolds, 2018); and economic cultures (Gannon et al., 2010; Wojcik & Fisher, 2019) such as child trafficking and exploitation (Lee, 2017). Given that risk is found at each socioecological level, comprehensive strategies to prevent CSA are needed.

Public health approaches focus on the health, safety and well-being of whole populations. They draw on the expertise and knowledge of multiple disciplines such as medicine, education, psychology, economics and sociology. When tackling problems such as CSA multi-component public health models are recognised as appropriate means of preventing CSA as they target each socioecological level in an inclusive and comprehensive manner. CSA public health prevention strategies are usually categorised and explained on three levels: primary, secondary and tertiary (McMahon, 2000) but current Western approaches tend to adopt primary or tertiary approaches to prevention (McCartan, Merdian, et al., 2018). Primary prevention aims to prevent violence occurring in the first place by targeting universal and general populations. CSA interventions target potential victims and their caregivers, helping them recognise signs of abuse, how to respond and report it. Such approaches, however, place responsibility on children to recognise and understand CSA and have the capacity to resist and report would be abusers. Yet, little is known if such approaches prevent CSA (Finkelhor, 2009), indeed, our knowledge of primary prevention remains under-developed, and a greater examination of the utility and effectiveness of this approach is needed. More is understood of tertiary approaches, that adopt strategies with people already known to criminal justice or health care systems. However, prevention activities using this approach centre on the prevention of the re-occurrence of CSA, rather than preventing abuse in the first place. This is not to say that efforts should not be made to help prevent sexual re-offending, indeed they should, but low recidivism rates of between 10.1% and 13.7% (treated vs. untreated respectfully) in adult males (Schmucker & Lösel, 2017) demonstrate that the management of those known to the justice system is mostly effective. That is, once a person has been convicted, most appear to stop sexual offending.

Secondary approaches target groups or individuals who present specific risks or characteristics that might place them at increased risk of victimising others or being vulnerable to victimisation themselves. Surprisingly, little is known of the effectiveness of secondary prevention approaches, in particular those that target people at risk of perpetrating CSA. Given that most sexual assault arrests (over 95%) are perpetrated by a person not known to the criminal justice system (Sandler et al., 2008), this is an important population to target. It is worth noting a distinction here between, detected,

and undetected *first-time* offences. While the majority of those arrested for CSA are officially recorded as first-time offenders (Sandler et al., 2008), this in reality only means their crime(s) have been detected for the first time. In most cases of CSA, the point of arrest or detection does not represent the onset or actual prevalence of CSA (Bentley et al., 2020). For instance, in familial CSA, offending can remain undetected for long periods of time, as such the point of arrest, does not genuinely reflect the rate of offending. Given that those already in the system are at low risk of reoffending (Schmucker & Lösel, 2017), targeting people not known to the criminal justice system but at risk of perpetrating CSA, would alleviate the devastating consequences suffered by victims and their families, and the significant economic burden to society in responding to the needs of victims, and the management of people convicted of sexual offending (Letourneau et al., 2018; Saied-Tessier, 2014).

In recent years, an increased interest in CSA secondary public health approaches is observed in countries such as England, Ireland, The Netherlands, Belgium, Canada, The United States, New Zealand, Australia and Germany, sparking some movement in this field. Research has explored professionals' perspectives of people at risk of CSA (Parr & Pearson, 2019); self-management strategies for at-risk individuals (Merdian et al., 2017); and focus on specific interventions for people at risk of engaging in CSA (Knack et al., 2019). This work, however, remains in its infancy, particularly when compared to what is known of primary and tertiary prevention. A lack of funding, knowledge, methodological restrictions and ethical hurdles (McCartan, Hoggett, et al., 2018) means that evidencing and promoting the efficacy of secondary prevention is an arduous task.

With the principle of "leaving no one behind" and the impetus to eliminate violence against children by 2030 (CoE, 2017; UN, 2015) strategies that target people at risk of perpetrating CSA and preventing actual first-time offences are likely to assist this goal. Thus, secondary public health prevention approaches targeting people at risk of engaging in CSA must be a priority to policy makers, researchers and clinicians alike. Our scoping review aims to consolidate current knowledge by exploring the nature and scope of secondary prevention interventions, specifically, those aimed at adults and children at risk of perpetrating harm against children (including online and contact behaviours). We aim to understand what prevention interventions are currently being delivered, how effective these are, and what challenges and barriers, researchers, practitioners and users of these interventions face.

Method

Protocol and registration

The *Preferred Reporting Items for Systematic Reviews and Meta-analysis Protocols Extension for Scoping Reviews* (PRISMA-SCR) was used to develop a protocol to guide the review (Tricco et al., 2018). PROSPERO (the international prospective register for systematic reviews) currently do not accept the registration of scoping reviews (PROSPERO, n.d.). To administer the protocol, we applied Arksey and O'Malley's (2005) five-stage framework for conducting scoping reviews.

Eligibility criteria

To be included in the review, sources were required to examine and/or discuss prevention interventions that target adults and/or minors, males and/or females at risk of committing CSA. There were no restrictions placed on the intervention type, indeed, all interventions were in scope e.g. educational, psychological, situational, one-to-one/group, online, telephone, face-to-face. Likewise, there were no limitations on the outcomes measured, however, measures were expected to include some discussion on CSA prevention, and/or secondary outcomes such as helping people at risk of committing sexual abuse (this might vary across intervention, but examples could have included education/awareness-raising, therapy, general support, pharmacological treatment). All study types were included e.g. experimental, observational, quantitative, qualitative and/or mixed methods studies. Studies were included regardless of the use of a comparison or control group.

The review scrutinised and considered sources that reported on any follow-up period and indeed any method of reporting outcomes, e.g. official reports, self-report, observations. Published and unpublished (grey literature) were included in the search, including peer-reviewed journal articles, organisational reports, governmental reports, book chapters and thesis published between January 2000 and February 2021. Sources which provided descriptive information were also included. Exclusion criteria centred on the reporting of primary, tertiary and victim interventions, inaccessible full records, and those not in the English language.

Information sources

To identify potentially relevant sources, the following databases were searched, between the years January 2000 and February 2021: Web of Science; EBSCO MEDLINE; CINAHL; PubMed; and PsycINFO. In addition, hand-sifting through reference lists and using existing networks, relevant organisations and conferences (Arksey & O'Malley, 2005) was also undertaken. Final database searches were conducted on 13th March 2021.

Search

The three-step method for systematic reviews was used (Aromataris & Riitano, 2014), (1) An initial search of relevant databases followed by a text words analysis of title, abstract and index words; (2) A search of identified keywords and index terms across all databases; and (3) A search through reference list of all identified reports and articles. An example of the search strategy of Web of Science database is provided in Figure 1.

Selection of sources of evidence

Following identification of sources, the selection process consisted of application of the criteria to the title and abstract by the first author, if selection criteria remained uncertain, the full article was accessed, read and a decision made. This was checked by the second and third authors. Once all articles were accessed, they were read through in full to reach a decision on inclusion by all three authors. The number of sources selected and rejected at each stage is detailed in Figure 2 (Moher et al., 2009).

Data extraction

Key characteristics and variables were agreed at the protocol design stage. These were saved to an Excel spreadsheet. This was reviewed and amended after initial searches to ensure all key characteristics were captured in the review. Authors one and two extrapolated the data into an Excel spread sheet, discrepancies were discussed between authors. Author three checked and reviewed data.

TI=("pedophil*" OR "child abuse*" OR "child sexual abuse*" OR "minor attracted person*" OR "sexual abuse*") OR AB=("pedophil*" OR "child abuse*" OR "child sexual abuse*" OR "minor attracted person *" OR "sexual abuse*") OR TS="Pedophilia" AND
TI=("prevent* sexual violence" OR "prevent* sexual abuse" OR "prevent* child sexual abuse") OR AB =("prevent* sexual violence" OR "prevent* sexual abuse" OR "prevent* child sexual abuse") OR TS="Child Abuse" AND
TI=("Secondary prevention" OR "prevention intervention" OR "prevention program*") OR AB=("Secondary prevention" OR "prevention intervention" OR "prevention program*") OR TS="Secondary Prevention"

Figure 1. Search terms used for the Web of Science.

Data items

Key characteristics and variables included general variables, as well as more specific areas of interest to our research question, these are detailed in Figure 3.

Data analysis of individual sources of evidence

Individual sources included in this review were qualitatively appraised and organised thematically. Data were analysed using the six steps of Thematic Analysis (Braun & Clarke, 2006): (1) Familiarisation required reading and re-reading of each source, the data charting process was useful for familiarisation, (2) features within the sources were then coded, codes included concepts such as "mandatory reporting" "features of successful interventions" "barriers", (3) next codes were clustered together, developing a thematic map of the prevalent codes/clusters across sources, (4) themes were reviewed and edited for both fit and essence across the sample, (5) themes and sub-themes were defined and labelled in preparation for the final stage (6) in which themes were written up providing a narrative account of the themes across the sample. Each of the five themes is presented in the discussion below.

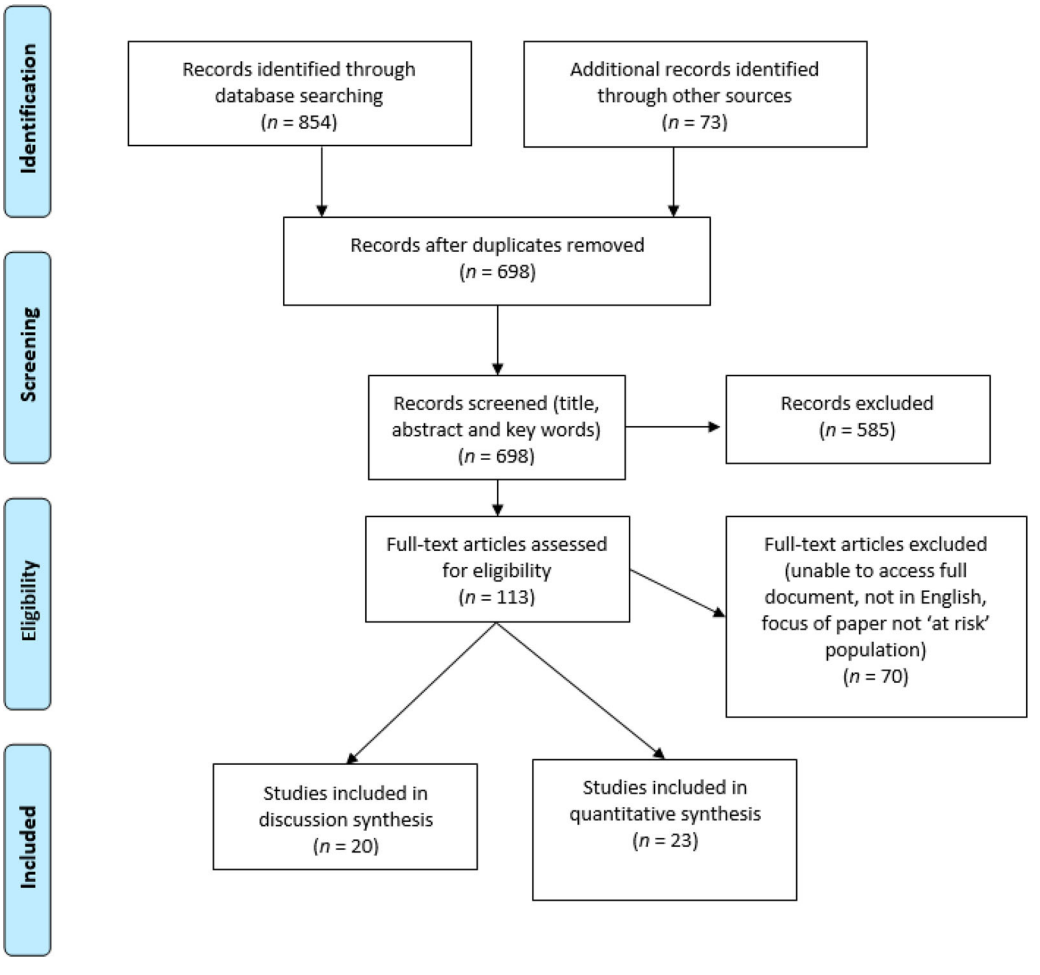

Figure 2. Selection process and source totals.

Results

We set out to explore the nature and scope of secondary prevention interventions, specifically, those aimed at people at risk of perpetrating sexual abuse against children. Our research question asked what prevention interventions are currently being delivered, how effective are they, and what challenges and barriers exist. Our review includes a blend of discussion and empirical sources; we present two tables summarising these. Table 1 includes discussion or review papers ($n = 20$) and Table 2 details empirical studies ($n = 23$).

Now, we present a thematic synthesis of these sources in which five themes were developed.

Theme one: current secondary prevention programmes that target people at risk of sexual harm

Most sources in this study summarise or provide examples of existing secondary prevention programmes targeting people at risk of CSA. To avoid a lengthy narrative of individual programmes, we provide a summary of each intervention in Table 3. Where available we also include a weblink to the organisation delivering the intervention.

Essential features of secondary programmes targeting people at risk of perpetrating CSA

Some of the key features noted by sources as vital for delivering secondary prevention interventions include those that deliver individualised strategies of care, are provided in a multi-disciplinary context, and administered using multi-modal approaches (Beech & Harkins, 2012; Beier et al., 2015; Bolen, 2003; Engel et al., 2018; Finkelhor, 2009; Heasman & Foreman, 2019; Knack et al., 2019; Konrad et al., 2017; Lasher & Stinson, 2017; Levine & Dandamudi, 2016; McKibbin et al., 2019; 2017; McKibbin & Humphreys, 2020; McMahon, 2000; Oliver, 2007; Ruzicka et al., 2021; Saleh & Berlin, 2003; Seto, 2009; Silovsky et al., 2019; Tabachnick, 2013). Programmes should provide opportunities for people, particularly young people (Shields et al., 2020) to develop or learn new skills (e.g. problem solving, emotional regulation, coping with sexual thoughts or behaviours, relationship/parenting skills) or alternative strategies to avoid harmful sexual behaviours or interests (Apsche et al., 2006; Beech & Harkins, 2012; Beier et al., 2015; Beier et al., 2016; Bentovim, 2002; Bolen, 2003; Carpentier et al., 2006; Heasman & Foreman, 2019; Jennings et al., 2013; Knack

1. Author
2. Year of publication
3. Title
4. Source origin/country of origin
5. Source Type
6. Aims/purpose
7. Study sample size
8. Population Type
9. Study design
10. Data Collection
11. Data Analysis
12. Intervention type
13. Duration of intervention
14. Key findings

Figure 3. Extraction fields.

Table 1. Summary of discussion sources.

Author and year	Title	Aim/Purpose	Key findings
Assini-Meytin et al. (2020)	Child sexual abuse: The need for a perpetration prevention focus	To detail the scope of the problem of sexual abuse, highlight limitations of responsive approaches and present promising perpetrator prevention interventions to assist in comprehensive response	Paper considers three main types of intervention targeting at risk perpetrators: (a) self-help (e.g. Help Wanted Prevention Intervention US, the Berlin Institute of Sexology and India online programme; b) school based (e.g. Responsible Behaviour with Younger Children); and (c) strategies to reduce harm in organisational contexts such as youth serving contexts (e.g. development of safety codes and policy, training and education, assessment and monitoring measures, hiring and screening practice and reporting and responding to allegations) – strategies are rooted in situational crime prevention frameworks. Authors highlight the need for federally funded public health approaches. Barriers include mandatory reporting laws and limited knowledge of risk factors in non-offending/un-convicted population
Beech & Harkins (2012)	DSM-IV paraphilia: Descriptions, demographics and treatment interventions	To provide an overview and demographic description of each of the DSM-IV-TR paraphilia and medical description of sexual crimes. Effectiveness of treatments are included	Authors summarise definitions of paraphilias and interventions/treatment available. Much of the treatment detailed is in health or criminal justice contexts post offending; while treatment discussed is likely to be useful for some at risk populations, evidence is not available. Treatment includes behavioural, cognitive behavioural therapy, chemical/physical castration and selective serotonin re-uptake inhibitors. The paper is broad in focus but provides useful narrative and definitions (e.g. definition of paedophile and the legal position). Key challenge is how people access this type of treatment before an offence has occurred
Bolen (2003)	Child sexual abuse: Prevention or promotion?	To compare current victim prevention strategies with alternative paradigm that promotes healthy relationships and targets those at risk of offending rather than only those at risk of being a victim	The author argues prevention strategies must (a) target high-risk populations (men and boys specifically stepfathers and sexually abused boys), (b) act as a deterrence (but awareness the behaviour is wrong is needed and increasing detection is essential as historically little punishment has resulted from sexual abuse), (c) provide sexual socialisation (sexual issues need to be confronted and discussed openly, with children) and (d) alter the male sex role (social pressures from traditional patriarchal structures reinforce the dominance of men over women, negative attitudes towards women and beliefs around interpersonal violence). A Healthy Relationships prevention programme delivered to children, integrated throughout school curriculum and the school philosophy, is proposed. Programme must promote healthy alternatives, with prosocial definitions of masculinity, how boys/men express masculinity pro-socially, it should incorporate deterrence messages linked to alternative choices for sexual behaviours and expressing sexual identity
Finkelhor (2009)	The prevention of childhood sexual abuse	To discuss current initiatives (and supporting evidence of effectiveness) aimed at preventing childhood sexual abuse	Finkelhor notes there is not one clearly evidenced strategy that can prevent child abuse, but dominant strategies include (a) criminal justice approaches and (b) educational school strategies. Criminal justice responses are too late, as offending has already occurred. Education targets potential victims and reporting mechanisms, but little empirical evidence suggest these approaches prevent abuse. Hotline and bystander approaches show some promise, but evidence they prevent harm is not fully understood. Situational prevention strategies are encouraging, particularly in child-serving organisations, as well as greater screening tools. Use of any strategy in isolation, is unlikely to be sufficient
Heasman & Foreman (2019)		To present the case that secondary prevention programme that target	Harm reduction approach is an ethical one that could be used to support PWPs live safer and offense free life (effective examples in substance misuse field). Secondary prevention

(*Continued*)

Table 1. Continued.

Author and year	Title	Aim/Purpose	Key findings
	Bioethical issues and secondary prevention for non-offending individuals with pedophilia	people with pedophilia (PWP) are ethically sound and essential to prevent abuse	programming is most effective when tackling health related issues that target greatest risk. Challenges include mandatory reporting laws where; health professionals have a duty to report if they suspect a person might at risk of causing sexual harm and unhelpful beliefs held by health care professionals about PWPs; de-stigmatising efforts are needed to increase access to support and health care
Jennings et al. (2013)	Using mindfulness in the treatment of adolescent sexual abusers: Contributing common factor or a primary modality?	To present the utility of mindfulness as a complementary therapy for adolescents at risk of sexual offending	Authors argue the importance of multi-modal approaches to treatment for this group; with mindfulness as a distinct mode of treatment or used in combination with others. Mindfulness enables greater self-awareness helping adolescent's address problems with sexual interests, thoughts, or behaviours. Although an absence of empirical research exists, developing skills that focus on "the present" will assist adolescents with a range of issues and complement treatment
Knack et al. (2019)	Primary and secondary prevention of CSA	To outline primary and secondary perpetrator prevention strategies that prevent sexual harm before it occurs, detailing the benefits and barriers along with recommendations for further development	Authors describe the following secondary programmes: Stop it Now, Preventions Project Dunkelfeld (PPD); Sexual Behaviours Clinic Ottawa; and The Safer Living Foundation Prevention Project UK. Demand for these services indicates a need. Benefits of prevention strategies includes preventing creation of victims; supporting people at risk to improve quality of life; reduce demand on criminal justice and health care system; economic benefits. Barriers preventing secondary prevention programmes operating are practical, ethical and systemic. Barriers to help-seeking include stigma; fear of being judged; and a lack of knowledge/availability of treatment. To overcome barriers problematic sexual interests' education is needed for healthcare, criminal justice professionals and the general public – media campaigns can assist; greater research examining needs and effectiveness of treatment (general and sexual interest health treatment). Successful prevention strategies would be multi-disciplinary, tailored to individual need, be free and voluntary. Marketing strategies must show empathy, avoid discrimination, reduce fear, ensure anonymity, decrease feelings of shame
Konrad et al. (2017)	Misuse of CSA images: Treatment course of a self-identified pedophilic pastor	To outline and apply the PPD programme to a case study. To recommend treatment that helps reduce the likelihood of sexual offending and improve sexual functioning deficits	Authors provide a summary of the PPD programme and apply it to a case example. The paper includes an outline of the case background; assessment following a clinical interview, psychometric test results and Acute-2007 score; the treatment plan (included one-to-one therapy, pharmacological intervention and couples counselling); and treatment outcomes. Each aspect of the treatment and the role of the PPD in supporting the client is discussed. They report sexual interests were managed and the case was able to regulate impulsiveness. Focussing on client needs was found to be particularly important as it enabled the client to engage in appropriate adult sexual behaviours and complete treatment without the fear of mandatory reporting
Lasher & Stinson (2017)	Adults with pedophilic interests in the United States: Current practices and suggestions for future policy and research	To contrast prevention efforts in US with Germany, Belgium and Canada and to outline five key areas to implement prevention programmes in the US	Authors summarise awareness raising prevention groups/organisations (e.g. Darkness to Light; Protecting God's Children), services to people at risk (e.g. Stop It Now; The Enough Abuse Campaign) and the organisations who provide support aim to reduce stigma (e.g. Virtuous Paedophiles; B4U-ACT; Help Wanted Project). Paper presents notion that the stigma associated with pedophilia prevents people seeking help resulting in greater health problems and an economic and social cost. Principle-based approach to ethics justifies harm reduction approach for PWPs not in the justice system. Barriers to treatment include mandatory reporting laws; stigma; cultural issues; and, putting organisational reputation

			ahead of person. Groups who support pedophilic interests (e.g. NA Man-Boy Love Association) caused great harm to prevention movement. Prevention approaches should: promote emotional expressiveness; provide healthy sex education; support sensitive and responsive parenting approaches; challenge myths and misunderstandings about CSA; challenge beliefs of entitlement; target sexual preference and self-control as primary targets and others as secondary goals
Lee et al. (2007)	Sexual violence prevention	The paper reviews the foundations and current strategies of sexual violence prevention	A brief history documenting the foundations of prevention work from the feminist movement to current attention on risk and protective factors is presented with authors detailing the importance of public health frameworks when developing strategies. Authors highlight how single session education interventions are unlikely to have great effect, they need to be part of a comprehensive offer that intersects with policy, norms and social structures. Comprehensive ecological models help but in order to sustain change, communities must reinforce and support changes; community mobilisation enables people to participate in decisions and shape strategies that impact their lives. Challenging social norms is vital, as myths and misperceptions are barriers to change. Social marketing is a positive tool that can support this process. While community support is vital, so too is support and financial commitment from policy makers
Letourneau et al. (2017)	Preventing the onset of CSA by targeting young adolescents with universal prevention programming	To review the literature examining school-based universal prevention programmes targeting adolescents at risk of CSA perpetration. To provide a summary of a new prevention programme	Authors provide an overview of the current literature, pressing the need for public health approaches to intervene with children at risk from an early age and before the onset of abuse. They highlight the limitations of traditional approaches (criminal justice, deterrence, or education programmes that teach potential victims how to protect themselves). The authors summarise three existing prevention programmes: Safe Dates; Shifting boundaries and Second Step–student success through prevention and outline the new Responsible behaviour with Younger Children (RBYC) programme designed to reduce the likelihood of adolescents engage in harmful and illegal sexual behaviour. Authors detail the design considerations of the programme including wat age is appropriate to deliver the programme to; its content; gender of participants; and role of parents
Levine & Dandamudi (2016)	Prevention of CSA by targeting pre-offenders before first offense	To describe a primary prevention model using an example of diabetes followed by application of the model to the prevention of CSA	Authors apply public prevention model to preventing sexual violence. Stage one summarises prevalence and scale of sexual abuse. Stage two highlights there is no one clear risk profile but draw on general classifications i.e. male, likely to be known to a child (or have access), between ages of 14-30, diagnosed or identify as a paedophile, have additional paraphilic interests, a personal of family history of abuse, issues coping with psychosocial stress, use child abuse images, some socioeconomic factors might be relevant. Third stage details how no tests currently exist to identify those at risk, but risk assessment could be carried out by professionals with those who identify themselves at being at risk would or who have sexual interests/behaviours that are considered as a risk (paramount is the understanding that even someone who has sexual interests, this does not mean they will go onto offend. Stage four details potential interventions e.g. PPD, pharmaceutical, physical monitoring, social and communal prosocial activities, and help with stable housing/employment (Circles of Support as a model). Stage five, while a lack of knowledge in the field regarding outcome data exists, some useful results from PPD shows early interventions are effective

(*Continued*)

Table 1. Continued.

Author and year	Title	Aim/Purpose	Key findings
McKibbin et al. (2019)	Respecting Sexual Safety: A program to prevent sexual exploitation and harmful sexual behaviour in out-of-home care	To describe the "Respecting Sexual Safety" secondary prevention programme that targets young people living in care	This paper discusses how care workers, working in children's residential homes need training and skills development to respond to the needs of young people engaging in problematic sexual behaviours to ensure appropriate interventions are targeted appropriately. Authors highlight the tension between children who engage in harmful behaviours and their experiences as victims of sexual exploitation. The Respecting Sexual Safety programme has three strands: Whole of house respectful relationships and sexuality education (all children are educated about respectful relationships safety and sexual health, sex education, children construct narratives about their life); The "missing from home" strategy (partnership between young person and key workers aims to counter grooming, use of social media to engage missing children); The sexual safety response (early identification, safety planning, advocacy and treatment for harmful sexual behaviours, exit strategies are developed for those exploited, multi-agency work and dating violence therapy responses are also provided). The programme is currently being evaluated
McKibbin & Humphreys (2020)	Future directions in CSA prevention: An Australian perspective	To draw on the work of Letourneau and colleagues, around public health approaches to preventing CSA and apply this to the Australian context	Authors outline reasons for policy resistance to working with this group: The problem is complex, targeting resources effectively is a challenge; the topic engenders an emotional response weakening the case that working with perpetrators is a good option; a binary or reductive narrative about the nature of sexual offenders (either offender or victim, not both) stifles discussion of wider solutions. However, current political and media climate show signs of readiness/change e.g. Australia's independent investigation into CSA and development of new policy framework. Authors provide example of changes to current public health approaches that might assist in developing more comprehensive approach e.g. develop more gendered focus on boys and men in primary prevention education; promote online safety education in marketing campaigns that target mothers and caregivers. Secondary prevention is underdeveloped work with young people presenting with harmful sexual behaviours is needed including specialised trauma-informed work. STOP it Now! is now operational in Australia as is pilot of Respecting Sexual Safety plus Worried About Sex and Porn Project for young people
McKillop (2019)	Understanding the nature and dimensions of CSA to inform its prevention	Chapter outlines developments of CSA prevention within the framework of a public health approach	Author draws on Bronfenbrenner's 1979 ecological model as a framework for preventing sexual violence and outlines the levels of individual, relational, community and society. They include theory on situational factors "in the moment" influences using Smallbone and colleagues' work who suggest the context or situation can influence CSA perpetration. Using prevention matrices and drawing on routine activities' theory (three key target groups – offenders, victims and situations) the author maps a prevention matrix. For secondary prevention: those at risk can access helplines and sexual programmes; victims need developmental prevention; and at-risk situations require safety planning. Promising interventions include Stop it Now! PPD, Safe Dates; social media campaigns (Tea and Consent); juveniles education programmes that build resilience and strengthen family bonds; improve parenting skills
McMahon (2000)	The public health approach to the prevention of sexual violence	Chapter outlines a public health approach including the three levels to prevent sexual violence before it occurs	The author details the four steps to a public health approach (surveillance, risk factors, development of programmes and dissemination of what works). Author details the prevalence and nature of sexual violence and risk factors. It is acknowledged individual predictors are not fully known so list of potential risk factors includes young male, living in

			hostile family environments, witness of violence or abuse and sexual promiscuity, sexual arousal to deviant stimuli, exposure to material, beliefs that support abuse, lack of empathy, hostility towards women, developmental problems. The author highlights how family interventions delivered at home to help improve family conditions have been successful
Oliver (2007)	Preventing female-perpetrated sexual abuse	To outline the common characteristics of female sexual offenders and propose some strategies to help prevent sexual abuse by females before it occurs	The author provides an overview of the characteristics of convicted female offenders; likely to be aged 20-30, targets children rather than adults, white, offends alone and with others (usually a male), juveniles usually offend against both male/female during babysitting type activities, usually related to victim, have depression/anxiety, suicide ideation and personality deficits, suffer from PTSD, have extensive experiences of sexual abuse. Thus, prevention strategies ought to target female victims of repeated sexual abuse, of multiple abusers. Treatment should address cognitive distortions, enhance empathy, myths, consider situational abuse theory as babysitting type training could support the knowledge and understanding of boundaries for girls. Little is known of the sexual fantasy and arousal in this group but pedophilic women ought to receive the same hope and access to treatment to help manage interest, pharmacological options ought to be considered. Increasing public and professionals' general awareness around female sexual offending is needed
Saleh & Berlin (2003)	Sex hormones, neurotransmitters and psychopharmacological treatments in men with paraphilic disorders	To provide a review on the efficacy and tolerability of pharmacological and psychopharmacological treatments	Due to biological abnormalities (genetic disorder, hormonal abnormalities, or neuropsychiatric disorders) there is no cure for some paraphilic disorders, but biological and/or psychotherapeutic treatments (not designed to treat such disorders) can help manage symptoms (sexual fantasy, urges and/or problematic behaviours). Pharmacological options that target testosterone levels have mixed results (some failing or finding harmful side effects). Psychopharmacological (drugs that affect mood, perception thinking and behaviour) not designed to specifically tackle paraphilias, have been proven effective in managing symptoms and useful to prevent sexual violence. Testosterone lowering treatments have potential adverse side effects but appear effective in treatment paraphilias as sex drive is suppressed in relatively short periods of time and reduced recidivism rates are found. Serotonergic antidepressant medications appear to reduce paraphilic symptoms
Seto (2009)	Pedophilia	To discuss diagnosis, assessment methods, risk assessment and interventions for PWP. Summary of primary and secondary efforts	Pedophilia is an unchangeable sexual interest, prevalence rates are unknown (estimated to be 3-9% of the population). Goals in treatment must therefore be around management of sexual interest. Options include Behavioural Treatment (techniques to control sexual arousal); CBT (assist in how to manage risky situations, tackling relapse prevention); Drug Treatments (use of SSRIs and testosterone reducing drugs); Surgical castration. Greater need for RCTs to test efficacy of treatment in this population. Chapter briefly summarises Stop it Now! and the PPD project as examples of secondary prevention
Tabachnick (2013)	Why prevention? Why now?	To provide a summary of the changes needed and public health approach required to prevent sexual abuse.	Author discusses a prevention matrix, highlighting the work of Krug using the social ecological model of violence. The author briefly applies interventions at each ecological level strategy with focus on both victim and those at risk (no examples are given at individual level). Relational level includes bystander interventions e.g. Bring in the Bystander and Green dot programme delivered at universities and PPD programme and Stop it Now! At societal level, the work of the State of New Jerseys Child Prevention program requires agencies working with children to engage in child safety policies etc. Issues include a lack of funding and direction towards prevention, compared to tertiary approaches

Table 2. Summary of empirical sources.

Author, year	Aim/Purpose	Study design, sample, population and source origin	Data collection and analysis	Key findings
Apsche et al. (2005)	To compare the efficacy of three treatment methods Cognitive Behavioral Therapy (CBT); Social Skills Training (SST); Mode Deactivation Therapy (MDT)	Randomised control trial of $N = 60$ adolescent males with problems of aggression and/or sexual aggression and conduct disorder/personality disorder: CBT $n = 19$; SST $n = 20$; MDT $n = 21$. Source: USA	Pre/post treatment data collection with baseline (pre-treatment) of physical and sexual aggression measured by the average number of incidents per week that occurred during the first 60 days following admission to clinic; post-treatment rating occurrence during the 60-day period prior to discharge. Data were analysed using independent *t*-test and one-way ANOVA	CBT – a structured programme designed for personality and conduct ordered youths was given. The treatment was psychoeducational in its design tackling issues such as problematic cognitions, sexual behaviours and beliefs, emotional management, mental health care and victim empathy. SST identified and reinforced positive behaviours using modelling, skill practice and role play, young people are encouraged to practice new skills. MDT – Core beliefs are not challenged instead they are validated, and the participant supported to deactivate maladaptive responses to these beliefs. All participants benefited from treatment regardless of theoretical orientation with a reduction in the rate of aggression post treatment. MDT was found to be superior to CBT with a reduction of post-treatment rates of sexual aggression only found in MDT
Beier et al. (2015)	To outline findings from the primary prevention Berlin project for juveniles (PPJ)	Case study of the PPJ included $N = 27$ male (1 female), mean age of 15.36 who engaged in treatment over a three-year period. Source: Germany	Data collected using initial diagnostic interview, and test battery version of the Berlin Dissexuality Therapy (BEDIT) measuring psychosexual areas. Descriptive analysis used to analyse	Authors found younger people tend not to contact professionals independently but instead did so through a guardian. High presence of co-morbid disorders presents in this group; needs are complex. Study relied only on self-report, and many were referred via guardians thus the motivation to contact the support independent of this is debatable. Paper highlights the need for treating this population as the demand is there. Media campaign was useful means to introduce the notion of therapy to this population
Beier et al. (2016)	To evaluate treatment related changes in dynamic risk factors (DRF) and sexual behaviors in paedophile/ hebephile participants of the PPD group treatment between 2005 and 2011	Non-randomised Control Trial of $N = 75$ adult men with self-reported sexual interest in pre/pubescent children. Taken from sample of 291 eligible participants $n = 34$ reported no previous offending, the remaining consisted of both detected and undetected offenders Treatment Group $n = 53$ Control Group $n = 22$/ Source: Germany	Pre-Test/Post-test comparison using self-report measures including Offense-Supportive Cognitions; Emotional Deficits; Sexual Self-Regulation Deficits; and Child Abusive Behaviors. Analysis used *t*-tests and Wilcoxon signed-rank tests	DRFs appear to reduce through treatment however persisting offending behaviours for both groups was found in contact offending (20%) and non-contact (91%) - these were undetected offences. 24% of participants who reported no previous offending disclosed an onset of accessing indecent images of children, during treatment. Emotional deficits and offense-supportive cognitions decreased, and sexual self-regulation increased. No official offending was reported by authorities. Highest risk offenders benefited most from treatment. Short period of observation plus, small sample size

Bentovim (2002)	Paper considers the nature of therapeutic work required to assist sexually abused boys from sexual offending in the future and reports findings form two studies	Cross sectional longitudinal study $N = 78$ young boys between ages of 11 and 16. Sample divided into four groups (a) victims of CSA but did not present any signs of engaging in harmful sexual behaviours; (b) victims of CSA but did present signs of engaging in harmful sexual behaviours against other children; (c) boys with no evidence of CSA victimisation but were engaging in harmful sexual behaviours against other children; and (d) children showing signs of antisocial behaviour, no evidence of CSA as a victim or perpetrator. The second prospective cross-sectional study examined ($N = 224$) male children referred to Great Ormond Street for reasons relating to sexual abuse between 1980 and 1992	Range of assessments, standard psychometric measures, observations, and information collected using intelligence, behavior, pubertal status, socioeconomic circumstances and friendship reports. Children underwent three months of individual weekly psychoanalytic psychotherapy. Birth mothers were interviewed, and a grounded theory approach used to examine the data and develop themes. In the prospective study, data were collected from clinical, social work and criminal record files.	This paper examines effective ways of working with victims of sexual violence to help prevent them engaging in harmful behaviours. Author notes being a victim of sexual abuse does not cause perpetration of abuse, however, rates of victimisation in perpetrators are significant, thus, care is needed when assessing likelihood of further abuse. Careful initial assessments are needed; author notes how key initial assessments are to determine prognosis, and formation of appropriate treatment pathway. Therapeutic work to prevent offending takes a number of forms: Reparation of attachments; Management of emotional dysregulation; Developing a positive sense of self. Therapy must be appropriate to the stage of reintegration/ rehabilitation: Consideration of returning back to family life; working in a climate of violence/exposure and experience of physical abuse; or when integrating into new families
Carpentier et al. (2006)	Ten years follow up comparing a cognitive behavioural therapy (CBT) programme with a play therapy (PT) programme	Randomised control trial of $N = 291$ Intent-to-treat group $n = 135$; Comparison group $n = 156$ Children aged between 5 and 12 years displaying sexual behaviour problems (SBP). Source: USA	Pre/post treatment, plus 1- and 2-year parent follow up between 1992 and 1995. Measures include Child Behavior Checklist-Parent Form; Child Sexual Behavior Inventoryv2; Ratings of SBP aggressiveness; KBIT and data from justice databases were drawn from to gather event reports of arrests and maltreatment reports	Each treatment consisted of twelve, 60-minute sessions. CBT relied on behaviour modification and psychoeducation. PT less structured, client centred psychodynamic play principles. Study highlights children with SBP can be effectively treated and helped to reduce problem behaviours using CBT. However, short term CBT appears most effective on this group, longer term follow ups are needed and replication of this type of study
Engel et al. (2018)	To investigate effects of a treatment programme aimed at reducing DRFs	Fractional factorial design of $N = 100$ men who contacted PPD and were eligible for treatment. 16.3% reported not offending, most had engaged in contact and internet related offending. A minority were known to the authorities. Treatment Group $n = 35$; Treatment refusers $n = 51$; Dropouts $n = 4$. Source: USA	Data collected 2010 and 2015 through clinical interviews (sociodemographic and sociosexual data) and survey (hypersexual behaviour, offense supporting attitudes, self-efficacy, impulsiveness, child identification, lifetime use of sexual imagery). Data analysed using one-way ANOVA, Mann–Whitney U tests and *T*-Tests	No differences were found regarding sociodemographic and sociosexual variables, education, relationship status, living solitarily and being a father/stepfather across the groups. Treatment refusers and dropouts lived farther away from treatment site. In the treatment group no participants commenced offending during the course of the study, plus a reduction in offence supportive attitude's, coping self-efficacy and child identification was noted. A reduction in DRFs was observed during treatment

(*Continued*)

Table 2. Continued.

Author, year	Aim/Purpose	Study design, sample, population and source origin	Data collection and analysis	Key findings
Grant et al. (2019)	To examine data from Stop It Now!'s Helpline between 2012 and 2018. To contextualise data with previous data gathered between 1995 and 2018. To offer insights into the needs of individuals and families confronting issues related to CSA	Non-experimental cross-sectional study of inquiries/contacts made to Stop it Now! Population includes bystander, person at risk, adult survivor/victim. Total sample of $N = 21,030$ (1995–2018 sample $n = 13,908$ and 2012–2018 $n = 7122$). Source: US	Two data sets collected by helpline staff between 1995 and 2018 and 2012–2018 were aggregated. Anonymous data recorded by helpline staff organised into key variables. Descriptive statistics and Chi-square tests were used to explore associations between the characteristics of the type of contact, level of assessment and gender	The study finds 37% of contacts to the Helpline had no contact or help from professionals, meaning population remains unidentified thus the helpline provides a valuable service to those reaching out for help (either victim, bystander, perpetrator). Largest users of service were bystanders (69%) indicating prevention strategies can empower others to intervene. One third of contacts represented concerns of a young person's behaviour indicating the role the service can provide in preventing juvenile offending. While only 10% of contacts were by those concerned by their own thoughts, feelings and behaviors majority male (82%) the helpline was able to support these contacts with advice and guidance in developing prevention strategies
Landgren et al. (2020)	To examine the effect of degarelix on the DRF for those with sexual interest in children	Randomised control clinical trial of $N = 51$ male adults aged 18–66, self-identified with Pedophilic Disorder (majority reported undetected previous offences) Treatment group $n = 25$ and control group $n = 26$. Participants were randomly selected to receive either two subcutaneous injections of 120 mg of degarelix acetate or equal volume of placebo between 1 March 2016, to 30 April 2019. Source: Sweden	Data collected at point one (2 weeks) included self-rated composite risk scores (4 DRF included pedophilic disorder, sexual preoccupation, impaired self-regulation and low empathy). Collection point two (2 and 10 weeks) included composite risk scores, quality of life, adverse effects and self-reported effects in structured interview. Intent-to-treat analysis and prespecified analysis for the primary end point. 2-sided *t*-test at secondary collection points linear random effects regression model. Interviews analysed using quantitative descriptive content analysis	Primary and secondary end points of efficacy in reducing the composite risk score at 2 and 10 weeks differed substantially, meaning dynamic risk factor scores decreased in the treatment group. There was no statistically significant difference in empathy. In the treatment group, positive attitudes toward sexuality (77%) and adverse effects on the body (89%) were the most common self-reported experiences. No serious adverse events occurred in the placebo group. An increased suicidal ideation was reported by 8% of treatment group which led to hospitalisation
Levenson & Grady (2019a)	To determine whether significant differences were detected in knowledge and attitudes about working with PWP after receiving a short training workshop	Pre-test/post-test comparison design of $N = 94$ mental health professionals, social workers and two interdisciplinary groups of counsellors who specifically work with people who sexually offend. Source USA	Pre-test/post-test surveys: (a) demographic and clinical experience (b) knowledge of pedophilia, mandatory reporting, treatment needs and goals (c) attitudes towards working with MAPs, empathy, therapist's belief in own capacity (d) confidence rating). Data	Overall, improved changes were found in items related to knowledge about mandatory reporting (interdisciplinary groups), goals for MAPs in counselling and DSM-5 criteria for Pedophilia (social workers). Attitudes were not particularly negative to begin with, perhaps unsurprising given the conferences these workshops were presented at. There were no significant between-group differences dependent on conference type or length

			analysed using independent sample *t*-tests and ANOVA	of training. Some significant differences were detected in knowledge and attitudes about MAPs after mental health professionals received training, suggesting that a brief intervention can increase knowledge about this population and foster an improved sense of competence in providing services
Levenson & Grady (2019b)	To obtain MAPs perspectives about (a) experiences with help-seeking for minor attraction, (b) perceived barriers to seeking help and (c) treatment priorities as identified by consumers of these services	Descriptive exploratory, cross sectional survey of 293 Minor-attracted persons (MAPs) with $n = 154$ answering all questions. Source: United States and United Kingdom	A non-random, purposive sample were recruited by online anonymous survey link distributed by Stop it Now!; Virtuous Paedophiles; and Lucy Faithful. Descriptive, bivariate correlational and comparative analyses was used to report prevalence of relevant variables. Open-ended questions were analysed using thematic qualitative analysis	Majority of respondents were male (91%) with 67% reporting attraction to prepubescent children <12 years. Approx. three quarters had sought help from health professionals or online while half reported a helpful experience, about one third said it was not. Participants reported helpful characteristics of therapeutic encounters included: being listened to, non-judgmental attitude, knowledge about MAPs, person-centred and holistic approaches. Barriers to seeking help included: uncertainty about confidentiality, fear of negative reaction or judgment, difficulties finding a knowledgeable therapist, and financial constraints. Understanding or reducing attraction to minors were common treatment goals, but participants also prioritised addressing general mental health and well-being related to depression, anxiety, loneliness and low self-esteem. Implications for effective and ethical counselling and preventative interventions for MAPs include better education for health professionals; clarity of mandatory reporting laws; use of client centred approaches; eliminate barriers to treatment; address and reduce stigmatising labels
Levenson et al. (2017)	To explore prior help-seeking experiences as well as the obstacles to help-seeking for those currently in treatment for criminal sexual behavior	Descriptive exploratory, cross sectional survey of $N = 372$ male adults convicted for a sexual offense. Source: USA	Postal survey distributed to five U.S. outpatient treatment programmes who provide counselling services to people who have committed sex crimes. Univariate, frequency, *t*-tests, and chi-square statistical analyses were used	Key themes include participants became aware of their attraction in adolescent; while some disclosure to family members had occurred, help was not sought from professionals due to fear and stigma; barriers to seeking professional help include issues around confidentiality, fear of social and legal consequences, shame or confusion, cost and finding a therapist. Many participants talked about the fear, shame and stigma that kept them from disclosing, sometimes even to themselves, the truth about their attractions.
McCartan, Hoggett, et al. (2018)	To discuss ethical, practical and moral issues surrounding secondary		Single roundtable table discussion followed by three smaller discussion	Four themes developed including (a) The psychology of self-reporting and disclosure, and the need to

(*Continued*)

Table 2. Continued.

Author, year	Aim/Purpose	Study design, sample, population and source origin	Data collection and analysis	Key findings
	prevention efforts of CSA from a professional and practice-based perspective to contextualise an informed debate.	Descriptive exploratory, cross sectional survey of $N = 15$ International CSA experts. Source: UK	groups ($n = 5$ each). Conversations were unstructured, allowing discussants to give in-depth, reflective and personalised responses. Data analysed using Thematic analysis	consider offender engagement, community safety and risk management issues; (b) the existing legal, social and professional frameworks, and how this informs and shapes the practicalities of their implementation; (c) the scale and type of an appropriate response, concerning the practical aspects of online versus offline support systems, the implications of each response possibility, and the willingness of the at-risk individual to engage in them; and (d) the potential hurdles (i.e. within media, public, politics) of these interventions. Ethical issues highlighted as key when introducing secondary prevention include aspects of risk management, safeguarding, confidentiality, ethical guidance, public/media/policy engagement, multi-modal approaches to prevention and integration within legal frameworks. Study serves as a platform to assist in the discussion around secondary prevention
McKibbin et al. (2017)	To explore the insights of young people who had engaged in harmful sexual behavior, as well as the reflections of treatment-providing workers, to identify prevention opportunities	Grounded Theory examined $n = 14$ young people (aged between 16 and 21) who completed harmful sexual behavior treatment and $n = 6$ treatment-providing practitioners. Source: Australia	Semi-structured one-to-one, one-hour interviews. Visual aids used with young people to discuss gender and sexuality topics. A statement made by young person was used to generate reflection and discussion with practitioners. Analysis used Constructivist Grounded Theory	Five key themes include: dealing with childhood victimisation; learning about sex, age and consent; having safe and respectful relationships; receiving supportive responses from others; and conceptualising self as changing over time. Authors draw on public health model of prevention to identify three opportunities to prevent onset of sexual abuse: (1) Reform sexuality education (2) Respond to childhood victimisation supportively (3) Help children manage and understand the impacts of pornography
Mitchell & Galupo (2018)	To investigate the role of forensic and related factors on the decision not to commit a sex offense. Aims to explore role if (a) the possibility of jail/ punishment, (b) mental health treatment and (c) not wanting to hurt the child helps prevent offending	Descriptive exploratory, mixed method cross sectional survey of $N = 100$ men who self-reported a sexual attraction to children $n = 29$ reported a history of acting on their attractions $n = 71$ reported never acting. Source: US	Participants selected from larger study. Online anonymous survey distributed through B4U-ACT. Survey questions included demographic, indication of acting on sexual interests, factors influencing decision to act or not. Analysis carried out using Chi-square analysis, Fisher's Exact Test (FET), Cramer's V. Group, *t*-test and Thematic Analysis	Results highlighted harming a child was a particularly salient factor in the decision not to act among participants. The influence and role of the possibility of jail/punishment and mental health treatment appears to play a secondary or minor role in decisions to act or not. Qualitative analysis also revealed harm to the child to be a salient concept for men in both groups

Parr & Pearson (2019)	To explore professionals" perspectives of the barriers non-offending MAPs face when seeking and receiving help and how these barriers can be reduced	Descriptive exploratory, cross sectional survey of $N = 20$ professionals with training/experience working with non-offending MAPs ($n = 4$ Lucy Faithfull Foundation and $n = 16$ StopSO). Source: UK	Survey was emailed to Lucy Faithful Foundation, individual therapists and those associated with StopSo network. Data analysed using inductive thematic analysis	Perceived barriers to seeking and receiving help were reported as: stigma associated with minor attraction; lack of understanding of the risks linked to offending; lack of professional help available with some professionals refusing to help non-offending MAPs due to personal biases or inadequate training. Solutions for identified barriers include increasing publicity, educating the public and offering enhanced training to professionals
Piché et al. (2018)	Exploratory study examining offenders' perceptions and interest in accessing secondary prevention help	Descriptive exploratory, cross sectional survey of $N = 100$ people arrested for a sex crime. Source: Canada	Survey 66 multiple choice questions: demographic; criminal history; sexual behaviour/fantasy; prior help-seeking behaviour; use of future preventative services; access to prevention services. Data analysed using descriptive, bivariate statistics and Thematic Analysis	The majority of respondents indicated preventative interventions, including individual and group treatment, would have been beneficial, but inaccessibility of interventions and fear of arrest prevented them seeking help. Experiences of help-seeking activities prior to offending were limited. Majority reported a likelihood in seeking help in the future. Some offence specific differences were noted, those with voyeurism and thoughts of rape less likely to access help compared to those accessing indecent images of children
Plummer (2001)	To report on the findings from a survey of 87 communities working in prevention of CSA	Exploratory survey of $N = 87$ program leaders and community advocates providing sexual abuse prevention programmes. Source: USA	Postal questionnaires sent to participants surveyed in prior studies (1985 or 1991) asked about programme history, funding, materials and approaches used, challenges and future plans. Data analysed using descriptive statistics and content analysis	Many factors had not changed from earlier studies including ongoing problems with resources, denial of the problem and community coordination issues. A range of agencies deliver programmes including sexual assault, education, law enforcement, child protection and mental health. Programmes used evidence from research and theoretical literature to improve performance of interventions. More education/awareness was needed with greater collaboration with parents
Ruzicka et al. (2021)	To describe the development and implementation of the RBYC program and summarise data from focus groups	Exploratory qualitative design of $N = 7$ focus groups ($n = 3$ educator; $n = 2$ Parent; $n = 2$ student) plus $n = 7$ interviews. Educators ($n = 18$), parents ($n = 4$) and students ($n = 10$) were eligible for participation in the focus groups but only $n = 7$ educators were interviewed. Source: USA	Data collected in three phases: (1) Focus group (2) Rapid feedback and delivery of revised RBYC (3) Interviews with educators. Audio recordings not permitted so notes taken. Data analysed from agreed notes. Interview notes recorded on interview guide, reviewed following each interview verified as accurate	Overall feedback in relation to the delivery of the RBYC programme was positive and supportive but included the need to ensure content did not overwhelm or bore young people. Seeking feedback from parents was a challenge and there were methodological limitations to the study, including not being permitted to audio record sessions
Schaefer et al. (2010)	To describe and compare undetected offenders (Dunkelfeld) with sexual	Comparative study of $N = 160$ respondents to media campaign for	Following media campaign promoting Dunkelfeld service, computer	Both groups were more likely to be middle aged, better educated and have higher social-economic

(*Continued*)

Table 2. Continued.

Author, year	Aim/Purpose	Study design, sample, population and source origin	Data collection and analysis	Key findings
	interest in children and those at risk of sexual offending (potential offenders)	people at risk of sexual offending (undetected offenders $n = 63$ and potential offenders $n = 97$). Source: Germany	assisted telephone interview, plus clinical interview and battery of questionnaires, collected participant demographics, mental health, sexuality, criminal history and victim characteristics. Data analysed using Chi-Square test for nominal data and *T*-test for metric data	status and better mental health than those with detected/prosecuted offences. No differences between the two groups were found in terms of sexual interest in minors, apart from a higher proportion of fantasy in those who had already had sexual contact with a pubescent. Many participants reported recurrent sexual fantasies involving minors, as well as related distress, suggesting a high prevalence of pedophilia and hebephilia. More than half feared they would sexually abuse a minor, with undetected offenders reporting 3.2 victims on average. Undetected offenders more likely to perceive themselves at risk of offending, compared to potential offenders
Shields et al. (2020)	To advance knowledge about prevention and mental health efforts for adolescents and young adults with a sexual interest in children	Constructivist grounded theory $N = 30$ people aged 18–30 who identified as being sexually attracted to younger children. Source: North America, South America, Europe and Australia.	Data collected using telephone interviews (60—90 min) and post interview online survey. One audio recording was accidentally deleted. Analysis (a) line-by-line inductive coding/development of codebook; (b) two teams, independently coded 29 interviews; (c) coded excerpts reviewed. Overarching themes agreed	Participants reported sexual interest in children emerged during adolescence, in which they experienced a variety of emotions, including fear, shame and feelings of isolation constructed by experiences of negative observations of how people with their interest are treated. Participants noted the need for role models who are sexually interested in children and have successfully navigated life, access to positive messaging, and support from families and the community would have been helpful. Lack of resources for young people with attraction to children was noted
Silovsky et al. (2019)	To examine the outcomes for 320 juveniles ages 10–14 years and their caregivers who participated in community based problematic sexual behavior – cognitive behavior therapy (PSBCBT).	Multisite quasi-experimental study of $N = 320$ Juveniles (10–14 years) with problematic sexual behavior and their caregivers. Source: USA	Across all three sites, measures of PSB, behaviour problems, trauma symptoms and parental skills, stressors and supports were taken pre and post treatment. Problem behaviour measure administered every six weeks and three months post treatment. Data analysed using general linear modelling encompassing *t*-tests, ANOVA and ordinary least squares regression as special cases	PSBs decreased mid-treatment, with PSB continuing to drop through the end of treatment and maintained at low levels for those who completed post treatment assessments until approximately four months post-services. Caregivers reported improvements in parenting skills and support, reduced parental stress, and high levels of satisfaction with the programme. Data were collected by self-report only, official records not sourced

Van Horn et al. (2015)	To present callers' experiences to the Stop it Now! Helpline in UK and Netherlands	Descriptive exploratory, mixed method approach of $N = 115$ users of the helpline. Source: UK & Netherlands	Online structured questionnaire distributed via Stop it Now! (UK $n =$ 112; NL $n = 3$), qualitative in-depth interviews and focus groups (UK $n =$ 47; NL $n = 11$). Analysis included descriptive statistics, frequencies and Framework Analysis	A number of factors were reported by users that helped them modify their own or others' actions to minimise risk of abuse. Overcoming external and internal barriers were reported prior to contacting the helpline (awareness of the service, resources, shame, guilt, fear, etc). Therefore, challenge remains to ensure helplines are accessible to those most in need
Wilpert & Janssen (2020)	To compare characteristics of offending and non-offending Dutch callers seeking advice/help from Stop it Now!	Descriptive exploratory, cross sectional survey of $N = 330$ Offending and non-offending Dutch subjects, who sought advice/help from Stop it Now! helpline during 2012–2016. Source: Netherlands	Data from contact log template was entered into SPSS. Variables include demographics and other characteristics (social network, access to children, attraction to minors, health issues, substance use, promoting and risk factors. Descriptive statistics used to analyse data	Minor attraction and preference to boys were not differentiated between offending and non-offending groups. Encouraging number of callers indicated they would enter treatment (40.9%) remaining did not intend (not all require treatment), those who already offended intended to access treatment. Non-offenders may have less urgency to access treatment, as managing sexual attraction adequately, with criminal sanction deterrent, sufficient. Significant discrepancies regarding three promoting factors were found: substance abuse was relevant in offender sample, whereas more non-offenders considered access to children and negative emotionality as potential pitfalls toward offending. Concerning impeding factors: social and professional help (more relevant for offenders), whilst fear of consequences avoidance of risk situations (and lacking access to children were mentioned as offense restraining by more non-offenders)

Table 3. Summary of global secondary prevention interventions.

Intervention	Where	Description
Stop it Now! https://www.stopitnow.org.uk/	Online in the UK and Ireland, US, Canada, Netherlands, Australia, Grenada, Kenya, Colombia, Nigeria and India	Stop it Now! provide a confidential telephone helpline in which people can call to discuss concerns about their own sexual interests/behaviours and get help to keep children safe from sexual abuse. The helpline is available to people struggling with their own thoughts or behaviours or those concerned about the behaviours of another person. The helpline provides a place for people to discuss concerns, plan safeguarding action, help consider what to do next, refer or signpost onto other agencies. Live chat and email are available in addition to telephone service. Stop it Now! also have an online provision of self-help sessions that include information about the facts about having a sexual interest in children; self-awareness activities and exercises to understand behaviour, increase feelings of self-esteem; and help to look forward to building a positive good life.
The Prevention Project Dunkelfeld (PPD) and the Berlin Project for juveniles (PPJ)	Institute of Sexology and Sexual Medicine at the Charité, University of Berlin	PPD launched in 2005 with an extensive media campaign to encourage people with sexual interest in children to seek help and support to help prevent them from sexually abusing children. The specialist multi-modal treatment programme "*Berlin Dissexuality Therapy*" draws on CBT, sexological tools and pharmaceutical treatment to help with impulse control, intimacy deficits, self-esteem, coping, sexualised coping. A juvenile programme is also available (PPJ) for 12–18-year-olds with sexual preference for prepubescent and/or early pubescent children.
The Aurora Project https://www.saferlivingfoundation.org/what-we-do/adult-projects/aurora-project/	Safer Living Foundation, England	The Aurora Project provides free group and one-to-one support, therapy, and signposting for people (able to travel to Nottingham) wanting help with managing their sexual thoughts and behaviours. The work draws on the principles of Acceptance and Commitment Therapy (ACT) and Compassion Focussed Therapy (CFT) and aims to help people cope, manage and live with sexual interest thoughts they are having. The project aims to help people live a positive and meaningful life without causing harm.
Virtuous Paedophiles https://www.virped.org/	Internet	This is online mutual support group is aimed at people sexually attracted to children. Users of the site support the fact that any sexual contact with children is harmful and therefore must be prevented. The site provides advice, support and signposts users to professional support services. An additional aim for the web site is to help reduce the stigma associated with pedophilia.
B4U-ACT https://www.b4uact.org/about-us/	Internet	This online platform is aimed at supporting people with a sexual attraction to children, as well as working with professionals and researchers interested in working with and studying this group. B4U-ACT aims to promote services and resources for people attracted to children and to educate the public and professionals of the issues faced by this group.
Help Wanted Project https://www.helpwantedprevention.org/	Internet	This is online programme is designed and hosted by the Moore Center for the Prevention of CSA and is targeted at people with a sexual attraction towards children. The online course is aimed at providing support and tools to help people live a life free from abuse. The anonymous course provides educational facts about abuse, helps people make safe disclosures, cope with their sexual attraction, learn to build a positive self-image and engage in healthy sexual functioning.
Sexual Behaviours Clinic https://www.camh.ca/en/your-care/programs-and-services/sexual-behaviours-clinic	Centre for Addiction and Mental Health Toronto, Canada Australia	Outpatient treatment is offered for people with sexual behaviours or urges that has or could result in personal and or legal difficulties. The clinic provides assessment and treatment in the form of one-to-one, group therapy, brief family support/psychoeducation, referral onto other agencies and pharmacological assessment and treatment.

Power to Kids: Respecting Sexual Safety https://www.mackillop.org.au/institute/power-to-kids-respecting-sexual-safety		A programme that targets young people in residential care contexts. A "whole of house" approach is adopted that promotes respectful relationships and sexuality education. The project fosters a culture that promotes gender equality and respectful relationships, helps children engage in therapeutic life story work and engage in conversations with care workers around a number of topics such as gender-based violence, sex education, sexual health etc. Where harmful behaviours are exhibited, treatment and safety planning is undertaken or resourced so that children can participate in therapeutic treatment to prevent continued or future harm.
Chauraha https://aanganindia.org/	Mumbai, India	The programme is delivered in two residential observation homes and targets vulnerable boys at risk of violence – trained social workers mentor the children and their families and work to develop risk assessment and life plans, including educational and vocational goals; group work includes sessions to address violence, impulsiveness, peer pressure and decision-making; the project refer children onto relevant other services to help build community support.
Inform Young People Programme https://www.lucyfaithfull.org.uk/strategy.htm	Lucy Faithful Foundation, UK	This programme targets young people with concerning online sexual behaviours (individual or group work) through the delivery of between 1–5 psycho-educational sessions. Following initial assessment session are then delivered face to face in a way that meets the needs of the young person with the aim of planning strategies for safe and responsible behaviour. Work is carried out both with the child and with parent/carer
Turn the Page https://learning.nspcc.org.uk/services-children-families/turn-the-page#heading-top	The National Society for the Prevention of Cruelty to Children (NSPCC) UK	The programme uses the "Change for Good" treatment manual (McCrory, 2011) and consists of 26 structured 1:1 sessions plus 4 additional sessions that address the individual needs for young people including those with learning difficulties who are presenting with harmful sexual behaviours. The sessions cover engagement, relationships, self-regulation and a road map for the future.
G-Map https://www.g-map.org/	Manchester, UK	This programme targets children and young people aged 6–18 years, who display problematic or harmful sexual behaviour. A multi-disciplinary team work together to provide therapeutic services to young people using the Good Lives Model and strengths-based principles to underpin their work. Following comprehensive assessment, the needs of the child are identified, and strategies developed to help address them through group, one-to-one and family work.
Troubled Desire https://troubled-desire.com/en/	Online delivered by the Institute of Sexology and Sexual Medicine at the Charité, Berlin	Troubled desire is an online self-management tool for people with attractions to children and who are unable to receive treatment or access a therapist. The anonymous sessions aim to address the persons feelings and thoughts considering issues of consent, dispelling some myths around sexual abuse, look at distorted thinking, how to self-regulate and manage fantasy and behaviour, considerer personal triggers, empathy, impulse control, consider medical treatment and focus on well-being more generally.
Boys 2 https://www.barnardos.org.uk/sites/default/files/uploads/boys-2-workbook-english.pdf	Barnardo's Cymru and Barnardo's Base Project South West England, UK	Boys 2 is a project working with boys and young men who have experienced trauma and abuse and are at risk of engaging in harmful sexual behaviours or being further exploited. Following a one-year project that looked to improve identification, assessment and interventions for this group a workbook was produced developed for professionals working with this group to use during sessions with those at risk.
Stop So https://stopso.org.uk/	UK	Stop So are a registered charity who offer people access to a network of private therapists for people at risk of sexual offending.
Sexual Behaviour Problems Cognitive Behavioural Treatment	University of Oklahoma Health Sciences Center, USA.	This weekly programme of between 12 and 14 sessions aims to work with children and their caregivers when behavioural problems have been identified with the aim of reducing or

(*Continued*)

Table 3. Continued.

Intervention	Where	Description
Programme: Pre-school Programme		eliminating SBP. The programme includes educational aspects as well as skill development (emotional regulation, coping skills, problem solving, social skills, etc.) and strategies for future behaviours (boundary setting, peer relationships, etc.)
Espace romand de prevention DIS NO https://www.disno.ch/	Online	This is an online and telephone helpline for people worried about their own sexual attraction to children, the helpline offers them support and advice and can refer them onto additional services such as a therapist.
Multi-systemic Therapy for Youth with Problem Sexual Behaviours https://www.mstpsb.com/	USA	This programme is available in English, Dutch, Japanese and Spanish and must be delivered by qualified therapists. The programme is an adaptation of the Multi-systemic Therapy developed for children and young people aged 10–17.5 years with sexually related delinquent behaviours, including aggressive (e.g. sexual assault, rape) and non-aggressive (e.g. molestation of younger children) sexual offences. Treatment incorporates intensive family therapy, parent training, skills building, cognitive behavioural therapy. It is a blend of psychoeducation and clinical treatment helping the child and family live safe and offence free
Recovery Nation http://www.recoverynation.com/index.php	Online	This online platform provides online support workshops for people with compulsive behaviours or addictions (including pornography, sexual addiction etc some specific paraphilias are explored, this site is not dedicated to only those with an attraction to children). The online platform helps with general health related issues, as well as specific awareness workshops, skill development and personal coaching.
The global prevention project http://theglobalpreventionproject.org/maps	US	Weekly psycho-educational telephone support groups are provided for people with sexual attractions to children. Calls are accepted worldwide
Safe Dates https://youth.gov/content/safe-dates	US	School-based intervention to prevent dating violence. Aimed at ages 14–15 year. Nine 50-minute health teacher led sessions. Sessions conclude with the students performing a drama production and a poster competition. Programme aims to (a) change norms associated with partner violence (b) reduce gender stereotypes (c) develop conflict management skills.
Shifting Boundaries https://youth.gov/content/shifting-boundaries	US	School-based intervention designed to reduce dating violence and sexual harassment in schools. Component one includes six sessions targeting 10–15-year-olds, followed by component two in which a school-level intervention in which the whole school responds to these issues from a situational building-based perspective considering "hot spots" posting signs, etc.
Responsible Behavior with Younger Children	US	A school-based programme designed to reduce the likelihood of adolescents (aged 11–13) engage in harmful and illegal sexual behaviour. Ten, 45-minute interactive and discussion sessions, four are student led, delivered weekly by trained staff. Aim is to increase student knowledge and skills in preventing and intervening in the sexual abuse of younger children by providing appropriate knowledge and clear rules.

et al., 2019; Konrad et al., 2017; Lasher & Stinson, 2017; Letourneau et al., 2017; Levine & Dandamudi, 2016; McKibbin & Humphreys, 2020; McKillop, 2019; McMahon, 2000; Oliver, 2007; Seto, 2009; Silovsky et al., 2019; Tabachnick, 2013). Prevention interventions should recognise that for many people their own experiences of CSA are likely to be untreated, and as such, a provision of trauma-informed care is equally essential (Bentovim, 2002; Bolen, 2003; Jennings et al., 2013; Knack et al., 2019; McKibbin et al., 2019; McKibbin & Humphreys, 2020; Oliver, 2007; Seto, 2009; Silovsky et al., 2019). Programmes should provide pharmacological and/or psychopharmacological options for adults at risk of engaging in CSA, however, such treatment ought to complement therapy and not be provided in isolation (Beech & Harkins, 2012; Beier et al., 2015; Knack et al., 2019; Konrad et al., 2017; Landgren et al., 2020; Levine & Dandamudi, 2016; Saleh & Berlin, 2003; Seto, 2009). Programmes must ensure confidentiality/anonymity (Heasman & Foreman, 2019; Knack et al., 2019; Levine & Dandamudi, 2016); assist with disclosure (Bentovim, 2002; Knack et al., 2019; Konrad et al., 2017; McKillop, 2019) and where safe to do so (particularly for young people), include a family centred approach, that helps repair attachments with others (Bentovim, 2002; Konrad et al., 2017; McKibbin et al., 2017; McKibbin & Humphreys, 2020; McKillop, 2019; Shields et al., 2020; Silovsky et al., 2019).

Programmes should have a future-focused philosophy, one that helps build healthy sexual identities, promote healthy relationship patterns and narratives about masculinity and femininity and challenge socially constructed norms around traditional patriarchal male and female roles (Bentovim, 2002; Bolen, 2003; Jennings et al., 2013; Letourneau et al., 2017; Levine & Dandamudi, 2016; McKibbin et al., 2019; McKillop, 2019; McMahon, 2000; Oliver, 2007; Ruzicka et al., 2021; Tabachnick, 2013). Likewise, other social problems compounding the person's life must be supported (e.g. addiction; unemployment; housing) to enable adaptive functioning (Heasman & Foreman, 2019; Knack et al., 2019; Lasher & Stinson, 2017; Levine & Dandamudi, 2016; McKibbin et al., 2019; McKibbin & Humphreys, 2020; McKillop, 2019). Finally, all secondary interventions ought to engender hope. They should reduce the shame and stigma associated with risk factors linked to CSA (Bentovim, 2002; Heasman & Foreman, 2019; Jennings et al., 2013; Knack et al., 2019; Lasher & Stinson, 2017; McKibbin et al., 2019; McKibbin & Humphreys, 2020) by building individual psychosocial capacity and opportunities that help meet individual needs and fostering a fulfilling and meaningful life that is free from harm.

Theme two: barriers to secondary prevention programmes that target people at risk of perpetrating sexual harm against children

Mandatory reporting laws limit the provision of help

One of the considerable barriers preventing the effective development and implementation of secondary prevention programmes, are mandatory reporting laws across most countries in Europe, the US, Canada and Australasia (Beier et al., 2015; Levenson & Grady, 2019b). While paradoxically these are aimed at protecting children, their very nature prevents people at risk of engaging in CSA reaching out and seeking treatment (Assini-Meytin et al., 2020; Lasher & Stinson, 2017; Mitchell & Galupo, 2018). Although some slight variance across jurisdictions, legislation makes it a requirement for health professionals to report any reasonable suspicion that a child has, or is, at risk of being abused. In some US States, the privilege between a solicitor and a client is greater than between a health professional and patient, the exception being if an intention to harm is clear, serious and imminent (Heasman & Foreman, 2019). Thus, the issue for health professionals working with people at risk of perpetrating CSA is often around the boundaries of intent and imminence. Without greater flexibility, health professionals are bound, by law, to report such suspicion, which unintentionally creates barriers (including fear of a break in confidentiality, legal consequences and shame) for people seeking help (Assini-Meytin et al., 2020; Beier et al., 2016; Finkelhor, 2009; Lasher & Stinson, 2017; Van Horn et al., 2015).

The impact of such legislation not only prevents people accessing help but is likely to reinforce the stigma associated with people at risk of perpetrating CSA, as it promotes the notion that where risk factors exist, abuse is inevitable and that all people ought to be dealt with through criminal justice proceedings. Sources report how stigma, in fact hinders the development of therapeutic relationships between clients and health professionals (Levenson & Grady, 2019b). Therapeutic relationships ought to build trust, enable meaningful exploration of the needs and risks a client presents, and support them to develop skills and strategies to help cope and live safely. While secondary prevention providers attempt to effectively work within current legislation by informing clients of their duties and boundaries around disclosure (Knack et al., 2019) this constraint prevents many people concerned about their sexual behaviour from reaching out for help in the first place (Wilpert & Janssen, 2020). Legislation in Germany, unlike many jurisdictions has less restrictive reporting laws (Heasman & Foreman, 2019). Mental health professionals are required to report concerns regarding the safety of a child, but only in cases where a child is at risk of imminent danger or death (Lasher & Stinson, 2017). It is believed these laws have played a key role in the success of Germany's Prevention Project Dunkelfeld programme, as people are free to access help and treatment, without the threat of legal penalties (Assini-Meytin et al., 2020).

The pervading taboo and sensitive nature of CSA

All included records report the challenging and complex nature of CSA. Historically a perception exists in which sexual violence is perceived as binary, adults are viewed as perpetrators and children only as victims (McKibbin & Humphreys, 2020); viewing CSA through a binary and reductive lens is problematic as evidence shows, children themselves can exhibit harmful sexual behaviours against other children (Letourneau et al., 2017). Likewise, rates of CSA experiences in populations of people convicted of sexual offending are reported to be disproportionate to that of the general population. Thus, binary conceptualisations of CSA are likely to hinder the development of comprehensive strategies. As awareness of the nature and scale of CSA began to surface during the 1970s and 1980s, arguably the reactionary response to the "crisis" was to target interventions at those at risk of victimisation i.e. children (Bolen, 2003). Policymakers set out to educate or warn children of the dangers of CSA and help them develop skills to protect themselves by avoiding situations or to disclose should CSA occur. However, Bolen argues the assumption that CSA prevention programmes that target potential victims will reduce the prevalence of abuse, is flawed. Instead, relying on children to identify perpetrators and an overreliance on tertiary responses provides only limited protection after CSA has occurred (Assini-Meytin et al., 2020; McKibbin & Humphreys, 2020).

The taboo nature of CSA further serves to increase the stigma and fear associated with people at risk of causing harm, preventing them from reaching out for help (Grant et al., 2019; Knack et al., 2019; Levenson & Grady, 2019b; Piché et al., 2018; Van Horn et al., 2015; Wilpert & Janssen, 2020). Healthcare professionals can help reduce this stigma and fear; however, they too require education and support to understand the needs of this group (Heasman & Foreman, 2019; Levenson & Grady, 2019a). Lasher and Stinson (2017) note negative and hostile experiences when seeking help from healthcare professionals, work colleagues/employers, family and friends. However, training and knowledge workshops can help improve reduce negative attitudes (Levenson & Grady, 2019a).

Social and political climate has been a hostile one – but interest in prevention is beginning to shift

Prevention strategies that target people at risk of perpetrating CSA have historically been notoriously difficult to reach policy-level support. The political and social climate across most countries has been hostile to working with people at risk of CSA, despite evidence suggesting this approach would support a comprehensive and coordinated approach to preventing sexual violence (Lasher & Stinson, 2017; McKillop, 2019). However, encouraging signs are noted by prevention academics and advocates who report a growing interest in secondary prevention for people at risk of perpetrating CSA (McKibbin & Humphreys, 2020). One of the reasons for this change is likely a result of heightened

public awareness of systemic, historical and institutional CSA across the globe, as found by several national inquiries (Wright et al., 2020). Recent ongoing inquiries include the Australian *Royal Commission into Institutional Responses to Child Sexual Abuse* (2017); the *Independent Inquiry into Child Sexual Abuse* in England and Wales (2016); *The Scottish Child Abuse Inquiry* (2018); and the *Royal Commission of Inquiry into Abuse in Care* in New Zealand (2020). Given the heightened public, media and political awareness of the scale and nature of sexual abuse, a more tolerant landscape in which secondary prevention strategies might be considered is in sight (Assini-Meytin et al., 2020; McKibbin & Humphreys, 2020; Tabachnick, 2013).

Theme three: methodological limitations

Comprehensive empirical evidence is needed to inform key risk and protective factors to identify which population/individuals are at risk

When considering secondary prevention public health approaches to tackle CSA, initiatives require a clear understanding of which populations are appropriate to target (McKillop, 2019). Central to secondary prevention is to target people at risk of committing a sexual offence before they do so. Much has been learned in regard to the motivations, behaviours and situations in which people sexually offend through the extensive study of convicted populations. While there is utility in drawing from this knowledge pool, particularly around our understanding of sexual interests, secondary prevention strategies should not be devised solely on this evidence. A more comprehensive understanding of the risk and needs of those who have not sexually offended is needed to bolster current theory. In saying this much is already understood about this population and the sources examined in this study suggest several populations appropriate for secondary prevention. Drawing on the work of Finkelhor, Bentovim (2002) notes the value in providing prevention work with young people who have themselves been victims of sexual abuse. While sexual victimisation does not predict sexual perpetration, rates of sexual victimisation in those who offend are notable (Bentovim, 2002; Oliver, 2007), thus, the type and timing of trauma-informed interventions is crucial, both in terms of supporting the recovery of the young person's victimisation as well as the prevention of future CSA.

McMahon (2000), also identifies young males who have experienced sexual violence as a key risk factor. In addition, she includes young men with experiences of hostile family environments, witnesses of violence or abuse, and those engaging in high-risk sexual behaviours. Additional factors drawn from sexual offending literature include sexual exposure and arousal to deviant stimuli, beliefs that support abuse, a lack of empathy, hostility towards women and developmental problems. Bolen (2003) identifies all young males as an appropriate target for secondary prevention work, but as noted by Finkelhor, a more suitable focus are stepfathers and boys who have been sexually abused. Of concern is the risk that this already vulnerable group could be exposed to further stigmatisation and shaming, thus, the support and help offered to help prevent future abuse must be administered with great care and sensitivity (Bentovim, 2002).

Sexual offending is of course complex and multifaceted, people with criminal histories are heterogeneous, indeed, Levine and Dandamudi (2016) note there is not one clear profile of who is, or is not, at risk. However, they note some general classifications that could be used to target secondary interventions including being male; having access to children; aged between 14 and 30; have diagnosed or recognised themselves as a person with paedophilia; have additional paraphilic interests; have a personal family history of abuse; have issues coping with psychosocial stress; and use child abuse images. They also indicate some socioeconomic factors might be relevant, such as socioeconomic status and social isolation.

To appropriately inform the development of secondary prevention programmes, an understanding of risk and need must be drawn from evidence generated by high-quality and rigorous research studies. Although, increasing interest and research in this field is observed, there remains an over-reliance on our knowledge of risks and needs from forensic populations already convicted of

sexual offending (Assini-Meytin et al., 2020; Beech & Harkins, 2012; Beier et al., 2015; Bolen, 2003; Engel et al., 2018; Oliver, 2007; Schaefer et al., 2010; Seto, 2009). While it is likely many risk factors are transferable to those at risk of perpetrating CSA, this assumption is not fully tested, and it is as likely many unknown differences also exist.

Interventions are in their infancy with many not yet tested under rigorous "gold standard" testing such as RCTs

It is encouraging to report a worldwide interest, development and implementation of secondary prevention programmes helping prevent people from perpetrating CSA in the first place. Unlike tertiary programmes, where an abundance of meta-analysis evaluation exists and continues to be tested; secondary prevention programmes are far less rigorously examined (McMahon, 2000). This is in part due to the embryonic nature of these interventions (Beier et al., 2015) and ethical challenges when designing random control trials (Engel et al., 2018; Schaefer et al., 2010; Silovsky et al., 2019). Yet, understanding what effective treatment or interventions look like for people at risk of perpetrating CSA is vital in the development of building a comprehensive response to preventing sexual violence (Apsche et al., 2005; Assini-Meytin et al., 2020; Bentovim, 2002; Bolen, 2003; Carpentier et al., 2006; Knack et al., 2019; McKibbin & Humphreys, 2020; McKillop, 2019; Seto, 2009).

Theme four: working with people at risk of engaging in sexual abuse, while ethically justified, conflicts with community protection norms

An ethical case is made across several sources in this review, they state that working with people at risk of CSA, prior to offending is the moral and right thing to do (Heasman & Foreman, 2019; Knack et al., 2019; Levenson & Grady, 2019b; Silovsky et al., 2019). Human dignity is a universal concept, and as such, the right to equal access to services (irrespective of what that service supports) is bestowed on all. Thus, among other things, people ought to have the right to access health care and services and have these rights protected. It is reported however, that society's norms, conflict with this notion, indeed, people at risk of engaging in CSA or have a sexual attraction to children are perceived a threat and, therefore, not entitled to the same privileges as others in the community. This unintelligible norm extends to people who have never acted on their sexual interest and as a result is embedded across community protection approaches and legislation in the form of preventative sentencing (McCartan, Merdian, et al., 2018).

As a result of this ethical conflict, people with sexual interests in children are branded less valuable or worthy than others. Indeed, they are perceived a serious threat to the well-being of society and thus, disqualified from pursuing the same life goals as other members in the community. Yet, people with a sexual attraction to children, even those who have never offended, tend to have extensive health and social care needs, often with histories of untreated trauma (Bentovim, 2002; Jennings et al., 2013; Levine & Dandamudi, 2016; McKibbin et al., 2017; McKibbin & Humphreys, 2020; Oliver, 2007; Saleh & Berlin, 2003). Such conditions, if left untreated, place them and others at risk of harm (Knack et al., 2019; Saleh & Berlin, 2003; Seto, 2009; Tabachnick, 2013). Indeed, those at risk of harming others can become so stigmatised and vulnerable to community protection legislation (Heasman & Foreman, 2019) they do not seek help (Assini-Meytin et al., 2020). Paradoxically, for those socially isolated, lonely and experiencing co-morbid conditions, community protection approaches are likely to place them at greater risk of acting on their sexual interests and thus, harming others. While health care professionals are bound by ethical principles and standards, they too are vulnerable to societies norms, and as such it is essential, they receive training and education (Heasman & Foreman, 2019; Oliver, 2007) to help address or reduce unhelpful beliefs that might impede the care and help required for this population.

One of the benefits of a public health approach that targets people at risk of engaging in CSA is that counter to community protection norms and values, it is ethically justified on the grounds of human dignity (Heasman & Foreman, 2019; Knack et al., 2019). Indeed, working with people,

before they act, has a clear ethical rationale as it; (a) protects and prevents those at risk of victimisation from ever being abused in the first place (Bolen, 2003; Grant et al., 2019; Knack et al., 2019; Levine & Dandamudi, 2016; McKibbin & Humphreys, 2020; McKillop, 2019; McMahon, 2000; Tabachnick, 2013) and (b) provides those at risk of first-time CSA access to opportunities to help and treat conditions causing them significant psychological and social harm (Apsche et al., 2005; Jennings et al., 2013; Knack et al., 2019; Lasher & Stinson, 2017; Levine & Dandamudi, 2016; McKibbin & Humphreys, 2020; McKillop, 2019; Mitchell & Galupo, 2018; Tabachnick, 2013; Van Horn et al., 2015).

Theme five: preventing sexual violence before it occurs is more economically viable than responding to it

Putting to one side moral and ethical reasons for preventing abuse occurring in the first place, sources in this review highlight the economic justifications for operating in this way too (Letourneau et al., 2017; Tabachnick, 2013). Of course, the "true" cost of sexual violence, or its prevention, can never be fully detailed (Knack et al., 2019), however sources present the economic case that responding to CSA after it occurs is far more costly (economically) than preventing it in the first place. Although the presentation of an economic analysis is not the aim of any sources detailed in this review, this features in several discussions. Tabachnick (2013) and Lasher and Stinson (2017) highlight costs of criminal justice strategies predominantly aimed at containing and controlling those convicted of CSA do not demonstrate effective deterrence or prevention of CSA. Indeed, many were implemented without evidence of their effectiveness. Knack et al. (2019) reference sources that detail the vast financial costs of responding to abuse after it occurs including health care, child services and correctional systems, as well as economic costs due to loss of productivity in the labour market. While an economic argument appears to support the notion that preventing sexual violence is far more effective than responding to it, Assini-Meytin et al. (2020) note that federal funding is absent in the United States, instead providers of secondary prevention interventions rely on ad hoc funding from state or private sources. These funds are of course welcome, but equally an unsustainable method to provide a comprehensive public protection approach to preventing CSA (Lee et al., 2007; Letourneau et al., 2017).

Discussion

To prevent CSA occurring in the first place multifaceted and comprehensive interventions are required. In particular, programmes that target people at risk of engaging in CSA, before they offend, ought to be a priority. Given that people who commit CSA are a heterogeneous group and the aetiology of CSA occurs as a consequence of interacting biological, ecological and neurological causal factors (Ward & Beech, 2016); public health approaches are fundamental to a comprehensive solution. Despite knowledge of this, marginal attention has been given to secondary prevention strategies that target people at risk of CSA. Thus, our paper aims to advance knowledge in the field by synthesising the current literature on secondary prevention interventions, by considering their effectiveness, challenges and barriers.

Themes developed from this scoping review found overwhelming support for the notion that to provide a comprehensive response to CSA, secondary prevention interventions that target people at risk of CSA, must be central. Despite a clear sense of the essential factors needed to provide secondary prevention services (Theme One), several barriers and challenges exist (Theme Two). Barriers to people seeking help and those providing help are in the main driven by legislative restrictions as well as problematic social and cultural perceptions, each of which generates unhelpful social constructions around those at risk of CSA, fuelling stigma and shame. This is unsurprising as despite observations of a surge in public and political interest to address and prevent CSA, a persistent reticence to commit public funds and health care resources to people at risk of CSA, even before they offend was noted. Increasing resources continue to be directed into tertiary criminal justice services, long after

abuse has occurred. This is despite knowledge that the prevention of CSA is not only a more ethical response to CSA (for both victims/families and people at risk of engaging in CSA) but is a more cost-effective approach too (Theme Four and Five). Instead, *post hoc* "help" comes under the guise of "public protection" and is underpinned by pervasive policies that result in ongoing stigmatisation, disproportionate punishment and the failure to prevent CSA (Kewley & Brereton, in press).

Regardless of Western CSA prevention approaches being dominated by correctional policy, we do note and report some encouraging shifts such as an increased provision of secondary prevention interventions across several regions (Table 3). However, to ensure interventions and services are effective, researchers and funders must overcome methodological limitations (Theme Three). To do this investment in research, policy development and the design, implementation and rigorous testing of services that help and support people at risk of CSA warrants significant national and global improvement.

Limitations

A number of limitations are evident in this work. The first found an under-representation of studies that examined prevention for female populations. While we are mindful the majority of CSA is perpetrated by boys/men, understanding effective strategies that help prevent women and girls from engaging in CSA is an equally important area of concern. Similarly, many countries and regions were not represented in the studies included in this paper. One explanation for this might be the restriction of our search criteria limiting sources to the English language, alternatively, an absence of sources from non-Western regions might also indicate socio-cultural differences and approaches to prevention that require further scrutiny. A third limitation includes the fact that a critical appraisal of sources included was not undertaken, thus, we were unable to establish the reliability of interventions and strategies included. Finally, only the first author undertook the initial screening of titles and abstracts, having a second researcher verify this sift would have strengthen this process.

Conclusions

All children have the right to live free from violence (UN, 1989) the UN *Convention on the Rights of the Child* (Article 34) specifically requires "States parties undertake to protect the child from all forms of sexual exploitation and sexual abuse." The World Health Organization (2016) call governments to action by strengthening seven key strategies to prevent CSA and end violence against children; these include the implementation and enforcement of effective laws, changes in the societal norms and values, provision of safer environments, effective caregiver support, economic strengthening, improved support service, and increased education and life skills (WHO, 2016). With greater social and political awareness of CSA, an appetite to respond to this call and prevent CSA before it occurs, is now observed. However, if an effort to prevent CSA occurring in the first place is to be realised, a multisectoral comprehensive response must include strategies for young people and adults at risk of perpetrating CSA. We call for researchers and policy makers to help address this gap by examining the risks related to the perpetration of CSA at all four socioecological levels. Engaging in research and service development through both criminal justice and public health lens will serve to strengthen our knowledge of appropriate target populations, and help facilitate the implementation, testing and review, of secondary prevention interventions for those at risk of offending. CSA is preventable but can only be achieved with commitment from policymakers and long-term funding from central government.

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ORCID

Stephanie Kewley http://orcid.org/0000-0001-6841-5577
Rosemary Mhlanga-Gunda http://orcid.org/0000-0002-9825-7124
Marie-Claire Van Hout http://orcid.org/0000-0002-0018-4060

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