How Does Society View Minor-Attracted People and What Effect Does This Have On Their Wellbeing and Help-Seeking Behaviour?

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Psyc695 MSc Thesis

20th January 2022

Acknowledgements

I would like to acknowledge and thank my senior supervisor Dr Jacinta Cording who made this research possible. Her guidance and knowledge has carried me through all stages of this thesis. I would also like to thank my other supervisor Dr Sarah Christofferson, for her contributions, support and guidance with this thesis. Special thanks also go to the scientific advisors at B4UACT for their knowledge and input in ensuring my questionnaire was non-stigmatising and their support in advertising my research.

I would also like to thank my family for their support over the past year and a half. I especially thank my mum, who inspired me to pursue this research opportunity and my dad for consistently being my number one supporter. I also want to thank my sister, brother, grandparents, friends and work colleagues for always supporting me with my research and listening when I needed it.

I finally would like to express my biggest thanks to my participants, as without them there would be no research. Thank you for trusting me with a deeply difficult topic and answering my questions openly and honestly.

Abstract

Minor-attracted persons (MAPs), or individuals who identify themselves as having a sexual attraction to children are a highly stigmatised population. This study sought to build on existing research about the stigmatisation of minor-attracted persons (MAPs) by examining how the general public perceives MAPs and how this marries with how MAPs perceive the public to view them. We also examined what effect these perceptions have on the wellbeing and help-seeking behaviours of MAPs. The study used a cross-sectional, between-groups design, with data collected via an anonymous online survey. Two samples were collected: a sample of MAPs recruited from online forums Virtuous Pedophiles and B4Uact (n = 94); and a sample of the general public recruited using the paid survey platform Prolific (n = 98). We found that the general public had generally negative views of MAPs in relation to ideas of dangerousness, disgust, unpredictability and untrustworthiness. This was consistent with how MAPs thought the general public would perceive them. We also found that MAPs had significantly lower levels of wellbeing than the general public, except for negative emotions and loneliness for which there was no significant difference. Internalised and externalised stigma was found to be associated with wellbeing of MAPs, with internalised stigma having a stronger relationship with wellbeing than externalised stigma. Both internalised and externalised stigma were not found to be associated with actual help-seeking however internalised stigma was associated with considering seeking help. The results from this study largely support an existing theoretical framework of stigma-related stress developed for MAPs (Jahnke et al., 2015), except for how barriers to treatment are conceptualised in the framework, due to no significant association with stigma and actual help-seeking.

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How Does Society View Minor-Attracted People and What Effect Does This Have On Their Wellbeing and Help-Seeking Behaviour?

Within the media and throughout society, the word 'paedophile' is often used to describe individuals who sexually offend against children (Levenson & Grady, 2019). This label comes with significant stigma and punitive attitudes towards people who are perceived to be a 'danger to society' (Imhoff, 2015). However, the term 'paedophile' is an incorrect term to use when referring to people who sexually offend against children, as not all people who sexually offend against children meet the criteria of paedophilic disorder (Levenson & Grady, 2019) This labelling has contributed to a large amount of stigmatisation of the individuals in society who are have been diagnosed with paedophilia or identify that they are sexually attracted to minors, even if they do not sexually offend against children in any form throughout their lifetime (Levenson & Grady, 2019). This stigmatisation is associated with significant decreases in emotional and social functioning as well as mental health issues (Elchuck et al, 2021).

The introduction section will explain the basic definitions of paedophilia, minor-attracted persons and sexual offending. We will then go on to examine what stigma is, and explore stigma within the context of MAP. Furthermore, we will examine how stigma is related to the wellbeing and help-seeking of MAPs. We will also explore Jahnke et al. (2015)'s framework on stigma-related stress in paedophiles and how it may relate to MAPs.

Paedophilia

Paedophilia or paedophilic disorder is defined by the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; *DSM-5*; American Psychiatry Association [APA], 2013) as 'an exclusive primary sexual attraction to prepubescent children'. The diagnostic criteria for paedophilic disorder in the DSM include a person having recurrent sexually arousing fantasies, urges or behaviour with pre-pubescent children over at least 6 months

(APA, 2013). Further, the person has either acted on the urges or caused a high level of distress for the person. It is estimated that about 3-5% of males within the population, and a very small amount of females meet the criteria for paedophilic disorder (Seto, 2013).

Minor-Attracted Persons (MAP)

The origins of the term ‘minor-attracted persons’ (MAP) does not lie in academia but with an organisation called ‘B4UAct’, a collaboration between individuals who are sexually attracted to minors, and mental health clinicians (Levenson & Grady, 2019). B4UAct (2011) defines a MAP as ‘an adult who experiences feelings of preferential sexual attraction to children or adolescents under the age of consent’. The difference between the term paedophile and the term MAP is that paedophilia is a diagnosis within the DSM, whereby the diagnostic criteria includes acting on the urges, whether it be by directly sexually offending against a child or accessing child pornography, or that the sexual attraction to minors causes significant distress to the individual (Levenson & Grady, 2019). Some MAPs may also be diagnosed with paedophilic disorder, however, some may not meet the criteria of paedophilia which only encompasses sexual attraction to pre-pubescent children, not all minors(Levenson & Grady, 2019).

Previous research suggests that the term ‘MAP’ is preferred by individuals who are sexually attracted to minors, as it avoids the stigma attached to the term ‘paedophile’, and also avoids sounding diagnostic. Further, this term acknowledges that many people who identify themselves as a MAP do not sexually offend against children, and may explicitly identify themselves as within the non-offending MAP population (also known as ‘NOMAPs’; Levenson & Grady, 2019). These individuals acknowledge and understand the harm that sexual offending has on minors, and are committed to not engaging in these behaviours (Levenson & Grady, 2019).

Minor Attraction and Sexual Offending

The use of the word paedophile interchangeably with 'child sexual offender' has contributed to the immense stigma that is associated with individuals who have a sexual attraction to minors (Levenson & Grady, 2019). For example, Imhoff (2015) used a series of online studies ($N = 345$) to explore whether punitive attitudes were held by the public towards MAPs, regardless of whether they had sexually offended against children, and whether this effect was increased by the use of the 'paedophilia' label. The study also measured to what extent the public saw MAPs as dangerous, deviant, and responsible for their sexual interests. Participants were assigned to either the 'paedophilia label' condition or the descriptive term 'sexual interest in children' condition. Results showed high levels of punitive attitudes towards MAPs, especially with the use of the paedophilia label. Although the paedophilia label slightly increased punitive attitudes towards MAPs, the effect size for punitive attitudes was only small ($d = 0.29$). There was a medium effect size for deviance ($d = 0.44$), therefore the paedophilia label may influence the public's perception of deviance to a greater extent. Interestingly, Imhoff (2015) did not find any differences in perceptions of dangerousness for both labels. This shows that the participants in this study saw it as unavoidable that people who are sexually attracted to minors would offend, regardless of the label.

These findings were then replicated by Imhoff and Jahnke (2018). They also examined the labelling effect ('paedophilia' versus 'people with a sexual interest in prepubescent children') and its influence on punitive attitudes, intentionality, dangerousness and deviance. This study also introduced the concept that being sexually attracted to minors is something that can be controlled and therefore 'wilfully changed'. The researchers predicted that participants would express higher levels of punitive attitudes, especially when the paedophilia label was present. The results indicated that participants showed harsher punitive attitudes towards 'paedophiles' than towards 'people with a sexual interest in

prepubescent children ($d = 0.26$). Furthermore, paedophiles were perceived as more dangerous than those with a sexual attraction ($d = 0.22$). Both the findings of Imhoff (2015) and Imhoff and Jahnke (2018) highlighted the effect of the label of a paedophile to express stronger punitive attitudes and higher ratings of perceived dangerousness. It could be theorised that social desirability may influence this labelling effect, as it is assumed to be more socially desirable to portray greater negative attitudes towards paedophiles (Imhoff & Jahnke, 2018).

One limitation of these studies is that it is not clear whether the label was the only thing that was changed between conditions. For example, changing the label may actually prompt people to think of different behaviours that are associated with the label, rather than just changing the label for the same behaviour. Further research is needed to explore the exact mechanisms through which labels may be associated with stigma.

Theories of Stigmatisation

What is stigma?

The term ‘stigma’ was originally developed by the Greeks to refer to signs on the body that aimed to portray something unusual or bad about a person’s moral status (Goffman, 1963). The Greeks would burn or cut marks into a person’s body to portray whether they were a criminal, slave or a traitor, branding a person and therefore casting them out from society (Goffman, 1963). Nowadays, most cultures have ceased to brand or mark people perceived as ‘other’, however society still uses individual differences to shun and reject people through a ‘cognitive manifestation’ (Coleman, 2007).

To explain the existence of stigma, it has been proposed that people depend on stereotypes in society to guide them in their categorisation and interactions with others (Goffman, 1963). Stigma is maintained in society by negative emotions such as dislike, disgust and fear (Coleman, 2007). Fear often stems from the unknown and unpredictable.

This may account for the high level of stigma attached to mental health issues, where people fear the unpredictability of the illness (Coleman, 2007). Minor attraction is also an unpredictable concept to many in society, with a lack of awareness, but also no perceived way that MAPs can ethically and legally pursue their attraction and assumptions that all MAPs will sexually offend against children. This creates a great level of fear contributes to the stigmatisation of MAPs.

Fear can also be a response to different racial, ethnic or gender groups. This fear may develop as a response to an experience with one person of that certain characteristic; therefore, a person's perception of the entire person is based on their experience of the virtual social identity (Goffman, 1963). Similarly, deviance literature suggests that people who hold high levels of stigmatisation towards others may feel that their socially, economically or politically dominant position will be destroyed by members of the stigmatised group (Schur, 1980, 1983).

Fear is also often experienced by the people who are stigmatised. People who have been stigmatised may be fearful that their stigmatised attribute will be discovered, and that they will therefore have to endure negative consequences on both their place in society and their wellbeing (Coleman, 2007).

Stigmatisation of MAPs

A systematic review was completed by Lawrence and Willis (2021) to update and expand on a systematic review by Jahnke and Hoyer (2013), which examined the stigmatisation of MAPs. Thematic synthesis was used to examine thirty-five empirical studies from eight countries with the aim of understanding factors contributing to public stigma, effects of stigma on MAPs and the effectiveness of interventions designed to challenge public stigma (Lawrence & Willis, 2021).

Lawrence and Willis (2021) identified three themes to distinguish factors that

contribute towards the stigma of MAPs; misperceptions and stereotypes, negative affective responses and discrimination. Seventeen studies analysed the link between misperceptions (the inaccurate beliefs held by members of the public regarding MAPs) and public stigma. The review identified that agreement with statements that examined perceived dangerousness, deviance, the choice to have a sexual interest and inability to control their actions were linked with this theme (Lawrence & Willis, 2021). Participants of studies that examined if sexual interest in children was a choice, largely believed that it was not a choice. These studies found that these views were linked to a higher level of blame and lack of trust, due to the perception that it is incurable (Lawrence & Willis, 2021).

The theme of negative affective responses (participant's negative responses to MAPs) was distinguished in six studies by participants agreement with measures used to examine fear, anger, disgust and empathy. It was found that in studies examining perceptions by the general public there were high levels of anger, fear and lower levels of empathy (Jahnke, 2018, Jahnke et al., 2015). The final theme; discrimination was distinguished by agreement with items that measured low levels of social acceptance, punitive attitudes and punishment. Seventeen studies explored this theme. As seen with negative affective responses, the studies that examined the general public's view showed high levels of discrimination, and moderate levels of punitive attitudes and punishment (Imhoff, 2015; Jahnke, 2018).

Three themes were also identified for the effects of stigma; mental distress internalized public stigma and negative experiences and effects of disclosure (Lawrence & Willis, 2021). Mental distress was seen in 14 studies and was often distinguished by self-reported depression, anger, anxiety, shame, loneliness, isolation and low self-esteem. Eight studies also reported participants' self-reported suicidality. Internalized public stigma was seen by the personalisation of negative stereotypes perceived regarding MAPs. It was identified that these negative beliefs held in society were that they were deviant, a monster

and destined to offend. These labels had a profound effect on participants' mental distress (Lawrence & Willis, 2021). The final theme identified for effects of stigma; negative experiences and effects of disclosure included the participants' decisions to disclose their attraction. Eleven studies explored participants' experiences and the effects of personal disclosure. This included increased stress, misunderstanding, loss of relationships, fear and being outed to others without their consent. The participants also spoke of how this impacted mental distress and their wellbeing.

Two themes were identified to challenge stigma; humanization and informative interventions (Lawrence & Willis 2021). Several studies examined how informative interventions increased understanding and empathy towards MAPs (Harper et al., 2018). The studies found that these interventions were effective, especially in decreasing negative affective responses and attitudes supporting punitive punishment. Further studies also explored the views that mental health professionals held regarding MAPs and how these views could be challenged so more support is available to MAPs (Lawrence & Willis, 2021). Humanization narratives were associated with an increase in empathy and understanding across six studies. Accurate tangible representations of MAPs who did not offend was found to be associated with improving attitudes towards MAPs.

The findings also highlighted the widespread stigmatizing assumptions, discrimination, negative and punitive emotions that the public and professionals have towards MAPs and the profound effect that this has on MAPs (Lawrence and Willis, 2021).

Internal versus external stigmatisation

Stigmatisation can also be broken down into two broad constructs: externally driven social stigmatisation, and internally driven self-stigmatisation. Externally driven social stigma arises when the general public holds negative attitudes toward a certain population of people who share a characteristic, and use that characteristic to discriminate against them

(Vogel et al., 2013). The externally driven stigma of MAPs is related to and impacted by the cognitive processes contributing to the perception that there is a degree of controllability and choice in being sexually attracted to minors (Leivesley et al., 2020, Janhke & Hoyer, 2013). Furthermore, there is an assumption that all people who are sexually attracted to minors will sexually offend, due to not being able to resist their sexual urges (Seto, 2008). Contrary to this belief, many MAP's have not or will ever engage in child sexual offending (Seto, 2008).

Internally driven self-stigma is defined as the process whereby a person with a certain characteristic, e.g., sexual attraction towards minors, cognitively and emotionally digests the negative stereotypes about this characteristic (Leivesley et al., 2020). The individual then begins to believe and put weight on these stereotypes themselves (Leivesley et al., 2020). The influence of the negative external stereotypes can lead to a fear of being 'discovered', that somehow their secret will be found out. For MAPs, this fear is related to a reduction in cognitive and emotional functioning, including distancing themselves from the general population, social isolation and low self-esteem (Leivesley et al., 2020)

The Impacts of Stigma on Wellbeing

The externalised stigma from society and internalised stigma felt by MAPs has a significant impact on all aspects of their wellbeing. MAPs are aware of the social attitudes towards them and as a result, face a hostile world, therefore feeling no choice but to keep their sexual attraction private (Jahnke et al., 2015). Hiding such a central part of one's life involves a significant amount of planning and control over verbal and non-verbal communication. This can contribute to increased rates of social phobia, increased shyness and a deficit in social skills (Jahnke et al., 2015).

There is a well-established link between a solid social support network and increased psychological wellbeing (Turner & Turner, 2013). Social supports help individuals to maintain social functioning but also increase resilience during times of stress (Turner &

Turner, 2013). MAP's often isolate themselves to avoid their secret being found out which can lead to high levels of loneliness and isolation (Grady et al., 2019). They may also feel unsupported in relationships with family and friends due to the fear of discovery and rejection they may encounter as a result of their minor attraction (Jahnke et al., 2015, Elchuck et al., 2021). Consistent with previous literature (Cash, 2016; Cohen et al., 2019), Elchuck et al.'s (2021) study found that MAPs with higher levels of perceived social support had greater relationship quality and were less lonely. Elchuck et al. (2021) examined the association between stigma-related stressors (internalised pedonegativity, perceived closeness to others and disclosing minor attraction), relational quality, loneliness and psychological distress in an online sample of 202 MAPs. The participants were recruited from online forums (e.g. Virtuous Paedophiles, Visions of Alice) which provide support for people with sexual interests in minors to support them in living offending free lifestyles. The results showed that there were associations between stigma-related stressors with increased psychological distress and suicidality.

A further finding of this study demonstrated the importance of social support and relationships on MAP's mental health, wellbeing and loneliness levels. Loneliness was used as a mediator in a model to examine perceived support from friends and family. Support from friends was indicative of lower levels of loneliness however remained indicative of mental health outcomes. This suggests may contribute to a MAP feeling supported and understood which influences loneliness. Comparatively, perceptions of support by family were fully mediated by loneliness. The results indicate that family support may reduce a MAP's experience of loneliness, therefore, act as a protective factor for psychological distress and wellbeing.

The negative messages that MAPs are heavily exposed to from the general public can

also contribute to feelings of hopelessness, which is associated with both emotional distress and an increased risk of sexual offending (Grady et al., 2019). Stevens and Woods (2019) conducted a study to examine the coping mechanisms and rates of mental illness among MAPs. A thematic analysis of 5,200 posts on the Virtuous Pedophiles forum found that mental health, addictions, anxiety and depression all had similar representation. Addictions discussions ranged from gambling addictions to pornography, as well as drug and alcohol use. Anxiety and depression were often related to the attraction and societal stigmatisation of MAPs and fears that they will be outed.

Lievesley et al. (2020) examined the degree to which internalised stigmatisation within the MAP population impacted on their ability to help-seek and their avoidance of children. A cross-sectional anonymous survey design was used to recruit 183 self-identified MAPs from online support websites. They found that the suppression of minor attraction was linked with higher amounts of shame and guilt regarding their minor attraction and less hope regarding the future. Conversely, higher psychological wellbeing was found to be associated with lower levels of shame and guilt. Lievesley et al. interpreted these results to mean that MAPs feel internalised social stigma. This is consistent with prior work by Jahnke et al. (2015). If a MAP has higher levels of shame and guilt regarding their sexual attraction, likely, they have internally adopted the societal attitudes towards people with minor-attraction (Lievesley et al., 2020). Lievesley et al. also found that the association between negative emotions and suppression likely suggests that having minor attraction is unwanted and that those who experience it may feel imprisoned by their sexual attraction (Lievesley et al., 2020).

Stevens and Woods (2019) also found that self-hatred, self-harm and suicidality comprised 30% of all mental health references on the MAP forum studied. This varied from users informing other users of suicides, or conversations regarding previous suicidal attempts.

These findings are consistent with an earlier study conducted by B4U-ACT whereby 45% of their participants said that they have had chronic suicidal thoughts and 32% had considered suicide (B4U-Act, 2011b).

Factors that may be contributing to the high rates of suicidality among MAPs were highlighted in one recent study. Cohen et al. (2019) recruited 333 self-reported MAPs using an online survey, who completed various measures to assess their sexual attitudes, legal and clinical history, personality and suicidality. The study found that one-third of the sample have lived with chronic suicidal ideation which was not able to be attributed to sexual offending against children or interaction with the criminal justice system. This was determined by variables within this study that identified whether a participant was an ‘actor’ or a ‘non-actor’. This finding indicates that minor attraction appears to have more of an influence on MAP’s level of suicidality than a MAP committing illegal behaviours.

Those who were struggling with suicidal thoughts tended to be younger, with lower education levels and higher levels of psychiatric co-morbidities. Psychiatric co-morbidities would likely account for higher rates of suicidality. Further research would need to examine whether the psychiatric co-morbidities are directly related to a person’s minor attraction or unrelated. Through multivariate analysis, Cohen et al. (2019) found that being a victim of child sexual abuse, stigma, age and prior hospitalisation for mental health issues were all significant risk factors for suicidal ideation. The findings of this study indicate there is a strong relationship between internalised and externalised stigma felt by MAPs and suicidality. MAP’s who were suicidal reported a greater impact of stigma on their self-esteem, wellbeing and social isolation, hence social stigma is a major influence of suicidality among MAPs.

Experiences of internalised and externalised stigma and stigma-related stress have a

profound effect on the psychological distress and wellbeing of MAPs. MAP's who experience greater levels of stigma-related stress appear to have lower levels of wellbeing, higher levels of psychological distress and suicidality. The fear of discovery of their minor attraction has been linked to social isolation, loneliness and lower social support. The impact of stigma-related stress has been studied within the MAP population in recent years and frameworks have been developed to account for its impact on functioning and psychological distress.

Stigma-related Stress Framework

Jahnke et al. (2015) proposed a framework that outlined stigma-related stress and its effect on the emotional and social functioning, cognitive distortions and the likelihood of pursuing treatment of people who have a diagnosis of paedophilia. Although this framework was developed for people who have been diagnosed with paedophilia it can be applied to MAPs due to the similar experiences felt by both MAPs and people diagnosed with paedophilia.

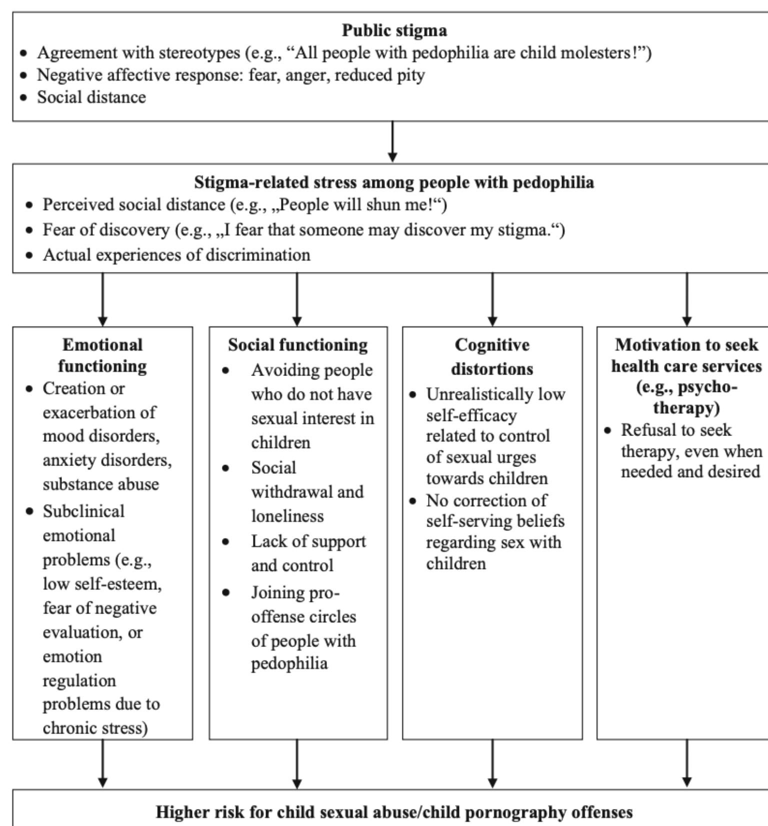
The framework was developed using stigma research from other groups, the minority stress model, and theories derived from research on sexual offending (Jahnke et al., 2015). The minority stress model (Meyer, 2003) is a theoretical framework that attempts to account for the intrapersonal and interpersonal effects of stigma and prejudice (Lievesley et al., 2020). The model was developed after an analysis of experiences and effects of stigma. Minority stress appears to be unique (i.e. it adds to stresses that occur in everyday life), chronic and is embedded in societies' norms and culture (Meyer, 2003). According to the model, three processes are key to the stress felt by minorities in society. Firstly, if it is a chronic or acute experience (Meyer, 2003). For MAPs, it could be something that is experienced physically or the continued experience of hate over time (e.g. hate in society or seen in the media) (Jahnke et al., 2015). The second process is one of expectation. A MAP

starts to expect negative experiences and becomes hyperaware of possible stressors (Lievesley et al., 2020). The final process in this model is that there is an internalisation of social stigma, which co-exists with activities to conceal their 'minority status' (Meyer, 2003). The interaction between concealment and stigma internalisation leads some people in minority groups to suppress their identities (Meyer, 2003).

The framework also aims to show how the consequences of stigma may indirectly affect the risk of sexual offences against children (Jahnke et al., 2015). In this model, public stigma represents the stereotypes, discrimination and prejudice that is experienced on a cognitive, affective and behavioural level (Jahnke et al., 2015). It is the public stigma that has an impact on the stigma-related stress felt by MAPs. Stigma-related stress is based on three factors: perceived social distance (e.g. I will be an outcast in society); the fear that people will discover who they are; and thirdly, the actual discrimination that MAPs experience. The framework proposes that stigma-related stress affects the emotional functioning, social functioning, cognitive distortions and motivations to seek help among MAPs, which all contribute to an increased risk of sexually offending against children.

Figure 1

Overview of the Framework for the Effects of Stigma-Related Stress Among People With Paedophilia



Note. Arrows represent the hypothetical casual association. From *Archives of Sexual Behaviour* (2015., p. 2174).

Jahnke et al. (2015) conducted an online survey on 104 self-identified German-speaking MAPs to test the validity of the proposed framework. They particularly focused on self-esteem, emotional coping, symptoms of mental health disorders (as a measure for emotional functioning), loneliness (as a measure of social functioning), self-efficacy to control their sexual urges (cognitive distortions) and motivations to seek help. Stigma-related stress was examined by assessing fear of being discovered and perceived social distance. These variables were examined using a series of Likert based questionnaires. This study yielded mixed results in terms of the proposed framework. Consistent with the proposed

framework, results showed that the fear of being discovered (a proxy measure for stigma-related stress) was negatively associated with both social functioning ($p < .001$) emotional functioning ($p < .001$). Fear of being discovered was also negatively associated with the fear of negative evaluation ($p < .001$) and emotional coping ($p < .01$). Fear of discovery was inversely associated with self-esteem ($p < .01$). Comparatively, fear of discovery was not associated with cognitive distortions or help-seeking which was not consistent with the proposed framework. The participants in this study also reported high levels of social distance; this is theorised to be due to the overestimation of already substantial levels of discrimination intention towards paedophiles from society, therefore, MAPs employ strategies to avoid their attraction being discovered due to the fear of discovery. Perceived social distance (a further proxy measure of stigma-related stress) did not predict cognitive distortions, emotional or social functioning or motivations to seek help. Jahnke et al., (2015) theorised here that due to these results, fear of discovery is a more appropriate variable to measure public stigma compared with the perceived social stigma.

Jahnke et al. (2015)'s framework proposed a link between stigma-related stress and cognitive distortions that were not able to be confirmed within these results. The link between stigma-related stress and motivation to seek therapy was also not confirmed. Jahnke et al., (2015) found that around half of the participants were reluctant to speak with mental health professionals regarding issues related to their minor attraction, it does not appear to relate to fear of discovery or perceived social distance. **I** hypothesise that if a different proxy measure was used to examine stigma-related stress, there may be an association between stigma-related stress and motivations to seek help. This measure would need to explain stigma related stress directly, encompassing the stigma felt and its impact on mental distress to then examine its impact on help-seeking. This would be better due to it being a more direct measure as opposed to being a proxy one.

Several factors limited the validity and generalisability of the results of this Jahnke et al. (2015)'s study. Its correlational design could not determine a causal relationship between stigma-related stress and the variables that were tested, due to the nature of the design. A longitudinal design would be needed to build on the results of this study and identify causal relationships. Furthermore, the use of proxy measures to examine stigma-related stress may influence the results and examining this study with alternative measures may be beneficial to further explore its validity. Despite these limitations, the research has indicated that the assumptions within this framework are valid and worth further exploration.

Barriers to Seeking Help

It can be hypothesised that stigma-related stress might influence MAP's decisions whether to seek help for their minor-attraction or related issues (Jahnke et al., 2015). Social isolation and the fear of discovery have been linked to MAP's unwillingness and fear of reaching out for therapeutic support for their sexual attractions (Lievesley et al., 2020). The ability for MAPs to seek help is key to their wellbeing and the prevention of child sexual offending (Parr & Pearson, 2019). Results from recent studies have shown that if left untreated almost 50% of people with minor-attraction feel depressed, suicidal, isolated, anxious and struggle to control their actions (B4U-Act, 2011). Although the research shows benefits of getting professional help, the stigmatisation of MAPs as a barrier to treatment has been a consistent theme throughout the literature that is currently available. External factors (e.g. difficulty accessing treatment, lack of treatment and financial barriers) have also been identified as a common theme within the literature.

To examine external factors that influence a MAP's ability to help-seek, Parr and Pearson (2019) used inductive thematic analysis to examine twenty participants' responses to an online survey that asked about the help-seeking behaviour of non-offending MAPs. The two main themes identified from this analysis were accessibility to treatment and the

perceived risk of disclosure. Within accessibility to treatment, two subthemes were identified; lack of professional help available and knowing where help can be found. Several participants identified that there was only a small number of services/trained professions that were able (or willing) to work with MAPs. Participants also identified they felt the professionals were either unskilled to work with their needs or held judgements and biases towards MAPs. Participants also spoke of a lack of information available regarding professional services for MAPs, potentially due to the professionals not broadcasting their services due to fear of losing other clients.

Two subthemes were identified within Parr and Pearson's (2019) study for barriers due to the perceived risk of disclosure: personal consequences and legal consequences. The participants expressed that MAPs were often concerned that they would be judged (by either the professional or close friends or family), ostracised, rejected and shamed. 55% of the sample expressed that a negative reaction from a friend or family member would be a strong influence on help-seeking. The legal consequences are also seen as a barrier to help-seeking; for example, the concern of MAPs that the professionals would break confidentiality and disclose their attraction to authorities. As MAPs are often assumed to have committed child sexual offending, the participants believed that MAPs would be concerned that firstly a professional would misunderstand their situation, or secondly have to carry out safeguarding (protection of children) actions against them.

Other previous research also highlights that the stigma placed on minor attraction may play a role in preventing professionals from being willing to work with MAPs. Levenson et al.'s (2017) study examined barriers to help-seeking for 372 people who were currently in treatment for sexual offending. The data was gathered using a pen/paper survey whereby participants were asked questions regarding unusual sexual interests, past attempts to seek help, perceived obstacles to seeking help and adverse childhood experiences. The participants

answered both Likert scale questions and also had room to write answers. The results showed that overwhelmingly, shame and secrecy that has arisen due to the stigmatisation of minor-attraction has prevented participants from seeking help. Consistent with Parr and Pearson's (2019) study, this study identified barriers to seeking help as concerns regarding confidentiality, fears of both social and legal consequences, financial/practical challenges to finding a professional who would be able to support them adequately.

Grady et al. (2019)'s study further confirmed conclusions from earlier research on the impact of stigmatisation on MAP's help-seeking. Their qualitative study examined the experiences of 293 MAP's who had sought help for their attraction and the experience they had seeking treatment. The significant finding of this study was the experience of stigma was the main barrier to help-seeking. Part of this stigma is experienced towards MAPs from the professionals providing the treatment. Often the participants felt judged and misunderstood due to the professional's lack of understanding and fear of legal/criminal repercussions if a professional were to report them for their sexual attraction to the authorities, even when they had now sexually offended against a child (Grady et al., 2019). Participants spoke of the incorrect assumptions that professional's made about their minor attractions and held the belief that they would act on their attractions. The participants further spoke of how professionals focused on preventing offending as opposed to supporting the MAP with their psychological distress and wellbeing. The lack of understanding of minor-attraction can be linked to the stigmatisation of MAPs and the information that is spread within wider society.

Previous research examining this topic has found a consistent correlation between high levels of stigmatisation and help-seeking behaviours. In contrast, a study by Lievesley et al.'s (2020) results was not consistent with previous research. A cross-sectional anonymous survey was administered to 183 MAP's using prominent online support forums which sought to examine internalized stigmatization (e.g. personal adoption of social views, thought

suppression and low psychological wellbeing). The results of a binary logistic regression that measured internalized stigmatisation and help-seeking, determined that the overall model was not significant *(p = .092)*, and did not accurately determine membership in the help-seekers versus non-help-seekers groups. The researchers concluded that internalization of social stigma may not be associated with levels of help-seeking behaviour.

There are several reasons why Lievesley et al.'s (2020) study may have yielded different results. Firstly, they measured internal stigmatisation using the constructs of thought suppression and index of psychological wellbeing. If a different construct was used to measure internalized stigma, the results of this survey may produce different results. Furthermore, the participants were asked generally regarding their help-seeking behaviours rather than being asked specifically if they've attended counselling or a programme. The terminology used in this survey may have meant different things to different participants. The inconsistency in these findings is a reason that further research needs to be carried out to determine the association between internalized stigmatisation and help-seeking.

Ajezen's (1991) Theory of Planned Behaviour is a theoretical framework that could help to explain the factors that have an impact on the decisions of MAPs to seek professional help (Parr & Pearson, 2019). The theory proposes that attitudes (how a person evaluates a behaviour), subjective norms (pressure from society to conform to 'normal' behaviours), and perceived behavioural control (how confident people feel in their ability to perform a behaviour) are key predictors of intention and behavioural achievement. If attitudes and societal norms are in favour of a certain behaviour, and the individual has confidence in their ability to perform the behaviour, then they are more likely to carry out the behaviour.

The Theory of Planned Behaviour posits that MAPs who do sexually offend against children may have the desire and intent to seek help and not offend, however, this has not been translated into actions due to weaknesses in their perception of behavioural control

(Ajzen, 1991). This may be because of an individual's past experiences and/or the anticipated barriers to the action. Further research needs to be done to examine the role of the Theory of Planned Behaviour for the help-seeking behaviour of MAP's to identify the gaps in the treatments and information available and how this could be altered to provide more support for MAPs, and therefore possibly reduce the risk of them committing a sexual offence.

The literature explored in this section has highlighted the influence of the stigmatisation of MAPs on help-seeking. It can be concluded that the stigmatisation of MAP's does not just influence the MAP's ability to seek help (through the shame, secrecy and worries regarding social and legal consequences) but also the mental health professional's ability to treat MAP's without making incorrect assumptions. Further key influences on a MAP's help-seeking behaviour are the accessibility barriers; including lack of options and financial barriers. These influences on help-seeking are consistent with the Theory of Planned Behaviour and how the barriers to action may impact MAP's help-seeking.

Current Study

The findings of previous MAP-related stigma research have shown that the public holds stigmatising views of MAPs, especially in relation to ideas of dangerousness and disgust, and perceived control of their sexual interest (Lawrence & Willis, 2021). This stigma is felt by MAPs and affects many aspects of their life including their wellbeing and levels of mental distress (Jahnke et al., 2015). MAPs who experience higher levels of stigmatisation also are seen to experience lower levels of wellbeing and higher levels of mental distress (Imhoff, 2015; Jahnke et al., 2015; Lawrence & Willis, 2021). Due to the way that samples are collected; often through convenience sampling and with small sample sizes, the reliability and generalisability of findings is affected. Replication of research is important, to build and strengthen the reliability of existing research.

The current research examining how stigmatisation affects help-seeking has yielded mixed results. Research such as Grady et al. (2019)'s study found that stigmatisation was associated with lower levels of help-seeking. Comparatively, Jahnke et al. (2015) did not find a significant association between stigmatisation and help-seeking. Our study seeks to build on that research to either support or disprove that stigmatisation is associated with help-seeking. To our knowledge, no study has examined the perceptions that MAPs have about how the public views them and compared that to what the public believes. Previous research has reported MAPs to overestimate the negative views that society have of them (Jahnke et al., 2015), therefore, examining this can contribute to the research by directly comparing individual statements regarding stigmatisation. Overall, our research seeks to build on existing research.

Research Aims, Questions and Hypotheses

The primary aim of the current study was to examine how the general public views MAPs, and how this marries with MAP's perceptions of public stigma and their self-stigma. The study also sought to explore the impacts of perceived internal and external stigmatisation on MAP's wellbeing and help-seeking behaviours.

The following research questions were used to guide the research:

1. How do the general public view minor-attracted people (MAPs), and how does this opinion correlate with how MAPs think, the public views them
2. How does the stigmatisation of MAP's relate to the wellbeing & help-seeking of MAPs?

Based on findings from previous research, the following hypotheses were made:

1. The general public will have a predominately negative view of MAPs (Jahnke et al., 2015; Janke & Hoyer, 2013; Leivesley et al., 2020).

2. MAP's view of how the general public views them will align with the first hypothesis; that the general public sees them negatively. (Jahnke et al., 2015; Janke & Hoyer, 2013; Leivesley et al., 2020).
3. The wellbeing of MAPs will be worse than the wellbeing of the general public (Grady et al., 2018; Jahnke et al., 2015; Meyer, I. H., 2003).
4. Higher levels of externalised and internalised stigma of MAPs will be related to lower levels of wellbeing and help-seeking. (Elchuck et al., 2021; Grady et al., 2019; Jahnke et al., 2015; Lievesley et al., 2020; Parr and Pearson., 2019)

Methodology

Ethical approval

Ethical approval was sought for this study from the University of Canterbury Human Research Ethics Committee. Approval was given on the 5th March 2021 (reference: HEC 2020/139). All participants were provided with full information about the study, before reading and agreeing to several consent statements before taking part in the research. They were advised that they were free to exit at any time. To protect the identity of the participants, neither their IP address nor any other identifying information was collected.

Participants

Both a sample of MAPs and a general population sample were recruited for the study. Specific demographic information for both the MAP sample and general population sample is presented in Table 1.

One hundred and eighty-one MAPs who self-identified as being sexually attracted to minors responded to the survey. A large number of participants were removed from the analysis due to incomplete surveys (n = 87); most participants who did not complete stopped during the SSMIS-modified, the first scale of our survey. This left a final MAP sample of 94

participants. The final MAP sample was predominantly male (83%), European/Caucasian (79.8%) and employed (62.8%). Just over half (52.3%) of the MAP sample were aged between 18-30 years old, with 19.1% aged 31-40 and the rest over 41 years old.

Table 1

Demographic Information for Study Sample

Demographic Characteristics	Minor Attracted People		General Public	
	n	%	n	%
Sex				
Male	78	83.0	51	52.0
Female	8	8.5	42	42.9
Other	7	7.4	3	3.1
Age				
18-30 years	50	53.2	54	55.1
31-40 years	18	19.1	29	29.6
41-50 years	11	11.7	10	10.2
51-65 years	10	19.6	2	2.0
65-80 years	3	3.2	3	3.1
Ethnicity				
European/Caucasian	75	79.8	45	45.9
Latino/Latina	10	10.6	32	32.7
Asian	2	2.1	5	5.1
African American	2	2.1	1	1.0
Other	4	4.3	15	15.3
Employment				
Employed	59	62.8	41	41.8
Unemployed	18	19.1	26	26.5
Student	159	16.0	30	30.6

Note. Percentages may not always equal to 100% due to missing data (when lower than 100%) or rounding (when above 100%).

The general population sample comprised 98 participants. Two participants were removed from the study due to asking for their data to be removed from the analysis. Although a majority of participants in this sample were male (52%), this proportion was lower than for the MAP sample. This sample was predominantly European/Caucasian (45.9%) and Latino/Latina (32.7%). Compared to the MAP sample, a slightly lower proportion of the general population was employed (41.8%), with instead a slightly higher proportion of the sample being students (30.6%) or unemployed (26.5%). The general

population sample also skewed slightly younger, with 55.1% of participants in this sample being between the age of 18-30 and 29.6% being aged 31-40.

All of the MAP participants reported whether they are attracted to pre-pubescent children (under 12 years), pubescent young people (12-15 years), post-pubescent young people (16-17 years), or adults (18+); participants could report attraction to multiple groups. These data are presented in Table 2, which show that 76.6% of participants reported attraction to pre-pubescent children. Just under two-thirds (65.5%) reported that they are attracted to pubescent young people and 56.6% to post-pubescent young people. Over two-thirds of MAP participants (69.4%) reported that they are also sexually attracted to adults, indicating a high level of non-exclusive sexual attraction to minors among this group (i.e. sexual attraction to both minors and adults).

Table 2

MAP's Self-reported Sexual Attractions

Types of Attraction	Yes		No	
	n	%	*n*	%
Pre-pubescent children	86	91.4	8	8.60
Pubescent young people	60	63.8	34	36.2
Post-pubescent young people	39	41.5	56	59.5
Adults	54	57.4	41	43.6

Measures

Demographics

Participants in both the MAP and general public samples were asked several demographic questions at the start of the survey. These included questions regarding their age, gender, ethnicity and occupation.

Self-Reported Sexual Attraction

The MAP sample was asked to identify what specific age group of children or young

people they were attracted to. They were asked to tick a box to identify whether they were attracted to pre-pubescent children (under 12 years); pubescent young people (12-15 years); post-pubescent young people (16-17 years); or adults (18+). Participants could select multiple age groups.

Self-Stigma Mental Illness Scale – Modified (SSMIS – modified)

The Self-Stigma Mental Illness Scale (SSMIS; Corrigan, Watson & Barr, 2006) is a 40-item measure that assesses the level of internalised self-stigma and externalised stigma among people with mental illness. The validity and reliability of the SSMIS was tested by Corrigan (Corrigan et al., 2006; Corrigan et al., 2011) but also by other researchers (Fung et al., 2007; Schomerus et al., 2011). Schomerus et al. (2011) found the SSMIS domains were reliable and demonstrated very good internal consistency when used to examine self-stigma in alcohol dependence (between 0.83 – 0.93).

The SSMIS was modified for the current study to assess stigma relating to minor attraction instead of mental illness; the reliability and validity of this modified version has not been tested, however the modifications were relatively minor i.e. replacing 'people with mental illness' with 'people with a sexual attraction to children' throughout the scale. Four domains are measured: awareness of common stereotypes held about those with minor attraction ('assume'; e.g., '*I think the public believes ... most people who are sexually attracted to children cannot be trusted*'); agreement that such stereotypes are factual ('agree'; e.g., *I think ... most people who are sexually attracted to children are disgusting*); the application of internalisation of such stereotypes to themselves ('apply'; e.g.*, Because I have a sexual attraction to children … I am unpredictable*); and, hurt to themselves as a result of the stigma ('hurts self'; e.g., *I currently respect myself less … because I cannot be trusted*). For the current study, the MAP group answered all of the 40-items of this measure. The general population sample, however, only completed the 'assume' and 'agree' domains from

the SSMIS-modified, due to the lack of relevance of the ‘apply’ and ‘hurts self’ domains for this sample.

All items in this scale were measured using a 10-point Likert scale (1 = strongly disagree, 5 = neither agree nor disagree, 10 = strongly agree). The responses within each domain were summed to result in total values for each of the four domains. The scoring range therefore spanned from 10 – 100 for each domain, with higher scores indicating higher levels of stigma towards minor attraction.

The SSMIS-modified demonstrated very good levels of internal consistency (α = .90 with the present sample. The ‘assume’, ‘agree’ and ‘hurts self’ domains all demonstrated very good levels of internal consistency (‘assume’ α = .86; ‘agree’ α = .91; ‘hurts self’ α = .89). The ‘apply’ domain demonstrated acceptable levels of internal consistency (α = .77).

PERMA Profiler

The PERMA Profiler (Butler & Kern, 2016) comprises 23 items and assesses five pillars of wellbeing (positive emotion, engagement, relationships, meaning and accomplishment), as well as negative emotion, health and loneliness. Three items are used to assess each pillar of wellbeing, negative emotion and health, whereas loneliness is assessed with only one item (*How lonely do you feel in your daily life?)*. All participants in the current study completed the full PERMA Profiler.

Each item (e.g. ‘*How much of the time do you feel you are making progress towards accomplishing your goal?*’, which is an item to measure accomplishment; ‘*In general, to what extent do you feel excited and interested in things?*’, which is an item to measure engagement) is measured using an 11-point Likert scale, with the anchoring statements changing depending on the wording of the items (e.g., 0 = never, 10 = always; 0 = terrible, 10 = excellent; or 0 = not at all, 10 = completely). Item scores were averaged within each factor to calculate each factor score (except loneliness, which is a stand-alone item). Potential factor

scores, therefore, ranged from 0 to 10, with higher scores indicating higher levels of each of the five wellbeing pillars, negative emotion, health and loneliness. An ‘overall wellbeing’ score was also calculated by averaging the items from the positive emotion, engagement, relationships, meaning, and accomplishment pillars, as well as the happiness stand-alone item. The potential overall wellbeing score also ranged from 0 to 10, with higher scores indicating higher levels of overall wellbeing.

The PERMA profiler demonstrated very good levels of internal consistency ($\alpha = .90$) with the present sample. The factors ‘positive emotion’ ($\alpha = .90$), ‘relationships’ ($\alpha = .87$), ‘meaning’ ($\alpha = .93$), and ‘health’ ($\alpha = .89$) all demonstrated very good levels of internal consistency. The overall wellbeing score also demonstrated very good levels of internal consistency ($\alpha = .94$). The ‘accomplishment’ ($\alpha = .65$) and ‘negative emotion’ ($\alpha = .69$) factors demonstrated acceptable levels of internal consistency. The ‘engagement’ factor, however, did not demonstrate acceptable levels of internal consistency ($\alpha = .59$). Results relating to engagement should therefore be interpreted with caution.

Help-seeking Behaviour

The MAP participants were additionally asked if they had previously sought help for their sexual attraction to children or any related issues (Yes/No). They were also asked if they had considered seeking help for their sexual attraction to children or any related issues (Yes/No).

Procedure

The study used a cross-sectional, between-groups design, with data collected via an anonymous online survey.

The study was advertised to the MAP sample on the English-speaking online forums/MAP support organisations, B4UAct and Virtuous Pedophiles (VirPed). A consultation was completed with the B4UAct scientific advisory team before the survey was

advertised, to ensure survey quality and appropriateness, and that no questions asked were of concern. The advertisement for this study contained a brief overview of the study and a link to access the survey. The survey for the MAP sample was administered using the SoSci survey platform. This platform was chosen due to its compatibility with Tor internet browsers and high level of data/participant security. The survey did not record traceable information (e.g. IP addresses), to ensure the anonymity of participants.

Individuals who wished to take part in the survey followed the link, which took them to a page that contained information about the survey and participation. The information sheet also provided the researchers' contact details and mental health or MAP support options. If individuals wished to proceed from there, they were directed to a form to provide consent to participate. Once this was completed, they were able to proceed to the full survey, which took around 10 – 15 minutes to complete. Before they exited the survey, participants were asked if they were still comfortable for their data to be used for analysis, or whether they would like their data withdrawn. If they selected the latter option, their data were deleted before analysis. No inducement/compensation was offered to MAP participants, to maintain full anonymity.

The study was advertised to the general population group using the online participant recruitment platform, Prolific. Potential participants were pre-screened to be over 18 years old and be English-speaking. Eligible Prolific 'workers' (i.e. potential participants) were presented with a summary of the study and a link to the survey, which was administered using Qualtrics. As with the MAP sample, the link took the participants to an information page detailing the study, researchers' details, and information about mental health supports. They then proceeded to the consent form and then on to the full survey; this also took 10 – 15 minutes to complete. As with the MAP sample, no identifying information (including IP addresses) was collected and they had the opportunity to withdraw their data from analysis at

the end of the survey. The participants were paid £1.80 for completing the survey, which was distributed through the Prolific payment system. If they chose to withdraw their data from the analysis they still received their payment for completing the survey.

Planned Data Analysis

The data were analysed in several ways. Firstly, to explore research question one (hypothesis one and two), we ran an independent samples *t*-test to compare the means of the 'agree' section for the general public sample and the 'assume' section for the MAP group; this tested for any significant differences in the views of MAPs held by the general public compared with how MAPs believed the public would view them. Due to the potential for a bimodal distribution of stigma responses affecting the results of the independent samples *t*-tests (i.e. the sample being split into people who were extremely low or high on measures of stigma, resulting in means that 'cancelled out' at the aggregate level), further exploratory analyses were conducted that examined the proportion of participants who disagreed, were neutral, or agreed with the statements in the 'assume' and 'agree' sections of the SSMIS-modified for both the general public and MAP sample. Chi-square tests for independence were also conducted to further test these hypotheses, with group membership as the independent variable and categorical stigma responses (disagree/neutral/agree) as the dependent variable.

An independent samples t-tests were conducted to compare the means of the five PERMA Profiler pillars of wellbeing, negative emotion, health and loneliness for the MAP sample and general public sample. This tested hypothesis three; to see if there were any significant differences between the wellbeing of MAPs and the general public.

Finally, we investigated the second research question; how does the stigmatisation of MAP's relate to the wellbeing & help-seeking of MAPs?. We did this by using bivariate regression to examine the relationship between internalised and externalised stigma and

levels of wellbeing among MAPs. Binary logistic regression was used to examine the relationship between internal and external stigma, and help-seeking.

Results

The General Public's Views of MAPs

To examine hypothesis one, that the general public will have negative views of MAPs, average stigma ratings for the 'assume' and 'agree' domains of the SSMIS-modified are presented below for both the MAP and general public samples. These figures showed that the average awareness of, and agreement with, MAP-related stigma was around the middle of the stigma scale for the general public, indicating somewhat neutral views towards minor attraction.

Table 3

Descriptive Statistics for the SSMIS-Modified

	Minor-Attracted People		General Public	
Domain	M	SD	M	SD
Aware	61.0	20.2	58.3	9.91
Agree	29.9	10.8	57.7	14.7
Apply	27.0	12.3		
Hurts Self	27.3	18.8		

The proportion of the general public who agreed (responded 7-10 on the response scale), were neutral (responded 5-6), or disagreed (responded 1-4) with the statements in the 'agree' and 'assume' domains of the SSMIS-modified were examined; this was an unplanned exploratory analysis. These results can be found in Table 4.

As expected, despite stigma ratings across the domains averaging to around the middle of the stigma scale at the aggregate level, this more fine-grained analysis showed that a large proportion of the general public agreed with MAP-related stigma, and assumed that

other members of the general public also held these beliefs. When compared, the proportion of the participants who 'assumed' the statements and who 'agreed' with the statements was very similar for nine out of ten of the items. One item which had substantial differences was the item '*Most people who are sexually attracted to children are dirty and unkempt*'; 49% of participants disagreed with this statement, compared with 34.7% who felt the general public would disagree with this statement.

For items that examined ideas of dangerousness, trustworthiness, unpredictability and disgust, there was over 50% of agreement from participants when asked what they thought. When asked if they thought that MAPs were unintelligent, unable to get a job, or unable to take care of themselves, over 50% of the general public participants disagreed with the statements. These results were consistent with what participants believed the public thought of MAPs, except 39.8% of the participants thought that the general public would agree with the statement regarding MAP's unpredictability, compared with the 56.1% who agreed with that statement when asked their opinion. For some items, there was a relatively even split across the groups. For example, the statement that referred to MAPs being dirty or unkempt had an even split for the assume section (34.7% disagreed, 28.6 % were neutral and 36.7% agreed). None of the items within the agree section had this same type of split.

These results partially supported hypothesis one; that the general public would have a predominantly negative view of MAPs, as there were reasonably large proportions of the public who disagreed, especially in terms of the ideas of unpredictability, dangerousness, disgust and untrustworthiness. It was unexpected that more of the general public did not agree with the statements regarding MAP's ability to take care of themselves and their intelligence as the hypothesis predicted. Furthermore, the hypothesis would have predicted that more of the general public were to blame for their sexual attractions.

Table 4

The Proportion of the General Public Who Disagreed, Were Neutral, or Agreed with the SSMIS-modified 'Agree' and 'Assume' Statements

SSMIS-modified item		'Agree' I think …			'Assume' The Public thinks …	
	Disagree (%)	Neutral (%)	Agree (%)	Disagree (%)	Neutral (%)	Agree (%)
Most people who are sexually attracted to children are to blame for their attraction	28.6	30.6	40.8	27.6	29.5	42.9
Most people who are sexually attracted to children are unpredictable	20.4	23.6	56.1	23.5	36.5	39.8
Most people who are sexually attracted to children will not stop being attracted to children	26.5	29.6	43.9	27.8	24.8	47.4
Most people who are sexually attracted to children are unable to get or keep a regular job.	58.2	27.5	14.3	55.1	21.4	23.5
Most people who are sexually attracted to children are dirty or unkempt	49.0	25.5	25.5	34.7	28.6	36.7
Most people who are sexually attracted to children are dangerous	8.2	20.4	71.4	12.2	15.4	72.4
Most people who are sexually attracted to children cannot be trusted	7.1	18.4	74.5	5.1	16.4	78.6
Most people who are sexually attracted to children are below average in intelligence	56.1	34.7	9.2	61.5	20.8	17.7
Most people who are sexually attracted to children are unable to take care of themselves	54.1	28.6	17.3	65.7	19.8	14.6
Most people who are sexually attracted to children are disgusting	5.1	11.2	83.7	4.1	10.3	85.6

Note. Disagree = selected 1-4; Neutral = selected 5-6; Agree = selected 7-10

Comparison of the General Public's Views with How MAPs Think They Are Perceived

To examine Hypothesis 2 (how the general public's views align with how MAP's think they are perceived), we examined the proportions of MAPs who disagreed, were neutral, or agreed with statements for the 'agree' and 'assume' sections of the SSMIS-modified. These results are displayed in Table 5.

Independent Samples t-test

An independent samples *t*-test was conducted to examine whether there was a significant difference between how the general public views MAPs (i.e. 'agree' stigma domain scores), and how MAPs think they are perceived by the general public (i.e. 'assume' stigma domain scores). There was no significant difference between average rates of how the general public views MAPs and how MAPs think they are perceived by the general public, $t(190) = 1.31$, $p = .192$, $d = .189$.

Proportions

When MAPs were asked whether they disagreed or agreed with the stigma-related statements regarding MAPs, they overwhelmingly disagreed with the statements. All of the items, bar one, yielded more than 75% of participants disagreeing with the statements. The only statement which had a high proportion of MAP participants who agreed (83.9%) was that '*Most people who are sexually attracted to children will not stop being sexually attracted to children*'.

Table 5

The Proportion of the MAPs Who Disagreed, Were Neutral, or Agreed with the SSMIS-modified 'Agree' and 'Assume' Statements

SSMIS-modified item	'Agree' I think …			'Assume' The Public thinks …		
	Disagree (%)	Neutral (%)	Agree (%)	Disagree (%)	Neutral (%)	Agree (%)
Most people who are sexually attracted to children are to blame for their attraction	93.5	4.3	2.2	25.0	19.6	55.4
Most people who are sexually attracted to children are unpredictable	77.4	15.1	6.3	16.1	18.3	65.6
Most people who are sexually attracted to children will not stop being attracted to children	6.5	9.6	83.9	8.6	15.1	76.3
Most people who are sexually attracted to children are unable to get or keep a regular job.	86.0	9.7	4.3	32.6	44.6	22.8
Most people who are sexually attracted to children are dirty or unkempt	91.4	7.5	1.1	37.5	28.4	34.1
Most people who are sexually attracted to children are dangerous	85.7	9.9	4.4	14.0	7.5	78.5
Most people who are sexually attracted to children cannot be trusted	86.0	6.5	7.5	18.3	2.1	79.6
Most people who are sexually attracted to children are below average in intelligence	84.8	14.1	1.1	37.6	37.7	24.7
Most people who are sexually attracted to children are unable to take care of themselves	94.6	3.2	2.2	46.7	29.4	23.9
Most people who are sexually attracted to children are disgusting	82.8	9.7	7.5	16.1	3.3	80.6

Chi-Square Tests

A series of chi-square tests of independence were run to identify whether there were statistically significant differences in the proportions of participants who disagreed, were neutral, or agreed with the SSMIS-modified 'assume' (for MAP participants) and 'agree' (for general public participants) statements. The results of these tests can be found in Table 6. These analyses yielded mixed results. Small to moderate significant differences were found between groups for the items that measured blame ($\Phi = .29$ $p < .001$), unpredictability ($\Phi = .23$, $p < .001$), whether MAPs would stop being attracted to children ($\Phi = .31$, $p < .003$) and below average in intelligence ($\Phi = .34$, $p < .001$). For blame, MAP's believed that 55.4% of the public would agree that they are to blame for their attraction however 40.8% agreed. There was a similar trend for unpredictability, whereby MAP's believed that 65.5% of the public would agree, however 56.1% did. When the general public was asked if they thought MAPs would stop being sexually attracted to children; 43.9% of the general public agreed with this statement, whereas the MAP participants estimated that 76.3% of the public would agree. MAP participants also overestimated how the public would perceive their intelligence. The MAP participants predicted that 24.7% would have agreed they were below average in intelligence, compared with the 9.2% of general public who did agree.

The further six items did not have statistically significant differences between groups. These results indicated that MAPs' responses relating to how the public thinks of them (i.e. the 'assume' scale) were generally consistent with the proportion of the general public sample who agreed and disagreed with the statements (i.e. the 'agree' scale). These findings suggest that MAPs were generally correct in their assumptions about how the public perceives them, with some notable exceptions.

Table 6

Chi-Squared Tests to Examine the Differences in the Proportions of Answers for the SSMIS-Statements

SSMIS-modified item	X^2	p	df	Φ
Most people who are sexually attracted to children are to blame for their attraction	15.89	<.001	2	.29
Most people who are sexually attracted to children are unpredictable	9.76	.008	2	.23
Most people who are sexually attracted to children will not stop being attracted to children	17.96	<.003	2	.31
Most people who are sexually attracted to children are unable to get or keep a regular job.	2.703	.259	2	.26
Most people who are sexually attracted to children are dirty or unkempt	3.97	.138	2	.14
Most people who are sexually attracted to children are dangerous	10.46	.005	2	.23
Most people who are sexually attracted to children cannot be trusted	2.23	.525	2	.11
Most people who are sexually attracted to children are below average in intelligence	21.52	<.001	2	.34
Most people who are sexually attracted to children are unable to take care of themselves	7.38	.025	2	.20
Most people who are sexually attracted to children are disgusting	1.72	.422	2	.10

Comparison of the Wellbeing of MAPs Versus the General Public

Hypothesis three predicted that the wellbeing of MAPs will be worse than the wellbeing of the general public. Descriptive statistics for the PERMA Profiler wellbeing measures and help-seeking questions are found below in Table 7.

A series of independent samples *t*-test was used to examine if there were any significant differences between the wellbeing of MAPs compared with the general public participants; these results are also presented in Table 7. Levene's test for equality of variances indicated that two wellbeing pillars - meaning and positive emotion - violated the assumption of equal variances. Non-parametric analyses were conducted separately for these pillars; the results aligned with the results from the parametric analyses, and therefore only the results from the *t*-test are reported below.

As expected, the general public participants reported significantly greater levels of: overall wellbeing (d = -1.13); positive emotions (d = -1.04); engagement (d = -0.76); relationships (d =-1.12); meaning (d = -0.75); accomplishment (d = -0.70); and physical health (d = -1.02). These represented moderate to large differences in wellbeing for engagement, meaning and accomplishment, and large differences in wellbeing for overall wellbeing, positive emotions, relationships and physical health. Unexpectedly, there were no significant differences in the levels of negative emotion (d = -0.22) or loneliness (d = 0.10) between MAPs and the general public.

These results are largely consistent with hypothesis three, that the general public would have better wellbeing than MAPs. The inconsistent result is that neither negative emotions nor loneliness differed between the general public and MAPs.

Table 7

Descriptive Statistics for the PERMA Profiler, and Differences in Wellbeing between MAPs and the General Public

Wellbeing outcome			General Public		Cohen's *d*	Cohen's *d* 95% CI	*t*	*p*
PERMA Profiler	M	SD	M	SD				
Positive Emotion	4.61	2.43	6.83	1.79	-1.04	-1.34, -.740	7.23	<.001
Engagement	6.74	1.74	8.04	1.68	-.759	-1.05, -.465	5.26	<.001
Relationships	4.96	2.73	7.66	2.05	-1.12	-1.43, -.818	7.78	<.001
Meaning	4.96	3.03	6.93	2.17	-.749	-1.04. -.456	5.19	<.001
Accomplishment	5.62	2.07	6.90	1.60	-.695	-.986, -.403	4.82	<.001
Health	5.84	2.35	6.29	2.12	-1.02	-2.90, -1.63	7.03	<.001
Negative Emotion	5.84	2.03	8.11	2.09	-.221	-.505, .063	1.53	.127
Loneliness	6.76	2.60	6.48	2.90	.100	-.508, 1.06	.694	.489
Overall Wellbeing	5.32	1.96	7.30	1.51	-1.13	-2.47, -1.48	7.86	.<.001
	Yes		No					
Help-seeking	N	%	N	%				
Sought help	48	51.6	45	48.4				
Thought of seeking help	40	23	63.5	36.5				

How Externalised and Internalised Stigma Influence MAP's Wellbeing and Help-Seeking

Wellbeing

Hypothesis four predicted that higher externalised and internalised stigma would be related to lower levels of wellbeing and reduced willingness to seek help where needed for MAPs. A series of bivariate regression analyses were therefore conducted to examine if there were any significant relationships between externalised and internalised stigma and measures of wellbeing. The results can be found in Table 8.

Assume. The 'assume' section of the SSMIS-modified examined a facet of externalised stigma by examining how MAPs believe the general public views them. The results of the linear binary regression for the average 'assume' ratings were mostly inconsistent with what was hypothesised; assumptions regarding the general public's views of MAPs did not explain a significant proportion of variance for the positive emotion, engagement, relationships, accomplishment, overall wellbeing, negative emotion and health measures. Assumptions regarding how the general public viewed MAPs did, however, explain a significant proportion of variance for both the measure of meaning ($R^2_{adj} = .050$, $F(1,92) = 5.92$, $p = .017$) and loneliness ($R^2_{adj} = -.032$, $F(1,92) = 4.10$, $p = .046$). Within this model, higher levels of externalised stigma were associated with lower reported levels of meaning and higher levels of loneliness.

Agree. The 'agree' section of the SSMIS-modified examined the externalised stigma felt by MAPs by asking them which stigma-related statements they agreed with in relation to MAPs in general, not specific to themselves. The bivariate regressions again yielded mixed results as to the relationship between average agreement with stigma statements and reported wellbeing. Average agreement with stigma statements did not explain a significant proportion of variance for the positive emotion, relationships,

accomplishment, negative emotions, health and loneliness measures. However, agreement with these statements did explain a significant proportion of variance for the measures of engagement (R^2_{adj} = .051 , F(1,92) = 5.99 , p = .016), meaning (R^2_{adj} = .057 , F(1,92) = 6.59, p = .012), and overall wellbeing (R^2_{adj} = .064 , F(1,92) = 7.37 , p = .008). Within this model, higher levels of agreement with stigma-related items were associated with lower levels of reported engagement, meaning and overall wellbeing.

Apply. The 'apply' section of the SSMIS-modified examined the internalised Stigma experienced by MAPs by asking them the extent to which the stigma-related statements applied to themselves. The results of the bivariate regressions were largely consistent with what was hypothesised. The extent to which MAPs believed the stigma-related statements applied to them explained a significant proportion of variance for a number of wellbeing measures, including positive emotion (R^2_{adj} = .134 , F(1,92) = 15.39 , p = <.001), relationships (R^2_{adj} = .057 , F(1,92) = 6.59, p = .012), meaning (R^2_{adj} = .162, F(1,92) = 18.97, p = < .001), accomplishment (R^2_{adj} = .115, F(1,92) = 13.05, p = < .001), overall wellbeing (R^2_{adj} = .153 , F(1,92) = 17.82, p < .001), negative emotion (R^2_{adj} = .137, F(1,92) = 15.70, p < .001), health (R^2_{adj} = .115, F(1,92) = 13.09 , p < .001), and loneliness (R^2_{adj} = .068 , F(1,92) = 7.24 , p = .008). The extent to which MAPs felt the stigma-related statements applied to them did not explain a significant proportion of variance for the engagement measure.

Within this model, higher levels of internalised stigma were associated with lower levels of positive emotion, relationships, meaning, accomplishment, health and overall wellbeing, and higher levels of loneliness and negative emotion.

Hurts self. The 'hurts self' section of the SSMIS-modified examined a facet of internalised stigma experienced by MAPs by asking them to consider if they respected themselves less due to stigma related to their minor attraction. The results of the related

bivariate regressions were largely consistent with what was hypothesised. Ratings of stigma-related self-respect explained a significant proportion of variance for a number of wellbeing-related measures, including positive emotion ($R^2_{adj} = .119$, $F(1,92) = 13.52$, $p < .001$), relationships ($R^2_{adj} = .062$, $F(1,92) = 7.19$, $p = .009$), meaning ($R^2_{adj} = .248$, $F(1,92) = 31.74$, $p < .001$), accomplishment ($R^2_{adj} = .086$, $F(1,92) = 9.70$, $p = .002$.), overall wellbeing ($R^2_{adj} = .150$, $F(1,92) = 17.45$, $p < .001$), negative emotion ($R^2_{adj} = .135$, $F(1,92) = 14.17$, $p < .001$), health ($R^2_{adj} = .124$, $F(1,92) = 14.17$, $p < .001$), and loneliness ($R^2_{adj} = .072$, $F(1,92) = 8.21$, $p = .005$). Stigma-related self-respect ratings did not explain a significant proportion of variance for the engagement measure.

Within this model, lower levels of self-respect were associated with lower levels of positive emotion, relationships, meaning, accomplishment, health and overall wellbeing, and higher levels of loneliness and negative emotions.

Table 8

Bivariate Regressions Examining the Relationship Between Stigma and Wellbeing Among MAPs

	Stigma Domain											
	Assume			Agree			Apply			Hurts self		
Wellbeing outcome	β	*p*	95% *CI* (β)	β	*p*	95% *CI* (β)	β	*p*	95% *CI* (β)	β	*p*	95% *CI* (β)
Positive emotions	-.019	.858	-.027, .023	-.197	.057	-.090, .001	-.379	<.001	-.113, -.037	-.358	<.001	-.071, -.021
Engagement	-.156	.133	-.031, .004	-.247	.016	-.072, -.008	-.164	.114	-.052, .006	-.197	.057	-.037, .001
Relationships	-.079	.449	-.039, .017	-.184	.076	-.098, .005	-.258	.012	-.102, -.013	-.269	.009	-.068, -.010
Meaning	-.246	.017	-.067, -.007	-.259	.012	-.129, -.016	-.413	<.001	-.149, -.056	-.506	<.001	-.111, -.053
Accomplishment	.030	.771	-.018, .024	-.133	.201	-.065, .014	-.352	<.001	-.352, -.027	-.309	.002	-.056, .012
Health	-.025	.808	-.027, .021	-.166	.109	-.081, .008	-.353	<.001	-.105, -.030	-.365	<.001	-.105, -.030
Negative Emotion	.029	.784	-.018, .024	.184	.076	-.004, .073	.382	<.001	.032, .095	.380	<.001	.020, .062
Loneliness	.207	.046	.001, .053	.140	.178	-.016, .083	.270	.008	.015, .099	.286	.005	.012, .067
Overall Wellbeing	-.139	.180	-.033, .006	-.272	.008	-.086, -.013	-.403	<.001	-.094, -.034	-.399	<.001	-.061, -.022

Help-Seeking

A series of binary logistic regressions was conducted to establish whether measures of externalised and internalised stigma were significantly predictive of whether participants had sought help for issues related to minor attraction. Hypothesis four predicted that higher levels of external and internalised stigma relate to lower levels of help-seeking for issues related to their minor attraction. Table 9 shows the results of the series of these binary logistic regressions for both if the MAP participants had sought help, and if they had thought of seeking help for issues related to minor attraction.

Assume. The 'assume' section of the SSMIS-modified examined a facet of externalised stigma by examining how MAPs believe the general public views them. The results of these binary logistic regressions for the 'assume' section of the SSMIS-modified were not consistent with hypothesis four; that externalised stigma would act as a barrier to treatment. Neither actual nor considered help-seeking was significantly associated with assumptions about how the general public viewed MAPs (Actual help-seeking: $R^2_N = .002$, $X^2(1) = .231$, $p = .631$; Considered help-seeking: $R^2_N = .024$, $X^2(1) = .1.56$, $p = .212$). This indicates that externalised stigma does not act as a barrier for MAPs to seek help for issues related to their minor-attraction.

Agree. The 'agree' section of the SSMIS-modified examined the externalised stigma felt by MAPs by asking them which stigma-related statements they agreed with in relation to MAPs in general, not specific to themselves The results of the binary logistic regressions for the 'agree' section of the SSMIS-modified were not consistent with hypothesis four; that externalised stigma would act as a barrier to treatment. Neither the actual help-seeking item or considered help-seeking item's variance yielded statistically significant results (Actual help-seeking: $R^2_N = .006$, $X^2(1) = .540$, $p = .462$; Considered help-seeking: $R^2_N = .031$,

$X^2(1) = 1.98$, $p = .159$). This shows that externalised stigma does not act as a barrier for MAP's to seek help for issues related to their minor-attraction.

Apply. The 'apply' section of the SSMIS-modified examined the internalised stigma experienced by MAPs by asking them the extent to which the stigma-related statements applied to themselves The results of the binary logistic regression for the 'apply' section of the SSMIS-modified yielded mixed results for hypothesis four. This section measured internalised stigma. For the actual help-seeking item, the model was not statistically significant, $R^2_N = .001$, $X^2(1) = .061$, $p = .805$. This shows that internalised stigma was not predictive of whether MAPs sought help for issues related to minor-attraction. For the considered help-seeking item, the model was statistically significant $R^2_N = .104$, $X^2(1) = 6.93$, $p = .008$. This is consistent with hypothesis four, that higher levels of internalised stigma are associated with lower levels of seeking help.

Hurts Self. The 'hurts self' section of the SSMIS-modified examined a facet of internalised stigma experienced by MAPs by asking them to consider if they respected themselves less due to stigma related to their minor attraction. The results of the binary logistic regression for the 'hurts self' section of the SSMIS-modified yielded mixed results for Hypothesis four. As with the 'apply' section, hurts-self measures internalised stigma. For the actual help-seeking item, the model was not statistically significant; $R^2_N = .003$, $X^2(1) = .298$, $p = .585$. This shows that internalised stigma was not predictive of whether MAPs sought help for issues related to minor-attraction. For the considered help-seeking item, the model was statistically significant; $R^2_N = .150$, $X^2(1) = .10.21$, $p <.001$. This is consistent with Hypothesis four, that higher levels of internalised stigma are associated with lower levels of help-seeking.

Table 9

Binary Logistic Regressions Examining the Relationship Between Stigma and Help-Seeking Among MAPs

	Stigma Domain											
	Assume			Agree			Apply			Hurts self		
Wellbeing outcome	Exp *(B)*	p	95% *CI* Exp *(B)*	Exp (B)	p	95% *CI* Exp *(B)*	Exp *(B)*	p	95% *CI* Exp (*B*)	Exp (B)	p	95% CI Exp (B)
Actual Help-seeking	.995	.632	.975, 1.11	.985	.465	.946, 1.03	.996	.805	.963, 1.03	1.01	.586	.984, 1.03
Considered Help-seeking	.984	.214	.959, 1.01	.964	.175	.915, 1.02	.939	.019	.891, .990	.948	.008	.911, .986

Discussion

Drawing from previous research on the stigmatisation of MAPs, the aim of this study was to examine how the general public views MAPs, and how this marries with MAP's perceptions of public stigma. The study also intended to explore the impacts of perceived internal and external stigma on MAP's wellbeing and help-seeking behaviours.

Based on the results presented above, the general public was seen to mostly have negative views of MAPs, especially in terms of dangerousness, trustworthiness, unpredictability and disgust. MAP's perceptions of public stigma were consistent with the general public's negative views. These negative views contribute to the externalised and internalised stigma felt by MAPs. Both higher levels of externalised and internalised stigma were found to have been related to numerous wellbeing measures. Actual help-seeking was not found to be related to externalised and internalised stigma, however, it was associated with consideration of help-seeking.

The rest of the discussion will explore how the specific findings relate back to the previous research on stigmatisation of MAPs and the implications of these results. The limitations and future directions will also be discussed.

Specific Findings and Implications

The General Public's Views of MAPs

The results partially supported Hypothesis 1, that the general public would have negative views of MAPs. We found that the general public tended to agree with statements regarding MAPs that examined the ideas of dangerousness, untrustworthiness, unpredictability and disgust. Comparatively, the general public generally disagreed with statements that examined intelligence levels and the ability of MAPs to carry out activities of daily living. These results were consistent for both how the general public personally thought of MAPs, and how they believed members of the public would view MAPs.

We can interpret these results to mean that the general public generally holds negative

views of MAPs, especially in regards to perceptions of MAPs as a danger to society. These results were consistent with studies reviewed in Lawrence and Willis's systematic review and the three themes identified within stigma research that related to contributions to public stigma. The review found that higher amounts of misperceptions were held in agreement with statements used to examine dangerousness, deviance and controllability of sexual interest. Furthermore, our results were consistent with the theme of negative affective responses (Jahnke, 2018; Jahnke et al., 2015), due to agreeableness our participants had with statements that examined disgust and untrustworthiness. It can be theorised that the responses of the general public to MAPs is the consequence of a fear response provoked by the idea of minor attraction. The misconceptions surrounding minor attraction have led to many people believing all people who have minor attraction will sexually offend, hence are a danger to society. This is a key area to target in the future education of the general public regarding MAPs.

One possible influence on the negative attitudes seen within this research is social desirability bias. This may have occurred due to the sensitive nature of our research, whereby the participants may feel they need to give a socially acceptable answer. In this case, that would be seen to be placing harsher rating of the SSMIS-modified statements. This would be difficult to mediate due to the way participants are recruited for this type of research, and the sensitivity of the topic.

Interestingly, only 43.9% of the general public agreed with the statement '*Most people who are sexually attracted to children will not stop being sexually attracted to children.*'. Due to the stereotypes surrounding paedophilic disorder and its enduring nature (Seto, 2013), we might have expected that more of the general public would have agreed that MAPs would be incapable of change. This has been shown in previous research which has seen that when the general public has acknowledged that minor attraction is enduring, they have perceived that MAPs are incapable of managing their attraction. This has led to higher levels of perceived danger and mistrust. This was not seen in our results, as there were reasonably high levels of agreement with danger and mistrust, but lower levels of agreement with minor attraction as enduring (Lawrence and Willis, 2021). Further

research would be needed to examine the differences in negative views between the general public who believed minor attraction was a choice, and those who believed it is enduring.

Comparatively, 83.9% of MAPs agreed that most people who are sexually attracted to Children would not stop being sexually attracted to children. There were a significantly higher proportion of MAPs who agreed with this statement than the general public. This may mean that the general public is not aware of sexual attraction to children as having an enduring nature and that if they were aware of this, they may harbour even more negative views than what they currently do. The MAP's answers may suggest that MAPs assume that the enduring nature of minor attraction contributes to the stigmatisation of MAPs and the negative views of MAPs.

In conclusion, the results were only partially supportive of Hypothesis 1, as although the general public tends to hold negative views of MAPs in terms of dangerousness, untrustworthiness, unpredictability and disgust, there was still a large proportion of disagreement from the general public to stigmatising statements. These findings can be used to inform the education of the general public of MAPs. As it was found that the general public typically views MAPs as dangerous, unpredictable and untrustworthy, targeting these areas in education may support the general public to better understand MAPs, and reduce the perception that minor attraction is synonymous with child sexual abuse. Typically, education material regarding MAPs has appeared to increase stigmatisation rather than make it better, especially in written narratives (Jara & Jeglic, 2021). Several options for education have been found to be promising to target the stigmatisation of MAPs. Psychoeducation and the presentation of humanising narratives have shown promising results when compared with the use of factual information (Harper et al., 2019). Humanising narratives, which target the areas of dangerousness, untrustworthiness, unpredictability and disgust may be key in helping reduce the stigmatisation towards MAPs to reduce the stigma-related stress experienced.

MAP's Views of how the General Public Perceive Them

Consistent with Hypothesis 2; the MAPs view of how the general public sees them

will align with Hypothesis 1, our results indicated that MAPs perceive that the negative public view them negatively.

At first glance, the proportion of the general public who agreed, were neutral or disagreed with the statements in the agree section of the SSMIS-modified was consistent with the proportion of MAPs who agreed, were neutral or disagreed with the statements in the assume section. This was confirmed by the results of the independent samples t-test which showed that there were no significant differences in the proportions of answers of the general public for the agree section compared with the MAP's answers to the assume section. However, a more comprehensive (albeit unplanned) analysis of each statement through a series chi-square tests did yield significant differences for some items. There were significant differences for the statements that examined blame, unpredictability, the enduring nature of minor attraction and intelligence. For all these items, MAP participants believed that more of the general public would agree with the statements than they actually did. For blame, unpredictability and intelligence, the proportions of participants who agreed, were neutral or disagreed showed that these were reasonably insignificant differences. However, for the item that examined the enduring nature of minor attraction, MAPs believed that more of the general public would agree with the statement than the proportion that actually did. This begs the question of whether this is a variable that is particularly stigmatising to MAPs. Our results have indicated that this is possibly not as stigmatising an item as presumed. In the future, it would be interesting to examine how the general public views the enduring nature of minor attraction, do they accept that this is another sexual orientation. If this is the case, then does viewing minor attraction as a sexual orientation increase stigmatisation or decrease it? Despite the significant results, all of these statements had small to moderate effect sizes, meaning there were only small differences between the groups. The other six statements measuring stigma did not show significant differences. These results show that although there were some small differences, the results confirmed Hypothesis 2 and MAP's perception of how the general public views them is correct.

We can interpret these results to mean that MAPs are aware of how the general public

sees them, and the level of externalised stigma that is present due to their minor attraction (Vogel et al., 2013). Within their study that examined the stigma-related stress framework, Jahnke et al. (2015) found that participants may overestimate the negative attitudes that the general public has towards them, due to the negative attitudes that they are constantly bombarded with within society, especially in the media. Our results were not consistent with this proposal. The MAPs in our study were largely accurate in their predictions of how the general public sees them. There are several reasons why our results differed from Jahnke et al. (2015). Firstly, their study focused on people with paedophilic disorder as opposed to MAPs which may have influenced the stigma felt, who due to the fear of discovery may avoid talking to anyone about paedophilia related topics. If this is the case, they may only see the extreme discrimination of people with paedophilic disorder from the media or a small minority of vocal people. The MAP participants in our study were recruited from online forums which aim to support MAPs with their attraction. These forums may allow MAPs to share knowledge with each other, especially in regards to stigmatisation from the outside world, hence they may have a better understanding of what the world thinks of them.

In conclusion, our results largely confirmed Hypothesis 2, as MAP's views of how the public perceives them generally marries what the general public thought.

The Wellbeing of MAPs Compared with the General Public

Consistent with Hypothesis 3, we found that the wellbeing of MAPs tends to be lower than that of the general public. The series of independent samples t-tests showed significant differences between MAP and general public participants for all five pillars of wellbeing (positive emotion, engagement, relationships, meaning and accomplishment), as well as for overall wellbeing and health. Interestingly, the results did not show a significant difference in levels of negative emotion or loneliness between MAPs and the general public. This is consistent with previous research examining wellbeing of MAPs which found that higher levels of stigmatisation were associated with worse reported wellbeing (Elchuck et al., 2021; Grady et al., 2019; Jahnke et al., 2015; Lievesley et al., 2020; Parr and Pearson., 2019).

Our results were not consistent with research completed by Grady et al. (2019) which found higher levels of isolation and loneliness among MAPs. Participants for both the general public and MAP samples of this study were recruited during 2021 amid the height of the COVID-19 pandemic. The pandemic has had a huge influence on people's livelihoods, wellbeing and levels of isolation across the world. Some participants in both samples will be living in countries around the world that have been in different forms of lockdown for almost two years, which can further escalate levels of isolation and loneliness. The COVID-19 pandemic may be a potential reason why we see no differences in negative emotion and wellbeing between MAPs and the general public participants. If this study was completed outside of a global pandemic, it is possible that the results would produce different conclusions, similar to previous research on the levels of loneliness and isolation for MAPs compared with the general public.

The Relationship Between Externalised and Internalised Stigma and Wellbeing

Hypothesis 4 predicted that higher levels of externalised and internalised stigma would be related to lower levels of wellbeing. Previous research that examined these types of stigmatisation and its relationship with wellbeing had found that both externalised stigma (Cohen et al., 2018; Jahnke et al., 2015) and internalised stigma (Lievesley et al., 2020) were associated with wellbeing outcomes for MAPs. The results of the current study suggest that externalised stigma (i.e. awareness of stigma held by the public about MAPs and agreement with stigmatising statements about MAPs) did not account for differing levels of positive emotions, relationships, negative emotions, health and accomplishment among MAPs. Higher levels of externalised stigma were, however, associated with lower levels of meaning, engagement and overall wellbeing and higher levels of loneliness, albeit inconsistently.

Comparatively, higher levels of internalised stigma (i.e. application of stigmatising statements to themselves and if they respect themselves any less due to their minor-attraction) was found to be associated with lower levels of positive emotion, relationships, meaning, health, accomplishment and overall wellbeing and higher levels of negative emotions and loneliness. Internalised stigma was not

associated with differing levels of engagement. These results were consistent with previous research on internalised stigma (Lievesley et al., 2020).

Overall, our results suggest that a combination of higher externalised and internalised stigma is associated with lower levels of wellbeing outcomes and higher levels of loneliness and negative emotions. That said, it can be argued that internalised stigma may have more of an association with wellbeing than externalised stigma. This may be due to the personalised nature of internalised stigma. It may be easier for MAPs to separate externalised stigma (i.e. how they see other MAPs) compared with when they apply it to them personally. The finding that internalised stigma has more of an association with wellbeing than externalised stigma can also be used to inform treatment, as it is an area that would particularly need to be targeted.

The Relationship Between Externalised and Internalised Stigma and Help-seeking

Hypothesis 4 predicted that higher levels of externalised and internalised stigma would be related to lower levels of wellbeing. The results of this study were inconsistent with Hypothesis 4. Externalised stigma did not appear to act as a barrier to help-seeking, nor influence whether MAPs had considered seeking help for any issues related to their minor attraction. Furthermore, internalised stigma also did not act as a barrier to help-seeking, however, higher levels of internalised stigma was associated with whether MAPs had considered seeking help for any issues related to minor-attraction.

These findings are consistent with what Jahnke et al. (2015) found in their evaluation of their framework, that there was no significant relationship between their measures of stigmatisation and barriers to treatment. As mentioned previously, our MAP participants were recruited from supportive online forums, which may not be an accurate representation of the population of MAPs. MAPs who are seeking support from online forums are already taking steps to support themselves to not offend against children, therefore, are likely to have considered seeking help, even in their journey to find support. It is possible that online forums are seen as a stepping stone to getting further professional help, as although they are supportive there is still an element of anonymity that comes with using the

internet. Further research is needed to form conclusions as to how stigma may influence help-seeking behaviours before this is included or rejected from the proposed framework.

How Our Results Support the Proposed Stress-Related Stigma Framework

An implication of the findings from Hypotheses 3 and 4 is that we have evidence to support the proposed framework by Jahnke et al., (2015). As previously seen, Jahnke et al. (2015) proposed a framework that examined how public stigma influenced stigma-related stress, to influence emotional and social functioning, barriers to treatment and cognitive distortions.

The results of our study mostly supported the stigma-related stress framework proposed by Jahnke et al. (2015). Jahnke et al.'s framework focused on measures of emotional and social functioning to determine the influence of public stigma. Although we did not specifically measure emotional and social functioning, several of the wellbeing measures can be seen as proxy measures. Firstly, the relationships variable can be viewed as a proxy measure for social functioning. Our results suggested that higher levels of internalised stigma are associated with lower levels of relationship quality, although externalised stigma was not. The framework suggests that higher levels of public stigma (i.e. agreement with stereotypes related to paedophilia, negative affective responses and social distancing) would be associated with difficulties in social functioning. Public stigma encompasses aspects of both externalised (i.e. agreement with stereotypes related to paedophilia) and internalised stigma (i.e. negative affective responses). This means that our results are consistent with the proposed framework, as although externalised stigma is not associated with varying levels of relationship quality, internalised stigma is.

Furthermore, we can consider our variables of positive and negative emotions, and overall wellbeing as proxy measures for emotional functioning. The results of our study are supportive of the framework's proposal that lower levels of emotional functioning would be associated with higher levels of stigma. For example, higher levels of externalised stigma are associated with lower levels of overall wellbeing, but not positive or negative emotion. Higher levels of internalised stigma

are associated with lower levels of overall wellbeing and positive emotion, and higher levels of negative emotion. Although our study did not examine specifics regarding diagnosable mental health conditions, we can theorise that having poor emotional functioning due to the influence of stigmatisation could correlate with higher levels of diagnosable mental health conditions. We are unable to comment on the sections of the framework that examined cognitive distortions or likelihood of child sexual offending as these variables were not examined within this study. It would be helpful for future research to examine these variables to confirm or reject their place in the proposed framework. Our study and previous studies have failed to find support for the idea that help-seeking is associated with stigma (Jahnke et al., 2015; Jahnke, 2018), therefore may need to be removed from the stigma-related stress framework.

Based on our findings, several minor alterations to this framework could be made so it may be able to be used to inform the treatment of MAPs. Firstly, perceived social distance would be removed as a measure for stigma-related stress due to the findings of Jahnke et al. (2015) analysis. It could be replaced with a scale that measures stigmatisation directly (for example, the SSMIS-modified). A further alteration to the framework would be the removal of motivations for help-seeking. Our study was not able to confirm that stigma was associated with motivations to seek help. As shown above, the results of our study supported the association between stigma-related stress, emotional and social functioning.

Limitations

There are several limitations associated with this study that may influence its validity and generalisability. Firstly, the correlational design of this study has meant that were are unable to determine if there is a causal relationship between externalised and internalised stigma, wellbeing and help-seeking. A longitudinal study design would be needed to examine whether there is a causal relationship between variables.

The variables in this study were given in a specific order in the survey for both the MAP and general population samples. The SSMIS-modified was placed before the PERMA Profiler items. This

may have affected the results for MAPs due to the confronting nature of some of the questions (i.e. asking MAPs if they think they are disgusting due to their minor attraction) which may have influenced the answers to subsequent wellbeing items.

For both the general public sample and the MAP sample we relied on participants to self-report if they were sexually attracted to minors. This may be subject to self-report bias, whereby participants will disclose only what is seen as socially desirable. For the MAP group, we have to rely on them to be honest regarding their sexual attractions, although one would theorise that if a MAP is participating in this study they may not be influenced by self-report bias, as being sexually attracted to minors is generally not seen as desirable. The general public may, however, be influenced by self-report biases; there may be participants within the general public group who experience sexual attraction towards children. This may affect the results as it would have been more appropriate for these participants to be within the MAP group.

Furthermore, participants for the MAP group were recruited from online forums which aim to support their users to abstain from sexual offending against children. Due to the online forum's nature, participants recruited for our study may not be representative of the entire population of MAPs. This means that selection bias may have occurred. We may expect that MAPs who use the online forums will still be subjected to the same discrimination and stigmatisation as the entire population of MAPs, however may have different experiences of stigma, which may allow them to seek support from online forums.

In our study, the general public sample and MAP sample were recruited separately which has meant they both have a unique demographic makeup. For example, 83.0% of the MAP sample identified themselves as male, compared with 51.0% of the general public sample. Furthermore, 79.9% of the MAP sample identified their ethnicity as European compared with 45.9% of the general public sample. These differences in demographics have the potential to confound the results for the comparison of wellbeing due to the different life experiences and cultural expectations of the participants. The difference in demographics may also influence their views of minor-attraction

and the stigma they portray, as different cultures and experiences may account for differences in views. In hindsight, it would have been preferable to first recruit the MAP sample (as this is the more difficult group to recruit) and then match the demographic details in the general population, to limit the demographic differences influencing results.

This study had reasonably small samples for both the MAP sample and general public sample. The study had 94% statistical power to detect a medium between-groups effect ($d = .50$, $p < .05$) and 29% to detect a small effect ($d = .20$, $p < .05$). This means that our study would likely detect a medium effect if it was present, however it is unlikely that we would detect small effects if present. A larger sample size would therefore have been preferable to ensure that small effects were more reliably detected, however we were operating under the time constraints of a Master's thesis and the difficulties of recruiting community-based MAP samples.

Future Directions

Several research directions could be pursued in the future. Firstly, as noted above in the limitations section, we did not recruit our general public sample to match the demographics of the MAP sample. If demographic details were matched and subsequently controlled for, further research would be able to determine if the demographic differences confounded the results in this study. In particular the comparison between the wellbeing of MAP participants and general public participants would be useful, due to the unexpected non-significant results for loneliness and negative emotion. This would build on our research as replication of study results is important to confirm on the validity and reliability of results.

Due to constraints imposed by the platforms used to recruit participants for the MAP sample, we were unable to ask questions to determine if the MAPs in our sample had committed any sexual offending or related behaviours. It would be interesting to compare offending and non-offending populations of MAPs to explore whether this influences their wellbeing, help-seeking and stigmatisation experiences. The results may be different due to the differences in experiences of offending versus non offending MAPs. We could expect that if there was a population of offending

MAPs, some of them would have spent time within the justice system as a consequence of their minor attraction. It would be important to determine if time spent in the justice system was an influence on a MAP's experience of stigma, their wellbeing and their ability to seek help. It would also be interesting to examine whether stigma differentially affects wellbeing and help-seeking among those who have and who have not sexually offended. As our research did not ask if our participants had sexually offended against children, we were unable to determine if this is a confounding factor for our results. This extension would also be useful in determining barriers to treatment for issues related to minor attraction. It could also inform possible treatment options for MAPs who feel at risk of offending against children, as a form of 'preoffending' treatment, to reduce child sexual offences.

To examine internalised and externalised stigma we used the SSMIS, which was modified from examining mental health stigmatisation to examine stigmatisation of people who are sexually interested in children. Although this scale (and the subscales) were found to demonstrate very good internal consistency, this has never been used to examine the stigmatisation of minor-attracted people before. Replication of internal consistency results in other studies, as well as testing of broader validity and reliability, is needed before being able to conclude that the SSMIS-modified is an accurate scale to measure stigmatisation.

It may also be interesting to alter the wording within the scale to examine the effect of labels on stigmatisation. Instead of using 'sexual interest in children, it would be useful to use other labels such as 'sexual attraction to minors' or 'paedophile'. It would be useful to examine the effect of labels to determine if the label has an influence on the perceptions that MAPs will sexually offend against children, regardless of if there is an absence in offending. Furthermore, changing the label may prompt people to alter their perceptions of behaviour exhibited by MAPs, so more research is needed to examine this mechanism.

Future research is needed to examine whether education surrounding the differences between MAPs who do not offend against children and child sex offenders would influence the stigmatisation of MAPs. If this was the case it would be important to know if this, or other

interventions could be used in the real world to reduce stigmatisation and subsequently the stigma-related stress of MAPs.

Conclusions

In summary, the aim of this study was to examine how the general public viewed MAPs, and how this marries with MAP's perceptions of how the public view them. We also explored the impacts of perceived internalised and externalised stigma on MAP's wellbeing and help-seeking behaviours. One of the main findings of this study was that the general public generally had negative views of MAPs in relation to the ideas of dangerousness, disgust, unpredictability and untrustworthiness. This suggests that these would be areas to target in education programmes aimed at reducing stigma for Maps. A further finding of this study is that internalised stigma may be particularly relevant for MAPs wellbeing, therefore an important focus for treatment for this population Our results largely support the stigma-related stress framework proposed by Jahnke et al. (2015). With a few alterations, this framework has strong potential to meaningfully inform treatment and support to MAPs, and inform educational initiatives to help reduce the stigmatisation of MAPs.

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Appendices

Appendix A

Advertisement for the MAP Participant Recruitment

"I am part of a research team at the University of Canterbury, New Zealand, that is conducting a study looking at public perceptions and self-stigma among individuals with a sexual attraction to children and the impact these perceptions have on wellbeing. Data for this study is being collected through an online survey conducted via SoSci which is a secure online survey platform that uses Transport Layer Security (TLS) encryption to protect the identity of survey participants.

We invite individuals who identify as having a sexual attraction to minors to participate in the study. Your assistance with the study would be greatly appreciated, and will help us better understand the needs of people who live with minor attraction. We will not know who you are, and will not be able to find out who you are. Any information you provide in the survey will be completely anonmyous and untraceable. The platform we are using for this survey will not be collecting your IP address or any identifiable medical or personal information about you.

Please select the link below to read more information about the study, and if you consent to participation, to complete the survey. The survey will take approximately 15 minutes to complete. We would also appreciate if you are able to share this survey with other individuals who might be interested in participating in this study"

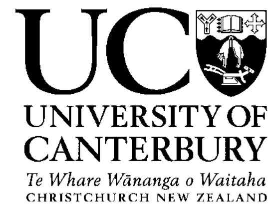
Where required, we will contact forums and organisations for permission to display our advertisement. We will advertise on social media platforms such as twitter and Facebook. We will also be contacting online chatrooms/forums that are known to MAPs such as b4UAct, Virtuous Paedophiles, Reddit, 4chan, Girl Chat and Boy Chat. We will ask the moderators/site owners if they are willing to advertise our study.

The project has received ethical approval from the University of Canterbury Human Ethics Committee.

HEC reference number: 2020/139

Appendix B

Information & Consent Form for MAP Participants



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23/03/2021
HEC Ref: 2020/139

Public Perceptions of Minor-Attracted People and their Effect on Wellbeing of Minor-Attracted People

Information Sheet for MAP Sample

My name is Charlotte Lindo and I am a Master's student at the University of Canterbury, New Zealand. I am conducting a study looking at how the general public view minor-attracted people (MAPs) and how these perceptions correlate with how minor-attracted people think that the public views them. An additional aim is to assess the effect that public and individual perceptions have on the wellbeing of MAPs. Data will be collected for this study using an online questionnaire. Two samples will be recruited: a general population sample and a sample of people who identify as being minor attracted.

Advertisements for this study have been posted on a variety of websites that may be accessed by individuals with minor-attraction, including Facebook, twitter, b4UAct, Virtuous Paedophiles, Reddit 4chan, Girl Chat and Boy Chat. You are invited to take part in this study if you identify as

someone who is sexually attracted to minors (i.e people under the age of 16), you are fluent in English, and you are aged 18 or over.

If you choose to take part in this study, your involvement in this project will be to fill out an online questionnaire. The questionnaire asks about demographic details (e.g. age and gender), any sexual experiences you might have had with minors, your thoughts about minor attraction and how this affects your life, and any help you might have sought to address concerns related to minor-attraction. This study should take around 15 minutes to complete.

The survey will be conducted using the online survey platform Qualtrics. To ensure anonymity and confidentiality, the survey will not ask your name or any other personally identifying details. Your IP address will not be collected, and Qualtrics uses encryption to protect the identity of survey participants. Each participant will be assigned a code, which will be used to identify participants while in the data analysis process. The primary researcher, supervisor and co-supervisor will be the only people who have access to the data, which will be stored in password-protected files on the secure UC server. This data will be securely destroyed after 5 years.

There are risks of mental and emotional distress as a result of completing the survey. The discussion of minor attraction and/or child sexual abuse can be a difficult topic for many people to discuss, therefore there may be some distress from the content. If you find the content distressing, you are able to stop completing the survey at any point by closing the browser. Additionally, below is a list of websites that you can access for support with any emotional distress, or support with minor attraction.

- **CALM**- https://www.calm.auckland.ac.nz (An online programme for building mental health resilience)
- **The Mood Gym**- https://moodgym.com.au (An online self-help portal for mental health

- **Warmline-** www.warmline.org (a free peer-run listening line staffed by people in recovery themselves.)
- **7cups**- www.7cups.com (a free anonymous and confidential conversation with trained active listeners)
- **My Depression Team**- www.MyDepressionTeam.com (a social network for those living with depression)
- **NAMI**- www.NAMI.org (Free support and education for families and individuals seeking help for a range of mental illness)

United States

https://www.mentalhealth.gov/get-help

Canada

https://www.canada.ca/en/public-health/services/mental-health-services/mental-health-get-help.html

United Kingdom

https://www.nhs.uk/conditions/stress-anxiety-depression/mental-health-helplines/

Australia

https://www.healthdirect.gov.au/mental-health-helplines

New Zealand

https://www.mentalhealth.org.nz/get-help/in-crisis/helplines/

Participation is voluntary and you have the right to withdraw at any stage without penalty. As the study is anonymous, we will not be able to remove any data once you have submitted the survey. However, participants will have the option at the end of the survey to indicate that they would like the data removed from analysis.

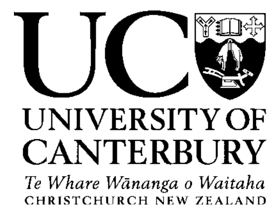
The results of the project will be used for a Master's thesis and may be published in academic journals, but you may be assured of the complete confidentiality of the data gathered in this investigation: your identity will not be made public at any point. A thesis is a public document and

will be available through the UC Library. If you would like to receive a copy of the summary of results of the project, check the UC Library website from early 2022 for the submitted thesis (https:/ir.canterbury.ac.nz/).

The project is being carried out as a requirement for a Master of Science at the University of Canterbury, New Zealand by Charlotte Lindo with the assistance of Anneliese Westerman under the supervision of Dr Jacinta Cording and Dr Sarah Christofferson. Charlotte can be contacted at cli162@uclive.ac.nz. She will be pleased to discuss any concerns you may have about participation in the project.

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and participants should address any complaints to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

If you agree to participate in the study, you will be asked to tick the boxes of the questions regarding consent for the study at the beginning of the survey.



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Public Perceptions of Minor-Attracted People and their Effect on Wellbeing

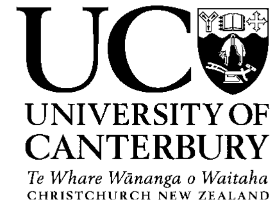
Consent Form for MAP sample

- ☐ I have been given a full explanation of this project and have had the opportunity to ask questions.
- ☐ I understand what is required of me if I agree to take part in the research.

- ☐ I understand that participation is voluntary, and I may withdraw at any time without penalty, by closing the survey browser. Withdrawal of participation will also include the withdrawal of any information I have provided should this remain practically achieveable.
- ☐ I understand that any information or opinions I provide will be kept confidential to the researcher, supervisor and co-supervisor and that any published or reported results will not identify the participants. I understand that a thesis is a public document and will be available through the UC Library.
- ☐ I understand that all data collected for the study will be kept in password protected electronic form and will be destroyed after five years.
- ☐ I understand the risks associated with taking part and how they will be managed.
- ☐ I understand that I can contact the researcher, Charlotte Lindo, at cli162@uclive.ac.nz for further information. If I have any complaints, I can the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).
- ☐ I understand that I can contact Charlotte Lindo if I would like a summary of the results of the project, or I can check the UC Library website for a copy of the thesis from mid-2021.
- ☐ By checking this box, I agree to participate in this research project.

Appendix C

Information and Consent Form for General Public Participants



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Public Perceptions of Minor-Attracted People and their Effect on Wellbeing of Minor-Attracted People

Information Sheet for General Public

My name is Charlotte Lindo and I am a Master's student at the University of Canterbury, New Zealand. I am conducting a study looking at how the general public view minor-attracted people (MAPs) and how these perceptions correlate with how minor-attracted people think that the public views them. A minor attracted person is a person who is sexually attracted to minors under the age of 18. An additional aim is to assess the effect that public and individual perceptions have on the wellbeing of MAPs. Data will be collected for this study using an online questionnaire. Two samples will be recruited: a general population sample and a sample of people who identify as being minor attracted.

You have been approached to take part in this study because you are a member of the Prolific Platform. You have viewed this survey information on the Prolific Platform as a registered member. All payment will be made directly through your prolific account, as would normally happen when you complete a survey.

If you choose to take part in this study, your involvement in this project will be to fill out an online questionnaire. The questionnaire asks about demographic details (e.g. age and gender), any sexual experiences you might have had with minors, your thoughts about minor attraction and how this affects your life. This study should take around 15 minutes to complete.

The survey will be conducted using the online survey platform Qualtrics. To ensure anonymity and confidentiality, the survey will not ask your name or any other personally identifying details. Your IP address will not be collected, and Qualtrics uses encryption to protect the identity of survey participants. Each participant will be assigned a code, which will be used to identify participants while in the data analysis process. The primary researcher, supervisor and co-supervisor will be the only people who have access to the data. This data will be securely destroyed after 5 years.

There are risks of mental and emotional distress as a result of completing the survey. The discussion of minor attraction and/or child sexual abuse can be difficult topic for many people to discuss, therefore there may be some distress from the content. If you find the content distressing, you are able to stop completing the survey at any point by closing the browser. Additionally, below is a list of websites that you can access for support with any emotional distress.

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- **MyDepressionTeam-** www.MyDepressionTeam.com (a social network for those living with depression)
- **NAMI**- www.NAMI.org (Free support and education for families and individuals seeking help for a range of mental illness)

United States

https://www.mentalhealth.gov/get-help

Canada

https://www.canada.ca/en/public-health/services/mental-health-services/mental-health-get-help.html

United Kingdom

https://www.nhs.uk/conditions/stress-anxiety-depression/mental-health-helplines/

Australia

https://www.healthdirect.gov.au/mental-health-helplines

New Zealand

https://www.mentalhealth.org.nz/get-help/in-crisis/helplines/

Participation is voluntary and you have the right to withdraw at any stage without penalty. As the study is anonymous, we will not be able to remove any data, but the participants will have an option at the end of the survey to indicate that they would like the data removed from analysis.

The results of the project will be used for a Masters thesis and may be published in academic journals, but you may be assured of the complete anonymity of the data gathered in this investigation: your identity cannot be made public as we will not have that information. You will be unknown, even to us. A thesis is a public document and will be available through the UC Library. If you would like to receive a copy of the summary of results of the project, check the UC Library website from early 2022 for the submitted thesis (https:/ir.canterbury.ac.nz/).

The project is being carried out as a requirement for a Master of Science at the University of Canterbury by Charlotte Lindo under the supervision of Dr Jacinta Cording and Dr Sarah Christofferson. Charlotte can be contacted at cli162@uclive.ac.nz. She will be pleased to discuss any concerns you may have about participation in the project.

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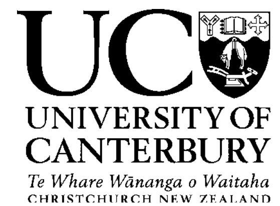

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- ☐ I understand that all data collected for the study will be kept in password protected electronic form and will be destroyed after five years.
- ☐ I understand the risks associated with taking part and how they will be managed.

I understand that I can contact the researcher, Charlotte Lindo, at

charlotte.lindo@pg.canterbury.ac.nz

- ☐ for further information. If I have any complaints, I can the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).
- ☐ I would like a summary of the results of this project and am happy for this to be sent via the Prolific messaging service.
- ☐ By checking this box, I agree to participate in this research project.

Appendix D

Questionnaire for General Public Sample

Demographics

- What is your age?
  - Under 18 (If this is selected, immediately exited from survey)
  - 18 – 30
  - 31 – 40
  - 41 – 50
  - 51 – 65
  - 66 – 80
  - 80+
- Please specify your gender.
  - Male
  - Female
  - Other (please state)
- Please specify your ethnicity.
  - Indigenous American
  - Asian
  - Australian Aboriginal
  - African American
  - African
  - European or Caucasian or White
  - Hispanic, Latinx or Spanish origin
  - Māori
  - Middle Eastern or North African
  - Native Hawaiian
  - Pacific Islander
  - Torres Strait Islander
  - Other ethnicity or origin (please specify)
- What is your current employment status?
  - Unemployed
  - Student

- Employment

Assessing Self-Reported Sexually Harmful Behaviours

Sexual Experiences Scale - Short form Perpetration (SES-SFP; Koss et al., 2006).

This part of the questionnaire contains graphic questions regarding sexual experiences with minors. This may be upsetting for some participants therefore I would like to remind you that you are able to withdraw from participating in this project if you do not wish to read and answer such questions.

The questions ask about the number of times you have had particular experiences with a child or teenage under the age of 16. In thinking about your answer for each experience, you should not count those that took place when you were aged under 18, *unless* the child was give or more years younger than you.

	Since age 14
1.How many times have you fondled, kissed, or rubbed up against the private areas (e.g. lips, breasts/chest, penis, or vagina) of a child or teenager under the age of 16, or removed some of their clothes (but did not attempt sexual penetration).	0, 1, 2, 3+
2.How many times have you had oral sex with a child or teenager under the age of 16 or had someone aged less than 16 perform oral sex on you.	0, 1, 2, 3+
3.How many times have you put your penis or put your fingers or other objects into a vagina or a female child or teenager under the age of. 16?	0, 1, 2, 3+
4.How many times have you put your penis or your fingers or other objects into the anus of a child or teenager under the age of 16.	0, 1, 2, 3+
5. Even though it did not happen, how many times have you TRIED to have oral sex with a child or teenager under the age of 16 or make them have oral sex with you.	0, 1, 2, 3+
6. Even though it did not happen, how many times have you TRIED to put your penis or put your fingers or other objects into the vagina of a female child or teenager under the age of 16?	0, 1, 2, 3+
7. Even though it did not happen, how many times have you TRIED to put your penis or put your fingers or other objects into the anus of a child or teenager under the age of 16?	0, 1, 2, 3+
8. How many times have you exposed or attempted to expose your genitals to a child or teenager under the age of 16?	0, 1, 2, 3+

9. How many times have you secretly viewed ("peeped" at) a child or teenager under the age of 16 without their knowledge for the purpose of obtaining sexual gratification (e.g., as they are getting dressed or using the bathroom)?	0, 1, 2, 3+
10. How many times have you encouraged or forced a child or teenager under the age of 16 to engage in sexual activity with someone else?	0, 1, 2, 3+
11. How many times have you created/viewed/or distributed images of children or teenagers under the age of 16 that could be used for sexual gratification?	0, 1, 2, 3+
12. How many times have you used the internet to make contact with a child or teenager under the age of 16 for the purpose of sexual gratification? (e.g., discussing sexual topics)	0, 1, 2, 3+
13. How many times have you used the internet to develop a relationship with a child or teenager under the age of 16 with the aim of engaging in sexual activity with that person?	0, 1, 2, 3+
14. How many times have you done any of the acts listed above to someone who was aged 16 years or older without their consent?	0, 1, 2, 3+

Participant's Sexual Interests Questions

1. Are you sexually interested in pre-pubescent children (under age of 12)?
2. Are you sexually interested in pubescent children (aged 12-15)?
3. Are you sexually interested in post-pubescent young people (aged 16-17)?
4. Are you sexually interested in adults (over age of 18)?

Self-Stigma of Mental Illness Scale: SSMIS – M

There are many attitudes about people who experience sexual interest in children. We would like to know what you think most of the public as a whole (or most people) believe about these attitudes.

Please answer the following items using the 9-point scale below.

I strongly Disagree			neither agree nor disagree					I strongly agree
1	2	3	4	5	6	7	8	9

Section 1:

I think the public believes…

1. _____ most people who experience sexual interest in children cannot be trusted.
2. _____ most people who experience sexual interest in children are disgusting.
3. _____ most people who experience sexual interest in children are unable to get or keep a regular job.
4. _____ most people who experience sexual interest in children are dirty and unkempt.
5. _____ most people who experience sexual interest in children are to blame for their problems.
6. _____ most people who experience sexual interest in children are below average in intelligence.
7. _____ most people who experience sexual interest in children are unpredictable.
8. _____ most people who experience sexual interest in children will not recover or get better.
9. _____ most people who experience sexual interest in children are dangerous.
10. _____ most people who experience sexual interest in children are unable to take care of themselves.

Section 2:
Now answer the next 10 items using the agreement scale.

I strongly Disagree			neither agree nor disagree					I strongly agree
1	2	3	4	5	6	7	8	9

I think…

1. _____ most people who experience sexual interest in children are to blame for their problems.

2. _____ most people who experience sexual interest in children are unpredictable.

3. _____ most people who experience sexual interest in children will not recover or get better.

4. _____ most people who experience sexual interest in children are unable to get or keep a regular job.

5. _____ most people who experience sexual interest in children are dirty and unkempt.

6. _____ most people who experience sexual interest in children are dangerous.

7. _____ most people who experience sexual interest in children cannot be trusted.

8. _____ most people who experience sexual interest in children are below average in intelligence.

9. _____ most people who experience sexual interest in children are unable to take care of themselves.

10. _____ most people who experience sexual interest in children are disgusting.

PERMA-Profiler

Perma1

How much of the time do you feel you are making progress towards accomplishing your goals?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

How often do you become absorbed in what you are doing?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

How often do you feel joyful?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

How often do you feel anxious?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

How often do you achieve the important goals you have set for yourself?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

H1

How would you say your health is?

Terrible 0	1	2	3	4	5	6	7	8	9	Excellent 10

Perma2

To what extent do you lead a purposeful and meaningful life?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

To what extent do you receive help and support from others when you need it?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

To what extent do you feel that what you do in your life is valuable and worthwhile?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

To what extent do you feel excited and interested in things?

Never	1	2	3	4	5	6	7	8	9	Always

0										10

How lonely do you feel in your daily life?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

H2

How satisfied are you with your current physical health?

Not at all 0	1	2	3	4	5	6	7	8	9	Completely 10

Perma3

How often do you feel positive?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

How often do you feel angry?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

How often are you able to handle your responsibilities?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

How often do you feel sad?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

How often do you lose track of time while doing something you enjoy?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

H3

Compared to others of your same age and sex, how is your health?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

Perma4

To what extent do you feel you have a sense of direction in your life?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

How satisfied are you with your personal relationships?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

To what extent do you feel loved?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

To what extent do you feel content?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

Hap

Taking all things together, how happy would you say you are?

Not at all 0	1	2	3	4	5	6	7	8	9	Completely 10

Data Removed Question

Would you like your data removed from the analysis of data process?

- Yes, I am happy for my data to remain in the final analysis.
- Yes, I would like my data removed from further analysis.

Appendix E

MAP Sample Questionnaire

Demographics

- What is your age?
  - Under 18 (If this is selected, immediately exited from survey)
  - 18 – 30
  - 31 – 40
  - 41 – 50
  - 51 – 65
  - 66 – 80
  - 80+
- Please specify your gender.
  - Male
  - Female
  - Other (please state)
- Please specify your ethnicity.
  - Indigenous American
  - Asian
  - Australian Aboriginal
  - African American
  - African
  - European or Caucasian or White
  - Hispanic, Latinx or Spanish origin
  - Māori
  - Middle Eastern or North African
  - Native Hawaiian
  - Pacific Islander
  - Torres Strait Islander
  - Other ethnicity or origin (please specify)
- What is your current employment status?
  - Unemployed
  - Student
  - Employment

Participant's Sexual Interests Questions

1. Are you sexually interested in pre-pubescent children (under age of 12)?
2. Are you sexually interested in pubescent children (aged 12-15)?
3. Are you sexually interested in post-pubescent young people (aged 16-17)?
4. Are you sexually interested in adults (over age of 18)?

Please answer the following items using the 9-point scale below.

I strongly Disagree			neither agree nor disagree					I strongly agree
1	2	3	4	5	6	7	8	9

Section 1:

I think the public believes…

1. _____ most people who are sexually attracted to children cannot be trusted.
2. _____ most people who are sexually attracted to children are disgusting.
3. _____ most people who are sexually attracted to children are unable to get or keep a regular job.
4. _____ most people who are sexually attracted to children are dirty and unkempt.
5. _____ most people who are sexually attracted to children are to blame for their problems.
6. _____ most people who are sexually attracted to children are below average in intelligence.
7. _____ most people who are sexually attracted to children are unpredictable.
8. _____ most people who are sexually attracted to children will not recover or get better.
9. _____ most people who are sexually attracted to children are dangerous.
10. _____ most people who are sexually attracted to children are unable to take care of themselves.

Section 2:
Now answer the next 10 items using the agreement scale.

I strongly Disagree			neither agree nor disagree					I strongly agree
1	2	3	4	5	6	7	8	9

I think…

1. _____ most people who are sexually attracted to children are to blame for their problems.

2. _____ most people who are sexually attracted to children children are unpredictable.

3. _____ most people who are sexually attracted to children will not recover or get better.

4. _____ most people who are sexually attracted to children are unable to get or keep a regular job.

5. _____ most people who are sexually attracted to children are dirty and unkempt.

6. _____ most people who are sexually attracted to children are dangerous.

7. _____ most people who are sexually attracted to children cannot be trusted.

8. _____ most people who are sexually attracted to children are below average in intelligence.

9. _____ most people who are sexually attracted to children children are unable to take care of themselves.

10. _____ most people who are sexually attracted to children are disgusting.

Section 3

Now answer the next 10 items using the agreement scale.

I strongly Disagree			neither agree nor disagree					I strongly agree
1	2	3	4	5	6	7	8	9

Because I am sexually attracted to children…

1. _____ I am below average in intelligence.

2. _____ I cannot be trusted.

3. _____ I am unable to get or keep a regular job.

4. _____ I am dirty and unkempt.

5. _____ I am unable to take care of myself.

6. _____ I will not recover or get better.

7. _____ I am to blame for my problems.

8. _____ I am unpredictable.

9. _____ I am dangerous.

10. _____ I am disgusting.

Section 4

Finally, answer the next 10 items using the agreement scale.

I strongly Disagree			neither agree nor disagree					I strongly agree
1	2	3	4	5	6	7	8	9

I currently respect myself less…

1. _____ because I am unable to take care of myself.

2. _____ because I am unable to get or keep a regular job.

3. _____ because I am dangerous.

4. _____ because I cannot be trusted.

5. _____ because I am to blame for my problems.

6._____ because I will not recover or get better.

7. _____ because I am disgusting.

8. _____ because I am unpredictable.

9. _____ because I am dirty and unkempt.

10. _____ because I am below average in intelligence.

Help Seeking Scale

1. Have you sought help from a mental health professional for any issues related to your sexual attraction towards children?
   - Yes
   - No

2. Have you considered getting help from a mental health professional for any issues related to your sexual attraction towards children?
   - Yes
   - No

PERMA-Profiler

Perma1

How much of the time do you feel you are making progress towards accomplishing your goals?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

How often do you become absorbed in what you are doing?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

How often do you feel joyful?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

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How often do you achieve the important goals you have set for yourself?

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H1

How would you say your health is?

Terrible 0	1	2	3	4	5	6	7	8	9	Excellent 10

Perma2

To what extent do you lead a purposeful and meaningful life?

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To what extent do you receive help and support from others when you need it?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

To what extent do you feel that what you do in your life is valuable and worthwhile?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

To what extent do you feel excited and interested in things?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

How lonely do you feel in your daily life?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

H2

How satisfied are you with your current physical health?

Not at all 0	1	2	3	4	5	6	7	8	9	Completely 10

Perma3

How often do you feel positive?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

How often do you feel angry?

Never	1	2	3	4	5	6	7	8	9	Always

0										10

How often are you able to handle your responsibilities?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

How often do you feel sad?

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How often do you lose track of time while doing something you enjoy?

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H3

Compared to others of your same age and sex, how is your health?

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Perma4

To what extent do you feel you have a sense of direction in your life?

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How satisfied are you with your personal relationships?

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To what extent do you feel content?

Never 0	1	2	3	4	5	6	7	8	9	Always 10

Hap

Taking all things together, how happy would you say you are?

Not at all 0	1	2	3	4	5	6	7	8	9	Completely 10

Data Removed Question

Would you like your data removed from the analysis of data process?
- Yes, I am happy for data to remain in the final analysis.
- No, I would like my data to remove from further analysis.

B4Uact Question

In designing our study, we have our best attempt to be respectful to our MAP study participants but we are looking to imrpove. Please tell us about any ways you may have found our study biased, stigmatising, stereotyping or otherwise flawed in ways that could lead to misleading results.