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RESEARCH ARTICLE

Secret-keeping in therapy by clients who are sexually attracted to children

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ABSTRACT

Objective This study investigated the reasons why pedohebephilic clients disclose their sexual attraction to children in therapy and the experiences associated with this decision among English-speaking samples. **Method**: The pre-registered online survey combined (1) quantitative correlational data of self-reported improvement, alliance, therapist reaction to disclosure, and the belief that mandatory reporting laws were in place, and (2) qualitative data about reasons for disclosure or no disclosure as well as perceived consequences. The sample consisted of pedohebephilic people who have been clients in therapy and have disclosed ($n = 96$) or not disclosed ($n = 40$). **Results:** While the disclosure and no disclosure groups did not differ in improvement or beliefs about mandatory reporting, those who had disclosed reported a stronger alliance. Clients who did not perceive the therapist's reaction as supportive reported less improvement than the no disclosure group. Thematic analysis of qualitative data identified three themes concerning motives for disclosing or not disclosing and a fourth regarding differential impacts of disclosure. **Discussion**: This study indicates that disclosing pedohebephilia does not in and of itself lead to improvement but is contingent on a therapist's reaction.

Keywords: pedophilia; disclosure

Clinical or methodological significance of this article: This research suggests that disclosure of secrets in therapy, which in the present study refers to sexual attraction to children, is not necessarily related to improvement, as improvement depends on whether the therapist reacts in a supportive way.

Objective

Between 1 and 5% of the male population report a sexual attraction to prepubescent children (i.e., pedophilia) or pubescent children (i.e., hebephilia, Bártová et al., 2021; Dombert et al., 2016). Among the female population, less than 1% report pedophilic or hebephilic attraction (Bártová et al., 2021). In recent years, psychological and psychiatric therapy for pedohebephilic persons has gained scholarly attention as a strategy to increase client well-being and prevent child sexual abuse (Heasman & Foreman, 2019; Lasher & Stinson, 2017; Levenson et al., 2020). Despite this, pedohebephilia remains highly stigmatized, even among therapists (Lawrence & Willis, 2021), who according to recent surveys lack knowledge about the needs of pedohebephilic clients and are reluctant to offer therapy to this group (Schmidt & Niehaus, 2022; Stiels-Glenn, 2010). Research further suggests that a non-trivial number of therapists will break confidentiality following a

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client disclosing pedohebephilia, regardless of the presence of other risk factors for child sexual abuse (Stephens et al., 2021). This puts pedohebephilic clients in a difficult position: Should they disclose their sexual attraction to children or not? On the one hand, disclosure can help the therapist plan more appropriate interventions to help the client improve. On the other hand, disclosure may expose the client to mistrust, rejection, and the potential consequences of breaches of confidentiality. The present mixed-method study investigates how disclosure of pedohebephilia in therapy relates to the alliance between the client and the therapist, client improvement, and the therapists' reaction to disclosure.

Nondisclosure in Therapy is Common and May Have Deleterious Effects

It is common for clients to not disclose secrets to their therapist (Blanchard & Farber, 2016; Hill et al., 1993; Love & Farber, 2019). In a therapy context, secrets are conceptualized as personally meaningful facts, experiences, or feelings that clients consciously withhold from their therapist (Hill et al., 1993, p. 278). In a survey of 547 clients in therapy, 73% admitted to having kept secrets from their therapist at least once on a therapy-related topic (Blanchard & Farber, 2016). Secrets in therapy are often of a sexual nature (Hill et al., 1993; Love & Farber, 2017, 2019; Pope & Tabachnick, 1994), and three out of four clients who did not disclose their secret reported to have done so because of shame and embarrassment (Baumann & Hill, 2016). Other common reasons to not disclose include a desire to be polite or to avoid rejection, besides more pragmatic considerations like perceiving there being more important things to talk about (Baumann & Hill, 2016; Hook & Andrews, 2005). For clients who concealed suicidal ideation from their therapist, the most important reason was fear of practical consequences of disclosure outside of therapy (e.g., hospitalization), more so than fears related to reasons specific to therapy or a desire to avoid negative emotions (Blanchard & Farber, 2020).

Establishing a collaborative relationship and affective bond is a key process in psychotherapy (Flückiger et al., 2018). Not disclosing therapy-relevant information is associated with a weaker alliance (Kelly & Yuan, 2009). Many clients who disclosed a secret in therapy reported that doing so was beneficial, typically because they experienced relief (Baumann & Hill, 2016) or because they received more feedback (Kelly & Yuan, 2009). More broadly, keeping secrets from others in daily interactions may have deleterious effects (Larson & Chastain, 1990). The mere intention to conceal can lead to frequent spontaneous thoughts about the secret. Compared to active concealment in relevant social interactions, mind-wandering in irrelevant situations occurs more frequently and is more strongly related to reduced well-being (Slepian et al., 2017). People who tend to be secretive about, for instance, their sexual orientation or having had an abortion, report higher levels of depression, anxiety, and/or somatic symptoms (Flentje et al., 2020; Major & Gramzow, 1999; Meyer, 2003). Experimental research suggests that simply writing about non-disclosed traumatic events can alleviate distress and depression, alongside other positive health benefits (Pennebaker, 1997; for meta-analytic evidence, see, e.g., Frattaroli, 2006; Smyth, 1998).

Empirical studies reveal a more complex relationship between disclosure and therapy outcomes, whereby the potential benefits may be offset by significant risks (Farber et al., 2019). For instance, women who disclose childhood sexual abuse in treatment may benefit from experiencing emotional closeness, authenticity, validation, and catharsis, but may also be at risk of feeling ashamed, confused, or vulnerable (Farber et al., 2009). Hence, it is perhaps not surprising that studies that have attempted to quantify the link between disclosure and therapy outcomes report conflicting results (Hill et al., 2000). In one study, clients who tended to more readily disclose distressing information prior to therapy have been found to have better therapy outcomes (Kahn et al., 2001). Similarly, another study found that disclosure of depression-related symptoms was linked to less depressive symptoms among clients who had been in psychological therapy with depression (Hook & Andrews, 2005). Yet, these authors could only confirm this link among clients with depression who were no longer in therapy at the time of the study, but not among clients who were still in therapy. Another study found that disclosure predicted *more* symptoms (controlling for initial symptomatology and general propensity to keep secrets, Kelly, 1998). Yet, the lack of a positive link between disclosure and therapy improvement does not necessarily show that disclosure is therapeutically irrelevant (Farber et al., 2019). This is because it is possible that disclosure is both a helpful means to relieve distress and also indicative of an underlying disorder which is causing distress and the impetus to disclose (Stiles, 1995).

Is Disclosure Beneficial for Pedohebephilic Clients?

While pedohebephilic clients often keep their sexual attraction a secret (Jahnke et al., 2015), research

finds that as many as 60% have disclosed their attractions to others in their lives (Elchuk et al., 2022). Disclosure was not necessarily perceived as beneficial; although disclosure followed by positive support from others was associated with less loneliness and suicidality (Elchuk et al., 2022). Similarly, potential benefits of disclosure, such as client improvement or a stronger alliance, may not translate for clients who disclose a highly stigmatized characteristic or disclose symptoms that a therapist lacks competence to treat. Both are likely to be true in the case of pedohebephilia (Schmidt & Niehaus, 2022).

Consequences of non-disclosure and disclosure for therapy outcomes likely rest on the real or perceived response by the therapist (Kelly & McKillop, 1996). For pedohebephilic clients, deciding whether to seek treatment is informed by perceptions of being stigmatized by therapists and in many jurisdictions, concerns regarding therapists' understanding of when to make a report regarding a child at risk of being harmed. Recent research shows that this concern is not misplaced: Vignette-based research examining therapist ethical decision-making following a client disclosing pedohebephilia found that therapist stigma towards pedohebephilic people predicts therapists making a child protection report, even in circumstances that would not warrant such a report (Stephens et al., 2021). These findings suggest that not receiving positive support following a disclosure in therapy may be associated with negative outcomes.

The Present Research

The present study investigated the therapy outcomes associated with disclosing pedohebephilia. A mixed methods research design was employed, with quantitative methods used to detect differences between the disclosure and no disclosure groups and qualitative methods used to help explain quantitative findings. The study is anchored in the postpositivist paradigm (Ponterotto, 2005), which prioritizes the quantitative analysis and uses the qualitative data to augment the quantitative findings (Hanson et al., 2005).

The following hypotheses were formulated before data-collection:

(1) Disclosure in therapy is associated with self-reported client improvement.
(2) Disclosure in therapy is associated with the strength of the alliance.
(3) Disclosure in therapy is associated with the belief that mandatory reporting laws were in place at the time of therapy.
(4) For clients who have disclosed to their therapist, we predict there will be associations between the perceived therapist reaction on the one side and self-reported client improvement and strength of alliance on the other side.

After data collection was completed, we added the following post-hoc hypotheses:

(5) Clients who perceived support from their therapist after disclosure will report more improvement compared to participants who did not disclose.
(6) Clients who did not perceive support from their therapist after disclosure will report less improvement compared to participants who did not disclose.

Given the novelty of these research questions and the complex, dynamic, recursive, and transactional nature of client and therapist behavior, we supplemented the quantitative findings with a thematic analysis of qualitative data about reasons for disclosure or non-disclosure and perceived effects of the decision to disclose or not disclose.

Method

Participants and Recruitment

Participants were recruited between January 2021 and May 2021 on English and German web-forums for pedohebephilic persons (B4U-ACT, BoyChat, Virtuous Pedophiles, VisionsofAlice, jungsforum, krumme13, kinder-im-herzen). Pedohebephilic individuals use these forums to anonymously share their sexual interests, create a sense of community and belonging, educate others about pedohebephilia, and/or provide and receive support. The forums also provide a unique opportunity for researchers to study pedohebephilia outside of forensic contexts (e.g., Elchuk et al., 2022; Grady et al., 2019; Jahnke et al., 2015). The present study was advertised as a survey about preferred labels as well as stigma- and therapy-related attitudes and experiences among adults with a sexual attraction to prepubescent and/or pubescent children, and participants received no compensation (which would have been difficult to deliver due to the anonymity needs of this population). The survey was only available in English. A priori power analysis was conducted using G*Power (Faul et al., 2007). Assuming a medium-sized effect ($f^2 = .25^2$), 158 participants are required for a Type II error rate of .20 and Type I error rate of .05 when conducting MANOVA with two dependent variables. It was planned to oversample by 25% to account for non-eligible cases. Hence, we were striving for a sample size of 198 participants with therapy experiences.

In total, data from 346 participants was collected. Of these, 283 cases passed the pre-registered quality checks (see below), meaning that they reported sexual attraction in prepubescent or pubescent children that are equal to or stronger than their sexual attraction to adults. Participants who did not report any prior therapy experiences ($n = 128$) or whose last therapy was court-mandated ($n = 19$) were also excluded. This resulted in a sample of 136 pedohebephilic persons who had previously been in clients in therapy.

Measures

Erotic age preference. Sexual attraction to children was assessed using self-reported attractions to different stages of development and sex combinations (Jahnke & Malón, 2019). Participants were asked their degree of sexual attraction to females and males before, in, or after puberty, resulting in a total of six items. For each item, participants were provided with a description of the developmental stage (e.g., pubertal girls were described as "girls who show some signs of physical maturity like sparse pubic hair or developing breasts") and a non-pornographic drawing (i.e., designed to demonstrate anatomy, not to stimulate sexual arousal) of a corresponding nude character. The same pictures are included in the intake assessment of the online intervention Troubled Desire (Schuler et al., 2021). The response scale was a 10-point Likert-type scale that ranged from no sexual interest to maximum sexual interest.

We calculated several sexual attraction indices: (1) The pedohebephilic attraction index was computed by subtracting the maximum level of sexual attraction to adult stimuli from the maximum level of sexual attraction to prepubescent or pubescent stimuli; (2) the male-oriented pedohebephilic attraction index was computed by subtracting the maximum level of sexual attraction to the female prepubescent or pubescent child from the maximum level of sexual attraction to the male prepubescent or pubescent child; and (3) an index to quantify the relative degree of pedophilic versus hebephilic attraction was computed by subtracting the maximum level of sexual attraction to the male or female pubescent child from the maximum level of sexual attraction to the male or female prepubescent child. Previous research demonstrated the validity of the procedure to correctly classify online participants as pedohebephilic or teleiophilic based on overlap with results from a viewing time test (with φ ranging between .50 and .69, indicating a strong positive relationship, Jahnke, Schmidt, et al., 2022). The retest-reliability of the scale has not been tested.

Therapy information, disclosure status, and belief that mandatory reporting laws were in place. Participants were asked whether they have been in psychological or psychiatric therapy because of a mental disorder or because of problems related to their sexual attraction to children. We furthermore assessed whether participants were currently in therapy, whether they sought therapy due to a court order following a sexual offence allegation, and whether they have disclosed their sexual attraction to children to their last therapist. Participants' belief that mandatory reporting laws were in place during their time in therapy was measured with the following item: "Were mental health professionals in your country required by law to report suspicions of child sexual abuse (mandatory reporting), at the time when you were in treatment? If you have been in treatment multiple times or over several years, please refer to your last therapy.". Response options for these items were dichotomous (Yes/No), with the exception of belief that mandatory reporting laws were in place, which had a 5-point response scale (ranging from "Yes, surely" to "No, surely not") to assess for participants' level of certainty, as past research detected some level of uncertainty about these laws even among therapists (Levenson et al., 2020). We assessed the year that participants were last in therapy, deleting one implausible value ("1920"). The variable *Years since last therapy* was calculated by subtracting the year from 2021.

Perceived effects of disclosure in therapy scale (PEDTS). The Perceived Social Support for Minor Attraction Scale (PSS-MAS; Elchuk et al., 2022) was adapted to assess perceptions of therapist response to disclosure of one's sexual attraction to children (see Table S1, Supplementary Materials, for a list of items). The PSS-MAS has shown adequate reliability (αs between .74 and .80) and adequate convergent validity evidence (e.g., associates with loneliness, internalized stigma, distress, quality of relationships, suicidality; rs between |.34| and |.52|; Elchuk et al., 2022). Specifically, the PSS-MAS items were revised to inquire about support from a therapist versus friends in the original items. In addition, the term *minor attractio*n was replaced with the more descriptive term *sexual attraction to children*. One of the PSS-MAS items was removed for the scale (i.e., "I fear that my friends will never accept my minor attraction") because this did not fit well with a therapeutic relationship, which is

discontinued at the end of therapy. An additional item was developed for the purposes of the present research context ("I believe that my therapist was reluctant to work with me because I was sexually attracted to children"). Finally, a single item was revised from referring to relationships with friends to refer to the alliance with a therapist. These revisions resulted in a 5-item Perceived Effects of Disclosure in Therapy Scale (PEDTS), with a fully labeled Likert scale with responses ranging from "Strongly disagree" to "Strongly agree". Higher scores indicate higher perceived support from a therapist. Information about dimensionality and internal consistency is provided in "Factor Structure of the Perceived Effects of Disclosure in Therapy Scale" (see Results).

Functioning before and after treatment, client improvement and alliance. Client improvement and alliance were assessed using self-report measures asking participants to recall their functioning before and after therapy and their impression of the alliance, based on the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS; Duncan, 2012). The ORS assesses a client's level of functioning on four visual analog scales (individually, interpersonally, socially, and overall). The SRS measures the client's perception of the alliance with their therapist by assessing whether they felt heard and respected by their therapist, alignment on goals and topics in sessions, fit of therapist's approach, and overall satisfaction with therapy. The response range for the ORS and SRS is 0 –100. The original ORS has demonstrated sensitivity to improvement in clinical studies, as well as convergent validity, particularly with measures of depression (Meier, 2020). The original SRS has shown low to moderate convergent validity with longer alliance scales (Murphy et al., 2020). Both the ORS and SRS had high internal consistency in previous studies (Meier, 2020; Murphy et al., 2020).

In the present study, because participants were being asked about past therapy experiences, the instructions of the ORS were modified to ask for retrospective ratings of psychosocial functioning immediately prior to entering and immediately following therapy, while the SRS instructions were modified to ask about the *overall* strength of the alliance during therapy. Pre- and posttherapy modified ORS scores and SRS scores were computed using the average score for the four items in each scale. *Client improvement* is calculated as the difference between the ORS score after therapy and the ORS score before therapy. The values of client improvement can range from −100 to 100, with *positive* scores indicating increased psychosocial functioning over the course of therapy and *negative* values indicating that psychosocial functioning has deteriorated over the course of therapy. Higher scores on the SRS indicate that the alliance is perceived as stronger. The scales showed high internal consistency in the present survey (see Table I).

Participants' experience of therapy in relation to the decision to disclose or not disclose. After the quantitative section, participants were presented the following open question: (1) "We have asked you before about whether or not you have disclosed your sexual interest in children to your therapist. Now, we would like to ask you for the reasons behind this decision. What was important for your decision?" and (2) "In what ways, if at all, do you think that your decision to disclose or not disclose has affected your experience in therapy?". Participants could type in their responses to each question in an open field.

Sociodemographic information. Participants were asked about sex assigned at birth, current gender identity, current age, educational attainment, history of contact sexual offending against children, and history of accessing child sexual exploitation material.

Quality checks. We employed the honesty and seriousness check items by Aust et al. (2013) and Sischka et al. (2022), respectively, at the end of the survey. Participants who responded that they have answered more than one item dishonestly (honesty check) or reported to not have participated seriously (seriousness check) were excluded in line with preregistered criteria.

Data Analytic Strategy

Mixed-method design. A concurrent explanatory design was employed to merge the quantitative and qualitative data (Hanson et al., 2005). This means that qualitative and quantitative data were collected at the same time and that the quantitative data is given priority. Data integration takes place in the discussion section.

Quantitative analysis. The significance level was set to $\alpha = .05$ for all analyses. Parametric testing was conducted if the distribution of the residuals (for *t*-tests) or variables (for correlations) was reasonably normal (i.e., skewness between –2 and +2 and kurtosis between –7 and +7). We preregistered a multivariate analysis of variance

Table I. Univariate comparisons of clients who did and did not disclose on study variables.

		Nondisclosers			Disclosers			*95% CI* of the mean difference[a]		Nonparametric sensitivity test		χ^2-tests		Effect sizes	
Variables	α	*M*	*SD*	*n*	*M*	*SD*	*n*	*Lower*	*Upper*	*U*	*p*	$\chi^2(df)$	*p*	Hedge's *g*	Cramer's *V*
Pedohebephilic index	-	2.88	2.55	40	4.47	2.96	96	−2.55	−0.63	1323.5	.004			0.56	
Male-oriented pedohebephilic index	-	−0.30	5.63	40	0.00	6.44	96	−2.44	1.84	-	-			0.05	
Pedophilic index	-	0.05	3.20	40	1.54	3.78	96	−2.71	−0.27	1382.0	.010			0.41	
Educational attainment: % Finished and got credit for 12th grade	-	88	-	40	83	-	96	-	-	-	-	0.38(1)	.540		.05
In therapy at the moment (% yes)	-	25	-	40	43	-	96	-	-	-	-	3.78	.052		.17
Years since last therapy	-	4.39	4.96	38	4.85	8.04	95	−2.61	1.77	2009.0	.302			0.06	
Sex (% female)	-	28	-	40	11	-	96	-	-	-	-	5.36(1)	.021		.20
Gender identity (% female/ % other[b])	-	5/ 15	-	40	9/ 10	-	96	-	-	-	-	1.17(2)	.556		.09
Age	-	31.30	11.62	40	37.41	14.55	96	−10.55	−1.42	1446.0	.024			0.44	
Functioning at pretreatment	.86	27.35	19.10	39	29.15	20.80	95	−8.92	5.54	1771.5	.693			0.09	
Functioning at posttreatment	.89	49.13	22.93	37	53.55	22.53	93	−12.89	4.38	-	-			0.19	
Client Improvement	-	22.61	23.07	37	24.55	26.23	93	−10.90	7.23	-	-			0.08	
Alliance	.95	49.11	25.66	37	66.97	31.05	95	−28.05	−7.36	-	-			0.60	
Mandatory reporting beliefs	-	1.87	1.17	39	2.23	1.41	96	−0.80	0.12	1636.5	.225			0.26	
Perceived Effects of Disclosure in Therapy (items 2-5)	.90	-	-	-	5.45	1.66	96	-	-	-	-				

Notes: We only conducted nonparametric sensitivity tests (i.e., Mann–Whitney *U*-tests) if the variable contained outliers in the D+, D-, or both groups.

[a]Based on 1000 bootstrap samples, we used the Welch (or Satterthwaite) approximation to the degrees of freedom.

[b]Other labels: 7 participants self-labeled as non-binary, every other label was only given once: agender, agender/genderless, divers, genderfluid, genderfluid/non-binary, Male identifying non-binary, non-binary masculine, none and void.

(MANOVA) as a global test of the effects of disclosure status on client improvement and the SRS because both were conceptualized as outcomes affected by disclosure that are associated with one another. Conducting a global test before moving on to individual tests (if the global test is significant) can protect against familywise Type 1 error. The MANOVA.RM package (Friedrich et al., 2019) was used for the MANOVA analyses, given several desirable features of the package's approach (e.g., calculating a resampling-based test of multivariate data that does not require multivariate normality of error terms, similar sample sizes, or homoscedastic variances). To assess the effect of disclosure status on single dependent variables, bootstrap *t*-tests based on 1,000 resamples were conducted. The Welch (or Satterthwaite) approximation to the degrees of freedom was applied by default, following recommendations for best-practice for group comparisons (West, 2021). For analyses containing variables with outliers, robust rank-based sensitivity tests (in this case Mann–Whitney *U* test) were conducted. Outliers were defined as values that fall above the 3rd quartile + 1.5*interquartile range or below the 1st quartile − 1.5*interquartile range. Links between two continuous variables were assessed with Kendall's τ for variables with outliers or severe deviations from the assumption of normality, while Pearson *r* was used in all other cases. The R package *lavaan* (Rosseel et al., 2020) was used to conduct confirmatory factor analysis (CFA) on the PEDTS. We fitted a one-factor model using the *weighted least squares means and variance adjusted* (WLSMV) estimator. We assumed good model fit for models with factor loadings > .40 (Howard, 2016), CFI > .90, and RMSEA < .08 (T. D. Smith & McMillan, 2001).

We proceeded with non-preregistered analyses exploring differences in therapy outcomes between those who did not disclose (*No disclosure* group), those who did disclose and did not feel supported (*Disclosure- no support* group) and those who did disclose and felt supported (*Disclosure + support* group), following similar procedures in Elchuk et al. (2022). Support status was determined based on the response to the item "My therapist had become a real support regarding my sexual attraction to children" from the PEDTS. Participants who disclosed in therapy and scored above the midpoint of the scale (i.e., 5 or more on a scale from 1 to 7) were categorized as Disclosure + support, while participants who scored below the mid-point (i.e., 3 or less on a scale from 1 to 7) were grouped as Disclosure–no support.

Qualitative analysis. Text responses to questions regarding experience in therapy in relation to the decision to disclose or not disclose were analyzed using thematic analysis, a method for identifying, analyzing, and reporting patterns and themes within a data set. Thematic analysis aims to capture rich detail and represent the range and diversity of experience within the data. It has been described as a "contextualist method," sitting between the two poles of constructionism and realism (Braun & Clarke, 2006). This position thus acknowledges the ways individuals make meaning of their experience, and, in turn, the ways in which the broader social context impinges on those meanings. As such, thematic analysis reflects "reality," even if that reality is inherently subjective (Braun et al., 2016; Braun & Clarke, 2006). The analysis adhered to the phases of qualitative thematic analysis as outlined by Braun and Clarke (2021), consisting of familiarization and detailed readings of the data collected, progressing to initial and systematic coding of the data, and then generating initial themes from the coded data. The final phases included reviewing themes, ensuring that they were consistent with the coding and that they were grounded in the qualitative data (Braun & Clarke, 2006; J. A. Smith, 2015). This process has been referred to as "complete coding" (Braun & Clarke, 2006, p. 206) – that is, coding that allows the identification of anything and everything of interest within the data. It was this complete process which was used to identify and highlight data relevant to the research question. The final themes were representative of the sample. It is important to note that the extracts utilized in the analysis are, as outlined by Clarke and Braun (2013) and Braun et al. (2016), illustrative of the theme rather than "proof" of the theme, due to the subjective nature of coding (Braun & Clarke, 2021).

A form of inter-coder agreement was used as a verification procedure to check coding of qualitative data (de Wet & Erasmus, 2005; Miles & Huberman, 1994). In qualitative research, this occurs when two or more researchers code the same data (or aspects of the data) independently and check for consistency across coders (de Wet & Erasmus, 2005). The coding of the qualitative data in this study was conducted by one of the authors and a researcher independent of the research. Both researchers have an extensive track record in qualitative research. Both coders independently analyzed sections of the data and then shared coding and themes in data analysis sessions, where the coders discussed emerging codes/themes, as well as both similarities and differences in data analysis. In this case, there were no real differences in the coding and there was consistency in the types of codes and themes emerging. However, this dialogical process can help to produce safeguards against bias and allow for greater understanding of the data.

Transparency and Openness

We report how we determined our sample size, all data exclusions, and all measures in the study. This study's design, hypotheses, and analyses were pre-registered before the start of the data collection on Open Science Framework (see Research Question 3; https://osf.io/fd34k). Two other Research Questions have been registered alongside the current project and have been or will be tested based on the different sections of the same survey (Jahnke, Blagden, et al., 2022; Jahnke et al., 2023). Data were analyzed using R, version 4.2.1 (R Core Team, 2022). The first author will share the raw data and syntax for re-analysis upon reasonable request but will not make the dataset publicly available. This is in line with information provided to participants during the informed consent procedures, as publication of the dataset is likely to deter pedohebephilic people from participating in research studies due to fears of being identified. The study materials and code book can be accessed via https://osf.io/kpza6/.

Results

Quantitative Data

Comparison of disclosure and no disclosure group. Participants' disclosure status was used to group the sample into those who disclosed their pedohebephilia to a therapist ($n = 96$) and those who did not disclose their pedohebephilia to a therapist ($n = 40$). Univariate comparisons of the two groups are presented in Table I. The majority in our sample finished 12th grade and there were no differences between the two disclosure groups. There was a higher proportion of female participants in the non-disclosure group than in the disclosure group (based on sex assigned at birth). A large majority in both groups (85.3%) reported a stronger attraction to children than to adults, while the remaining 14.7% reported an equal sexual attraction to both. The sample was split about equally between people who were preferentially sexually attracted to male (43.4%) and female children (47.1%; 9.6% reported equal attraction to both sexes). The disclosure group reported a higher relative pedohebephilic (as opposed to teleiophilic) attraction and a higher degree of pedophilic (as opposed to hebephilic) attraction compared to the no disclosure group (see Table I).

MANOVA results showed that the disclosure group differed from the no disclosure group (Wald type statistic = 13.80, $df = 2$, $p = .001$, resampled p [parametric bootstrap approach] = .002) on the two dependent variables client improvement and alliance. Re-running the MANOVA without outliers ($n = 1$ based on Mahalnobis distance) did not change the results. We investigated how people in the two groups differed with respect to client improvement, alliance, and eight other personal or therapy-related variables. The disclosure group did not significantly differ from the no disclosure group on client improvement (Hypothesis 1) or belief that mandatory reporting laws were in place (Hypothesis 3) but reported significantly higher perceptions of the strength of the alliance (Hypothesis 2, see Table I). Of note, participants who disclosed were older and had a higher pedohebephilic, male-oriented pedohebephilic, and pedophilic attraction index compared to participants who did not disclose.

Factor structure of the perceived effects of disclosure in therapy scale. Confirmatory factor analysis was conducted to assess the dimensionality of the PEDTS. The fit of the first model was poor, robust χ^2 ($df = 9$) = 32.49, $p < .001$, robust RMSEA = .17, 95% CI [.11, .23], robust CFI = .99, and item 1 showed a factor loading below the cutoff of .40 (Table S1, Supplementary Material). In hindsight, experiencing difficulty disclosing in therapy may not be a good indicator of therapist support, as difficulties could be due to unrelated factors, such as pre-event rumination. Furthermore, modification indices indicated a residual covariance between items 5 and 6, which may be explained by both items including the word "work." After removing item 1 and adding a residual covariance term for items 5 and 6, model fit was acceptable, for all but one model fit indicator, robust χ^2 ($df = 4$) = 9.01, $p = .061$, robust RMSEA = .12, 95% CI [.00, .22], CFI = 1.00. A high RMSEA-value may reflect the small sample size and small df, rather than model misspecification (D. A. Kenny et al., 2015). Hence, we assumed that a unidimensional model fit the data. As the resulting latent variable was nearly identical to the average score of the 5 items ($r = .95$), we will use the average score instead of the latent score in subsequent analyses. The internal consistency (Cronbach's α) of the five-item PEDTS was excellent (see Table I).

Perceived effects of disclosure and its links to personal and therapy-related variables. We found a positive correlation between PEDTS and client improvement ($r = .49$, $p < .001$) as well as the alliance ($r = .71$, $p < .001$, Hypothesis 4). Exploratory non-pre-registered tests showed a negative relationship between PEDTS and Years since therapy ($\tau = -.28$, $p < .006$). PEDTS scores were

not related to age ($r = -.09$, $p = .387$), functioning before therapy ($\tau = .02$, $p = .803$), and belief that mandatory reporting laws were in place ($r = -.01$, $p = .913$).

Post-hoc comparison based on disclosure and perceptions of therapist support. Forty participants were categorized as No Disclosure, 25 as Disclosure-No Support, and 64 as Disclosure + Support. Seven participants who scored at the midpoint were removed from the analyses. The Disclosure + Support group did not report higher client improvement than the No Disclosure group (Hypothesis 5; Table II). Yet, this result may have been affected by outliers, as the nonparametric sensitivity test detected a significantly higher client improvement score for Disclosure + Support compared to No Disclosure. The Disclosure-no Support group reported lower client improvement than the No Disclosure group (Hypothesis 6). We detected no differences between each of the three groups on level of functioning before therapy.

Qualitative Data

The results of thematic analysis yielded four superordinate themes that captured participants' reasons for disclosing or not disclosing, the experiences of disclosure, and the impacts of disclosure. The analysis unpacks the four inter-related themes (1) *Disclosure as a process of desperation and emotional turmoil*, (2) *Disclosure reluctance – experiential and perceived*, (3) *Therapist as "MAP" aware* and (4) "*Differential impacts of disclosure*". MAP or minor-attracted person is an alternative term to refer to people who are sexually attracted to children in a stricter sense (i.e., pedohebephilia) or a broader sense (i.e., also including teleiophilic attraction to individuals below the age of consent), which some pedohebephilic participants prefer as a self-label (Jahnke, Blagden, et al., 2022). The MAP terminology was retained in the context of the qualitative data analysis, even at the loss of definitional precision, as this terminology is closer to the language used by the participants.

Theme 1: disclosure as a process of desperation and emotional turmoil. One of the most prominent themes within the qualitative data, and one shared by most participants, was how disclosure came from a process of desperation or emotional turmoil that resulted in a need or compulsion to disclose.

> Extract 1: My emotions erupted like a volcano … I repressed my sexual orientation for too many years. So suddenly it all came out.

> Extract 2: Before having a gradual and painful breakdown, I would never had [*sic*] told a soul about my attraction. I was going to take it to the grave. But as things were getting worse and starting to impact my life it was becoming harder to ignore and suppress. […] I can realise now that I was very distressed and depressed.

Extracts 1 and 2 both suggest how for many participants suppressing such feelings was having a negative impact on their daily functioning and causing the experience of volatile emotional states and difficulties in regulating such emotions. Participants in this sample indicated an experience of psychological distress and self-disgust resulting from their sexual attraction. For some, this manifested as turmoil and desperation.

> Extract 3: Under tremendous stress in almost all facets of my life. Extremely depressed. Broke, crying all the time, sleeping little, nowhere to turn, hopeless, no real friends, strained relations with family. […] Felt my interest in children was elephant in room and most other things could not be worked on effectively without my interest in children being out in the open. Really desperately needed someone to talk to […].

Extract 3 again emphasizes the "desperation" in participants' motivation to disclose their sexual attraction to their therapist. Many participants articulated feeling "tortured" by their sexual attraction. The above extract also points to how the sexual attraction to children was straining relationships and creating relational barriers with others including their therapist.

> Extract 4: I needed to be able to talk about it with someone who was not a MAP and since I was building a relationship of trust with my therapist it felt necessary for me to come out. I was also at a point where I felt worse and worse about being a MAP and I needed validation that I was not worth less because I had these attractions.

As highlighted by extract 4, some participants expressed that it was important to disclose to someone who was not part of the minor attracted community in order to develop and validate a positive identity. The participant emphasized the "need" to talk someone who was "not a MAP" and how building trust within relationships including therapeutic relationships was important for facilitating disclosure.

Theme 2: disclosure reluctance – experiential and perceived. There was a prevalent theme on the reluctance of disclosure that was shared by the majority of participants, and this appeared to have

Table II. Univariate comparisons of disclosure and no discloser group on treatment outcomes, depending on perceived therapist support (not pre-registered).

	(1) No disclosure (D-, $n = 40$[a])		(2) Disclosure, no support (D + S-, $n = 25$[b])		(3) Disclosure, support (D + S+, $n = 64$[c])		*95% CI* of the mean difference[d], Hedge's *g*		
Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*	(1) vs (2)	(1) vs (3)	(2) vs (3)
Functioning at pretreatment	27.35	19.10	29.37	21.94	28.10	20.13	[−12.77, 7.87][e], 0.10	[−8.38, 7.13][e], 0.04	[−8.11, 11.69][e], 0.06
Functioning at postreatment	49.13	22.93	35.90	25.90	59.87	18.07	[0.71, 25.36], 0.54	[−19.17, −2.11], 0.53	[−34.78, −12.53], 1.16
Client Improvement	22.61	23.07	6.61	19.90	31.96	25.78	[5.06, 26.47][e], 0.72	[−18.96, 0.35][e,f], 0.37	[−34.88, −14.58][e], 1.03
Alliance	49.11	25.66	32.66	27.73	81.25	20.67	[2.75, 29.91], 0.61	[−41.56, −22.59][e], 1.41	[−59.93, −36.51][e], 2.11

[a]Due to missings, actual *n*'s were ranging between 37 and 39.
[b]Due to missings, actual *n*'s were ranging between 24 and 25.
[c]Due to missings, actual n's were ranging between 63 and 64.
[d]Based on 1000 bootstrap samples, we used the Welch (or Satterthwaite) approximation to the degrees of freedom.
[e]We conducted nonparametric Mann–Whitney *U*-tests as sensitivity tests for all comparisons that were affected by outliers. (1) vs. (2): $U = 463.5$, $p = .746$ for Modified Outcome Rating Scale before, $U = 636.5$, $p = .005$ for Outcome Change Score; (1) vs. (3): $U = 1221.5$, $p = .860$ for Modified Outcome Rating Scale before, $U = 853$, $p = .026$ for Outcome Change Score, $U = 364$, $p < .001$ for Modified Session Rating Scale; (2) vs. (3): $U = 794$, $p = .960$ for Modified Outcome Rating Scale before, $U = 297$, $p < .001$ for Outcome Change Score, $U = 154.5$, $p < .001$ for Modified Session Rating Scale.
[f]For this comparison, Mann–Whitney *U*-tests finds a significant group difference.

two distinct aspects. The first aspect reflects a reluctance borne out of actual experiences of seeking therapy. The second aspect was based on their perceptions and fears of the disclosure process. In terms of participants' actual experiences, many described helpful therapeutic interactions, but participants also pointed to the perceived shaming message of interventions that have a predominant focus on child sexual abuse prevention.

> Extract 5: I hated that they were all about CSA [*child-sexual abuse*]. Clearly not about helping me. All they wanted to do was make me feel dangerous and evil. They're [*sic*] adverts were designed to scare me into speaking to them. It made me feel so much more anxious and alone. I … knew they hated me.

Here the participant's extract highlights how some child abuse prevention services' messaging is perceived as stigmatizing and may, as an unintended consequence, increase the reluctance of those wanting to seek therapy. This perception of messaging was supported by other participants' and also related to other help seeking behaviors.

> Extract 6: I had very negative experiences with other psychotherapists before finding a suitable replacement. One of them retroactively reported me to police and social services which lead to further negative experiences with forensic psychiatrists, psychologists, therapists, and assessors. The one positive experience though was my replacement therapist supported me.

Finding therapists who were accepting and willing to work with them was difficult, with many participants expressing fear that a therapist may react negatively to a disclosure of a sexual in interest in children. While some participants discussed negative experiences of therapy, very few ($n = 2$) mentioned that they had been reported by a therapist to the authorities. The reluctance to disclose may then be based more on fears or perception rather than actual experience. Participants were ambivalent about whether to disclosure their sexual attraction due to fears of perceived consequences from disclosure.

> Extract 7: I wish I felt safe enough to do so, but I don't want to take the risk. Even if my therapist trusted that I am not in danger of committing a crime and don't pose a threat to a child, I am not sure what would have to be reported in my notes for insurance purposes. My own safety is the deciding factor.

> Extract 8: I did not disclose due to concerns about being reported as a potential risk, being misunderstood and judged and the high likelihood my therapist would not understand my experience … The

> overall level of risk outweighed any potential benefit of disclosing.

Extracts 7 and 8 highlight the perception of some of our participants that therapy did not provide a safe environment for disclosure, as well as their fear of being reported. Both extracts point to the inherent cost-benefits analysis some participants made in their decision to disclose and how disclosure is perceived as high risk or has high personal stakes. However, as can be noted in the disjunction between real and perceived experience, it is unclear how balanced, accurate, and informed their cost–benefit analysis may be.

> Extract 9: I worry about the therapist rejecting and or reporting me, as I have looked at child porn in the past. I do not feel that it is safe to be truthful about being a map [*sic*]*;* the risk is way too high. This is evidenced by the many testimonials on nomap [*nonoffending minor attracted person*] sites.

Extract 9 again highlights how perceived rejection and risk of judgement motivate non-disclosure. Self-perseveration and fears about personal safety are again important and prevalent themes within the data. Extract 9 also point to fears of rejection and of being judged and the experience of shame in having a sexual attraction to children. The extracts so far in this theme highlight the tensions and ambivalence within many of the participants who have not disclosed their interest in therapy. While they believed it was the right decision, they also acknowledge that it would have been beneficial in reducing the psychological difficulties they were struggling with (e.g., their experience of shame regarding their attractions).

> Extract 10: In order to disclose, to anyone – personal or professional – I have to trust that person implicitly in all things. That's a long road. I've only told three people in my life.

Extracts 10 demonstrates that trust plays a central role in decisions to disclose, and the level of trust required is quite high and hard to achieve.

Theme 3: therapist as "MAP" aware. One strategy that some participants utilized was to seek out individuals who had previously worked with pedohebephilic clients or who were affiliated with well-known organizations.

> Extract 11: Well I sought out a therapist who had extensive experience working with MAPs, through a referral service with [prevention service] on their website. […] During our meet and greet online, she reassured me that I have nothing to be ashamed of … She is incredibly compassionate, supportive, and is becoming a very positive influence in my life.

There was a theme within the data that some participants found comfort in selecting a therapist who was "MAP aware". Finding a therapist that had experience with treating people who are sexually attracted to children helped with some of the fear, shame, and stigma associated with seeking therapy. In some cases, having a therapist with this expertise (or at least experience) helped facilitate disclosures and more open dialogue.

> Extract 12: It has been transformative. I was able to talk about MAP concerns with a previous therapist but only by disguising it as another sexual paraphilia and talking about that instead. That took me so far, but it meant I couldn't reveal aspects of my experience, such as being in MAP online communities, and therefore diminished my ability to be uninhibited and honest in the therapy.

> Extract 13: I chose my therapist specifically because I already knew he was MAP aware. I interviewed him before a first session and felt secure that nothing I told him would trigger an inappropriate report/escalation. Previous to this I had seen a "regular therapist" … but because I didn't feel she was a specialist in the area, I didn't feel comfortable disclosing to.

As extracts 12 and 13 highlight, finding a therapist with the right experience and characteristics can be "transformative" and allow the individual to be more honest within therapy. Extract 13 also emphasize how the participant had previously "disguised" their actual problem with another and how they recognized how this limited therapeutic outcomes.

Theme 4: differential impact of disclosure. The final theme within this analysis unpacks the impacts of disclosure on participants. As with other themes within the analysis the impacts are not uniform and are differentially experienced.

> Extract 14: It has helped me trust my therapist more and allowed myself to be more open and know I could talk about things related to it, including self-hatred.

> Extract 15: It made me more trustful of therapists. They reacted well with me. Cheered me up. Said I shouldn't have to worry and beat myself up so much just for having these thoughts and sexual attractions in my head said I'm not a ticking time bomb.

Extracts 14 and 15 demonstrate the importance of trust in the therapeutic relationships with this client group and how positive experiences following

disclosure can enhance trust, leading to open discussion between therapist and client. Disclosure was seen as enabling acceptance of self and of their sexual attraction and that they are not a "ticking time bomb" or "sex offenders in waiting," but rather individuals who need help and support. In this sample, roughly a quarter of those who disclosed ($n = 18$) had outright positive experiences of disclosure and in most of those cases it was the therapists' characteristics and response that was the main reason.

However, roughly the same number of participants ($n = 17$) had negative experiences following disclosure and again the therapist response was perceived as crucial in this experience.

> Extract 16: Therapist became suddenly cold and abrasive. Gave me a lecture on how she disapproved of any form of adult child sexual contact. Told me she could do nothing more for me than suggest I attend Parents Anonymous session. End of therapy.

> Extract 17: I feel it resulted in a very negative reaction by the therapist. A female she couldn't/wouldn't acknowledge that my feelings were anything but evil/abhorrent. That all I wanted to do was go out and rape children!

Extracts 16 and 17 highlight the negative impacts of disclosure and how this led to a discontinuation and a reluctance to engage in any further therapeutic work for some individuals. The negative "cold" and rejecting reaction only reinforced pre-existing negative feelings and it appeared related to termination of therapy.

Discussion

Dating back to Freud, the clinical belief that disclosure of secrets is mostly beneficial for therapy clients is widespread (Farber et al., 2019), even though the empirical literature reveals a more complicated picture for many populations (Blanchard & Farber, 2020; Farber et al., 2009). In line with a previous survey about disclosure experiences among pedohebephilic clients in a non-clinical context (Elchuk et al., 2022), the perceived outcomes of disclosing sexual attractions to children in therapy are associated with the reaction of the therapist, with a more supportive therapist reaction relating to better therapy outcomes and a stronger alliance. When support is being withheld, clients are unlikely to be able to "reap the benefits of revealing secrets so often touted by researchers" (Kelly & McKillop, 1996, p. 461).

Not disclosing their sexual attraction to children was also common among this sample, with about a third reporting to not have disclosed. People with a more exclusive attraction to children were more likely to disclose to their therapist. This is in line with previous research indicating that non-exclusive sexual attraction to children is associated with lower levels of distress and/or a lower perceived need for therapy (Ahlers et al., 2011; Dombert et al., 2016). Participants who had not disclosed perceived the risk of being reported to authorities by a therapist or the negative intrapersonal effects of rejection by a therapist as being too great. This result aligns with prior results on barriers to seeking mental health therapy (Grady et al., 2019; Houtepen et al., 2016) and extends our understanding that these barriers exert an influence on pedohebephilic clients' decision-making within therapy.

For other participants, the distress, desperation, and functional impairment they were experiencing outweighed perceived risks of disclosure. Others searched for therapists who they knew were experts in the field or have been recommended to them to maximize their chances of receiving support. Although we identified the fear of being reported as a common concern in the qualitative section, quantitative analyses found no link between disclosure and the belief that mandatory reporting laws were in place. This is not necessarily contradictory, as one refers to participants' perception of mandatory reporting law, while the other refers to the subjective apprehension of being reported. Good knowledge of the legal situation may also assuage fears, when participants understand what information they can disclose without triggering a report. Some participants provided specifics for disclosure experiences in therapy, which resonate with results reported in previous research (e.g., Houtepen et al., 2016; Levenson & Grady, 2019; Parr & Pearson, 2019). Negative experiences included, for instance, rejection by a therapist or disappointment over not having received the help and support they had hoped for. This is also in line with Levenson and Grady (2019) who found that the most helpful characteristics of professionals encountered by people with a sexual attraction to children was consistent with the general therapeutic literature (e.g., warmth, empathy, positive regard). Furthermore, the present research confirmed the positive link between disclosure and alliance described in previous research (Kelly & Yuan, 2009).

Limitations

Due to the self-report, correlational, and retrospective nature of our data, there are alternative explanations to our findings that cannot be ruled out. It is unclear whether disclosure occurred because of a

strong alliance, whether a strong alliance resulted from disclosure, or whether a third variable, such as the therapists' skill or the client's general secretiveness (Kelly & Yip, 2006) can explain the observed link. Furthermore, due to the non-experimental nature of our comparison, participating pedohebephilic clients who disclosed may differ from pedohebephilic clients who did not disclose in ways that have affected outcome variables or the likelihood of receiving support, such as the strength of their attraction to children relative to their attraction to adults or the length of therapy.

The use of self-report data presents another caveat, as memory is likely to be biased or incomplete. For instance, people with depression are more likely to recall negative events as opposed to positive events and to interpret ambiguous situations as more negative compared to individuals with good mental health (Mathews & MacLeod, 2005). Lokhorst and Reich (2022) have found evidence for a possible halo effect, whereby observers rated the therapy alliance of a videotaped therapeutic session as worse when they were informed that the therapy outcome was negative as opposed to positive. Additionally, while some participants reported to be in therapy at the time of data collection, others have had their last therapy session many years ago and may not remember it in detail. Moreover, while the addition of qualitative analysis augmented the quantitative study, the online format did not allow for further inquiry or follow-up questions.

Our sample is not representative of pedohebephilic people, and likely to be biased towards people who are more fluent in English and more engaged in online communities. It is possible that people who we were *not* able to reach would have reported different experiences. We were also not able to reach the pre-registered sample size of 158. This was in part due to our strict inclusion and exclusion criteria. Honesty and seriousness checks helped detect participants who were not providing high quality data. Yet, as the data quality items appeared at the end of the survey, we delete all cases who dropped out prior to these items being presented, even though their responses may have been honest. While we would encourage the use of these or similar quality checks, we strongly recommend placing them at the midpoint of the survey and after all items that researchers would expect to be particularly sensitive. We could have also increased our sample size by changing pre-registered inclusion criteria, particularly with regards to data from pedohebephilic clients who are *more* attracted to adult partners than children, that is, teleiophilic men with a non-trivial degree of attraction to children. Yet, as this group tends to not perceive their (non-dominant) attraction to children as problematic nor to perceive a need for therapy in relation to this attraction (Ahlers et al., 2011), we believe that the inclusion of this group would have complicated the interpretation of our findings. Furthermore, we would discourage to ascertain pedophilia, hebephilia, or teleiophilia based on responses to single items of our measure to assess self-reported sexual attraction, rather than difference scores.

Implications and Outlook

The present study indicates that a non-negligible number of people who are attracted to children do not disclose their attraction to their therapist. This is a relatively novel finding, as few prior studies have assessed whether pedohebephilic clients had disclosed to (prior) therapists. The authors are only aware of one prior study, which reports that 19 out of 40 clients in a German prevention project who had been in therapy before had not disclosed their sexual attraction to their therapist (Marx et al., 2019). From the clients' point of view, not disclosing is rational, if it can be expected that it leads to a negative reaction in the therapist. The desperation that some pedohebephilic individuals reported as a driver of making a disclosure should alert therapists to an acute state of vulnerability, which requires a high level of care and support. Scientists need to be aware that secret-keeping commonly occurs even in supposedly trusting or "safe" therapeutic relationships (Farber, 2003) and that pedohebephilic clients are no exception to this rule. In fact, they may have more reason than other client groups to expect that the therapist would reject them.

One main implication of the present findings, in combination with past research, is that therapists continue to work towards establishing strong working alliances and therapeutic relationships with clients. Clients who perceive a close bond and alliance with their therapist tend to be more willing to disclose person information (Bachelor, 2013; Cruwys et al., 2023). Alliance-building is a central feature of effective psychotherapy (Flückiger et al., 2018) and may be of particular relevance for pedohebephilic clients, even if the therapist is unaware of these interests. Part of these recommendations includes the implication that therapists should monitor their clients' reactions when they speak about difficult and shameful subjects (Farber et al., 2009). Furthermore, therapists can reflect on how they present informed consent information and their mandatory reporting obligations. Clearly communicating the therapist's obligations may be

central to providing pedohebephilic clients with the understanding of the ethical and legal strictures in which therapy takes place. These obligations differ between different legislations, with some allowing a breach of confidentiality only as a means of averting a clear and imminent danger to a child (Beier et al., 2009), while others require therapists to report any past or planned sexual offending. Recent scholarship provides thorough-going reviews of these ethical and legal strictures to guide clinicians (M. C. Kenny et al., 2017; McPhail et al., 2018).

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No potential conflict of interest was reported by the author(s).

Ethical Approval

The study was approved by the Board for Research Ethics at Åbo Akademi University.

Informed Consent from Participants

Informed consent was obtained at the beginning of the online survey.

Supplemental Data

Supplemental data for this article can be accessed here [https://doi.org/10.1080/10503307.2023.2265047].

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