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UNDERSTANDING AND CHALLENGING STIGMATIZATION OF PEOPLE WITH PEDOPHILIA

DISSERTATION

zur Erlangung des akademischen Grades

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Gutachter: Prof. Dr. Jürgen Hoyer

Prof. Dr. Roland Deutsch

Note.

The present thesis is based on several published peer-reviewed articles, as listed below (in order of appearance within the thesis). In accordance with doctoral degree regulations of the faculty of mathematics and natural sciences of the Technische Universität Dresden, the text of these articles has been altered minimally to ensure consistency and to create a self-contained work. Sara Jahnke was the first and corresponding author for all listed publications.

Section 4.1: Jahnke, S., & Hoyer, J. (2013). Stigmatization of people with pedophilia: A blind spot in stigma research? *International Journal of Sexual Health*, 25(3), 169-184. Adapted with permission from Taylor & Francis.

Sara Jahnke worked out the theoretical background, conceptualization, and design of the review and conducted the literature search. She also wrote the corresponding article, for which she received feedback from Prof. Hoyer.

Section 4.2: Jahnke, S., Imhoff, R., & Hoyer, J. (2015). Stigmatization of people with pedophilia: Two comparative surveys. *Archives of Sexual Behavior*, 44, 21–34. Adapted with kind permission from Springer Science and Business Media.

Sara Jahnke researched the theoretical background of this publication, designed the study, and generated items for the scale assessing stigma. She and Prof. Imhoff were equally involved in the subsequent item selection process (including pretests of the scale and the analyses of pretest results). Sara Jahnke furthermore gathered data for Study I and developed a translated online version of the survey for Study II. She analyzed the data sets for both studies and wrote the complete article, receiving feedback and comments from both co-authors.

Section 4.3: Jahnke, S., Schmidt, A., Geradt, M., & Hoyer, J. (2015). *Stigma-related stress and its correlates among men with pedophilic sexual interests*. Manuscript submitted for publication.

Sara Jahnke developed the theoretical framework for this correlational study, which she also conceptualized. Before data collection, she received feedback from her co-authors that she integrated into the survey. She was fully in charge of the data collection and conducted all statistical analyses. Moreover, she wrote the complete article, adapting it to the feedback of her co-authors.

Section 5.1: Jahnke, S., Philipp, K. & Hoyer, J. (2014). Stigmatizing attitudes towards people with pedophilia and their malleability among psychotherapists in training. *Child Abuse & Neglect*. Advance Online publication. Adapted with permission from Elsevier.

This study was part of Kathleen Philipp's diploma thesis that Sara Jahnke supervised. Sara Jahnke contributed to the recruitment of participants and training institutes and continued data collection after Kathleen Philipp finished her diploma thesis. Sara Jahnke furthermore conducted all statistical analyses (with the exception of the analyses based on multilevel mixed models, which were performed by a statistician) and wrote the publication, integrating comments and feedback from both co-authors.

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This dissertation is based on original publications that were realized within the MiKADO project (German acronym for “Sexual abuse of children: Etiology, Dunkelfeld and victims”). I wish to thank the German Federal Ministry of Family Affairs, Senior Citizens, Women, and Youth for funding this project. I also want to thank all people who were part of the MiKADO team for their expertise and open-mindedness. I will miss our MiKADO meetings and the great discussion that we had in seminars, cozy bars, and Finnish saunas! In particular, I wish to thank my co-authors Prof. Dr. Roland Imhoff and Dr. Alexander Schmidt for their support and advice.

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List of Abbreviations

CBT	Cognitive behavioral therapy
CI	Confidence interval
FESAP	Framework for the Effects of Stigma-related Stress among people with Pedophilia
LGB(T)	Lesbian, gay, bisexual, (and transgender)
M	Mean value
PSS/PAT	People with sexual sadism/antisocial tendencies
PWP	People with pedophilia
RWA	Right Wing Authoritarianism
SD	Standard deviation

Research Summary

For decades, researchers have documented how stereotyping and unfair treatment affect the lives of people with stigmatized characteristics. Pedophilic sexual interests, however, have received remarkably little academic attention. This research gap should be closed for two important reasons. First of all, people with pedophilia have a particularly high risk of experiencing negative stigma-related consequences as, arguably, one of the most feared and despised groups in Germany and many other Western countries. Secondly, vulnerability factors that are hypothesized to contribute to a higher risk of sexually abusive behavior towards children (e.g., low self-esteem, emotion regulation problems, and reduced motivation to seek mental health services) are likely to be enhanced by stigma-related stress. That means that stigmatization of people with pedophilia might not only have a negative effect on members of this group but may also compromise child sexual abuse prevention.

This thesis aims at laying the much-needed groundwork for the scientific study of stigma against people with pedophilia by (1) conducting a systematic and comprehensive review of the literature on stigma against people with pedophilia, (2) assessing the prevalence and strength of public stigma against people with pedophilia compared to other despised groups, (3) developing and testing a theoretical framework for the study of stigma-related stress and associated problems among people with pedophilia, and (4) creating and evaluating an anti-stigma intervention program.

(1) Our literature review documented a lack of research on this issue as well as the need for theoretical concepts and methodological designs conceptualized specifically for this field of study. (2) A scale to assess public stigma against people with pedophilia was designed and used to survey a sample of German pedestrians and US American workers from the Internet marketplace MTurk. A parallel set of items was employed to measure public stigma against other groups (people who abuse alcohol, sexual sadists, and people with antisocial tendencies). Results of these surveys documented people with pedophilia to be massively disadvantaged by stereotyping beliefs, negative affective reactions, and social distance, even compared to the three other stigmatized groups. (3) To reach the third sub-goal, the author of this thesis formulated the “Framework for the Effects of Stigma-related Stress among People with Pedophilia”. It contains a set of assumptions highlighting the relationship between the stigma-related stress and the risk of child sex offending, which is assumed to be mediated by

impairments in emotional and social areas of functioning, as well as cognitive distortions, and the person's motivation to seek mental health services. The model was tested in an online sample of men with a sexual interest in children. Overall, results provided preliminary evidence for the hypotheses previously laid out. (4) Finally, these ideas were put to practical use in the development of an anti-stigma program for psychotherapists in training that was experimentally validated online. Findings indicated that a number of stigma-related beliefs, affects, and behavioral intentions can be changed at a cost-effective level. Motivation to treat help-seeking patients with pedophilia, however, could not be increased within the sample.

In summary, this thesis shows that stigma against pedophilia is a serious and widespread problem, and offers concrete propositions to promote a more realistic and empathetic view of this group. By approaching the emotionally charged concept of pedophilia from a stigma perspective, the research presented in this thesis challenges the way in which not only people from the general public, but also scientists and health care professionals think about pedophilia, and corroborates the importance of stigma reduction within the wider context of child sexual abuse prevention.

1. Introduction

There is a wide consensus among theorists and practitioners that a pedophilic sexual interest cannot be chosen or changed (Berliner Institut für Sexualwissenschaft und Sexualmedizin, 2013; Seto, 2012). Thus, people who are sexually attracted to prepubescent children have to find a way to cope with their deviant sexual interests and society's devaluating reaction towards them. In the Austrian documentary "Outing" (Moser, 2012), Sven, a young man with pedophilia, talks about how his sexual interest has affected his idea of himself and his psychological well-being.

"In the years before [my stationary psychotherapy] I thought about killing myself regularly. Mainly because of my pedophile fantasies. [...] Because I thought I didn't belong in this world and I was hoping that I could get another chance in another life. As if to say, 'It didn't work out this life. Game over. Try again.'" (Sven from the documentary "Outing;" Moser, 2012).

Given the extremely negative public opinion towards people with pedophilia (who I will from now on refer to as PWP), it is to be expected that many of them suffer from similar experiences of alienation and stress as Sven, who apparently has never committed a sexual crime (Feldman & Crandall, 2007; Seto, 2008). Yet, despite the rising popularity of the stigma concept during the last decades (Major & O'Brien, 2005), public stigma against this particularly rejected group has barely been given more than cursory attention.

The decision to dedicate time, money, and effort to the research of negative societal experiences of PWP may seem odd or even inappropriate to some researchers. This reaction is understandable as pedophilia is a rare type of sexual interest that is often associated with sexually abusive behavior towards children. Yet, drawing on analogous research on the detrimental effects of stigma against people with a mental illness or a lesbian, gay, or bisexual (LGB) orientation with respect to the use of mental health services (e.g., Ben-Zeev, Young, & Corrigan, 2010) and cognitive, social, and emotional areas of functioning (e.g., Mustanski, Garofalo, & Emerson, 2010; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006), one can argue that the stigmatization of PWP is an overlooked public health issue. Furthermore, some of the factors that are believed to be negatively affected by stigma are also hypothesized to increase the risk of child sexual abuse (e.g., low self-esteem; Whitaker et al., 2008). The original studies presented in this thesis have therefore been planned and conducted to extend our knowledge about stigma against PWP. Moreover, I wanted to explore how this stigma

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may be changed, providing sensible arguments why studying pedophilia from this often overlooked perspective might constitute an important contribution to the fields of sex offender research and child sexual abuse prevention.

2. Basic Considerations

2.1 Stigma

2.1.1 Conceptualization

In antique Greece, people used to cut or burn marks on the skin of thieves, slaves, or traitors. These marks of disgrace were referred to under the term of “stigma” (Goffman, 1963; Herek, 2004). Many centuries later, in 1963, the sociologist Ervin Goffman revived the ancient term, this time applying it to failings, shortcomings, and handicaps that make their carriers “different from others [...] and of a less desirable kind,” reducing the individual “from a whole and usual person to a tainted, discounted one” (p. 3). Put another way, stigma is a “social construction,” involving “the recognition of difference based on some distinguishing characteristic, or ‘mark’” and “a consequent devaluation of the person” (Dovidio, Major, & Crocker, 2000, p. 3; see also Hinshaw, 2007). Therefore, an attribute may be stigmatizing “at one historical moment but not at another, or in one given situation but not in another within the same period” (Dovidio et al., 2000, p. 3).

Goffman (1963) identified three different types of stigma: blemishes of the body (e.g., physical handicaps), blemishes of the character (e.g., homosexuality or mental disorders), and tribal stigmas, that is, attributes that are passed on through lineages and affect individuals of the same family (e.g., ethnical or religious minority status). A person with such a mark is perceived by “us normals” (i.e., non-stigmatized people) as “not quite human” (Goffman, 1963, p. 5). Stigmatization, in turn, is “the condition of being denied full social acceptance” because of the devalued attribute (Goffman, 1967, p. 7, translation by author). People are stigmatized “because they possess a characteristic viewed by society [...] as constituting a basis for avoiding or excluding other people” like unpredictability or danger (Kurzban & Leary, 2001, p. 188). Oftentimes, there exist elaborate lay theories or ideologies that explain the exact nature of a stigmatized person’s untrustworthiness, dangerousness, or inferiority, deducing a large number of deficits based on the original one (Goffman, 1963).

As indicated by Goffman’s (1963) frequent use of the pronouns “we” or “us” when referring to people who stigmatize others, stigmatization can be perceived as a normal and universal, yet oftentimes undesirable process among social groups (Dovidio et al., 2000; Hinshaw, 2007). People have a strong urge to distinguish between “us” and “them,” that is, members of groups that one belongs to and identifies with and those who do not fulfill these criteria, and

to devalue members of the latter group (Hinshaw, 2007). This general tendency to stigmatize might serve several functions on an individual and a group level. The following functions have been proposed by previous works: simplifying complex social information (Bodenhausen & Wyer, 1985), enhancing self-esteem through social comparisons (Rubin & Hewstone, 1998), justifying economic and political differences (P. W. Corrigan, Watson, & Ottati, 2003), avoiding people who are poor social exchange candidates (Kurzban & Leary, 2001), securing resources against competing groups (Hinshaw, 2007), and/or providing protection against contagious diseases and other social or biological threats (Kurzban & Leary, 2001; Mendes, Blascovich, Lickel, & Hunter, 2002).

For the individuals bearing the stigmatized attribute the public's reaction frequently creates an immense burden and social disadvantage. Sometimes it leads to devastating consequences for the affected individuals, including threats and physical attacks. In most cases, however, stigma affects health outcomes “indirectly – for example, through limiting access to health care, education, employment, and housing [...] as well as through increasing stress and creating anxiety” (Dovidio et al., 2000, p. 5).

While it often requires little justification to start categorizing others into groups of more or less socially acceptable people based on them possessing or not possessing certain attributes, this process is not inevitable. In fact, men and women are capable of correcting their previous stigmatizing assumptions or at least controlling their expression with a cognitive effort (P. W. Corrigan, 2000; P. W. Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012). Based on these considerations, there is hope that the development and implementation of programs designed to reduce stigma “will help bring about change in the stigmatizing attitudes of the general public” (P. W. Corrigan & O'Shaughnessy, 2007, p. 90).

2.1.2 Methodological Pitfalls of Studying Stigma

Our capacity to correctly and reliably assess stigma is crucial for our understanding of this phenomenon. To this end, researchers can choose from a variety of methods to assess different aspects of stigma. As different study designs are associated with different sets of strengths and weaknesses, the choice of the study type has profound consequences for the interpretation of the study results and should receive careful consideration.

Much of the research on stigma has been engaged in estimating the strength and pervasiveness of stigmatizing attitudes among samples of the general population (with

varying degrees of representativeness), usually via survey designs (Rasinski, Viechnicki, & O'Muircheartaigh, 2005). Correlational, cross-sectional studies, such as surveys assessing links between prejudice and personality traits (e.g., Duckitt, 2006; Zick et al., 2008) are also very common. In comparison to experiments which often take place in a controlled laboratory setting, non-experimental surveys can be administered easily in a variety of situations, and may be used to reach population estimates on a wide range of topics concerning stigma. Despite those merits, the predominance of correlational or descriptive methods and the lack of studies on effective strategies to combat stigma has drawn criticism among researchers (Thornicroft, Rose, Kassam, & Sartorius, 2007). For the field of mental illness stigma, only 16% of studies published between 1995 and 2003 relied on experimental methods (while 60.1% of the studies could be classified as non-experimental survey-based research and 13.8% as qualitative research; B. G. Link, Yang, Phelan, & Collins, 2004). In most experimental studies reviewed by B. G. Link et al. (2004), vignettes describing people with varying behaviors, mental illness symptoms or labels, and/or other characteristics were used as a stimulus that participants were asked to respond to (e.g., by indicating how dangerous they believed the described individual to be). In recent years, however, a growing body of experimental research on interventions that target stigmatizing assumptions and behaviors has emerged (Adam et al., 2011; P. W. Corrigan et al., 2012).

Typically, measures in stigma research rely on self-report (but note that some researchers employ behavioral or implicit measures; Peris, Teachman, & Nosek, 2008; Stier & Hinshaw, 2007). Self-reports provide an easy, inexpensive, and straightforward way to assess people's conscious experiences, including thoughts, emotions, experiences, and intentions. Despite these advantages, self-report based measures suffer from a number of validity problems. Among those problems is the fact that self-reported intentions may not always accurately reflect people's real life choices (Baumeister, Vohs, & Funder, 2007) as participants might simply misjudge their reactions.

Another limitation of self-report based designs arises when study participants try to hide or downplay negative responses towards specific groups in order to make a better impression (Rasinski et al., 2005). This social desirability bias makes surveys difficult to interpret as it is impossible to tell whether lower rates of stigma can be attributed to actual favorable views or to the participant's attempts to appear enlightened, liberal, or gentle-hearted. Responses are likely to be particularly tainted by social desirability bias when a clear social norm (voiced by, e.g., important spokespersons or anti-stigma campaigns) exists (B. G. Link et al., 2004). This

is likely to be the case for same-sex attractions and psychological disorders such as depression or schizophrenia, but probably not as much for all stigmatized characteristics. For the stigma of having a sexual interest in children, social desirability may also be associated with more negative attitudes if such reactions are perceived as the social norm. There exist different strategies to counteract social desirability bias. These strategies include guaranteeing anonymity, so that responses that a person may perceive as threatening to his or her reputation if others knew about them seem more harmless. Furthermore, social desirability scales are frequently used to estimate the degree to which an individual in general tends to adapt his or her responses to social norms (Stöber, 1999). Implicit measures like the Implicit Association Test represent another option to assess socially undesirable reactions like stigma (Teachman, Wilson, & Komarovskaya, 2006).

Taken together, both survey designs and experimental designs are valuable methods to study stigma, depending on the purpose of the study. Non-experimental survey designs, for instance, are appropriate if the research goal is to provide a descriptive overview of a range of phenomena among a large group of people. Therefore, they represent a valuable tool to assess stigma among the general public as well as attitudes, feelings, and behaviors among members of the stigmatized group. To gauge the efficacy of interventions designed to reduce stigma or other causal hypotheses, however, experimental designs are indispensable. Scientists who intend to use self-report scales in their experimental or non-experimental research need to consider strategies of dealing with biased responses.

2.1.3 Areas of Stigma Research

Starting with Goffman's (1963) seminal account of stigma, the literature in this area has undergone tremendous growth and diversification. Resonating with researchers of different professional backgrounds and disciplines (e.g., sociology, psychology, and the health sciences; Bos, Pryor, Reeder, & Stutterheim, 2013), the concept has been applied to numerous groups who were assumed to be affected by unfair assumptions and discrimination.

Mental illness, minority sexual orientation, obesity, HIV/AIDS, disability, and minority race/ethnicity have emerged as foci of stigma research (Hatzenbuehler, 2009). Research effort, however, is distributed unequally over and within these fields, with a small number of stigmas getting the lion's share of scientific attention. A combination of the search term "stigma*" and "schizophrenia," for example, gets 211 hits on Web of Knowledge (title search). On the other hand, a combination of the word "stigma*" with the terms "alcohol," "personality disorder,"

or “pedophilia” earns a meagre 23, 7, or 0 results, respectively (research period from 1960 to 2012 for all four searches, search conducted on November, 18, 2014). This discrepancy reflects trends and tendencies in stigma research and cannot be explained by lower prevalences, lower societal, and/or individual costs of each disorder, as alcohol related disorders, personality disorders, and pedophilia all have a higher or similar prevalence compared to schizophrenia, and some may also compare to schizophrenia with respect to disruptiveness. This is especially true when violent or otherwise dangerous or undesirable behaviors that may result from drunkenness or sexual interest in children are included in the equation.

The research presented within this thesis is informed by previous scientific accounts of stigma against people with a mental illness and stigma against sexual minorities, as pedophilia is a rare sexual interest that is, in some cases, also considered a mental disorder (but note that a sexual interest in children is not by itself considered pathological, see also Chapter 2.2.1). In the following sections, these research traditions and their similar conceptual foundations are described, while also pointing out unique features that each field brings to the table.

Stigmatization of People with Mental Disorders

A mental disorder is defined as “a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning,” which is “usually associated with significant distress and disability” in important areas of life (American Psychiatric Association, 2013, p. 20). The experiences of people diagnosed with a mental disorder have been studied from a stigma perspective since the earliest times of stigma research. Yet, the degree to which stigma plays a causal role (or any role at all) in creating disabilities among persons diagnosed with a mental disorder has been widely contested among researchers and mental health providers for a long time (P. W. Corrigan & Kleinlein, 2005).

On one side of this debate, supporters of the labeling theory have pointed out that the public treats people who are labeled as “mentally ill” differently from others and often in negative ways (Scheff, 1974). Such reactions that include rejection and discrimination may, according to this theory, shape the feeling, thinking, and behavior of the labeled persons until they become what society believed them to be in the first place (P. W. Corrigan & Kleinlein, 2005). Thus, people who are stigmatized by the label applied to them initially do not differ markedly

from others who are not labeled, but develop a new identity as a “mentally ill” person, because a self-fulfilling prophecy has been initiated (Gove, 1970). On the other side of the debate, defenders of the medical model (e.g., Gove, 1975) argued that typically a mental disorder (and not the label) produces the impairments often found among people with such a condition. These difficulties may become apparent and lead to rejection in personal interaction (P. W. Corrigan & Kleinlein, 2005). According to this view, social isolation of a person with schizophrenia, for instance, is more likely due to people reacting negatively to the aberrant behavior caused by this condition, such as screaming in public or speaking incomprehensively. Also, people with mental disorders may have skill deficits in social and other areas of functioning (e.g., failing to maintain proper standards of hygiene) that could lead to negative reactions, irrespective of whether or not they are labeled as “mentally ill”.

Since the 1980s, modified stigma theories have emerged (B. G. Link, Struening, Cullen, Shrout, & Dohrenwend, 1989; Rusch, Angermeyer, & Corrigan, 2005a) that attempted to resolve the debate between labeling theorists and scientists supporting the medical model by taking a middle ground. Rusch et al. (2005a), argued that while many disadvantages that people possessing certain stigmatized characteristics experience may directly originate from the mental disorder, negative reactions from the public are likely to exacerbate these existing problems. In a similar vein, B. G. Link et al. (1989) pointed out that “even if labeling does not directly produce mental disorder, it can lead to negative outcomes” (p. 400). Hence, people who have a mental diagnosis are faced with the double problem of having to deal with the symptoms of their disorder and a public who is largely misinformed about the course and characteristics of mental disorders and tends to stigmatize people that are affected by one (Rusch et al., 2005a). There is empirical evidence to support the idea that these negative reactions exist, even when the labeled individual does not show behavior that is socially disruptive or peculiar. B. G. Link, Cullen, Frank, and Wozniak (1987) conducted an experiment in which they presented a number of vignettes to participants, manipulating the label of mental illness (whether or not the described person is presented as having this disorder) and the degree of socially objectionable behavior. Their results demonstrated that people who believe patients to be dangerous are less likely to accept a labeled individual, even if the person is not portrayed as showing aberrant behavior. Another study showed that people form a more negative first impression of another person when the experimenter gives them the (manipulated) information that this person is pursuing psychotherapy (Sibicky & Dovidio, 1986).

Rusch et al. (2005a) have presented a widely used social-cognitive model that describes the stigma process for people with a mental disorder. While explicitly tying in sociological ideas of labeling that, for the authors, serve as the background of the stigma process, their focus is more on the psychological aspects of stigma by distinguishing between its cognitive, affective, and behavioral components. This distinction can be applied not only to the public's negative reaction to stigmatized groups (public stigma) but also to the results of stigmatized people adopting the public's negative views about themselves (self-stigma; Rusch et al., 2005a; Bos et al., 2013), as can be seen in Table 1.

Table 1. Components of the public stigma and self-stigma of mental illness

Public Stigma	Self-Stigma
<i>Stereotype:</i>	<i>Stereotype:</i>
Negative belief about a group such as	Negative belief about the self, such as
Incompetence	Incompetence
Character weakness	Character weakness
Dangerousness	Dangerousness
<i>Prejudice:</i>	<i>Prejudice:</i>
Agreement with belief and/or	Agreement with belief
Negative emotional reaction such as	Negative emotional reaction such as
Anger or	Low self-esteem or
Fear	Low self-efficacy
<i>Discrimination:</i>	<i>Discrimination:</i>
Behavior response to prejudice such as:	Behavior response to prejudice such as:
Avoidance of work and housing opportunities	Fails to pursue work and housing opportunities
Withholding help	Does not seek help

Note. Reprinted from “Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma” by N. Rusch, M. C. Angermeyer, and P. W. Corrigan, 2005a, *European Psychiatry*, 20, 531. Copyright 2005 by Elsevier Masson SAS. Reprinted with permission.

The cognitive basis of stigma, also referred to as stereotypes, are knowledge structures about members of certain groups that, while being efficient in that they allow to quickly generate ideas about what to expect from such individuals, are often false, biased or oversimplified (Rusch et al., 2005a). Even without having first-hand experiences with patients who are diagnosed with a mental disorders, people are usually aware of negative stereotypes about such individuals, with notions of weakness, incompetence and dangerousness being the most common and pervasive (Rusch et al., 2005a).

Prejudice arises when people have a (usually negative) evaluative reaction towards stigmatized groups, either because they are convinced that the stereotypes associated with them are true or because they experience strong feelings toward members of such groups (P. W. Corrigan & Kleinlein, 2005). People tend to experience anger towards a person with a mental illness when they believe that the person is in control (and therefore responsible) for

his or her symptoms, and sympathy or pity when they perceive the psychological disorder or physical handicap as uncontrollable (Dijker & Koomem, 2003; Weiner, Perry, & Magnusson, 1988). There is no perfect association between knowing stereotyped assumptions about another group and holding prejudices. People can be aware of stereotypes and choose not believe them, in which case there would be no resulting prejudice.

Discrimination represents the behavioral component of stigma. Depending on the type of affective responses that precede such acts, discriminatory behaviors may be avoidant (in the case of fear) or aggressive (in the case of anger). In one of the rare stigma studies that focused on people's real life behavior, Page (1977) found that telephone callers who told potential landlords about their (ostensible) status as a patient in a psychiatric clinic were less likely to receive a positive response than when no such mention was made.

The self-stigma of the affected individual is described on parallel levels of analyses. People diagnosed with a mental illness who live in a community where negative stereotypes about such disorders are widely held are very likely to be aware of such ideas. If they adopt these stereotypes and begin feeling inferior to others as a result thereof, people with a mental disorder turn the prejudice against themselves. Consequently, negative consequences like diminished self-esteem and self-efficiency may ensue on a cognitive/affective level (P. W. Corrigan & Watson, 2002; see also Chapter 4.3.1 for a more detailed discussion). This might lead to a "why try" attitude concerning life-goals (e.g., living in a nice environment or finding a satisfying job) and dissuade the person from pro-actively seeking out opportunities that would increase the chances of reaching said goals (P. W. Corrigan, Larson, & Rusch, 2009). Also, people who are prejudiced against patients with a mental illness and know that they themselves belong to this group are likely to avoid seeking mental health care services (Ben-Zeev et al., 2010; Chew-Graham, Rogers, & Yassin, 2003).

Stigmatization of Sexual Minorities

Individuals differ in their sexual make-up. The majority of adults worldwide have a heterosexual orientation, which means that they have a dominant sexual attraction to physically mature opposite-sex partners. Sexual minorities - a term usually referring to LGB (sometimes also LGBT, including transgender) individuals - have known a long history of discrimination. At the birth of stigma research in the early 1960s, homosexuality was still on the list of psychological disorders and sexual acts between same-sex partners (especially male ones) were prosecuted in many countries. During the course of the 20th century legislation,

however, diagnostic practice and public opinion have shifted tremendously towards more acceptance regarding sexual minorities and their choice of sexual partners (Ahmad & Bhugra, 2010; Herek, Chopp, & Strohl, 2007). In 1973, the board of trustees of the American Psychiatric Association deleted homosexuality from the DSM with a vote of 13 to 0 and 2 abstentions (Minton, 2002). By the end of 2000, sexual acts between same-sex partners were legal in most developed countries (including Germany). Regarding transgender, there is an ongoing debate about whether or not the phenomenon of identifying with a gender that is not in line with the gender one has been assigned at birth should be construed as a mental illness (Meyer-Bahlburg, 2010).

In the decade of the 1970s began a growing scientific interest in stigmatizing reactions towards LGB people. As one of the first practitioners to discover prejudice against people with a same-sex attraction as a societal issue, Weinberg (1972) introduced the term homophobia in 1972, referring to “the dread of being in close quarters with homosexuals” (p. 4). In the following years, the concept evolved to mean general negative feelings (e.g., disgust, fear, aversion) towards people attracted to same-sex partners (Ernulf & Innala, 1987). While the term and the idea behind “homophobia” have had a huge impact on the study of homosexuality, most modern scholars opted for a new vocabulary to avoid pathologizing a dislike, and to stress the fact that people who have hostile attitudes towards gays or lesbians typically experience anger or disgust (instead of fear or phobic reactions; see Herek, 2004). For this purpose, Herek (2004) proposed the concepts sexual stigma (i.e., “society’s antipathy toward that which is not heterosexual,” p. 15), heterosexism (i.e., “the cultural ideology that perpetuates sexual stigma,” p. 6), and sexual prejudice (i.e., “individuals’ negative attitudes based on sexual orientation,” p. 6).

In accordance with predictions from attribution theory and the results of similar studies on people with a mental illness (Dijker & Koomem, 2003; Weiner et al., 1988), sexual prejudice is higher among individuals who believe that people can control whether they have a homosexual orientation or not (Whitley, 1990). Also, the tendency to stigmatize others based on their sexual orientation seems to be dependent on the gender of the perceiver and the gender of the perceived, with heterosexual men reporting higher levels of prejudice than heterosexual women and lesbian women being judged less negatively than gay men (Kite & Whitley, 1996). The distinction between cognitive, emotional, and behavioral aspects of the stigma process (as in, e.g., the social-cognitive model of mental illness stigma described above; Rusch et al., 2005a) can of course also be applied to the study of homophobia or

sexual prejudice. Research has shown that people who agree with negative statements about gay men and lesbian women also tend to report anger and discriminatory behavioral intentions concerning these groups (VandeVen, Bornholt, & Bailey, 1996). People who believed that gay men are sick, sinful, and violating gender roles and that lesbian women are dangerous experienced higher levels of social distance towards the respective groups (Gentry, 1987).

The experience of having a stigmatized minority status causes psychosocial stress, also referred to as *minority stress* (Meyer, 1995, 2003). While this concept is in theory applicable to other stigmatized minority groups as well (e.g., people with mental disorders), it has gained its greatest popularity for the study of LGB experiences (e.g., Kuyper & Fokkema, 2011; Lehavot & Simoni, 2011). Assumptions about minority stress include that it is unique (i.e., distinct from and additive to the general stressors that everybody experiences), chronic, and socially based (Meyer, 2003). For LGB people, the following minority stressors were identified: actual stressful events like the experience of violence or threats, expectations of being rejected or discriminated against (resulting in heightened vigilance), and internalized homophobia (Meyer, 2003). People with a non-heterosexual orientation experience internalized homophobia when they adopt the public's negative attitudes towards them (Ahmad & Bhugra, 2010; Bhugra, 1987; Herek, 2004; Meyer, 1995; Smolenski, Stigler, Ross, & Rosser, 2011).

Taken together, the presented evidence within this chapter shows that stigmatized persons share many concerns irrespective of the type of their stigma. For these reasons, it is not surprising that stigma theories often share similar core concepts. As an example, the internalization of stereotypes (as discussed for people with a mental illness; Rusch et al., 2005a) is paralleled by a similar concept for lesbian women and gay men, only this time referred to under the term "internalized homophobia" (Herek, 2004; Newcomb & Mustanski, 2011; Smolenski et al., 2011). Hence, what has been learned about one stigmatized group is likely to also be relevant for other stigmatized groups (LeBel, 2008).

2.2 Pedophilia

2.2.1 Conceptualization

From a phenomenological perspective, pedophilia can be construed as a sexual orientation (Seto, 2012). Like heterosexuality, homosexuality, and bisexuality, it represents a distinct phenomenological category of sexual interest (and, to individually varying degrees, desires for love and romantic attachment; see Berliner Institut für Sexualwissenschaft und Sexualmedizin, 2013; G. Schmidt, 2002). PWP are sexually attracted to children that have not yet reached puberty. In some cases, this interest is exclusive, that is, the person experiences sexual motivation only towards children with no signs of pubertal development and has no sexual attraction to sexually mature persons (American Psychiatric Association, 2013).



Figure 1. Clothed pictures of people at different Tanner stages from the Virtual People Set.

Note. From “*The virtual people set*” by B. Dombert, 2013 (unpublished picture set, see Dombert et al., 2013 for excerpts). Copyright 2013 by B. Dombert. Printed with permission.

Prepubescence is usually defined as the lowest score on the Tanner scale of physical maturation (i.e., Tanner Stage 1 of 5, see Figure 1). Children who have no pubic hair (both sexes), genitalia of about the same size and proportion as in early childhood (boys), and no visible breast development (girls) are considered to fall into this category (W. A. Marshall & Tanner, 1969; Tanner, 1973).

The age at which puberty starts varies, and by some accounts has declined drastically over the last centuries in the Western world (Kaplowitz, 2008). Recent reports revealed that on average, German girls reach their menarche between the ages of 12 and 13, and the majority of children of both sexes show some signs of secondary sexual development (e.g., pubic hair) before age 12 (Kahl, Schaffrath, & Schlaud, 2007). Therefore, when an adult today feels sexually attracted to a child slightly below the (legally defined) age of consent of, for instance, 14 years according to current legislation in Germany or the clinical cutoff age of 13 (detailed discussion on clinical criteria below), this person does not necessarily have a pedophilic interest. In contrast, the term hebephilia refers to a sexual attraction towards adolescents, that is, young people during the period of their puberty (proposed to involve boys and girls on Tanner stages 2 and 3), while ephebophilia was proposed to describe a sexual interest to individuals in late adolescents (Tanner stage 4; Hames & Blanchard, 2012). People who are sexually interested in physically mature individuals (regardless of their sex) are sometimes referred to as teleiophilic (Tanner stage 5; Hames & Blanchard, 2012).

Clinical Definitions

The term pedophilia is also used as a diagnostic label. Modern clinical definitions can be found in the main classification systems provided by the World Health Organization (the International Classification of Diseases and Related Health Problems, ICD, currently in its 10th edition) and the American Psychiatric Organization (Diagnostic and Statistical Manual of Mental Disorders, DSM, currently in its 5th edition). The ICD-10 definition differs from the DSM-5 in that it also includes a hebephilic sexual attraction under the label of pedophilia (see Table 2).

The distinction between DSM-5 and its predecessor DSM-IV-TR is of terminological nature (Blanchard, 2010; Wakefield, 2011). According to DSM-5, Pedophilia can be ascertained (but not diagnosed) in persons who only meet Criterion A (see Table 2). The diagnosis of a pedophilic disorder, however, requires that both Criterion A and B are met. Thus, the diagnosis that used to be called pedophilia in the DSM-IV is termed pedophilic disorder in the

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latest edition of the DSM, with the term pedophilia being employed merely to describe a sexual interest in children. This decision stresses that pedophilia as a sexual interest in children is not considered pathologic in itself.

Table 2. Clinical definitions of pedophilia.

Definition (Source)
<i>DSM-5 pedophilic disorder</i> (American Psychiatric Association, 2013) A: Over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger). B: The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty. C: The individual is at least age 16 years and at least 5 years older than the child or children in Criterion A.
<i>ICD-10 paedophilia</i> (World Health Organization, 2010) A sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal age.

Based on the current DSM-5 definition, the terms “pedophilia,” “pedophilic disorder,” and “child sexual abuse/pornography offenses,” are construed as overlapping, but not interchangeable (see Figure 2).

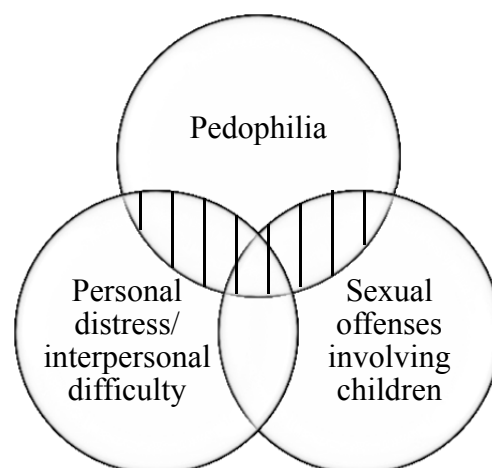


Figure 2. Relationship between pedophilia, sexual offenses involving children (i.e., child sexual abuse and/or child pornography offenses), and distress/ interpersonal difficulties.

Note. The striped area represents the DSM-5 diagnosis of pedophilic disorder. There are PWP who fulfill the diagnostic criteria for a pedophilic disorder because they experience personal distress and/or interpersonal difficulty because of their sexual interests in children, and/or commit child sexual abuse or child pornography offenses. Some, but not all, child sex or child pornography offenders experience a corresponding sexual attraction to children.

Child sexual offending is not always motivated by corresponding pedophilic interests (see also Chapter 2.3.2). For example, it has been proposed that sexual offending against children might occur because of situational factors like alcohol intoxication or the loss or unavailability of a physically mature sexual partner (Simon, Sales, Kaszniak, & Kahn, 1992). Pedophilia is not necessarily a mental disorder (but note that a subgroup of PWP who fit this

definition also meets the diagnostic criteria for pedophilia or a pedophilic disorder according to the DSM if they commit sexual crimes or experience distress or interpersonal difficulty). Only an individual with a preferential sexual interest in prepubescent children is considered to have pedophilia, regardless of this person's legal record (see also Feelgood & Hoyer, 2008; Harrison, Manning, & McCartan, 2010), while surrogate offenders who commit sexual offenses against children despite being predominantly or even solely attracted to adults and/or adolescents are excluded from this definition. As a consequence, pedophilia is a stable sexual make-up that differs from sexual orientations like heterosexuality or homosexuality (teleiophil) with respect to the preferred age of one's sexual partners and the legal/moral implications of sexual acts involving a person of this age group.

2.2.2 Methodological Pitfalls of Studying Pedophilia

Although pedophilia has undoubtedly become a high-profile issue in modern society and a widely researched field of study, research has failed to provide a sense of cohesiveness and scientific clarity to the understanding of this phenomenon (Malón, 2012; K. McCartan, 2008). The dispute and diagnostic uncertainty surrounding the diagnostic label of pedophilia (or pedophilic disorder) has led to the problem that its clinical definitions are virtually ignored by clinicians and scientists alike (W. L. Marshall, 1997), compromising comparability of results from different samples of (supposed) PWP. This section provides an overview of these conceptual problems as well as of different ways to recruit PWP, while addressing the different sets of advantages and biases associated with each strategy.

Problems of the Current DSM Diagnostic Criteria

The DSM diagnosis has drawn criticism for a number of different, sometimes opposing reasons (Ahlers et al., 2011; Harrison et al., 2010; O'Donohue, 2010). One of its fiercest critics, the founding president of the International Academy of Sex Research, Richard Green (2002), argued that "sexual arousal patterns to children are subjectively reported and physiologically demonstrable in a substantial minority of 'normal' people" (p. 470). Basing his conclusions on cross-cultural and historic examples, he furthermore concluded that these sexual arousal patterns have been "common and accepted in varying cultures at varying times" (Green, 2002, p. 470). Yet, Green's (2002) proposal to eliminate this diagnosis from the DSM altogether (akin to homosexuality in the 1970s) was never widely shared. In fact, the majority of researchers and clinicians appear to prefer a problematic diagnosis to having no diagnostic category at all. For them, the problem that a number of people with a sexual

interest in children are in need of psychiatric services “constitutes an important basis for considering pedophilia to be a psychiatric disorder, even if that consideration is based, at least in part, on an implicit set of values” (i.e., the judgment in contemporary society that pedophilia is “a bad thing”; Berlin, 2011, p. 243).

Flawed or imprecise aspects of the pedophilia diagnosis include a lack of empirical foundation (e.g., arbitrary cut-off ages for the patient and the child; Kramer, 2011), and a lack of specificity. For instance, the DSM does not give a clear instruction about when a desire should be considered “intense” and there is uncertainty regarding the range of legal and illegal behaviors that could theoretically be subsumed under the description “has acted on these sexual urges” (Ahlers et al., 2011; Harrison et al., 2010; O'Donohue, 2010). Furthermore, pedophilic disorders may be diagnosed in absence of (reported) sexual fantasies including children, when the person's sexual behavior indicates their existence (American Psychiatric Association, 2013; Gert & Culver, 2009). This decision is most likely prompted by forensic concerns such as the notion that child sex offenders with pedophilia “have little objective motivation to be truthful and many good reasons to dissemble” (Blanchard, 2010, p. 3). While this decision may increase forensic utility, it further blurs the boundaries between pedophilia as a psychological or psychopathological characteristic (that might or might not lead to child sex or child pornography offences) and criminal behavior (that might or might not be related to a sexual attraction to children). It also perpetuates the public “image of these men as dangerous slaves of their own libido, without the capacity for love, lacking any empathic feeling for children, and incapable of managing their condition in a socially acceptable way” (Malón, 2012, p. 26).

Recruitment Strategies for PWP

Avoiding the problems and uncertainties associated with the diagnosis of pedophilia, more and more researchers choose the simpler road of studying people who have committed child sexual offenses. In many cases, researchers even use the term “pedophilia” when in fact the correct term would have to be “child sex offender” (Feelgood & Hoyer, 2008). This is problematic for a number of reasons. Firstly, many cases of sexual offending against children are not related to pedophilia. In fact, samples of child sex offenders are likely to include high numbers of non-pedophilic men, who may also differ systematically from offenders with pedophilia with respect to more attributes than just the age or body type of their preferred sexual partners (Feelgood & Hoyer, 2008). Secondly, PWP in correctional samples are not

representative for PWP in general. In fact, a substantial number of past and recent studies about PWP (revealing, e.g., lower levels of education or brain functioning and higher rates of comorbid axis I and II disorders compared to control groups; Abel, Becker, & Cunningham-Rathner, 1984; Cantor et al., 2004; L. J. Cohen, McGeoch, Gans, et al., 2002; R. C. W. Hall & Hall, 2007; Raymond, Coleman, Ohlerking, Christenson, & Miner, 1999) may say less about pedophilia and more about prison samples. High rates of antisocial attitudes, for instance, may be more indicative of study participants' status as prisoners or their past behavior that has resulted in them committing criminal acts and getting institutionalized than their (assumed) sexual attraction to children (Alanko, Salo, Mokros, & Santtila, 2013). Similarly, lower IQ scores (compared to the average population) which are sometimes reported for PWP (e.g., Cantor et al., 2004) might be expected among a group of people that has failed to find legal ways to fulfill their sexual desires or failed to avoid detection for criminal acts. Thus, PWP with higher levels of functioning and/or more prosocial attitudes who do not commit antisocial or illegal acts would be underrepresented in forensic samples.

Findings from forensic samples have furthermore been criticized on the basis that an unknown number of sexual offenders might underreport the frequency or intensity of sexual fantasies involving children. Indeed, offenders with pedophilia have little reason to be open about their sexual interests, as disclosing pedophilia may influence the length of their prison sentences and whether or not they will be assigned to therapy (Blanchard, 2010; Gannon, Keown, & Polaschek, 2007; Seto, Cantor, & Blanchard, 2006). Other information like the experience of sexual abuse in the offender's own childhood might be made up or exaggerated "in order to gain sympathy in the judicial system" (L. J. Cohen & Galynker, 2002, p. 283).

With the development of new community-based prevention programs directed at non-offending PWP or offenders with pedophilia who have not been detected by legal authorities like the *Berlin Prevention Project Dunkelfeld*, clinical samples of PWP have become more easily accessible. Studying these previously neglected groups helps to shed light on the hopes and problems of those who seek therapy, which may in turn be used to develop more effective therapeutic interventions (Schaefer et al., 2010). Yet, findings based on samples of PWP in clinical settings are also limited by selection bias and cannot be generalized to other groups of PWP, as those who seek therapy are likely to report higher distress because of their pedophilic attraction and to experience a range of psychological or social problems that they felt they could not overcome on their own (Schaefer et al., 2010). Although evidence is still sparse in this regard, the few published studies that included men who self-identified as being

pedophilic and that were neither drawn from prison nor from clinical files usually reveal low levels of psychological disturbance (Wilson & Cox, 1983).

To-date, research has achieved little with respect to studying pedophilia in an everyday, non-forensic, and non-clinical setting. About 20 years ago, Okami and Goldberg (1992) prophesized that “the social stigma attached to pedophilia combined with current professional reporting laws make it unlikely that the problem of obtaining representative samples of pedophiles will be solved in the near future” (p. 322). However, with today’s online technology and increasing rates of Internet availability and proficiency (at least in developed countries), research may have come closer to this goal than ever. Yet, a major disadvantage of studying PWP outside of forensic or clinical settings lies in the lack of information that does not entirely depend on self-report (Seto, 2008). Compared to clinical and forensic samples where researchers often have other information like criminal records or third person accounts at their disposal, this presents a serious limitation, especially when the research focus is on criminal or otherwise undesirable behavior.

In summary, different subgroups of PWP are likely to differ with respect to various characteristics (e.g., social status or motivation to respond truthfully), making it impossible to generalize results that have only been obtained in one type of setting. To overcome selection bias, researchers should make efforts to research pedophilia beyond easily attainable prison populations and find out whether results found among different subgroups of PWP are, in fact, convergent. Evidence from heterogeneous studies needs to be combined to draw scientifically sound conclusions about whether PWP are different from other populations with regard to their personality profile, their behavior, risk factors for sexual offenses, and other variables. Larger and more representative samples are needed to reach a sufficient level of certainty concerning what has often been described as typical characteristics of people with a sexual interest in children, but has in fact only been confirmed in one specific type of setting (R. C. W. Hall & Hall, 2007).

2.2.3 Clinical Features of Pedophilia

Prevalence

Prevalence estimates for a sexual interest in children in the male population typically range between 3% and 10% (Ahlers et al., 2011; Briere & Runtz, 1989; Wurtele, Simons, & Moreno, 2013), but most estimates are based only on small ad-hoc samples. The largest and

most informative community-based studies to-date have been conducted among 1312 male Finish twins (Santtila et al., 2010) and 8780 German men between 18 and 89 years (Dombert et al., 2015). The Finish study revealed that 3.5% of their sample showed indicators of sexual fantasizing or sexual behaviors relating to minors under the age of 16, but the authors did not differentiate between fantasizing and behaviors, or pedophilia and hebephilia. In the German sample, 4.1% reported sexual fantasies and 3.2% sexual behaviors involving children below the age of 12. Among this group, 68% fantasized about girls, 13.3% about boys, and 18.3% about children of both sexes. Only 0.1% of all participants in the German sample reported to have a preferential sexual interest in children (i.e., they reported to have more sexual fantasies or experiences involving children than involving adults). The existence of such fantasies would, however, not suffice to diagnose a pedophilic disorder, as information on the persistence and intensity as well as potential personal distress or interpersonal difficulty were not assessed in the above mentioned prevalence studies. Therefore, these figures can only provide upper limits for the prevalence of pedophilia among men in the clinical sense (Seto, 2008), assuming that pedophilic fantasies were not underreported due to social desirability bias or anonymity concerns. There is considerably less research on women's sexual interest in children, but previous findings indicate that this phenomenon is less common among women than among men (Fromuth & Conn, 1997; Wurtele et al., 2013).

Start and stability

To date, there are no longitudinal data that would permit a definite conclusion concerning the start and stability of pedophilic attraction. Nevertheless, there is some evidence that pedophilia might compare to homosexual and heterosexual orientation with regard to its early onset and relatively stable course throughout life. In fact, most individuals with pedophilia recall a start of their sexual fantasies involving children in adolescence or early adulthood (Freund & Kuban, 1994; Neutze, Seto, Schaefer, Mundt, & Beier, 2011). As a pedophilic sexual attraction shows little if any responsiveness to therapeutic intervention, most researchers believe it to be a stable aspect of a person's sexual make-up (e.g., Fagan, Wise, Schmidt, & Berlin, 2002; R. C. W. Hall & Hall, 2007; Seto, 2008; but see Briken, Fedoroff, & Bradford, 2014, for a dissenting opinion).

Etiology

Until today, little is known about the development of heterosexual, gay, lesbian, or bisexual fantasies and identities. Hence, it is perhaps not surprising that the origins of pedophilia have

so far remained equally obscure. While there exist a number of theories on the etiology of pedophilia, they are relatively few compared to, for instance, the number of etiology theories of child sexual offending, and none of them is substantiated by compelling evidence (Seto, 2008). Nevertheless, research has found a number of differences between PWP (in correctional settings) and other offender groups or members of the general population that point to a shared neurobiological/genetic and environmental basis of pedophilia.

Interestingly, “throughout the 20th century,” most investigators appeared to favor “nonbiological over biological theories in the development of pedophilia” (Cantor, Blanchard, Robichaud, & Christensen, 2005, p. 565). Current research, however, suggests that biological factors have an influence as well. Also, differences in biological variables such as brain functioning may help explain why some people who experienced certain environmental factors associated with pedophilia develop a sexual interest in children, while others do not.

A number of researchers have proposed that sexual interest in children is heritable, as are other aspects of human sexuality, including sexual orientation to an adult partner of the same sex (Bailey & Pillard, 1991; Kendler, Thornton, Gilman, & Kessler, 2000). While a recent twin study indicated the existence of a hereditary component in the development of sexual fantasies and masturbatory behavior involving young people under the age of 16, this component seems relatively weak compared to the rates that are typically detected for psychopathologies, personality traits, and sexual orientations (Bailey, 2003), as only 14.6% of variance was attributable to heritability (Alanko et al., 2013). Yet, the finding of this genetic component leads to an evolutionary paradox, given that a sexual interest in individuals who are too young to reproduce would lead to a decrease of reproductive success. By the rules of natural selection, genes contributing to such an interest should be driven to extinction over many generations, unless these genes have additional advantages that outweigh these disadvantages. It is possible that some genes, while they may have negative consequences for the reproduction of some persons carrying it, are beneficial for the reproductive success of these persons’ direct relatives. In one study aiming to clarify potential positive evolutionary outcomes for same-sex attraction, female relatives of gay men showed fewer gynecological disorders and were less likely to have complicated pregnancies than female relatives of heterosexual men (Ciani et al., 2012), suggesting that these women could have benefited genetically with respect to producing offspring. Alternatively, the genes that predispose people to develop pedophilic interests might represent a form of youthfulness attraction that in

a less extreme form would lead to a sexual interest in highly fertile sexual partners, as youthfulness is an indicator of fertility (Alanko et al., 2013).

Furthermore, pedophilia has been found to be associated with indicators of neurodevelopmental deficits such as head injuries before the age of 13, but not afterwards (Blanchard et al., 2003). Sexual offenders who were diagnosed as having pedophilia are furthermore approximately 2 cm shorter than teleiophilic controls without offending histories (Cantor et al., 2007). Cumulating the results of many individual studies, sexual offenders against children scored lower on IQ tests than sexual offenders against adults, which in turn scored lower than non-sexual offenders (Cantor, Blanchard, et al., 2005). Cantor, Blanchard, et al. (2005) attributed these differences to pedophilia rates, which were likely to be highest in the group of sexual offenders against children. Also, erotic attraction to children has been found to be associated with high rates of left-handedness, “comparable to the rates observed in pervasive developmental disorders, such as autism, suggesting a neurological component to the development” of pedophilia (Cantor, Klassen, et al., 2005, p. 447).

Despite progress in neuroimaging during the last two decades, relatively little is known about the neurobiology of pedophilia as compared to, for instance, schizophrenia or anxiety disorders (Cantor et al., 2008). This lagging behind might be attributed to the fact that research so far has failed to develop well-supported etiological theories of pedophilia, which would be needed to guide the search for relevant brain areas (Cantor et al., 2008). Nevertheless, a number of neuroimaging studies have revealed differences between sexual offenders with pedophilia and control groups without pedophilia or criminal background. Some studies indicated pronounced grey matter decreases in several areas of the brain, including the amygdala and related structures (Schiffer et al., 2007; Schiltz et al., 2007), but it remains unclear whether these findings are attributable to pedophilia, general criminology, or reduced behavioral control (Mohnke et al. 2014; Poepl et al., 2013). In a neuroimaging study that compared child sex offenders with pedophilia with non-sexual offenders, the authors found large regions with significantly lower volumes of white matter compared to the controls in temporal and parietal areas, but no differences regarding grey matter (Cantor et al., 2008). This results led the authors to hypothesize that a disconnection between certain areas in the brain that are part of a larger cortical network underlying detection of sexually relevant cues might be a biological antecedent of pedophilia, rather than lesions in specific areas (which would produce lower volumes of grey matter).

The only robust environmental factor that is known to predict sexual fantasies and behaviors involving children later in life is having been sexually abused as a child (but note that most children who have been sexually abused never develop pedophilic fantasies or commit sexual offenses in later life; Seto, 2008). The observation that PWP report higher than expected rates of child sexual abuse histories represents the basis of the abused-abuser theory, that is, the idea that there is a unique causal link between having been abused as a child and engaging in related sexual fantasies and/or activities as an adult (L. J. Cohen & Galynker, 2002). Erotic age preference for child bodies compared to mature bodies, as assessed by *phalometric assessments* (i.e., the measurement of penile circumference or volume change in response to different stimuli) among child sex offenders, significantly predicted (self-reported) childhood sexual abuse (Freund & Kuban, 1994). Using a meta-analytic approach, another team of researchers found that childhood sexual abuse, but not other early adverse experiences such as physical abuse, was linked to criminal sexual acts as an adult (Jespersen, Lalumiere, & Seto, 2009). Other involvement in sexual activities as a child (e.g. “playing doctor” among children of the same age) has also been suggested to explain the etiology of pedophilia (Santtila et al., 2010).

Beyond speculation, little is known about the underlying psychopathological pathways linking sexual abuse or other childhood sexual experiences and pedophilic fantasies or behaviors in later life, although conditioning or other learning experiences are commonly assumed to play a mediating role (Laws & Marshall, 1990; Seto, 2008). According to supporters of the conditioning theory, if an unconditioned stimulus (children) is coupled with a positive emotional reaction (sexual pleasure) during childhood sexual experiences or masturbatory activities, conditioning is taking place that predisposes the individual to become aroused by children, even in adulthood (Finkelhor & Araji, 1986). Yet, this theory is not fit to explain pedophilia by itself, as many children have their first sexual experiences with peers of the same age (Seto, 2008). Other currently unknown variables, such as genetic differences leading to an increased suggestibility to conditioning (Santtila et al., 2010), are necessary to explain why children rarely develop pedophilia as they grow up. For childhood sexual experiences involving an adult, the conditioning hypothesizes is even less plausible to explain why the child would develop pedophilia. From the point of view of the child, the adult abuser would become the sexual stimulus, which should lead to the child developing an interest in older and mature partners instead of children (Cantor, 2014).

2.3 Child Sexual Offenses

2.3.1 Definition of Child Sexual Abuse and Child Pornography Offenses

The World Health Organization and International Society for Prevention of Child Abuse and Neglect (2006) defined child sexual abuse as “the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared” or that, in ways not further specified, “violates the laws or social taboos of society” (p. 10). Acts of sexual abuse may refer to, for instance, showing pornographic images to a child, talking to the child in a sexual way, tongue-kissing the child, masturbating in front of a child, fondling the child’s genitals (or prompting the child to fondle the adult’s genitals), and intercourse. Child sexual abuse does not necessarily involve violence or threats and may be committed by adults and other children. About 1% of boys and 5% of girls experienced forms of sexual abuse that involve direct physical contact (e.g., touching the offender or being touched by the offender in a sexual way, intercourse) below the age of 14 in Germany ($N = 11.428$; Bieneck, Stadler, & Pfeiffer, 2011). Child sex abuse was found to be associated with a number of psychological problems in later life (Irish, Kobayashi, & Delahanty, 2010; Najman, Dunne, Purdie, Boyle, & Coxeter, 2005) but due to the presence of confounding variables, causality could not safely be assumed (Rind, Tromovitch, & Bauserman, 1998).

As another important field of sexual exploitation of children, child pornography offenses have recently gained public and scientific awareness (Lam, Mitchell, & Seto, 2010; Seto et al., 2006). While the use of pornography does not directly harm children, the acquisition of pornographic images “may create a demand for its production” and contribute to further distress for victims “through the knowledge that the documentation of their abuse has been made public and remains accessible” (Berliner Institut für Sexualwissenschaft und Sexualmedizin, 2013, p. 14). The German Criminal Code does not only prohibit the dissemination, possession, and acquisition of images of children’s genital or anal areas or sexual acts between children and adults, but also any sexually explicit fictional material (i.e., written texts or computer animations) involving children (§ 184b). This legislation also pertains to pornographic material involving adolescents (§ 184c). According to recent estimations based on a large community-based survey among German men, about 2.2% had consumed child pornography (Dombert et al., 2015).

2.3.2 Risk Factors for Child Sexual (Re-)Offending

For primary prevention of child sexual offending, it is important to know which factors predict or determine or such behavior. There are a large number of theories that attempt to explain first-time offenses (for an overview see Seto, 2008). Finkelhor and Araji's (1986) four factor model, for instance, illustrates how the interplay of (1) emotional congruence with children (i.e., the emotional desire to be close to children), (2) sexual arousal to children, (3) blockage (i.e., the failure to find alternative ways to fulfill sexual or emotional needs), or (4) disinhibition (e.g., intoxication or other factors that lead to a failure to control harmful urges) may cause child sexual abuse. Yet, theoretical works such as these "have outpaced data collection, and there are little empirical data to indicate which risk factors are most important, and/or how they interact to produce child sexual abuse perpetration" (Whitaker et al., 2008, p. 530). Furthermore, as most studies on risk factors focus on convicted offenders, the current literature does not provide insight into predictive factors for *first-time* offending (Whitaker et al., 2008).

Conceptualization of Risk Factors

In risk factor research, there is a common distinction between static and dynamic risk factors for sexual offending. Static risk factors are fixed factors that are associated with a higher risk but cannot be changed (such as age or aspects of the offense history like the number or the sex of child victims; Hanson & Thornton, 2000), while dynamic risk factors are amenable to change during the course of an intervention (e.g., self-esteem, self-control skills; Mann, Hanson, & Thornton, 2010). Dynamic risk factors can be further classified as stable or acute. That means that stable dynamic risk factors are factors that, while they may change over time, represent relatively enduring aspects of the offender's personality. For instance, evidence shows that child sex offenders with pedophilia score higher on antisociality than matched non-offending controls without pedophilia (L. J. Cohen, McGeoch, Watras-Gans, et al., 2002). Acute risk factors represent highly transient, rapidly changing states (e.g., intoxication, negative emotions) or events (e.g., interpersonal conflicts) that may signal situations when offending or reoffending is likely to occur (Mann et al., 2010). For instance, men who have sexually offended against children have more often been found to report feelings of anxiety and depression prior to their offenses than men who have raped adult individuals (Pithers, Kashima, Cumming, Beal, & Buell, 1988).

Recently, the dichotomy between stable and acute risk factors has been criticized on a number of grounds, namely the lack of empirical support for the distinction and the sometimes unclear relationship between static risk factors (e.g., having offended against unrelated children as opposed to related children) and recidivism (Mann et al., 2010). To solve these conceptual problems, it has been proposed to conceptualize risk factors as enduring “individual propensities [similar to traits], which may or may not manifest during any particular time period [states]” (Mann et al., 2010, p. 194). Rather than simply acknowledging that a variable has predictive significance for sexual recidivism, Mann et al.’s (2010) approach attempts to elucidate the psychological meaning of such signals. According to this understanding, adverse environmental or personal circumstances (e.g., consuming disinhibiting substances or associating with delinquents) are less important than the supposed enduring tendency of an individual to gravitate towards or create such conditions or circumstances (e.g., offense-supportive attitudes or lifestyle impulsivity). For PWP, choosing professions or activities in which they have regular contact with children outside of the family (e.g., as a babysitter, teacher, or coach) may result in a higher offending risk, as this leads to more opportunities for sexual acts and grooming (Turner, Rettenberger, Lohmann, Eher, & Briken, 2014). Furthermore, static risk factors are predictive of future offending behavior, because “they act as markers of the past operation of dynamic risk factors” (Mann et al., 2010, p. 194). Past offences involving primarily male victims outside of the family, for instance, can point towards pedophilia as an underlying causal variable (Mann et al., 2010).

Empirical Evidence for Psychologically Meaningful Risk Factors

Empirically supported and psychologically meaningful risk factors for sexual recidivism among sexual offenders involving adult and/or child victims included, according to a recent meta-analysis (Mann et al., 2010), sexual preoccupation ($d = 0.39$), offense-supportive attitudes (including cognitive distortions regarding sexual acts between children and adults; $d = 0.22$), emotional congruence with children ($d = 0.42$), lack of emotionally intimate relationships with adults (e.g., $d = 0.36$ for conflicts in intimate relationships), self-regulation problems ($d = 0.37$), problem-solving deficits ($d = 0.22$), resistance to rules and supervision (e.g., $d = 0.30$ for childhood behavior problems), and hostility ($d = 0.20$). Promising, but not sufficiently tested risk factors included a lack of concern for others ($d = 0.29$) and dysfunctional coping (e.g., $d = 0.43$ for sexualized coping), among others (Mann et al., 2010). Loneliness, low self-esteem, and major mental illness have not been found to be supported as risk factors by accumulated evidence overall, but there was some evidence that they may be

important risk factors for sexual re-offenses under specific but previously unidentified conditions (Mann et al., 2010; Whitaker et al., 2008). For instance, a large Swedish study ($N = 1215$) found a positive link between mental illness, especially substance use disorders and personality disorders, and recidivism (Långström, Sjöstedt, & Grann, 2004).

Pedophilic sexual arousal was robustly found to predict re-offending among child sexual offenders (Hanson & Bussiere, 1998; Mann et al., 2010). Consequently, most theories of child sex offending agree on the notion that a sexual attraction to prepubescent children plays a role in the offending process (Finkelhor & Araji, 1986; G. C. N. Hall & Hirschman, 1992; W. L. Marshall & Barbaree, 1990; Seto, 2008; T. Ward & Beech, 2006; T. Ward & Siegert, 2002). Nevertheless, it is important to point out that pedophilia is neither a sufficient nor a necessary precondition of sexual offenses involving children. Even though their exact figure is difficult to estimate due to a lack of studies, there are people who feel sexually attracted to children and manage to live law abiding lives (Schaefer et al., 2010; G. Schmidt, 2002). In a sample of male undergraduate students, deviant sexual fantasies (including pedophilic fantasies) have been found to be only acted out by a small group of fantasizers (K. M. Williams, Cooper, Howell, Yuille, & Paulhus, 2009). Apparently, the link between fantasies and actions held only for those who scored high on psychopathy (K. M. Williams et al., 2009). A community-based study on German men found that pedophilic fantasy preferences were significantly linked to sexual offending against children and child pornography use, but the associations were only medium sized ($r = .24$ and $r = .23$, respectively, Dombert et al., 2015). More than half of the participants who admitted having a sexual interest in children also reported to have never committed child sexual offenses or child pornography offenses (Dombert et al., 2015). Conversely, based on phallometric responses to adult and child stimuli and their sexual offense history, only about half of the adults who were convicted of having committed sexual acts with children possess a corresponding sexual attraction to prepubescent bodies (Seto, 2008).

It is important to keep in mind that the empirical findings presented in this chapter (with the exception of Dombert et al., 2015 and K. M. Williams et al., 2009) were based on data about detected sexual offenders. This imposes constraints on the generalizability and interpretation of the above presented findings. Also, it is possible that reoffending among PWP may be predicted by different static or dynamic factors (other than the sexual fantasies) than reoffending among teleiophilic men who have sexually offended against children (and/or adults, as the sexual offender category in many studies included rapists with adult victims as

well). By merging the different groups, effects that might only be relevant for one subtype of sexual offenders may have become obscured (Whitaker et al., 2008). Hence, it is currently unclear whether child sex offenders with pedophilia differ from other subtypes of sexual offenders with respect to risk factors for recidivism, as findings are usually summarized for different offender groups.

2.3.3 Treatment of People with Pedophilia as Primary Prevention

Pedophilia was often reported to be experienced as ego-syntonic, that is, the person does not suffer from the fantasies but sees them as part of his or her normal identity (Green, 2002). Consequently, a person with pedophilia who seeks treatment may not perceive his or her sexual interest in children as problematic, especially if the person is capable of controlling corresponding urges that may lead to criminal behavior and is motivated to lead a law-abiding life. In this case, the person would not be diagnosed as having a pedophilic disorder, and would have no therapeutic objective with regard to sexual abuse prevention (see Chapter 2.2.1). Yet, of all therapy goals that a person with pedophilia might have (including coming to terms with stigma), the goal to abstain from criminal sexual behavior involving children has received most attention from clinicians and researchers so far.

Therapeutic approaches to reach this goal can be categorized in two broad domains, namely (1) changing or reducing the pedophilic attraction (e.g., aversion therapy, satiation, or masturbatory reconditioning; Barbaree, Bogaert, & Seto, 1995; Quinsey & Earls, 1990), and (2) changing the ways the person deals with this attraction (e.g., increasing motivation and control to help the person abstain from sexual acts with children). The present literature coalesced around the notion that sexual reaction patterns in PWP cannot be changed (Seto, 2008, 2012; but see Briken et al., 2014, for a dissenting point of view). One plausible explanation for the failure of reconditioning to alter pedophilic attraction was that “even if pedophilic desires had been learned, the learning involved may have been imprinting, a type of ‘stamping in,’” that, once learned, cannot be unlearned (Fagan et al., 2002, p. 2462).

Pharmacological treatments are also available and widely practiced to reduce pedophilic attraction. Administered drugs include antihormonal substances and some selective serotonin reuptake inhibitors that are known to reduce sex drive. Yet, androgenic medication in particular has been found to have severe side effects such as a deterioration of cardiac disease, anemia, and depressive moods (Hill, Briken, Kraus, Strohm, & Berner, 2003). Also, while generally reducing the patient’s sex drive, pharmacological treatment does not alter the sexual

preference for children. The goal to develop a medication that selectively reduces deviant sexual attraction, does not impair non-deviant sexuality, and has little to no side effects “appears more like a utopian than a realistic goal for the near future” (Hill et al., 2003, p. 408).

The view that “treatment is more likely to be effective if it focuses on self-regulation skills (in order to manage pedophilic urges, thoughts, etc.) than on trying to change sexual preferences” (Seto, 2012, pp. 234-235) has recently gained popularity among researchers and clinicians alike. The Berlin Prevention Project Dunkelfeld targets PWP who are worried that they may commit (further or first time) sexual offenses against children and choose to pursue therapy but have no current legal obligations to do so (Beier, Ahlers, et al., 2009). The program is based on principles of *cognitive behavioral therapy* (CBT) and is reminiscent of relapse prevention based programs for people with substance abuse disorders. The treatment includes interventions to “increase motivation, improve self-efficacy and self-monitoring,” “reduce sexual arousal and sexualized coping, by an increase of adequate coping strategies, emotional and sexual self-regulation, increase social functioning, decrease offense-supportive attitudes and behaviors,” and to “increase empathic response to children involved in sexual acts with an adult or depicted in CP [child pornography], and finally develop appropriate relapse prevention strategies and goals” (Berliner Institut für Sexualwissenschaft und Sexualmedizin, 2013, p. 22). During the program, patients learn that while they are not responsible for their sexual interests, they are responsible for the control of the behavioral expression of these interests.

The treatment was discovered to reduce emotional loneliness, emotion-oriented coping, and offense-supportive attitudes and to increase victim empathy effectively (among other variables), while in the waiting list control group, no changes occurred (Beier et al., 2014). Contrary to the authors’ expectations, treated PWP also showed a significant loss of self-esteem, while PWP from the control group did not change with respect to this variable (Beier et al., 2014). Regarding offense risk, 20% of those who had sexually offended against children at the start of the project persisted child sexual offending during the one-year period of treatment, whereas none who had previously not committed sexual offences started such behavior. Among child pornography users, 90% persisted in their offending behaviors, while 24% of those who previously did not use child pornography started using it. The authors discussed reasons for this apparent treatment failure (e.g., participants learning how to obtain pornographic material online by talking to other group members), but pointed out that an

increase in reported child pornography consumption might also be due to a reduced tendency to minimize or justify offending behavior among the treated sample (Beier et al., 2014).

In summary, there is tentative evidence that therapeutic approaches focusing on strengthening self-control, and motivation to abstain from sexual contacts with children could be better suited to decrease the risk of sexual offending against children than earlier attempts to recondition sexual interests. These strategies might be combined with pharmacological treatment to reduce sex drive, if necessary.

3. Research Questions and Study Overview

3.1 General Objectives

The general objective of this thesis was to adapt stigma concepts and theories for the study of the previously neglected field of stigma research pertaining to PWP. As explained in Chapter 2.1.3, the last decades have seen a plethora of research for many stigmatized groups, particularly people with a psychological disorder and people with a sexual minority orientation. Although these research traditions have developed separately, they all originated from Goffman's (1963) formative work on stigma and share the idea that stigma is a considerable source of social difficulties (Hatzenbuehler, Phelan, & Link, 2013). Also, researchers in both fields have incorporated basic psychological concepts such as attribution, stress, and prejudice.

By adapting ideas and concepts from the aforementioned bodies of research, a model was developed that delineates stigma consequences for PWP. This model furthermore incorporated hypotheses about risk factors for child sexual abuse (see, e.g., T. Ward & Beech, 2006) and proposed several pathways through which public stigma may influence the risk of sexual offences involving children both online and offline (see Chapter 4.3 for an in-depth description of the framework). This indirect effect was assumed to be mediated by problems in emotional and social areas of functioning, cognitive distortions, and reduced therapy motivation. Empirical data was collected to assess public stigma and to test hypothesis derived from the stigma framework. Completing this line of work, the acquired knowledge was put into practical use by developing and investigating a stigma reduction intervention for psychotherapists in training.

3.2 Study overview

First, a thorough and systematic research of the literature was conducted in order to identify all previous works dealing with people's beliefs, attitudes, and reactions concerning PWP. This review revealed both conceptual and methodological limitations of previous investigations (e.g., small sample sizes, limited generalizability, equivocal use of the term pedophilia). Furthermore, many pivotal aspects of stigma or the stigma process (e.g., links between stigma awareness and health outcomes, stigma among mental health professionals) were discovered to have received little to no scientific attention. The following studies were designed to overcome the flaws and limitations of these previous endeavors and to investigate

stigma against PWP according to a systematic research agenda grounded in the relevant literature.

Study I and II researched public stigma towards PWP and related variables. To this end, an inventory to assess public stigma against PWP on a cognitive (stereotypes controllability and dangerousness), affective (fear, anger, and pity), and behavioral (social distance) level was developed using self-report scales. Compared to earlier studies, care was taken to find a clear formulation for pedophilia to make sure that participants rated a sexual interest and not sexually abusive behavior. A similar set of items pertaining to other stigmatized groups like people who abuse alcohol (Study I), sexual sadists, and people with antisocial personality traits (Study II) was generated to investigate how stigma against PWP compares to these other stigmas. All items referring to PWP and people who abuse alcohol were pretested among psychology undergraduates from the University of Bonn to ensure sufficient internal consistency. Also, Study I investigated potential predictors of social distance regarding PWP, thereby providing a basis for subsequent attempts to reduce stigma. As this was the first investigation of its kind, there were no previous reports on effects sizes for stigma against PWP as compared to other stigmas. A large sample ($N > 800$) composed of people that were heterogeneous with respect to gender, socioeconomic variables, and age was intended for Study I to overcome some of the limitations of previous studies. Study II was added as an amendment and replication of Study I with different comparison groups. Both studies were conducted as planned among two heterogeneous ad hoc samples ($N = 854$ pedestrians in Stuttgart and Dresden for Study I and $N = 201$ English-speaking Internet users in Study II, note that all participants had to be at least 18 years old).

Study III aimed at assessing self-stigma of PWP and its consequences, including dynamic risk factors for child sexual abuse. To guide this research, a framework for the consequences of stigma-related stress among PWP was introduced. This systematic set of assumptions was based on concepts and findings presented in the previous chapters, namely Chapter 2.1.3 and Chapter 2.3.2, and proposed a hypothetical indirect link between PWP's stigma-related stress and a heightened risk for sexual offenses involving children. More specifically, the study was designed to test the hypotheses that higher perceived social distance and fear of discovery are linked to (1) decreased emotional functioning, (2) more social problems, (3) stronger offense-supportive attitudes, and (4) a reduced motivation to seek therapy. Because of the lack of scales to assess self-stigma among PWP, this research required the development of a number of new inventories. These inventories included the Perceived Social Distance Scale, the Fear

of Discovery Scale, and the Therapy Motivation Scale for PWP (note that all items were rated by experts to ensure comprehensibility and content validity). Reliability of the Fear of Discovery Scale (with the instruction of responding to the items with respect to a secret of one's own choice) was furthermore affirmed among a pretest sample of psychology undergraduates. Avoiding the trappings of researching PWP in clinical or forensic settings, the study focused on the under-researched group of community men with pedophilia. Only male participants over 18 who reported an exclusive or non-exclusive sexual interest towards prepubescent children and gave informed consent to participate were included in the study. As links between an individual's perception of stigma and possible negative health (or other) outcomes were often found to be small to medium-sized (e.g., B. G. Link, Struening, Rahav, Phelan, & Nuttbrock, 1997; Mak, Poon, Pun, & Cheung, 2007; Meyer, 2003; Rosser, Bockting, Ross, Miner, & Coleman, 2008), a sample size of at least $N = 97$ was considered sufficient for this research (assuming that $r = .25$, $\alpha = .05$ and $\beta = .20$; Bortz, 2005; sample size calculated via www.statstodo.com/SSizCorr_Pgm.php, accessed April 25, 2013). To reach this many community men with pedophilia, an online design was favored to guarantee a high level of anonymity by allowing participants to keep their identity from the research staff. Hypotheses from the framework were tested online among $N = 104$ self-identified PWP, using a correlational survey design. It is important to point out that associations confirmed within correlational studies do not imply causation. Nevertheless, to achieve a higher level of certainty regarding the validity of the tested (causal) framework, a number of potential confounding variables (including social desirability bias) were statistically controlled in order to rule out alternative explanations for a correlation between two variables.

Study IV evaluated an online intervention for psychotherapists designed to reduce stigma against PWP. Effectivity of the intervention was assessed based on the study's randomized controlled design, which allowed for causal interpretations. It was assumed that participants who received the anti-stigma intervention would be less likely to have stigmatizing attitudes towards PWP, and more likely to offer therapy to PWP than participants from the control condition. Again, stigma was assessed using the inventory from Study I and II. Furthermore, a short scale was introduced to measure therapists' willingness to work with PWP and to take special courses to acquire skills and knowledge for the treatment of this patient group. Basing the sample size calculations on a recent meta-analysis that revealed small to medium-sized effects for randomized controlled trials related to stigma change interventions (P. W. Corrigan et al., 2012), a number of at least 126 participants was estimated to be sufficient to reach significance with $\alpha = .05$ and $\beta = .20$ (assuming that $d = 0.5$ and that the approximate

correlation between measures is .5). The investigation was conducted among $N = 137$ psychotherapists in training from various German CBT institutes. To assess stability of program effects, stigma levels and motivation to work with PWP were assessed directly after the intervention and again after an interval of approximately three weeks.

4. Understanding Stigmatization of People with Pedophilia

4.1 Review - Stigmatization of People with Pedophilia: A Blind Spot in Stigma Research

Abstract

Stigmatization restricts people's opportunities in life and has severe consequences on mental health and psychological well-being. This chapter focuses on stigmatization research on pedophilia. Based on an extensive literature search, it reviews studies that have empirically determined lay theories, stereotypes, prejudices, and discrimination against PWP, as well as the effect of stigma on this group. The review reveals a scarcity of empirical studies on the subject (11). While the majority of studies give at least an indication that stigma against PWP is highly prevalent, we also identified severe methodological limitations and a lack of a unifying and systematic research agenda. We discuss the need for more theory-driven, rigorous, and representative empirical studies and propose perspectives and requirements for the scientific study of stigma against PWP.

4.1.1 Theory

Detrimental effects of stigma have been known and discussed for decades. In his seminal work, Goffman (1963) defines stigma as an undesirable attribute that makes its carrier “different from others, [...] in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one” (p. 3). When this deeply discrediting attribute becomes known, it “spoils the social identity of the person carrying it and cuts him off from society and from himself so that he stands a discredited person facing an unaccepting world” (p. 19).

The initial accounts on stigma have fostered a long-standing empirical research tradition (Heatherton, Kleck, Hebl, & Hull, 2003). The amount of stigma and its negative impact on stigmatized individuals has been comprehensively documented for ethnic minorities (Bogardus, 1925; Gillen-O'Neel, Ruble, & Fuligni, 2011), obesity (Puhl & Heuer, 2009), gender (Spencer, Steele, & Quinn, 1999), social status (Croizet & Claire, 1998), diseases (Lebel & Devins, 2008; Leiker, Taub, & Gast, 1995), and mental disorders (Angermeyer & Dietrich, 2006). Stigmatization has also been investigated with regards to bisexual people, lesbians, and gay men (Ahmad & Bhugra, 2010; Bhugra, 1987; Herek, 2002, 2009; Steffens & Wagner, 2004) and, to a lesser degree, other sexual minorities like transgender people (M. E. King, Winter, & Webster, 2009).

The stigma process starts with the labeling of a person or group as deviant or fundamentally different from oneself (B. G. Link & Phelan, 2001). Therefore, many stigma researchers take an interest in naïve or lay theories of mental disorders (Angermeyer & Dietrich, 2006; Gaebel, Zaské, & Baumann, 2006; Phelan, 2005) or other stigmas (Hodson & Esses, 2005). Lay theories can be defined as theories (e.g., about causes and management of mental disorders) that people without expert knowledge use in an everyday context. Although lay theories do not necessarily lead to stigma, they might help “clarify the psychological basis of stigma” (Haslam, 2005, p. 42). Public stigma (i.e., the negative reaction of the public towards a discredited minority) consists of three aspects: stereotypes, prejudices, and discrimination (Rusch, Angermeyer, & Corrigan, 2005b). Stereotypes are beliefs about perceived or assumed characteristics of a social group (Ashmore & Del Boca, 1981) such as, e.g., the notion that homosexual men are effeminate and work as hairdressers (Madon, 1997). Being aware of stereotypes about other social groups does not imply agreeing with them (P. W. Corrigan & Watson, 2002). However, when an individual member of the community adopts discrediting

consensual stereotypes (e.g., that members of the group are dangerous), prejudice ensues (Rusch et al., 2005b). Empirical research further demonstrated that agreement with stereotypes and strong evaluative reactions can promote discrimination against stigmatized groups (P. Corrigan, Thompson, et al., 2003; Page, 1977), and reduce the likelihood of helping behavior (P. W. Corrigan & Watson, 2002).

However, not all potentially stigmatizing characteristics are obvious, and some are easier to conceal than others. When an individual who (knowingly) possesses a stigmatized attribute that is not readily apparent to others manages to keep it secret (e.g., by avoiding situations where others might discover it), this might be referred to as a “hidden stigma” (P. W. Corrigan & O’Shaughnessy, 2007). People with a minority sexual orientation or a mild mental illness can decide whether or not to disclose their status to other people, while people with, e.g., a cleft lip are easily identifiable as stigmatized and may become a target of discrimination, regardless of their behavior. However, even people with a hidden stigma may experience threat when confronted with stressors such as “having to make decisions to disclose one’s hidden status, anxiously anticipating the possibility of being found out, being isolated from similarly stigmatized others and being detached from one’s true self” (Pachankis, 2007, p. 328). To explain higher rates of mental disorders among gay men, lesbians, and the bisexual population, Meyer’s (2003) minority stress theory convincingly argues that multiple processes besides the direct experience of prejudice and discrimination may act as further sources of stress, such as expectations of rejection and the heightened vigilance it entails, efforts to hide and conceal the stigma, and internalization of stigmatizing views. Thus, belonging to a stigmatized group may not only reduce the quality of life, but might also lead to self-harm, including drug abuse (Baiocco, D’Alessio, & Laghi, 2010; Lehavot & Simoni, 2011), suicidal behavior (Haas et al., 2011; Liu & Mustanski, 2012; Mustanski et al., 2010), and reluctance to seek help if it includes being labeled as a member of a stigmatized group (Ben-Zeev et al., 2010; Vogel & Wade, 2009). While stigma against sexual minority orientations or mental illnesses such as depression or schizophrenia is widely recognized as an important problem of modern society, research will need to explore whether the above mentioned consequences of stigma also apply to other relatively hidden stigmas, such as pedophilia.

Pedophilia is a diagnostic term applied to people who are sexually interested in pre-pubescent children (American Psychiatric Association, 2000). However, according to a recent article (Seto, 2012), pedophilia also fulfills criteria of a sexual orientation with respect to the age of the desired partners (as opposed to their sex). Taking position on this controversial issue is

beyond the focus of this research. However, regardless of whether or not pedophilia should be considered a sexual orientation, we believe that stigma against PWP could be informed by the literature on the experiences of sexual minorities.

While there is evidence that child sex offenders with a deviant sexual preference are more likely to re-offend than non-paraphilic sex offenders (Hanson & Bussiere, 1998), pedophilia is neither a necessary nor a sufficient condition for child sex offenses. PWP make up for only 50% (or less) of the offender population (Seto, 2008), and there are those with pedophilia who cope with their sexual urges without committing sexual offenses or harming children (Feelgood & Hoyer, 2008; R. C. W. Hall & Hall, 2007).

In the general public however, it is to be expected that *sexually abusive behavior towards children* is often confused with pedophilia as a *sexual preference*. In the media, people with pedophile or other paraphile interests are often stereotypically portrayed as violent criminals (Diefenbach, 1997; Kitzinger, 2004). The public's view of sexual offenders is extremely negative (Fortney, Levenson, Brannon, & Baker, 2007). Agreement with the stereotype that pedophilia often or always coincides with child sex offenses is likely to prompt a high degree of discrimination against PWP, regardless of their actual behavior. This may have a negative impact on the mental health of a person suffering from pedophilia, and unwanted indirect effects on the likelihood of this person seeking therapy when needed. Both potential consequences may, presumably, put children at risk of child sexual abuse.

In this chapter, we will systematically review and summarize research on lay theories and public stigma regarding PWP. We will also search for indications on the consequences of public stigma on the beliefs and attitudes of a person with pedophilia towards himself. Additionally, we will build on the results of our review by developing ideas and perspectives for a more theory-driven and methodologically rigorous empirical study of stigma against PWP.

4.1.2 Methods

Studies were considered for review when they were dealing with (1) lay theories about pedophilia, (2) stereotypes about or prejudice towards PWP, (3) discrimination of PWP, and (4) the effect of stigma on individuals with pedophilia. The articles were also required to be quantitative studies and to be published in English, German, or French. Recent research on pedophilia and sexual abuse has shown a questionable trend to confuse sociolegal and

psychopathological classifications (Feelgood & Hoyer, 2008). To avoid this pitfall, we excluded papers dealing with public perception of sexual offenders in general (Fortney et al., 2007) or sex offender registration (Kernsmith, Craun, & Foster, 2009), unless they actually featured pedophilia as a psychopathological category. Studies were excluded in which participants were solely and unambiguously questioned about adult people engaging in sex with children (i.e., sex offenders), even though the authors used the term “pedophile” in their study description (e.g., Marzillier & Davey, 2004; P. S. Russell & Giner-Sorolla, 2011).

We searched the Web of Knowledge and PubMed databases, using a combination of the terms “attitude*”, “perception”, “stereotyp*”, “prejudice”, “social distance”, “discrimination”, “stigma*”, “lay theor*”, “implicit theor*”, “opinion”, “media”, “public”, “label*”, “disgust” and the words “pedophil*”, “paedophil*”, “paraphil*” or “sexual* devian*”. Web of Science and PubMed are among the most reliable and acknowledged search engines for their respective fields (Falagas, Pitsouni, Malietzis, & Pappas, 2008). However, like most academic search engines, they have the disadvantage of only searching bibliographic records (Jacso, 2005). Therefore, we additionally conducted a full-text search via Google Scholar, using the search terms “stigmatization” and “pedophilia” and limited further inspection to the 100 most relevant findings, including nonperiodical web documents.

Five hundred and thirty one publications in Web of Science and 655 in PubMed were identified, but only seven studies met the aforementioned criteria (note that two studies reported in a single article were counted individually). Based on an additional full-text search via Google Scholar, three more studies could be identified. An eleventh study was retrieved via checking reference lists. Ten studies were published in English and one study in German.

Although we decided to restrict the focus of the present paper to quantitative research, we would like to add that well-structured and carefully analyzed qualitative work can be illuminating and worth seeking out both for its own intrinsic value and as a means of generating well focused quantitative research.

4.1.3 Results

Overview of the reviewed studies

Table 3 summarizes the studies that fulfilled inclusion criteria. In the following, we briefly summarize their goals and methodology.

Understanding Stigmatization of People with Pedophilia

Table 3. Description of empirical studies referring to stigmatization of people with pedophilia

Publication	<i>N</i>	Age (mean)	Samples and sampling strategy	Topics
Feldman and Crandall (2007)	281		Undergraduate Students (Psychology) in the US	Discrimination: Social distance
Furnham and Haraldsen (1998)	105	18 – 39 years old (23.5)	Mostly (85.7%) Students in London, UK	Lay theories: Causes, cures Covariates: Personality, gender, religiousness
B4U-ACT, Inc. (2011, June 22)	193		Self-identified people with pedophilia, online, 48 % in the US, 10% Germany, 8% Canada, 8% the Netherlands and 7% UK, 98% male	Reaction to public stigma: Suicide ideation and suicide attempts in relation to pedophilia, beliefs about and experiences with health care professionals
B4U-ACT, Inc. (2011, December 30).	209		Self-identified people with pedophilia, 3% female, 1 % transgender	Reaction to public stigma: Beliefs about and experiences with health care professionals, opinions about professional writings about people with pedophilia
Lam, Mitchell, and Seto (2010) - 1 st Study	240	(20.9)	<i>N</i> = 142 participants from an introductory criminology course, <i>N</i> = 98 on university campus, Toronto, CA	Factors predicting lay theories and public stigma: Child pornography offender's sexual interests, severity, sentence length, probability of same re-offense, probability of past and future sexual contact
Lam, Mitchell, and Seto (2010) - 2 nd Study	252	(18.9)	Undergraduate psychology students	Factors predicting lay theories and public stigma: See 1 st study
McCartan (2004)	70		People in public places, e.g., restaurants, cafes, work places, in Leicester and Belfast, UK	Stereotypes: Pedophile activities, treatment of pedophiles, pedophilia in the media
McCartan (2010)	51	21 – 58 years old	Criminology postgraduate students in Leicester, UK	Stereotypes: Pedophile activities, pedophile personality
Stiels-Glenn (2010)	86		Psychotherapists in public health insurance system in Essen, Germany (56.6% of the targeted group)	Discrimination: Willingness to treat pedophiles Covariates: Gender
Twohig and Furnham (1998)	100	17 – 35 years old (20.93)	Mostly (91%) Students in London, UK	Lay theories: Coping strategies for overcoming paraphilias Covariates: Personality, attitudes to sex, siblings, gender, religiousness
Wilson and Cox (1983)	77	> 20 years old (35 – 40)*	Self-identified people with pedophilia, members of a self-help group (representing estimably 50% of the targeted group)	Reaction to public stigma: feelings towards sexual preference

* modal age range

- 1) Feldman and Crandall (2007) investigated which characteristics across mental disorders lead to stigmatization. They collected social distance ratings (modified by Crandall, 1991) of 40 vignettes, each describing a typical case of a mental disorder listed in the DSM-IV-TR (American Psychiatric Association, 2000) including alcoholism, paranoid schizophrenia, depression, and pedophilia. Each participant rated 13.5 disorders on average (range: 9 - 17).
- 2) Furnham and Haraldsen (1998) conducted a study to explore the structure, determinants, and relationship between participant's beliefs about the causes and cures for fetishism, sexual sadism, voyeurism, and pedophilia. Participants rated the importance of 16 possible causes and 14 treatments.
- 3) Kramer (2011, August, 17) authored two online surveys for people who self-identify as being sexually attracted to children. The first survey investigated the development of pedophilic interests, suicidal ideation, and attitudes towards seeking help. The second survey aimed at further investigating the experiences of PWP in the public health system, as well as assessing whether PWP felt stigmatized by professional writings about them. Both surveys were conducted by B4U-ACT, a Maryland-based patient advocacy group to promote health care resources for PWP. More detailed information about the results of both studies could be obtained from their website (B4U-ACT, Inc., 2011, June 22 for Study one, and B4U-ACT, Inc., 2011, December 30 for Study two).
- 4) Lam et al. (2010) conducted two studies on how different offense- and offender-related characteristics (such as perceived likelihood of pedophilia, among others) influenced the student's perceptions of child pornography offenses. Both studies used vignettes which varied with respect to age and gender of the depicted minor (Study one) and the offender (Study two).
- 5) K. McCartan (2004) sought to determine the relationship between the media and opinions concerning PWP in a small UK-based opportunistic sample. The author administered a self-developed questionnaire (22 items) to collect data about the respondents' opinions on various subjects concerning pedophilia (including the treatment of PWP, and the role of the media).
- 6) K. F. McCartan (2010) collected responses to two open-ended questions ("What is a paedophile?" and "What attitudes and behaviours do paedophiles typically display?") and summarized answers thematically.

7) Stiels-Glenn (2010) examined the availability of outpatient psychotherapy for PWP. The author sent questionnaires to all licensed psychotherapists in the German city of Essen, asking them whether they were willing to work with different types of offenders and individuals with pedophilia. About half of the respondents made annotations that allow further insights about their standpoint towards treating members of the aforementioned groups.

8) Twohig and Furnham (1998) investigated lay theories about overcoming each of the four paraphilias fetishism, sexual sadism, voyeurism, and pedophilia by asking participants to rate how important they considered 24 coping strategies for each of the paraphilias.

9) Wilson and Cox (1983) used a self-developed questionnaire to assess various aspects of psychosexual development, personality, sexuality, and attitudes towards their condition among members of a London-based self-help group for PWP. The leaders of the organization distributed the questionnaires via mail. The authors thematically summarized the responses obtained.

Lay theories about pedophilia

In this section, we describe lay theories about the causes and treatment of pedophilia based on the above listed publications.

With reference to lay concepts of possible causes of paraphilia, a factor analysis carried out for the items in Furnham and Haraldsen's (1998) study revealed four factors, a) Early Relationships (e.g., being beaten or sexually abused as children); b) Repressed Emotions; c) Lack of Guidance; and d) Biology. Regarding the potential cures, a factor analysis revealed the three factors: a) Therapy; b) External Control (e.g., belief in God, medication), and c) Internal Control (will-power, self-efficacy). For pedophilia, participants considered Early Relationships the most important etiological factor, followed by Repressed Emotions, Lack of Guidance, and Biology ($F(3, 12) = 3.59, p < .05$). They saw Internal Control and Therapy as more effective cures than External Control ($F(2, 11) = 28.76, p < .05$). The authors mentioned in a side-note that, despite a high degree of tolerance expressed towards paraphilias in their sample, this liberal attitude did not apply to pedophilia, which "can almost be regarded as belonging to a different genre of paraphilias" (p. 699).

A factor analysis of Twohig and Furnham's (1998) coping items revealed three factors a) Self-Reliance, b) Seeking Help, and c) External Control. While participants perceived Self-

Reliance to be important in the cure of fetishism, sadism and voyeurism, they saw Seeking Help as the most important factor in dealing with pedophilia, followed by Self-Reliance.

Summary: Lay theories indicate that pedophilia is mostly attributed to unusual early relationship experiences and inadequate ways of dealing with emotions (Furnham & Haraldsen, 1998). The emphasis on internal factors in curing pedophilia suggests that it is seen as a problem that is coming from within the person. However, whether or not pedophilia is actually caused specifically by early adverse experiences, it continues to be a topic of debate in scientific literature (Freund & Kuban, 1994; Jespersen et al., 2009). Moreover, the questioned samples viewed external sources of help and self-reliance as the most important therapeutic means for sexual deviance (Twohig & Furnham, 1998).

Stereotypes and prejudices concerning PWP

Here, stereotypes and prejudices towards PWP will be listed, as they occurred within the above mentioned publications.

K. McCartan (2004) found that most participants agreed that an individual with pedophilia partakes in a variety of sexual (e.g., kissing 61%, fondling 90%, masturbation 86%, sex 76%) and non-sexual (e.g., spending time 70%, talking 76%) activities with the child. Seventy-nine percent disagreed that pedophiles are mad, while a majority of 58% agreed that pedophiles are evil. Also, only 21% agreed that pedophilia can be successfully treated. The perceived re-offense risk was high (with 68% believing that pedophile sex offenders are more likely to re-offend than other offenders). The majority (58%) also agreed that the press has created a “witch hunt” in relation to pedophiles.

K. F. McCartan (2010) reported that when asked about which typical traits come to mind when they think of a pedophile, most students mentioned “sexually abusing children” (68.6%). Only a small minority suggested that this might not necessarily be the case (11.8%). Some stated that pedophiles were “not normal” (7.8%) "criminal" (9.8%), “mentally disordered” (15.7%) and "disgusting" (9.8%). No positive traits were mentioned. Answers to the question regarding typical behaviors or attitudes for this group included notions like, e.g., “appear normal” (25.5%), "secretive" (21.6%), and “spends time near kids” (21.6%).

Summary: In both studies by McCartan (K. McCartan, 2004; K. F. McCartan, 2010), participants mentioned many very negative and judgmental traits, such as pedophiles being

“evil” or “disgusting.” Furthermore, the literature does not support the assumption that sexual (re-)offense rates committed by persons with pedophilia are excruciatingly high (K. McCartan, 2004; K. F. McCartan, 2010), as recidivism rates in extra-familial boy-victim sexual offenders – both characteristics indicative of pedophilic sexual interests (Seto & Lalumière, 2001) – were only 35% after 15 years (Harris & Hanson, 2004). Additionally, many participants expressed pessimistic beliefs about the treatability of pedophilia (K. McCartan, 2004).

Discrimination of PWP

In prison, child sex offenders and PWP are outcasts prone to victimization at the hands of their fellow inmates (Jewkes, 2005; Vaughn & Sapp, 1989). Though some authors (e.g., Seto, 2008) reported anecdotes of actual – and sometimes even extreme – forms of discriminating behavior against people who were supposedly or actually sexually attracted to children, we found no quantitative study dealing with this topic. At this point, we would like to acknowledge that there are experts who speak out for a more accepting stance towards PWP among health care professionals in order to avoid sexual abusive behavior towards children (e.g., Beier, Ahlers, et al., 2009; T. Ward, Mann, & Gannon, 2007). However, there are no studies investigating whether this group or the general public would actually be willing to show prosocial behavior towards PWP (e.g., the intent to help them to not act upon their sexual impulses involving children).

Feldman and Crandall (2007) assessed behavioral intentions with the Social Distance Scale, which is considered a proxy for actual discrimination by some authors (e.g., P. W. Corrigan, Edwards, Green, Diwan, & Penn, 2001). Participants indicated lower willingness to interact with PWP than with people suffering from all the other presented disorders, except antisocial personality disorder.

In Stiels-Glenn’s (2010) study of German psychotherapists, 12.8% of the participants indicated to be willing to accept sexual offenders for treatment. However, only 4.7% would treat patients with pedophilia, and only 3.5% would treat child sex offenders. Some therapists specified the reasons for their responses with a lack of knowledge (20% of all who provided additional information), a focus on fields of work other than psychotherapy (13.3%) or further reasons that were unrelated to stigmatization. Other participants justified their refusal with negative feelings towards the aforementioned groups (13.3%), negative experiences they had had with them in the past (13.3%) or doubts regarding their motivation for therapy (11.7%). A

few therapists expressed doubts regarding the appropriateness of the therapeutic setting (6.7%), which hints at fears and uncertainties concerning the treatment of PWP.

Summary: Based on the few studies we could identify, evidence suggests that PWP are perceived as a threat that must be avoided. Feldman and Crandall (2007) discovered that individuals with pedophilia were more strongly rejected by students than other mentally ill patients (except for people diagnosed with antisocial personality disorder). In addition, psychotherapists do not seem inclined to accept PWP for treatment (Stiels-Glenn, 2010). Studies examining the general public's behavioral intentions or actual behavior towards PWP are still missing.

Factors predicting lay theories, stereotypes, prejudices, and behaviors

The following studies investigated which sociodemographic and psychological characteristics predict lay theories about and public stigma towards PWP in the broadest sense. Due to the scarcity of studies, they will be summarized here, although their focus and aims differed considerably.

Furnham and Haraldsen (1998) examined beliefs about the causes and cures of paraphilias and found the factor psychoticism of the Eysenck Personality Questionnaire (S. B. G. Eysenck, Eysenck, & Barrett, 1985) tested in study participants to be associated with a weaker belief in the effectiveness of therapy ($r = -.40$). Psychoticism is a personality dimension that is related to traits such as antisociality, unemotionality, and unhelpfulness (H. J. Eysenck & Eysenck, 1976). The more religious the participants rated themselves, the less they believed in the importance of biological and external factors in the cure of paraphilias ($r = .25$, $p < .05$). There was no link between gender or other tested sociodemographic and personality variables and the proposed “cures” for paraphilia.

In both parts of their study into the assumed links between child pornography and pedophilia, Lam et al. (2010) showed a significant effect ($p < .05$) of participants' sex on the perceived likelihood that the child pornography offender had pedophilia ($F(1, 230) = 4.17$ in the first part, $F(1, 245) = 5.3$ in the second part), with female participants (67.5% and 67.4%, respectively) being more likely to rate him as such than male participants (58.9% and 58.2%).

Lam et al. (2010) reported that the likelihood of the described child pornography offenders to be perceived as pedophile was 63.6% (study one). In their two studies, they found significant

correlations ($p < .05$) between the perceived likelihood of pedophilia and the perceived severity of the crime ($r = .24$ in study one, $r = .14$ in study two), the recommended sentence length (not significant in study one, $r = .30$ in study two), the probability of the same re-offense ($r = .26$ in study one; $r = .34$ in study two), the probability of past sexual contact with a child ($r = .54$ in study one, $r = .26$ in study two), and the probability of future sexual contact with a child ($r = .56$ in study one, $r = .48$ in study two).

Stiels-Glenn (2010) found that of the few psychotherapists who would agree to work with patients with pedophilia (13.3%), none was female.

In Twohig and Furnham's (1998) study, the participant's ratings of the importance of Seeking Help as a way of coping with paraphilia was predicted by gender ($t = 2.33$, $p < .05$) and psychoticism ($t = -3.17$, $p < .01$). Men ($t = -2.29$, $p < .05$), and people with a low self-perceived religiousness ($t = -2.05$, $p < .05$) were more likely to stress the importance of External Control. Religiousness was furthermore correlated with the factor Self-reliance ($t = 1.98$, $p < .05$). Neither attitudes to sex (H. J. Eysenck, 1970), political beliefs, siblings, nor the factors of the Eysenck Personality Questionnaire had an effect on the ratings of the cure factors.

Summary: Information on how personal or demographic variables relate to lay beliefs about and public stigma towards PWP are few, scattered, and inconsistent. Researchers have yet to put "classic" traits of stigma research that have repeatedly been shown to affect public attitudes like authoritarianism (J. Cohen & Struening, 1962) or familiarity with stigmatized people (B. G. Link & Cullen, 1986) to the test. In line with the empirical literature on the subject (Seto et al., 2006), students mostly see child pornography offenses as a valid indicator for sexual interest in children (Lam et al., 2010). They demanded higher sentencing the more they were convinced that the child pornography offender is pedophilic (Lam et al., 2010), suggesting that child pornography offenders with pedophilia might be socially disadvantaged compared to offenders without pedophilia. Though this assumption is highly speculative at this point, it deserves to be investigated in more detail in future studies. All therapists who stated their willingness to treat patients with pedophilia were male (Stiels-Glenn, 2010). However, the results only refer to self-reports and do not document actual decisions of therapists to treat (or reject) patients with pedophilia.

Consequences of public stigma on a person with pedophilia

Pedophilia has been shown to be associated with higher rates of mood, anxiety, and/or substance abuse disorders compared to the general population (Raymond et al., 1999; Schaefer et al., 2010). However, as the evidence for links between pedophilia and mental illness is cross-sectional, it is not clear whether higher rates of mental illness in pedophile samples should be interpreted as a psychopathology being a precursor of the condition, or a consequence of stigma. Among the articles that satisfied our search criteria, only three surveys investigated stigma experiences of people who self-identify as being attracted to minors (Kramer, 2011, August 17; Wilson & Cox, 1983).

B4U-ACT, Inc. (2011, June 22) found that 46% of the respondents conveyed having seriously considered suicide; 32% had plans to carry out suicide; and 13% have actually attempted suicide for reasons related to their pedophile sexual interests. Of the participants who reported suicide ideation, 67% responded that they were not able to talk about it to another person. Forty percent stated that they had wanted mental health care for a reason related to pedophilia, but did not obtain it. While a high number (82%) agreed that sometimes other PWP may profit from mental health care, 88% disagreed that mental health professionals had a good understanding of pedophilia, and 59% disagreed that they would seek help from a mental health professional if they had a problem related to their sexual preferences. Furthermore, about half of the participants doubted that a mental health professional would treat them ethically (46%), with respect (54%), or non-judgmentally (62%), or would keep confidentiality (51%). Forty-two percent of the sample reported having received mental health care for reasons related to their pedophilia sexual interests. Among this subgroup, therapy satisfaction was mixed (39% satisfied, 39% not satisfied).

In the second survey of the B4U-ACT group (2011, December 30), 58% of the participants agreed that they had once wanted to see a mental health professional for a reason related to their pedophile sexual interests (i.e., coping with the stigma), but failed to do so, mostly for fear that the professional would react negatively, report them or misunderstand their problems. Forty percent indicated that something they had heard or read a mental health professional say had discouraged them from seeking professional help, the majority of complaints relating to stigma. A number of 48% (37% uncertain) revealed that not receiving mental health care resulted in negative consequences, e.g., depression, low self-esteem, suicide attempts, and isolation. More than half of those who received health care services

reported to have hoped to improve their self-concept (67%), deal with public stigma (60%), and figure out ways to live in society as a person with pedophilia (57%). In the client's opinion, the professional less often attempted to address these issues (51%, 30%, and 33% respectively), while putting more emphasis on learning to control sexual urges (45%) and reduce or extinguish pedophile attraction (43%). These goals were seen as important by only a minority of patients (30% and 17% respectively). Especially clients in mandated treatments reported to have been confronted with assumptions they considered inaccurate and stereotyped (67% vs. 43% among clients voluntarily seeking treatment), such as believing the client to have or have had sex with a child, or only seeking sexual gratification from children rather than fulfilling romantic goals. Clients who reported to have been confronted with these statements usually felt that they impeded successful therapy. The majority of the participants agreed that the presented excerpts from a recent article on pedophilia ("Pessimism about pedophilia," 2010), the current DSM-IV-TR definition (American Psychiatric Association, 2000), and an article in favor of the DSM-Fifth Edition changes with respect to pedophilia (Blanchard, 2010) reflected current trends in professional writing. However, many also felt that these texts were inaccurate and promoted unethical treatment that did not befit a good client-professional relationship. In contrast, an article on the subject written about a non-forensic sample of persons with a sexual interest in children that will also be featured in this review (Wilson & Cox, 1983) was considered accurate and encouraging an ethical and beneficial treatment of clients with pedophilia.

In Wilson and Cox's (1983) survey, participants were divided in their feelings towards their pedophile preference: Some mentioned positive feelings (35% happy, proud, positive, 6% reconciled), but many responses were clearly negative (27% disturbed, 17% frustrated, 14% puzzled, 6% sad/hopeless/depressed, 5% guilty/ashamed, and 4% bitter or angry with society). The authors describe that "it was quite often the attitude of society that was the cause of their disturbance or puzzlement rather than their paedophilia per se" (p. 28).

Summary: A majority of PWP appear to have very negative attitudes towards their condition due to public stigma (Wilson & Cox, 1983). As the results of two online surveys indicate (Kramer, 2011, August 17), many PWP would not seek professional help for problems related to their sexual interests despite widespread belief that mental health care could sometimes be beneficial. Whether perceived stigmatization increases social isolation or other risk factors for committing offenses besides therapy motivation remains unclear.

4.1.4 Discussion

Based on an extensive literature review in medical and social science journals, we can argue that stigma research has a blind spot on pedophilia. Although the studies we found were too scarce, heterogeneous, and unsystematic to provide more than preliminary evidence, they seem to coalesce around the notion that pedophilia is among the most stigmatized human characteristics. In the following sections, we will discuss methodological problems of the studies and empirical and theoretical requirements for future research.

Only about half of the articles or book chapters that could be identified in this review made pedophilia their main focus (Kramer, 2011, August 17; K. McCartan, 2004; K. F. McCartan, 2010; Stiels-Glenn, 2010; Wilson & Cox, 1983). More importantly, only one of these used a well-established stigma measure, i.e., the Social Distance Scale (finding that discrimination of PWP might compare to that of persons with antisocial personality disorder, Feldman & Crandall, 2007). Generally, sample sizes were too small to draw conclusions about lay theories of pedophilia or stigma against individuals with pedophilia in the general public. Also, most samples were biased in favor of young and/or well-educated participants. As stigma research suggests, more educated people tend to express less stigmatizing views towards people suffering from mental illness (Angermeyer & Dietrich, 2006) and towards sexual minorities (Lambert, Ventura, Hall, & Cluse-Tolar, 2006). Thus, a testing of the general population is likely to find even more negative opinions and a more severe discrimination of PWP. All studies but one (Stiels-Glenn, 2010) were conducted by British or North American researchers, and their generalizability to cultures that are not Western is unclear, as the acceptance of pedophilia and adult child sex differs across cultures (Green, 2002). Hence, larger and more representative samples are needed to put stigmatization of PWP on the map.

Moreover, no single study explicitly asked participants how they would perceive and judge non-offending PWP or persons with pedophilia enrolled in preventive treatment programs like the Dunkelfeld project (Beier, Ahlers, et al., 2009). It is possible that when people are questioned about their attitudes towards *PWP*, many will give information on what they think and feel about *child sex offenders*, and none of the studies made an effort to counteract this confusion of terms (e.g., by giving a clear definition of the two distinct phenomena). It is uncertain if and how much the label *paraphilia* influences people's perception of individuals tainted with it when other personality traits of a "whole person" (Hayward & Bright, 1997) are brought into play. Students react more favorably to people whom they believe not to pose

a danger to the community (Feldman & Crandall, 2007). Hence, offense related characteristics of the person with pedophilia, such as attitudes towards adult-child sex, self-control, and motivation for therapy, are likely to have an effect on the public's opinion. However, this can only be true if the community is well-informed about the conceptual differences of pedophilia and child sex offences, and also willing to differentiate between the two.

The effect of stigma on the psychological well-being of the person with pedophilia has only been tested in three surveys, with one of them dating back as far as the early 1980s (Kramer, 2011, August 17; Wilson & Cox, 1983). Their results strongly suggest that many persons with pedophilia struggle with public stigma, and suffer from negative emotional and behavioral problems as a result. Stigma research on PWP is likely to produce highly different results depending on whether participants were sampled in clinical/forensic settings, self-help or patient advocacy groups, or independently from aforementioned clusters. All PWP who participated in the three surveys were recruited via self-help networks/patient advocacy organizations. This strategy might have resulted in a severe sampling bias, as it is possible that these groups disproportionately attract members who are particularly frustrated with the public's or health professionals' attitudes. Furthermore, self-reports might have been biased due to hidden political agendas among participants recruited by said initiatives. This is not to say that recruiting PWP in clinical or forensic settings would lead to more reliable or representative results. In fact, people with psychiatric problems or a criminal history involving child sexual abuse might have an even greater motivation to give biased accounts (Gannon et al., 2007).

More research is clearly warranted to determine whether there is a link between public stigma and adverse health and behavioral outcomes in diverse samples of PWP. Yet, a theoretical framework to derive hypotheses about the causes, characteristics, and consequences of stigma against pedophiles is currently missing. Such a framework would be indispensable to help researchers move forward in this under-researched area. In order to fill this gap in the literature, we suggest using ideas and concepts from stigma research on people with a mental illness (P. W. Corrigan & Watson, 2002) or sexual minority orientation (Meyer, 2003) as sophisticated 'templates' that might prove to be useful for the study of stigma against pedophiles as well. Despite differences relating to stereotype content, people with either pedophilia, mental illness, or a gay, lesbian, or bisexual orientation appear to be faced with similar conflicts with society at large. All three groups are clearly stigmatized, and (in the case of mental illness and pedophilia) may refrain from seeking treatment to avoid being labeled.

All have a hidden stigma that they may choose to reveal or keep a secret from others. Hence, it is to be expected that they undergo similar psychological processes in response to stigma, and are confronted with similar problems when they consider disclosing their stigma. Based on these considerations, we are presently developing such a theoretical framework (working title: Framework for the Effects of Stigma against PWP, see Chapter 4.3 for the complete model), which we plan to test within a sample of PWP.

While we do in no way wish to downplay or legitimize the severe crime that is child sexual abuse, we have reasonable grounds to believe that stigma against PWP is doing a disservice to the prevention of this particular form of violence. Firstly, public stigma is likely to discourage individuals who perceive themselves at risk of committing sexual offenses from seeking help among health professionals or their friends and family (Kramer, 2011, August 17; Seto, 2012), cutting them off from sources of social control and support. Furthermore, a lack of positive identification models (Fog, 1992), reduced self-esteem, or other problems resulting from or maintained by stigmatization (e.g., social phobia; Hoyer, Kunst, & Schmidt, 2001) could lead to less efficient attempts to deal with deviant sexual impulses (T. Ward, Hudson, & Marshall, 1995). Therefore, stigmatization is likely to not only contribute to higher risks of social, emotional, and cognitive problems among persons with pedophilia, but also to higher risks of abusive behavior.

Studies exploring the reaction of individuals with pedophilia to stigma would need to devise a research strategy, in which participants not having yet been identified as PWP by forensic or non-forensic clinical institutions can partake without risking juridical investigations or other adverse effects. Nevertheless, as complicated as the study designing may become, the personal dignity of every respondent is a core element of the rules for Good Scientific Practice.

An important barrier for research on stigmatization of PWP is the secretiveness of the phenomenon. However, the hidden nature of conceivable stigmas was not an insurmountable barrier for research on stigma against homosexual, mentally ill, or HIV-infected people. This can be taken as a hint towards an obstacle that seems to lie in the expert community itself. Beyond a few notable exceptions (e.g., Green, 2002; Seto, 2012), many researchers appear to be hesitant to attribute victim status to individuals with pedophilia and reluctant to approach their experiences from a stigma research perspective. At best, PWP are considered *potential offenders* (Schaefer et al., 2010), or offenders who have at one point in the past been victims

of sexual abuse as well. This apparent lack of openness towards the effects of ostracism on individuals with pedophilia may partially be explained by biased sampling. People who have committed child sex crimes are arguably harder to empathize with than people who deal with their pedophile needs in ways that are not illegal or harmful to children. However, child sex offenders with pedophilia are virtually the only source of information about people with pedophiles *in general* (R. C. W. Hall & Hall, 2007). Simply put, researchers should not ignore stigmatization of pedophilia just because it is controversial or unusual to construe "the pedophile" as a *victim of stigmatization* instead of a priori labeling the person as an *actual* or *potential offender*, let alone as someone who does not deserve respect as a human being.

4.2 Study I and II - Stigmatization of People with Pedophilia: Two Comparative Surveys

Abstract

Despite productive research on stigma and its impact on people's lives in the past twenty years, stigmatization of PWP has received little attention. We conducted two surveys estimating public stigma and determining predictors of social distance from this group. In both studies, pedophilia was defined as a "dominant sexual interest in children." The survey was comprised of items measuring agreement with stereotypes, emotions, and social distance (among others). Responses were compared with identical items referring to either people who abuse alcohol (Study I), sexual sadists or people with antisocial tendencies (Study II). Study I was conducted in two German cities ($N = 854$) and Study II sampled 201 English-speaking online participants. Both studies revealed that nearly all reactions to PWP were more negative than those to the other groups, including social distance. Fourteen percent (Study I) and 28% (Study II) of the participants agreed that PWP should better be dead, even if they never had committed criminal acts. The strongest predictors of social distance towards PWP were affective reactions to this group (anger and, inversely associated, pity) and the political attitude of right-wing authoritarianism (Study I). Results strongly indicate that PWP are a stigmatized group who risk being the target of fierce discrimination. We discuss this particular form of stigmatization with respect to social isolation of persons with pedophilia and indirect negative consequences for child abuse prevention.

4.2.1 Theory

Though little is known about the offending risk of people with a sexual interest in children (Hanson & Bussiere, 1998; Stadtland et al., 2005), the image of “the pedophile” as a predatory child sex offender is so commonly evoked in public debate that it has become a truism in Western cultures (Berlin & Malin, 1991; Jenkins, 1998; West, 2000). Given this mistaken equation of pedophilia with the criminal conduct of child sexual abuse (Feelgood & Hoyer, 2008), it does not seem surprising that pedophilia (termed pedophilic disorder in the new DSM-5) is among the disorders that provoke the greatest discrimination in the form of increased social distance, that is, the desire to reject stigmatized people at different levels of personal contact (Feldman & Crandall, 2007). Despite this, no previous research has systematically explored attitudes and affective reactions towards PWP in comparison to another clinical condition. Furthermore, although people seem to have a desire for social distance from PWP, the individual predictors of such social distance are unknown. The present research sought to fill these gaps in the literature.

A stigma can be understood as a negatively valued attribute of a person or group, that reduces its carrier “from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p. 3). The severe consequences of stigma become particularly apparent in face of discriminatory behaviors ranging from avoiding talking to a stigmatized individual to denying housing or job opportunities (P. Corrigan, Thompson, et al., 2003; B. Link, 1982; Page, 1977). A plethora of research has explored the stigmatization of mental disorders (for an overview, see Angermeyer & Dietrich, 2006). Similar to classical attitude concepts, public stigma (i.e., the reaction of the general public to discredited groups) consists of cognitive, affective, and behavioral components, also discussed under the labels of stereotypes, prejudices, and discrimination (P. W. Corrigan & Watson, 2002; Rusch et al., 2005a).

Given the multitude of mental disorders, dedicating a research program to stigmatization of PWP might call for justification, as pedophilia has a relatively low prevalence (with estimates usually ranging clearly below 5% of the general population; see Seto, 2008), and many people might find the idea of sexual interest in children so repulsive that they will experience little regret for any discrimination PWP might face. Yet, we argue that confusing the logically distinct categories of pedophilia and child sexual abuse does not only create an enormous social and emotional burden for the discredited PWP, who see their life opportunities diminished because of a condition they could neither choose nor change (Seto, 2012), but that

stigmatization of atypical sexual interests can also influence sexual (Smolenski et al., 2011) and non-sexual (Kuyper & Fokkema, 2010; Plöderl et al., 2013) behavior of stigmatized individuals. In the case of PWP, fear of discrimination may lead to social isolation and thus a reduction of social control of pedophilic sexual urges, as well as the chances to implement preventative measures (Goode, 2010; Jahnke & Hoyer, 2013). Data published by B4U-ACT (2011, December 30), a Maryland-based network of mental health professionals and PWP indeed indicate that many PWP fear being rejected or treated unfairly and unethically even by health care professionals, keeping them from seeking therapeutic help. Therefore, public stigma against PWP may not only have an important (negative) impact on people bearing the stigmatized characteristic, but also restrict meaningful and targeted prevention of sex offenses, which are sometimes related to pedophilic motivation. For all of these reasons, a more systematic investigation of public stigma toward PWP and its direct and indirect effects are strongly required.

We argue that many people associate the construct or diagnosis of pedophilia with stereotypical beliefs about the nature of the illness (e.g., that pedophilia necessarily leads to child abuse or that PWP could change their sexual preference if they wanted to). Likewise, prejudices are apparent in public reactions to pedophilia, either as an affirmation of negative stereotypes (e.g., “Yes, PWP are very dangerous”) or marked affective reactions (e.g., feeling angry about someone being pedophilic). Discriminatory behaviors against PWP can take such extreme forms as aggression (Seto, 2008) or the denial of treatment (Stiels-Glenn, 2010). Given that (together with antisocial personality disorder) pedophilia was the mental condition that respondents wanted to reach the largest social distance from in a previous study (Feldman & Crandall, 2007), we predict that negative reactions to pedophilia are stronger than the reactions to most other mental conditions on all three dimensions of public stigma: cognitive, affective, and behavioral.

Discrimination against PWP is of pivotal interest, because affective and cognitive reactions might remain private reactions, whereas actions in the form of (intended) behavior directly influence PWP, and may thus evoke the described negative outcomes of fear of rejection, social isolation, and refusal to seek therapeutic care. Thus, it is essential to better describe the predictors of social distance towards PWP as a proxy of discrimination.

The present research

We conducted two studies to estimate the prevalence and strength of public stigma against PWP compared with stigma against other groups with a mental illness that arguably causes greater or similar societal costs (please note, however, that sexual sadism would only be considered a mental disorder when it is practiced without consent or leads to marked distress). With a large and sufficiently diverse sample to befit this type of analysis, the first study also explored the variables constituting reliable predictors of discriminatory intentions (i.e., preference for high social distance).

In Study I we used a large German sample that does not only consist of college students or highly self-selected online participants. Public stigma to PWP was compared and contrasted with stigmatizing reactions to persons who abuse alcohol. We chose the latter group for the following reasons: (1) people who abuse alcohol are at a higher risk of committing violent or sexual offenses (Davis et al., 2012; Kerner, Weitekamp, Stelly, & Thomas, 1997) including child sex offenses (Looman, Abracen, DiFazio, & Maillet, 2004) than people who do not abuse alcohol, and (2) alcohol related problems are among the most stigmatized attributes, with the public clearly overestimating the risk of violent behavior (B. G. Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Siltan, Flannelly, Milstein, & Vaaler, 2011), therefore giving us an appropriate stigma benchmark. We argue that, just as people who abuse alcohol are disproportionately believed to be dangerous or to progress to reckless and/or illegal acts under the influence of alcohol, the public might likewise believe people who are sexually attracted to children will act on that attraction.

In Study II, we followed a very similar rationale by comparing public stigma towards PWP to reactions towards sexual sadists and people with aspects from antisocial personality disorder (disregarding other people's rights) as two groups that are linked even more closely to criminal and immoral behavior in the public's minds than alcohol abuse. To this end, we chose a smaller English-speaking sample that we assessed via the crowdsourcing service Amazon Mechanical Turk (see below for detailed explanations). The results of Study II are intended as an amendment to and a conceptual replication of the stigma contrasts assessed in Study I. Sexual sadism, that is, the paraphilia describing people who derive sexual pleasure from inflicting pain on others, has been linked to sexual violence and crime (Kirsch & Becker, 2007), but can also be practiced consensually and safely (Wright, 2006). Antisocial personality disorder is a severe mental disorder characterized by a continuous disregard for

other people's rights leading to "overt antisocial acts plus traits of impulsivity, irritability and remorselessness" (De Brito & Hodgins, 2009, p. 133) and most likely posing the greatest danger to society from all disorders discussed in this paper. In a study by Feldman and Crandall (2007), it was also the mental disorder from which students reported the highest social distance ($M = 5.93$ $SD = .99$ on a 7-point scale), closely followed by pedophilia ($M = 5.91$, $SD = 1.11$) and alcohol dependence ($M = 5.13$, $SD = .86$).

The second major research question of Study I sought to better understand the variables predicting discrimination. Instead of measuring discrimination directly, it is common to employ scales that assess behavioral intentions or attitudes as a proxy for actual behavior (P. W. Corrigan, Edwards, et al., 2001), especially when the stigma in question is rare or can easily be concealed. As one example of behavioral intentions towards people with stigmatized mental conditions, Feldman and Crandall (2007) asked a student sample to rate their desired social distance to 40 different patient groups. We followed their rationale by including desired social distance as our central dependent variable.

One central predictor of how negatively the public reacts to others' differentness may be the extent to which they attribute it to intentionality or other controllable factors (Weiner, 1985; Weiner, Graham, & Chandler, 1982). Controllability refers to the degree of volitional influence that the individual could have exerted over a cause (Weiner, 1985). The attribution of uncontrollability to a stigma usually leads to more favorable responses as people are convinced that the other person is not to "blame" for his or her condition (Borchert & Rickabaugh, 1995; P. W. Corrigan, 2000; B. R. King, 2001; Weiner et al., 1988; Whitley, 1990). The stereotype of controllability (and therefore, responsibility), however, is associated with reduced pity, increased anger, and aggressive behavior, whence people suffering from a condition that is perceived as controllable run a higher risk of being devalued (P. Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Greitemeyer & Rudolph, 2003). Obviously, agreement that a condition is very dangerous constitutes another negative stereotype that is strongly associated with anger, fear, reduced pity, and discriminatory intention (P. Corrigan, Thompson, et al., 2003; Feldman & Crandall, 2007; Liekens, Smits, Laekeman, & Foulon, 2012; B. G. Link et al., 1999).

As individuals from different social backgrounds show diverging knowledge about or tendency to agree with stereotypes about stigmatized groups, it is clear that they differ in their discrimination intention. Factors that have previously been found to be linked to stigma

include gender, residency in smaller versus larger cities, age, and educational level (Angermeyer & Dietrich, 2006; Steffens & Wagner, 2004). Also, personality traits such as *Right Wing Authoritarianism* (RWA) have been established as factors strongly associated with negative attitudes towards stigmatized people, especially if these people are perceived as a threat to social rules and norms (Poteat & Mereish, 2012; Whitley, 1999; Whitley & Lee, 2000; Zick et al., 2008). RWA manifests the “motivational goal of societal or group security and order (obtained through establishing and maintaining societal or group control, stability, and cohesion) generated by a view of the social world as dangerous and threatening” (Duckitt, 2006, p. 685).

In summary, while characteristics of stigma against many different stigmatized groups have been analyzed in detail in a multitude of articles, stigma against PWP has hardly been recognized or studied (Jahnke & Hoyer, 2013), making these two surveys the first to specifically address this issue. To this end, we compared stigma against PWP with other devalued groups (people who abuse alcohol, sexual sadists, and people with antisocial tendencies) and tested whether social distance can be predicted by stereotypes (dangerousness, controllability), affective reactions (anger, fear, reduced pity), personality (RWA), and sociodemographic variables (age, gender, educational level, residency in a smaller vs. larger city). Moreover, we expected parents with children in age groups vulnerable to child sex abuse to be more concerned about this crime (Stickler, Salter, Broughton, & Alario, 1991), and, by extension, PWP.

4.2.2 Study One

Methods

Participants and procedure

We collected data from October 15th to December 15th, 2012, in public areas in Dresden (in the Eastern part of Germany, $n = 449$) and Stuttgart (in the Western part of Germany, $n = 405$). Investigators approached pedestrians on the street and asked whether they would like to participate in a 10-minute survey authorized by Technische Universität Dresden. Whenever pedestrians approached showed interest, the investigators proceeded by providing information about the questionnaire and the aims of the study. In order to reduce bias and promote honest responding, the study objectives were presented in a morally neutral way, as in this excerpt of the information sheet: “Individuals differ in their opinion about people who abuse alcohol or

people with a dominant sexual interest in children. Some may feel more accepting [...], while others may have a very negative opinion about them. [...] Now we want to ask you about your opinions.” After obtaining written consent, participants were instructed to fill out the scale by themselves, answering items pertaining to people who abuse alcohol in the first part of the study, and PWP afterwards. In total, 854 participants were tested. Participants ranged from age 18 to 86 ($M = 39.78$, $SD = 18.03$, 48.1% male). Most participants (67.1%) had completed the *Abitur*, which is a German school certificate (similar to a US high school certificate and college entry exam). Among the participants, 46.2% had children (in the case of 15.5%, children were younger than 14), and 58.7% lived in a city with more than 100.000 inhabitants.

Measures

Describing pedophilia and alcohol abuse

As pedophilia is a highly debated and unclear term both in the field (Blanchard, 2010; Green, 2002; Malón, 2012) and the general public (K. McCartan, 2004; West, 2000), we decided to replace it with a short and simplified description of what we consider its main feature (see also Beier, Ahlers, et al., 2009; for the effect of the pedophilia label see Imhoff, 2015). Hence, participants were asked for their opinion about and feelings towards *people who are dominantly sexually interested in children* (as a description of PWP) and *people who almost daily drink large amounts of alcohol* (as the descriptive term for people who abuse alcohol).

Cognitive beliefs and stereotypes

The controllability scale (see Table 4) was developed and pretested in a heterogeneous ad hoc sample. The three items that best represented their respective scale were chosen for the final version of the questionnaire (pretest results available from the authors). In the present study, reliability of the scale was good ($\alpha = .79$ for people who abuse alcohol, $\alpha = .89$ for PWP). The dangerousness scale (see Table 4) contained three items, measuring agreement to statements concerning PWP or people who abuse alcohol being (generally) dangerous for children (item one), adolescents (item two), or adults (item three). Item #1 and #2 were combined in a scale that proved to be sufficiently reliable in this study ($\alpha = .90$ for people who abuse alcohol, $\alpha = .69$ as pertaining to PWP). Both stereotype scales were to be rated on a 7-point Likert scale (0-6) from *do not agree at all* to *completely agree*.

Affective reactions

We assessed fear, anger, and pity towards PWP and people who abuse alcohol with one item each (see Table 4). Participants had to rate how much they agreed with feeling one of the aforementioned emotions when thinking of PWP and people who abuse alcohol. The response format was a 7-point Likert scale (0-6) ranging from *do not agree at all* to *completely agree*.

Discriminatory behavioral intentions

The Social Distance Scale requires a rating of how much a person would agree to interact with another person at different levels of social contact. Based on Bogardus' (1933) second version of the Social Distance Scale, we developed a modified measure to assess social distance (items are displayed in Table 4). To the previously introduced description of pedophilia, we added the information that so far, no transgression of the law has been committed, rendering the instruction as follows: "How do you feel about interacting with people who (are dominantly sexually interested in children / almost daily drink large amounts of alcohol), but have never committed a crime?" As some of Bogardus' original items (e.g., "Would have several families in my neighborhood," "Would marry") did not fit well in this context, we applied modifications and replaced items where necessary. The items "These persons should be incarcerated" and "These persons should better be dead" were added as the extreme end of the scale. Participants indicated their response on a 7-point Likert scale (0-6) ranging from *do not agree at all* to *completely agree*. All positively formulated items were recoded, so that a higher score reflected a higher level of social distance. Reliability in the current dataset was sufficiently high ($\alpha = .77$ for people who abuse alcohol, $\alpha = .82$ for PWP).

Right-Wing Authoritarianism (RWA)

To measure RWA, we used a short four-item scale successfully employed in previous research (e.g., Davidov, Thorner, Schmidt, Gosen, & Wolf, 2011; Zick et al., 2008). Items read, "We should be grateful for leaders who can tell us exactly what we should do," "Obedience and respect for authority are among the most important characteristics a person can have," "Crime should be punished more harshly," and "To maintain law and order, stronger action should be taken against outsiders and troublemakers." Responses were given on a 7-point Likert scale (0-6) ranging from *do not agree at all* to *completely agree*. Reliability analysis showed an acceptable consistency index ($\alpha = .78$).

Results

Comparing public stigma against PWP and people who abuse alcohol

Descriptive statistics of each item as well as relative frequencies of people agreeing or expressing uncertainty are displayed in Table 4. As some scales deviated clearly from normal distribution, Wilcoxon Signed-Rank Tests were conducted to compare ranks in the two conditions (PWP vs. people who abuse alcohol).

Public stigma towards PWP was significantly stronger on all tested variables, except for the ratings on controllability and dangerousness for adults (see Table 5). While all comparisons showed medium to large effects (according to guidelines recommended by J. Cohen, 1992), the largest differences were found for the variables of anger (with 84% agreeing to feel anger towards PWP and 41% agreeing to feel anger towards people who abuse alcohol) and social distance, especially the items “I would accept these persons in my neighborhood” (10% agree for PWP, 47% agree for people who abuse alcohol), “These persons should be incarcerated” (39% agree for PWP, 5% agree for people who abuse alcohol), and “These persons should better be dead” (14% agree for PWP, 3% agree for people who abuse alcohol). Both groups were considered a danger to children and adolescents by a majority of participants (more than 90% agree for PWP, more than 70% agree for people who abuse alcohol). People who abuse alcohol were generally seen as more in control of their condition than PWP (with, e.g., 29% agreeing to the item “People have the choice whether they have a dominant sexual interest in children or not,” as compared with 56% who agree that “People have the choice whether they drink large amounts of alcohol almost daily”).

Table 4. *M*, *SD*, *N* and frequency of agreement (in %) with stigma items for PWP and people who abuse alcohol (Study I)

Scale	Items	Items pertaining to pedophilia		Items pertaining to alcohol abuse					
		<i>N</i>	(<i>M</i> / <i>S</i>)	Agree ^a	Uncert. ^b	<i>N</i>	(<i>M</i> / <i>S</i>)	Agree ^a	Uncert. ^b
Contr.	(A dominant sexual interest in children/Drinking large amounts of alcohol almost daily) is something that one can choose.	844	2.21 (2.07)	26.18	16.00	850	3.44 (1.96)	51.06	18.71
	People with (a dominant sexual interest in children/ who drink large amounts of alcohol almost daily) have taken a deliberate decision to have these interests.	842	2.41 (2.07)	30.29	15.32	849	3.07 (1.89)	40.16	21.44
	People have the choice whether they (have a dominant sexual interest in children/ drink large amounts of alcohol almost daily) or not.	841	2.41 (2.08)	29.37	16.65	844	3.81 (1.88)	55.69	19.31
Dang.	A person (with a dominant sexual interest in children/ who drinks large amounts of alcohol for almost daily) poses a danger to children.	850	5.73 (0.85)	97.29	1.06	854	4.48 (1.74)	72.37	13.11
& ado.	A person (with a dominant sexual interest in children/ who drinks large amounts of alcohol almost daily) poses a danger to adolescents.	849	5.15 (1.32)	91.05	3.30	854	4.47 (1.64)	72.37	14.40
	A person (with a dominant sexual interest in children/ who drinks large amounts of alcohol almost daily) poses a danger to adults.	848	2.81 (2.22)	38.56	13.92	854	3.91 (1.79)	57.26	20.96
Affect.	... afraid. ^d	824	3.88 (2.28)	62.50	10.19	810	2.54 (1.96)	32.22	17.16
react.	... pity. ^d	830	2.29 (2.27)	31.08	11.20	831	3.92 (1.93)	64.02	13.84
	... anger. ^d	837	5.01 (1.75)	84.11	4.30	814	2.90 (2.10)	40.66	15.11
Social	Would have these persons as friends.	848	0.96 (1.43)	7.08	8.37	845	2.38 (1.72)	23.79	23.43
dist. ^c	Would accept these persons in my neighborhood.	847	1.24 (1.63)	10.39	11.22	842	3.40 (1.72)	47.39	22.80
	Would accept these persons as colleagues at work.	845	1.43 (1.76)	14.44	11.48	842	2.56 (1.83)	30.64	22.21
	Would talk to them.	848	2.61 (2.12)	34.20	16.16	841	4.15 (1.77)	66.35	16.53
	These persons should be incarcerated.	845	2.80 (2.34)	38.70	11.83	841	0.66 (1.30)	5.11	4.88
	These persons should better be dead.	840	1.14 (1.94)	13.69	9.52	840	0.31 (1.04)	2.98	2.74

Note. Contr. = Controllability; Dang. = Dangerousness; child. & ado. = children and adolescents; Affect. react. = Affective reaction, dist. = distance
^a defined as a score of 4 – 6 (on a Likert scale of 0 to 6). ^b uncertain = defined as a score of 3 (on a Likert scale of 0 to 6). ^c Instruction: “How do you feel about interacting with people who (are dominantly sexually interested in children / almost daily drink large amounts of alcohol), but have never committed a crime?” ^d “When I think of a person (with a dominant sexual interest in children/ who drinks large amounts of alcohol almost daily), I feel...”

Predictors of social distance towards PWP

To analyze how different aspects of stigma towards PWP correlated with each other and participant characteristics, Spearman correlations were used (see Table 6, results on stigma towards alcohol abusers available from the authors). We found significant medium-sized correlations between social distance and RWA, dangerousness for children and adolescents, dangerousness for adults, pity, and anger. Smaller significant correlations were discovered for age, parental status (i.e., having children younger than 14), controllability, fear, and educational level. Younger age was linked to higher social distance towards PWP, but lower social distance towards people who abuse alcohol ($r = .17, p < .001$). Gender was not associated with social distance scores towards PWP, but women showed higher levels of fear, anger, and perceived dangerousness for children, adolescents, and adults.

Table 5. Comparison between public stigma against PWP and people who abuse alcohol (Wilcoxon Test, Study 1)

scale	<i>z</i>	<i>p</i>	<i>r</i>	<i>N</i>
Controllability	-14.82	$p < .001$	-.52	823
Dangerousness for children and adolescents	15.69	$p < .001$	.54	849
Dangerousness for adults	-12.90	$p < .001$	-.44	848
Fear	13.90	$p < .001$	.49	800
Pity	-16.25	$p < .001$	-.57	816
Anger	19.38	$p < .001$	.68	806
Social distance	22.08	$p < .001$	.77	814

Note. PWP = people with pedophilia

In order to determine the effect of each variable on social distance while controlling for all other parameters, we conducted a multiple regression with stereotypes of pedophilia (controllability, dangerousness for adults, dangerousness for children and adolescents), affective reactions towards PWP (fear, anger, and pity), and participant characteristics (age, parental status, educational level, residency, gender, RWA) as predictors. All factors were entered simultaneously (forced entry). Results are presented in Table 7. The regression model accounted for 36% of variance in the social distance score. Social distance was significantly related to greater anger, less pity, more RWA, younger age, less education, greater perception of dangerousness for adults, children and adolescents, and to having children in an age of potential victimization through child sexual abuse (from highest ranking to lowest ranking according to beta weights). Fear, controllability, gender, and residency in smaller versus larger cities did not significantly improve the model.

Table 6. Correlations (Spearman, two-tailed) for sociodemographic characteristics and public stigma towards PWP (Study I, *N* in brackets)

Scale	Age	Gender	RWA	Edu.	Parent.	Residency	Control.	Danger. for child. & ado.	Danger. for adults	Fear	Pity	Anger	Social distance
Age	1.00 (854)												
Gender	.01 (853)	1.00 (853)											
RWA	-.01 (838)	-.00 (837)	1.00 (838)										
Edu.	-.16** (845)	-.01 (844)	-.29** (831)	1.00 (845)									
Parent.	.029 (824)	-.03 (823)	-.00 (808)	-.06 (815)	1.00 (824)								
Residency	-.13** (848)	-.02 (847)	-.05 (832)	.034 (839)	-.01 (818)	1.00 (848)							
Control.	-.02 (837)	-.02 (836)	.33** (822)	-.13** (830)	.06 (809)	-.04 (831)	1.00 (837)						
Danger. for child. & ado.	.11** (849)	.16** (848)	.24** (835)	-.12** (841)	.03 (819)	-.02 (843)	.21** (833)	1.00 (849)					
Danger. for adults	-.08* (848)	.08* (847)	.33** (835)	-.14** (840)	.06 (818)	-.04 (842)	.29** (832)	.43** (848)	1.00 (848)				
Fear	.06 (824)	.25** (823)	.17** (810)	-.10** (817)	.12** (796)	-.07 (819)	.10** (808)	.28** (823)	.26** (822)	1.00 (824)			
Pity	.12** (830)	-.02 (829)	-.17** (818)	.12** (823)	-.04 (801)	-.00 (825)	-.28** (814)	-.16** (830)	-.11** (830)	.044 (817)	1.00 (830)		
Anger	.034 (837)	.16** (836)	.27** (825)	-.15** (830)	.00 (807)	-.05 (831)	.27** (821)	.38** (837)	.28** (837)	.28** (819)	-.22** (823)	1.00 (837)	
Social distance	-.17** (833)	.020 (832)	.38** (822)	-.20** (825)	.09** (803)	-.04 (828)	.29** (817)	.30** (833)	.31** (833)	.16** (807)	-.35** (817)	.44** (823)	1.00 (833)

Note. RWA = Right Wing Authoritarianism; Edu. = Educational level, Parent. = Parental status (whether or not someone has children younger than 14);

Residency = Residency in smaller vs. larger city (less or more than 100,000 inhabitants); Control. = Controllability; Danger. = Dangerousness; child. & ado. = children and adolescents, **p* < .05; ***p* < .01, all significant results are marked in bold.

Table 7. Predictors of social distance towards PWP (multiple regression, Study I, $N = 739$)

Predictors	Simultaneous multiple regression (PWP)				
	<i>b</i>	<i>SE b</i>	β	<i>t</i>	<i>p</i>
Constant	2.63	.38		6.92	$p < .001$
Anger	.18	.03	.24	7.12	$p < .001$
Pity	-.12	.02	-.20	-6.34	$p < .001$
RWA	.19	.03	.20	5.92	$p < .001$
Age	-.01	.00	-.17	-5.51	$p < .001$
Educational level	-.26	.09	-.09	-2.91	$p < .01$
Dangerousness for adults	.06	.02	.09	2.66	$p < .01$
Dangerousness for children and adolescents	.12	.05	.08	2.31	$p < .05$
Parental status	.26	.11	.07	2.37	$p < .05$
Controllability	.04	.02	.06	1.64	.101
Residency	-.08	.08	-.03	-.95	.343
Gender	-.07	.08	-.03	-.86	.388
Fear	.01	.02	.02	.46	.644

Note. Simultaneous multiple regression: $R^2 = .37$, adjusted multiple $R^2 = .36$, $F(12, 738) = 35.60$, $p < .001$, predictors were rank-ordered by beta weights.

4.2.3 Study Two

Methods

Participants and procedure

We gathered data online from 201 participants through the crowdsourcing service Amazon Mechanical Turk (MTurk). MTurk is a US-based Internet marketplace where requesters can seek workers for tasks that require human intelligence (as opposed to computer algorithms). Recently, MTurk has become increasingly popular for psychological researchers as the population of MTurk workers is more diverse than undergraduate psychology students and produces high quality data (Buhrmester, Kwang, & Gosling, 2011). Shapiro, Chandler, and Mueller (2013) have shown MTurk to be a promising research tool with respect to data quality and representativeness also for clinical research. Participants were paid \$0.35 for their participation. Participants' age ranged from 18 to 68 ($M = 33.38$, $SD = 11.69$), and 56.7% were male. About half (52.7%) lived in a city with more than 100,000 inhabitants and 22.4% had one or more children under 14 years of age. Ethnicity was mostly White (6.6% Asian; 6.1% Hispanic; 8.6% Black; 74.2% White, 4.5% other/mixed). Participants' sexual orientation and relationship status was mixed (90.5% heterosexual, 9.5% homosexual or bisexual, 52.2% with partner). Also, 43.3% held a Bachelor's degree or higher.

Measures

Describing pedophilia, sexual sadism, and antisocial tendencies

We used the same description for pedophilia already employed in Study I. Sexual sadists were described as *people with a dominant sexual interest in inflicting physical pain on others*, while the description of the third group, *people who continuously disregard other people's rights*, was based on one aspect of antisocial personality disorder. Following the logic of Study I, we asked for attitudes towards sexual sadists, PWP, and, at the end of the questionnaire, people with antisocial tendencies using the same set of items. All stigma measures from Study I underwent a translation/back-translation procedure involving a bilingual native English speaker and scientist.

Cognitive beliefs and stereotypes

We used the English version of the controllability scale and the dangerousness for children and adolescents scale that were employed in Study I (see above). Reliability in this study was high across all studied stigmatized groups (Cronbach's $\alpha = .92, .87,$ and $.89$ for controllability, and Cronbach's $\alpha = .77, .97,$ and $.97$ for dangerousness for children and adolescents with respect to PWP, sexual sadists, and people with antisocial tendencies, respectively).

Affective reactions

As in Study I, we assessed fear, anger, and pity towards PWP, sexual sadists, and people with antisocial tendencies with one item each.

Discriminatory behavioral intentions

We used the English version of the Social Distance Scale relating to PWP presented in the first study, again adding that, so far, the person with pedophilia, sexual sadism, or antisocial tendencies has not broken the law. Reliability in this study was, again, high (Cronbach's $\alpha = .84, .91,$ and $.79$ for PWP, sexual sadists, and people with antisocial tendencies, respectively).

Results

A descriptive analysis of our results ($M, SD,$ and the percentage of people agreeing with or being uncertain about each item) can be found in Table 8. We conducted Wilcoxon Signed-Rank Tests to test whether reactions towards PWP differed significantly from reactions

towards sexual sadists or people with antisocial tendencies, respectively (see Table 9). To correct for multiple comparisons, the alpha level was set at .025 (Bonferroni method). Comparing reactions towards PWP and sexual sadists, we found significant medium to large effects (J. Cohen, 1992) on all public stigma variables (except for dangerousness to adults, where we discovered no significant differences between the groups), with participants reacting more negatively to PWP, except for controllability and pity. Differences in dangerousness for children and adolescents and social distance were especially pronounced to the disfavor of PWP.

Results comparing PWP and people with antisocial tendencies were more mixed. For example, the latter group was seen as more dangerous to adults, while both groups did not differ significantly with respect to the anger that the great majority of participants reported feeling towards them. With 44% of the respondents agreeing that “having a dominant sexual interest in children is something that one can choose,” pedophilia was perceived as less controllable than sexual sadism and antisocial personality. Also, PWP were believed to pose a greater danger to children and adolescents than the two other groups (with, e.g., 94% agreeing that PWP pose a danger to children, but only 33% and 67% perceiving sexual sadists or people with antisocial tendencies in such a way). Forty percent of the participants reported feeling pity towards PWP, compared with 24% for sexual sadism and antisocial personality. Participants reported a very high desire for social distance towards PWP compared with the two other groups across all levels of intimacy, with only 5% willing to befriend these people (compared with 48% and 8% who would befriend sexual sadists or people with antisocial tendencies). A little more than half of the sample agreed that PWP should be incarcerated (compared with 9% and 22% recommending a similar treatment for the two other groups), and 28% agreed that they should better be dead (compared with 6% or 8% for sexual sadists or people with antisocial tendencies).

Table 8. *M*, *SD*, and relative frequency of agreement with items referring to PWP, sexual sadists, and people with antisocial tendencies (Study II, *N* = 201)

Item	Items pertaining to pedophilia		Items pertaining to sexual sadism		Items pertaining to antisocial tendencies	
	(<i>M/SD</i>)	Agree ^a Uncertain ^b	(<i>M/SD</i>)	Agree ^a Uncertain ^b	(<i>M/SD</i>)	Agree ^a Uncertain ^b
X is something that one can choose.	4.12 (2.08)	44.28 17.91	4.56 (1.89)	55.72 15.42	6.01 (1.45)	88.06 4.48
People with X have taken a deliberate decision to have these interests.	4.37 (2.08)	48.76 18.41	4.47 (1.78)	50.25 20.40	6.04 (1.35)	86.57 7.46
People have the choice whether they have X or not.	4.40 (2.06)	47.76 18.91	4.70 (1.79)	55.72 17.91	6.22 (1.23)	89.55 6.47
X poses a danger for children.	6.53 (1.00)	93.53 3.98	3.57 (1.95)	32.84 15.92	5.11 (1.73)	67.16 17.41
X poses a danger for adolescents.	5.89 (1.50)	83.08 8.46	3.71 (1.93)	38.81 16.92	5.21 (1.71)	70.65 14.93
X poses a danger for adults.	4.03 (2.09)	39.30 18.41	4.18 (1.95)	50.75 14.93	5.38 (1.61)	75.12 14.93
When I think of X I feel fear.	4.71 (2.18)	59.20 10.45	3.36 (2.02)	32.84 10.95	4.12 (2.06)	47.26 16.92
When I think of X I feel pity.	3.73 (2.35)	40.30 9.45	2.91 (1.94)	23.88 10.45	2.80 (2.04)	24.38 9.95
When I think of X I feel anger.	5.89 (1.64)	83.58 5.47	3.05 (1.93)	23.38 17.91	5.67 (1.59)	80.10 8.96
Would have as friends.	1.75 (1.27)	4.76 6.97	4.10 (2.00)	42.86 15.42	1.96 (1.30)	7.14 5.97
Would accept in my neighborhood.	1.85 (1.42)	5.71 7.46	4.41 (2.04)	52.86 12.94	2.47 (1.56)	11.43 13.93
Would accept as colleagues at work.	2.18 (1.63)	10.95 11.94	4.76 (1.94)	58.57 14.93	2.54 (1.57)	13.33 14.43
Would talk to them.	2.34 (1.77)	14.76 8.96	4.85 (1.99)	60.48 14.43	2.66 (1.77)	16.67 13.93
Should be incarcerated.	4.54 (2.20)	48.57 18.41	2.11 (1.60)	8.57 8.96	3.15 (1.98)	20.95 23.38
Should better be dead.	3.20 (2.25)	26.67 14.43	1.69 (1.38)	6.19 5.97	2.12 (1.64)	8.10 11.94

Note. X = description of pedophilia, sexual sadism, antisocial tendencies, respectively
^a defined as a score of 4 – 6 (on a Likert scale of 0 to 6). ^b uncertain = defined as a score of 3 (on a Likert scale of 0 to 6). ^c Instruction: “How do you feel about interacting with people who (are dominantly sexually interested in children / have a dominant sexual interest in inflicting pain on others / continuously disregard other people’s rights), but have never committed a crime?”

Table 9. Comparisons between public stigma against PWP vs. PSS, and PWP vs. PAT (Wilcoxon Test, Study II, $N=201$)

Scale	$z(PSS)$	$p(PSS)$	$r(PSS)$	$z(PAT)$	$p(PAT)$	$r(PAT)$
Controllability	-2.159	$p = .031$	-.15	-9.731	$p < .001$	-.69
Dangerousness for children and adolescents	10.945	$p < .001$	.77	7.417	$p < .001$	.52
Dangerousness for adults	-1.217	$p = .224$	-.09	-6.949	$p < .001$	-.49
Fear	7.319	$p < .001$	.52	3.745	$p < .001$	.26
Pity	4.419	$p < .001$	.31	5.325	$p < .001$	.38
Anger	10.877	$p < .001$	.77	1.560	$p = .119$	.11
Social distance	11.417	$p < .001$	.81	6.673	$p < .001$	.47

Note. PWP = people with pedophilia; PSS = people with sexual sadism; PAT = people with antisocial tendencies.

4.2.4 Discussion

The goal of the two studies presented within this chapter was to empirically examine the extent of stigmatization of PWP and the predictors of discrimination intent against this group. In order to contrast opinions towards PWP with opinions towards other groups, we developed an economic and reliable instrument to assess all attitudes with a similar set of items. Consistent with our assumptions, PWP are a group that the public strongly reacts to with negative emotions, social distance, and stigmatizing assumptions, even when contrasted with people who abuse alcohol, sexual sadists, or people with antisocial tendencies in their personality. As it is well-established that the latter groups (except for sexual sadists, where such a stigma can only be assumed due to lack of empirical data) are severely despised, stigma against PWP appears to be all the more devastating in comparison. Secondly, many people hold beliefs towards PWP (e.g., that they are in control of their sexual interests) that are not in accordance with empirical evidence (see below). Thirdly, in line with theoretical and empirical findings in stigma literature (P. W. Corrigan et al., 2002; Feldman & Crandall, 2007), social distance towards PWP is associated with a wide array of parameters ranging from stereotypes and affective reactions to socioeconomic and personality variables. A regression model with eight predictor variables accounted for 36% of the variance in social distance towards PWP. Although both studies converge in these main findings, the two samples are too different with respect to participant characteristics (cultural background, language, sociodemographic characteristics) and sampling modality (online vs. pen and paper) to directly compare the results of both studies. As we consider the smaller-sized Study II as a replication and extension of the first survey, we will focus our discussion on the results of Study I and include a much briefer section on Study II.

For the first study, an in-depth analysis of responses to PWP in contrast to people who abuse alcohol revealed marked differences between the two conditions. First of all, the latter group was perceived as more in control of their condition than PWP. A descriptive analysis of our data, however, showed that about one third of participants nevertheless considered pedophilia itself to be controllable in that one can choose whether to have a sexual interest in children or not. This assumption is not in accordance with scientific data or clinical experience (R. C. W. Hall & Hall, 2007). In fact, evidence strongly indicates that people with this condition have as little control over the object of their desires as individuals with a homo- or heterosexual orientation towards adults (Seto, 2008).

Furthermore, PWP were perceived as more dangerous to children and adolescents by far, but less dangerous to adults than people who abuse alcohol. As indicated by very high levels of perceived dangerousness, the public seems to assume that pedophilia is closely linked to, or even synonymous with, the criminal conduct of child sexual abuse (K. McCartan, 2004) that has been linked to severe consequences for the child's health and psychological functioning (Irish et al., 2010; please note that causal nature of these associations is in doubt owing to confounds; see also Rind et al., 1998). This however, represents a mix-up of psychopathological and legal terms (Feelgood & Hoyer, 2008; Murray, 2000; Seto, 2008). Child sex offenses may occur for many reasons other than a genuine sexual interest in children, and a subgroup of PWP whose size is currently unknown, but possibly large, deliberately abstains from sexual contacts with children (G. Schmidt, 2002). Although most participants disagreed that PWP are posing a danger to adults, more than one third nonetheless believed in this statement. One possible explanation is that high ratings of dangerousness for adults could have been caused by a negative halo-effect among particularly prejudiced study participants or the interpretation that adults would indirectly suffer harm when they learn of their children having been sexually abused. Yet, high dangerousness ratings in this category could also point to a genuine concern that PWP might display antisocial, sexually disinhibited, or otherwise undesirable behavior towards adults. Future studies are needed to determine whether any of the above-mentioned interpretations are empirically valid.

Participants reacted with high levels of anger and fear and little pity towards PWP, showing remarkably more negative affective reactions to this group than towards people who abuse alcohol. Anger was especially prevalent, with more than 80% agreeing that they felt angry when thinking about PWP. Attributions of uncontrollability usually lead to the reasoning that a stigmatized person is not to blame for his or her condition, which in turn triggers more

favorable emotional responses (Weiner et al., 1988). Therefore, the level of self-reported anger is an unexpectedly high estimate for pedophilia as a disorder that the majority does not perceive to be controllable.

Similarly unsettling findings were obtained for discrimination intention towards PWP. Participants intended to withhold companionship and personal contact from PWP across all levels of intimacy. A striking 14% of the sample agreed that they should better be dead (and even twice as many in Study II), and 39% would recommend imprisonment (compared with 3% or 5% who would demand similarly drastic measures for people who abuse alcohol), even though the questionnaire made clear that the person has never committed a crime. While it has previously been shown that social distance towards PWP is higher than towards persons suffering from one of many other mental disorders (Feldman & Crandall, 2007), this is the first study to reveal social distance towards this group to be prevalent even in the explicit absence of criminal behavior (for a similar effect on punitive attitudes, see Imhoff, 2015). In contrast to Feldman and Crandall's (2007) results obtained from a student population, participants in Study II reported even more social distance towards PWP than toward people with antisocial tendencies.

Another central aspect of Study I was to quantify the extent to which a number of psychological and sociodemographic variables predict stigmatizing responses towards PWP. In line with the literature on the appraisal of other mental disorders (e.g., schizophrenia; P. Corrigan, Thompson, et al., 2003), higher perceived controllability was related to anger, reduced pity, and social distance. Yet, there was no discernible individual effect of controllability on social distance in the regression model. It may be speculated that Weiner's original idea that uncontrollability triggers less discriminating behavior, is too simplistic for our analysis of stigma against PWP (see also Haslam, 2005). While it is common for others to be accepting towards a person who suffers due to a condition that is perceived as being out of his or her control, this reaction is probably less likely to occur when the person is believed to be causing suffering to other people due to the uncontrollable condition (in which case the perception of controllability might be of little consequence for social distance, or even lead to greater avoidance). In future research on stigma against PWP, this aspect should receive more conceptual attention, taking into account the above considerations. In line with previous findings, however, perceived dangerousness (for children and adolescents as well as adults) was shown to predict social distance towards PWP.

Among affective reactions, anger and pity were important predictors of social distance towards PWP, while fear was not. As predicted by attribution theories of stigmatization (P. W. Corrigan, Markowitz, et al., 2003), anger was related to increased social distance, and pity to increased acceptance. Furthermore, we found several sociodemographic and personality variables to be linked to social distance or other indicators of stigma. The results of our survey correspond with common scientific findings on public stigma, like the fact that people with a higher educational level show fewer tendencies to report stigmatizing opinions (for an overview, see Angermeyer & Dietrich, 2006).

RWA which has been associated with a consistently more stigmatizing stance (Poteat & Mereish, 2012; Zick et al., 2008) was the single most important predictor of social distance in our study. Believing strongly in “submission to established authorities and the social norms these authorities endorse” and “aggressing against whomever these authorities target” (Altemeyer, 1998, p. 86), people scoring high on RWA in this study showed reactions towards PWP that are even more hostile than the reports from people with average or low levels of RWA.

Moreover, in this study, women reported slightly more fear and anger towards PWP. This gender difference might be explained by the fact that women consistently report higher fear of crimes and a higher perceived vulnerability to be victimized (Lagrange & Ferraro, 1989). While women are generally less prejudiced towards gays and lesbians than men (Kite, 1984; Kite & Whitley, 1996), the link between gender and mental illness stigma is found to be inconsistent in most studies on the stigma of mental illness, with some studies failing to show an effect, and others reporting either men or women as holding more favorable attitudes (Angermeyer & Dietrich, 2006).

Though prevalent in all age groups, public stigma towards PWP seems to be particularly pronounced among younger people. This is a counterintuitive finding in stigma research, where older participants typically hold more discriminating opinions towards stigmatized groups (Angermeyer & Dietrich, 2006; Herek, 2002; Liekens et al., 2012). This correlation cannot be explained by older people being less likely to have children below the age of consent, as this variable was statistically controlled. To explain this finding, a look at the historical dynamics of how society perceived child sexual abuse and dealt with it might be particularly enlightening. Many authors list the current public fears concerning child sex offenders as a typical example of a moral panic situation (Jenkins, 1998; Schultz, 2008; West,

2000), “as public perceptions of the problem have become increasingly focused on sexual abuse and sensationally atypical cases outside the family” (S. Cohen, 2011, p. xvi). People born after the start of this moral panic situation, that is, during the 1980s (Jenkins, 1998), are likely to have more thoroughly absorbed corresponding stereotypes and prejudices concerning pedophilia and child sexual abuse. Subsequent studies, however, are necessary to explain whether this result is actually indicative of more open attitudes towards PWP among older citizens, or whether it is due to a selection bias in sample recruiting (such as older people with more discriminatory attitudes being more likely to refuse participation in the study than younger people with similar attitudes). Yet, the finding that the association between age and social distance was found to be in the expected direction for people who abuse alcohol argues for the overall validity of our findings.

An important limitation that needs to be addressed is that data were gathered in an unselected sample that, albeit being considerably large and heterogeneous, differs substantially from the German population with respect to age, educational level, and possibly other unknown variables. This survey therefore does not offer representative data on its subject, and is still not sufficiently large or diverse to statistically adjust it to match the demographic characteristics of the overall population. Another potential limitation, present in both studies, is the fixed order of target groups. Participants always reported their attitudes towards PWP after judging another target group (people who abuse alcohol in Study I, and sexual sadists in Study II). We can thus not rule out that the results are affected by order effects, as this would have required counterbalancing the target groups. While we have to admit that the exact size of our effects could be subtly different if the order was reversed, we strongly doubt that the effect of judging one group before the other provides an alternative explanation for the drastic differences we found. Despite these limitations, this survey provides, to the best of our knowledge, the most comprehensive analysis on public stigma towards PWP and prompts re-thinking ways of how to deal with the problem that PWP might pose for society.

Second Study

The second study added to the results of previously discussed data of the first study by showing stigma against PWP to be markedly high in an independent sample of English-speaking participants recruited via MTurk; a sample that differs from that of Study I not only with respect to cultural background, language, and the sampling procedure, but also sociodemographic characteristics (e.g., a younger age and higher number of children in the

MTurk sample). Comparing attitudes towards PWP with those towards sexual sadists and people with an antisocial personality, we showed many aspects of stigma against PWP to be comparable to or to surpass even the very negative reactions towards people with antisocial tendencies and sexual sadists, especially with respect to dangerousness for children, fear, anger, and social distance. In contrast to Feldman and Crandall's (2007) results obtained from a student sample, participants in this sample reported being more likely to shun PWP than people with antisocial personality. In this survey, 28% agreed that PWP should better be dead despite never having committed a crime (with less than a third of this number demanding a similar fate for non-offending sexual sadists or people with antisocial tendencies). While this drastic value points to the possibility that condemnation of PWP is even more extreme in this sample (of presumably mostly US Americans), this interpretation warrants some caution. As mentioned above, both studies do not only differ with regard to national context but also with regard to anonymity (web-based vs. face-to-face administration of the questionnaire), age (older sample in Study I), and gender distribution (more men in Study II) to name just a few. Although the latter two could be controlled statistically, the first (and in all likelihood most relevant one) cannot. We thus refrain from interpreting this difference as a national difference.

As another noteworthy aspect of Study II, a surprisingly large number of more than one-third of the participants reported feeling pity towards PWP; much more so than towards the other studied groups.

As Study I, this survey does not provide representative data on its subject, but offers evidence that (1) the extreme stigma we found in our German sample can be conceptually replicated in a culturally different sample assessed through a very different sampling procedure, and (2) reactions towards PWP are markedly negative even compared with groups that are arguably more despised than people who abuse alcohol.

As has been shown for many other mental disorders, trouble and suffering does not only arise from the symptoms of the disorder, but also from unfavorable societal reactions (Rusch et al., 2005a). For many people with a mental disorder, fears of being stigmatized as such hold them from seeking professional help (Leaf, Bruce, Tischler, & Holzer, 1987), and lead to lower levels of self-esteem (P. W. Corrigan, Faber, Rashid, & Leary, 1999) and self-efficacy (P. W. Corrigan, Watson, & Barr, 2006). Only very few data exist on how PWP in particular perceive and react to public stigma against them (Jahnke & Hoyer, 2013), but there is some evidence that PWP feel stigmatized and avoid seeking help because they expect negative reactions even

from the professional (B4U-ACT, 2011, December 30). This problem, alongside other possible adverse stigma-related effects on the individual with pedophilia, such as social isolation and reduced self-esteem, could lead to a lack of social control and support as well as intense negative states, all of which have been hypothesized to increase the risk of sexually abusive behavior (T. Ward & Beech, 2006). Obviously, a more compassionate and ethical treatment of PWP could help increase the number of PWP who risk disclosing their sexual interest in children to friends, family, and, of course, health care specialists. Thus, the effect of perceived stigma on variables like motivation for therapy or child abuse risk vulnerabilities needs to be considered, including planning and executing efficient child abuse prevention programs directed at PWP (Beier, Ahlers, et al., 2009; Seto, 2012).

As health care professionals live and work in an environment where many people have little regard for the needs (or even basic human rights) of PWP, they may feel reluctant or discouraged about offering help to patients with pedophilia. The experience of being turned away or treated unempathetically by a health care professional in a situation of heightened vulnerability is likely to be particularly stressful for a patient with pedophilia (who might have no one else to turn to). Therefore, it is of primary importance to educate practitioners about stigma and the mental health needs of PWP, and to counteract unfavorable attitudes towards this group, which a not negligible number of mental health professionals undoubtedly share with their communities. Considering that in the light of our results this would presently be the obvious and realistic goal for de-stigmatization of PWP, we should, however, not forget that loss of rightful life opportunities due to a stigma is a major problem, at least for “open societies” (in the sense of philosophers such as Henri Bergson and Karl Popper), regardless of which group or which person is being discriminated against.

4.3 Study III - Stigma-Related Stress and its Correlates among Men with Pedophilic Sexual Interests

Abstract

Despite decades of research on the adverse consequences of stereotyping and discrimination for many stigmatized groups, little is known about how PWP perceive and react to stigma. In this article, we present a framework that outlines how stigma-related stress might negatively affect emotional and social areas of functioning, cognitive distortions, and the motivation to pursue therapy, all of which may contribute to an increased risk of sexual offending. We tested our hypotheses in an online survey among self-identified German-speaking PWP ($N = 104$) using a wide range of validated indicators of social and emotional functioning (Brief Symptom Inventory-53, UCLA Loneliness Scale, Emotion Subscale of the Coping Inventory for Stressful Situations, Fear of Negative Evaluation-5, Rosenberg Self-Esteem Scale). Specific risk factors such as self-efficacy, cognitive distortions, and the motivation to seek treatment were also assessed. In line with our hypotheses, fear of discovery generally predicted reduced social and emotional functioning. Contrary to our predictions, perceived social distance and fear of discovery were not linked to self-efficacy, cognitive distortions, or treatment motivation. Results were controlled for the effects of confounding variables (e.g., age, educational level, social desirability, relationship status). We critically evaluate the empirical contribution of this study to research on stigma and child sex offenses, including a discussion of the results in light of the potential indirect effects that public stigma may have on the overall risk for sexual offenses.

4.3.1 Theory

In recent years, it has been established that having a pedophilic disorder, that is, a paraphilic disorder with a sexual interest in prepubescent children as its key feature (American Psychiatric Association, 2013; Beier, Ahlers, et al., 2009), is among the most despised mental disorders (Feldman & Crandall, 2007; K. F. McCartan, 2010). A rich body of research on diverse stigmatized groups shows that stigmatization is linked to a multitude of negative cognitive, emotional, and behavioral outcomes (for an overview see Hatzenbuehler, 2009), including high-risk sexual behavior (Smolenski et al., 2011) that have so far not been studied among PWP. Based on ideas and concerns from the literature (e.g., Fog, 1992; Okami & Goldberg, 1992; Seto, 2012) we sought to close this research gap and provide an enhanced perspective on child sexual abuse with a *Framework for the Effects of Stigma-related stress among PWP* (FESAP, Figure 3). The framework aims to delineate the consequences of stigma in terms of psychological functioning, while at the same time showing how it may indirectly affect the risk of sexual offending (but note that these consequences are mediated by people's perception of and reaction to stigma). Therefore, we wanted to test to what degree data from an online sample of self-identified PWP empirically corroborate the FESAP.

The term stigma “refer[s] to an attribute that it is deeply discrediting,” reducing the individual possessing it “in our minds from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p. 3). People are stigmatized based on attributes such as, for example, mental disorders (Angermeyer & Dietrich, 2006; Rusch et al., 2005a) or sexual orientation (Ahmad & Bhugra, 2010). Public stigma can be conceptualized on a cognitive, affective, and behavioral level, which many authors refer to as stereotypes, prejudice, and discrimination (Rusch et al., 2005a). Stigmatization has been identified as “a central driver of morbidity and mortality at a population level” (Hatzenbuehler et al., 2013, p. 813) due to the stress and social disadvantage that emerge from it. According to the minority stress theory (Meyer, 2003), hiding a discreditable attribute comes at considerable costs, which have been studied particularly often for the lesbian, gay, and bisexual (LGB) community (Pachankis, 2007). Besides external stressors such as experiences of violence or discrimination, these include expectations of stressful events (and the heightened vigilance that results from it), efforts to conceal the stigma, and the internalization of negative attitudes towards the self (Meyer, 2003). Fearful expectations of rejection and the internalization of discrediting stereotypes are potent sources of stress, which may lead to problems coping with negative emotional states

(Hatzenbuehler, 2009) and create or aggravate mental health problems (Meyer, 2003; Pachankis, 2007).

Experiences of people who belong to the LGB community or individuals with a psychological disorder seem relevant for research on stigma consequences for PWP, as pedophilia is an atypical sexual interest (i.e., less common compared to a heterosexual orientation), that is construed as a mental disorder in modern classification systems (but note that having a sexual interest in children is not in itself pathological). We propose that studying pedophilia from a stigma perspective supports attempts to protect children against child sexual abuse, as we will explain in more detail below (see also Jahnke & Hoyer, 2013).

Stigmatization and Pedophilic Interest

Roughly, only between 25% to 50% of sexual offenders against children are estimated to exhibit pedophilic preferences (A. F. Schmidt, Mokros, & Banse, 2013), and a number of people with sexual interests in children never commit sexual crimes involving children (Dombert et al., 2015). Nevertheless, pedophilia was the disorder that students reported the highest degrees of social distance towards among more than 40 different mental disorders (with the exception of antisocial personality disorder; Feldman & Crandall, 2007). In two recent surveys, reactions towards PWP were more negative and stigmatizing in almost all studied domains compared to people who abuse alcohol, sexual sadists, and people with antisocial tendencies (Jahnke, Imhoff, & Hoyer, 2015, Chapter 4.2). Common stereotyped beliefs include that pedophilia is controllable (in the sense that a person with a dominant sexual interest in children can choose whether to have these interests or not) and extremely dangerous (Jahnke et al., 2015). Consequently, many participants reported anger towards this group and intended to refrain from personal contact on virtually all levels of social interaction (Jahnke et al., 2015). Our framework hypothesizes that the substantial stigma against PWP might increase the likelihood of problems on an emotional, social, and cognitive level, and decrease their motivation to seek help, even if needed and desired (but note these effects are modulated by people's perception of stigma, and that perceived stigma may not correspond to actual stigmatizing opinions expressed or held by the general public).

Effects of Stigma on Emotional Functioning

Stigmatized individuals often show higher rates of mental disorders or other emotional problems (Meyer, 2003). Stigma-related stress due to the perception of stigmatization is

hypothesized to influence general psychological variables that mediate the association between stigma-related stress and psychological disorders (Hatzenbuehler, 2009). These general factors include low self-esteem (P. W. Corrigan et al., 2006) and deficits in coping and emotion regulation (Hatzenbuehler, 2009). As the overview in Table 10 shows, PWP exhibit high rates of mood, anxiety (especially social phobia), and substance disorders, which (among other feasible interpretations such as early psychopathology leading both to pedophilia and current psychopathology) could be interpreted as representing effects of stigma-related stress. Note, however, that these rates are potentially biased since most studies were conducted on offenders in correctional facilities.

Table 10. Prevalence of Axis-I disorders and related mental health factors among people with pedophilia (study overview)

Study	Sample	Results concerning mental health
Adiele, Davidson, Harlow, & del Busto (2012)	70 incarcerated sex offenders with pedophilia	38% mood disorders, 34% anxiety disorders, and 39 % substance disorders (all lifetime)
Hoyer, Kunst, & Schmidt, (2001)	23 incarcerated sex offenders with pedophilia, 19 incarcerated sex offenders with sexual sadism	53.3% social phobia (lifetime, groups were pooled for the analysis, because they did not differ with regard to results in standard questionnaires for social anxiety)
Leue, Borchard, and Hoyer (2004)	30 incarcerated sex offenders with a paraphilia (18 with pedophilia)	93% comorbid axis I or personality disorder, 73% any anxiety disorder, 57% any substance use disorder, 30% mood disorder; among anxiety disorders, social phobia (38%) was most common (53%, all lifetime)
Raymond et al. (1999)	45 incarcerated sex offenders with pedophilia	93% comorbid Axis-I disorder (lifetime), with mood (66.7%), anxiety (64.0%), and substance disorders (60.0%) being most prevalent; among anxiety disorders, social phobia (38%) was most common
Schaefer et al. (2010)	160 nonincarcerated people with pedophilia from the Berlin Prevention Project Dunkelfeld	51.5% of undetected offenders with pedophilia have sought professional help in the past, 38.1% of nonoffenders with pedophilia have sought professional help in the past

Sexual crimes are often preceded by negative emotions (Pithers et al., 1988) and child sex offenders appear to rely more on inadequate emotion-focused coping strategies like excessive self-preoccupation and fantasizing than non-sexual offenders or other controls (Feelgood, Cortoni, & Thompson, 2005; W. L. Marshall, Serran, & Cortoni, 2000). People who lack skills to manage negative emotional states may use sex as a powerful, yet often problematic coping mechanism (W. L. Marshall et al., 2000). Among other factors, emotional problems and low self-esteem are regarded to play an etiological role in sexual offending (Finkelhor & Araji, 1986; Seto, 2008; T. Ward & Beech, 2006). Although meta analyses have shown that a lack of self-esteem is cumulatively not a maintaining factor for sexual reoffending, there are

notable exceptions from this general pattern (i.e., studies from the UK report substantial relevant effects on sexual recidivism as opposed to studies from North America or New Zealand [$d = 0.67$ vs. $d = -0.02$]; Mann et al., 2010). Furthermore, a meta-analysis that specifically focused on risk factors for sexual offending against children (Whitaker et al., 2008) showed that child sexual abusers as compared to non-offenders exhibited higher levels of internalizing behavior problems. Moreover, self-esteem was reduced as compared to sexual offenders with adult victims, non-sexual offenders, or non-offenders (Whitaker et al., 2008). For these reasons, emotional disturbances induced by stigma may indirectly contribute to the risk of sexually abusive behavior by PWP, as indicated by the finding that sexual offenders show less functional coping strategies than non-offenders (Whitaker et al., 2008).

Effects of Stigma on Social Functioning

Secure attachments and social support are closely tied to well-being (Baumeister & Leary, 1995). In people diagnosed with a psychological disorder, perceived stigma was shown to be associated with more problems regarding social functioning and increased social withdrawal (B. G. Link et al., 1997). Facing a hostile, uncomprehending world, many PWP may see no other choice than to keep their sexual interests a secret. Considering the strategic planning and high level of control over one's verbal and nonverbal expressions required to keep a secret (Lane & Wegner, 1995), elevated rates of social phobia (e.g., Hoyer et al., 2001, Table 10), shyness, and deficient social skills (Wilson & Cox, 1983) among PWP are perhaps not a surprising finding. Although loneliness has in general not been shown to be predictive of sexual recidivism ($d = 0.09$), the evidence from a larger study needs also to be taken into account ($d = 0.35$; $n = 799$ as reviewed in Mann et al., 2010). Moreover, meta-analytic findings have revealed that child sexual abusers suffered from increased levels of general social deficits (particularly loneliness) as well as problems with intimate relationships (Whitaker et al., 2008).

In order to overcome their loneliness, PWP may prefer socializing with people who share their sexual interests. A number of web communities function as support circles (e.g., the German “Jungsforum”, www.jungsforum.net) by offering an “emotional outlet” (Holt, Blevins, & Burkert, 2010, p. 10) and positive identification models (Fog, 1992). Also, some forums explicitly encourage their members to resist sexual impulses towards children (e.g., the web group “Virtuous Pedophiles”, www.virped.org). Despite these constructive efforts, isolated groups of PWP may encourage each other to start relationships with a desired child or

otherways behave in problematic ways (Holt et al., 2010), which might increase their risk of committing sexual offenses involving children or child pornography.

Effects of Stigma on Cognitive Distortions

Many men who have sexually offended against children report cognitive distortions concerning their crimes, such as, for instance, that children desire sex with adults and are “able to make informed decisions about sexual activities with adults” (T. Ward & Keenan, 1999, p. 827). Such distorted cognitions are seen as a predecessor of (further) sexual offenses (Abel et al., 1984; T. Ward & Keenan, 1999). We identified several ways in which public stigma might create or exacerbate these cognitive distortions: As described above, we suppose that most PWP will go to great lengths to avoid discovery of their sexual interests. At the same time, they are confronted with a lack of role models that could openly point out ways to deal with one’s sexuality in a responsible, legally non-problematic way, instead seeing themselves portrayed as “monsters” or “beasts” in the media (West, 2000). Many PWP therefore might lack sufficient “knowledge of any appropriate script for the paraphilic behaviour that would satisfy” (Fog, 1992, p. 137) them, and instead be prone to develop distorted beliefs about sexual offending. On top of that, hiding pedophilic interests decreases opportunities to talk openly about beliefs regarding sexual involvement with children that they might endorse, especially if these beliefs legitimize such behavior. The likelihood to be confronted with alternative explanations that could be provided by most non-pedophilic (and in many cases also pedophilic, Holt et al., 2010) members of the community is reduced if the person with pedophilia is isolated due to stigmatization.

It is furthermore problematic that some cognitive distortions are not only held by many actual or potential sexual offenders victimizing children, but by a large number of people from the general public as well, such as the belief that people with a sexual interest in children are unable to control their behavior. If PWP adopt the widespread stereotype that all people who sexually fantasize about children will sexually offend sooner or later, they might feel little motivation to employ helpful strategies to avoid such offenses (T. Ward & Keenan, 1999). Hence, stigma, especially if leading to withdrawal, might increase the likelihood of a person with pedophilia to adopt problematic cognitions about sex with children, and, therefore, this person’s sexual offense risk (as indicated by the meta-analytic findings that cognitions minimizing perpetrator culpability or tolerating adult-child sexual activity are a risk factor for child sexual abuse; Whitaker et al., 2008).

Effects of Stigma on the Motivation to Pursue Treatment

An additional adverse consequence is that people who are suffering from symptoms of a mental disorder sometimes avoid seeking therapy because of potential stigmatization (Vogel & Wade, 2009). Although a large number of PWP who see themselves at risk of committing sexual offenses can be reached for preventive measures (Beier, Ahlers, et al., 2009), it can be hypothesized that many do not dare to contact mental health experts, because they anticipate negative reactions from the treatment staff. In fact, practitioners in a recent Finnish sample (Alanko, Haikio, Laiho, Jahnke, & Santtila, 2015) and a sample of German psychotherapists (Stiels-Glenn, 2010) were reluctant to work with this group and, in some instances, reported corresponding negative attitudes. On the other hand, the majority of a self-selected sample of German psychotherapists in training showed comparably positive attitudes towards PWP, especially after receiving a brief anti-stigma intervention (Jahnke, Philipp, & Hoyer, 2014, see Chapter 5.1). Nevertheless, if a therapist (or a fellow patient) makes an indiscrete remark that reveals the client's sexual interest to a third party, his or her personal safety and important social and professional relationships are compromised. Thus, stigma-related stress might deter this group from seeking help.

The Present Study

Utilizing the theoretical assumptions delineated above (see also Figure 3), we sought to explore associations between stigma-related stress and different areas of functioning. In particular, we examined self-esteem, emotional coping, and symptoms of clinical disorders (emotional functioning), loneliness (social functioning), self-efficacy related to control of sexual urges towards children and beliefs regarding sexual abuse of children (cognitive distortions), as well as the motivation to seek therapy. Participants' fears of being discovered and perceived social distance were assessed as indicators of stigma-related stress.

As the Internet has emerged as an important medium for people to share personal information, PWP have discovered new ways of building communities while remaining relatively safe and anonymous (Holt et al., 2010). Hence, we have decided to conduct the study online, which allowed us to a) guarantee a maximum of anonymity in order to increase the truthfulness of self-reports (Kays, Gathercoal, & Buhrow, 2012; P. Ward, Clark, Zabriskie, & Morris, 2012), and b) reach a previously understudied subgroup that is likely to differ systematically from incarcerated offenders (see also R. C. W. Hall & Hall, 2007; Schaefer et al., 2010). In order to build confidence and reduce inadvertent stigmatization, we collaborated with PWP involved

in online forums for this group, including the third author of the current research, who also helped recruiting participants via forum posts.

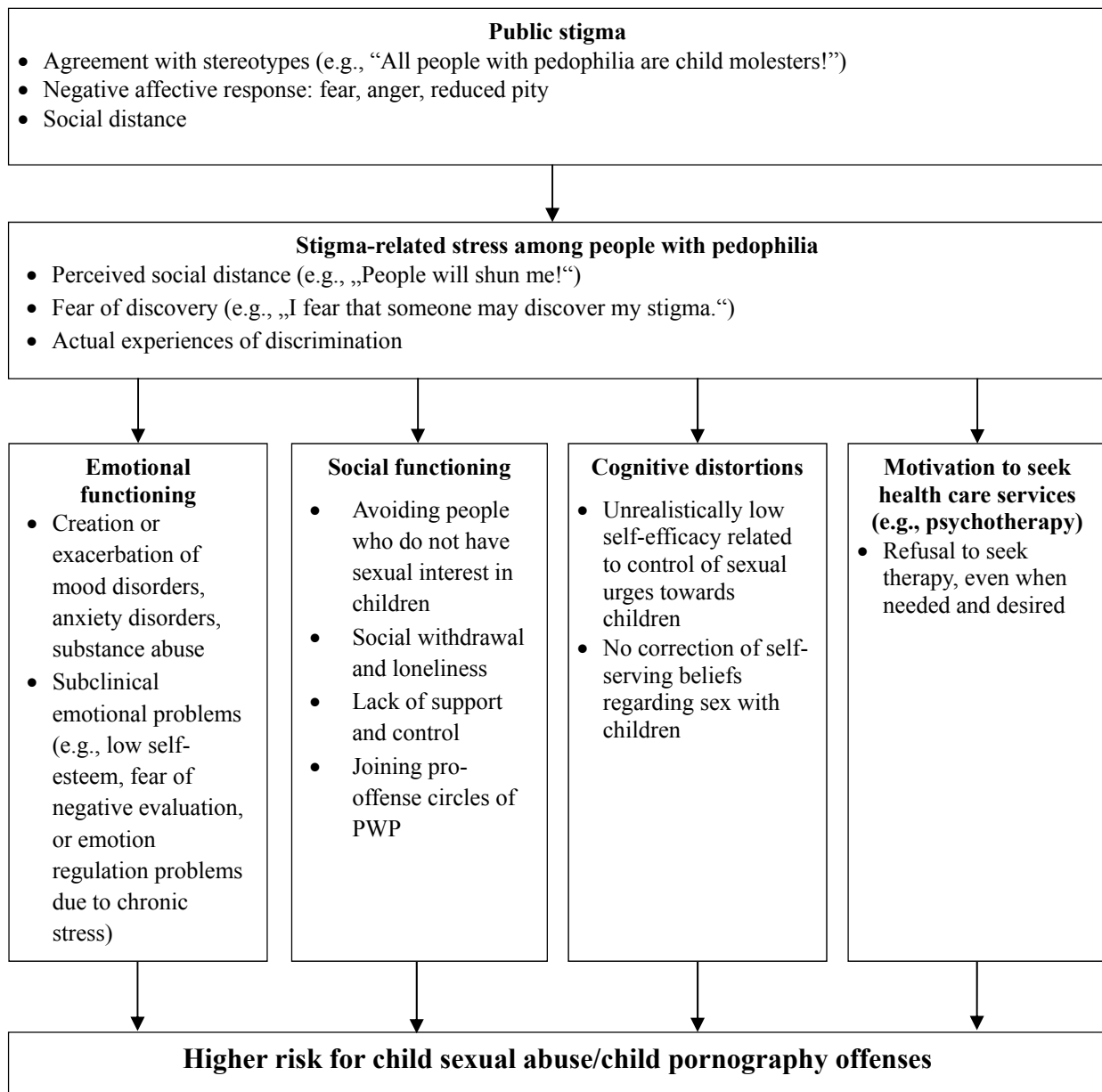


Figure 3. Overview of the Framework for the Effects of Stigma-related Stress among People with Pedophilia (FESAP).

Note. Arrows represent hypothetic causal associations.

4.3.2 Methods

Participants

Data from $N = 104$ German-speaking men (18 – 79 years old, mean age = 37.30, $SD = 11.86$, 85.6% from Germany) were collected between March, 7 and April, 28, 2014. Among all participants, 16% were married or living in a relationship with an adult partner, and 84% had

no children. Sixty-four percent had completed the *Abitur* (comparing to a US college entry exam or high school certificate). The great majority of participants (83%) was sexually interested solely or mostly in boys, but some reported to be equally attracted to children of both sexes (3%) or solely or mostly girls (14%). Sixty-eight percent described themselves as dominantly attracted to children below 12 years. Among those participants who reported other notable sexual interests towards adults (32%), 52% were attracted solely or mostly to men, 15% reported equal attraction to adults of both sexes and 33% were attracted solely or mostly to women beside their attraction to children. Seventy-three percent indicated to have never been convicted for sexual crimes against children (including child sexual abuse and child pornography offenses), and 68% to have never been in treatment for their pedophilic interests. About half of the sample (51%) had never participated in a study on pedophilia before.

Procedure

Participants were invited via advertisements in forums directed at PWP (www.jungsforum.net, www.krumme13.org; all forums operate on a strictly legal basis, and explicitly prohibit posting of illegal contents such as child pornography). Participation was voluntary and no compensation was offered. The survey started with sociodemographic information followed by the self-report scales in the order described in the Measures subsection. At the end of the questionnaire, participants were asked to recruit other individuals among their social network (snowball sampling). Potential participants with Internet anonymity concerns were encouraged to print out the questionnaire and send it to us without identifying information. One participant used this option.

Measures

Perceived Social Distance Scale

The Perceived Social Distance Scale is a modified version of the Social Distance Scale that was used in previous studies to assess stigma against PWP (Imhoff, 2015; Jahnke et al., 2015; Jahnke et al., 2014), where it displayed high internal consistency ($\alpha = .82$) and convergent validity (e.g., $r = .38$ with Right Wing Authoritarianism; Jahnke et al., 2015). Instead of indicating one's own agreement with each item (as in the original form of the scale), we asked participants to indicate how much they believe that the majority of people from Germany would agree with the item (instruction: "The following questions are *not about your personal beliefs* on the subject. Instead, please indicate how, in your belief, most people in Germany

would respond to these statements concerning people who are dominantly sexually interested in children, but have never committed a crime. I believe that most people in Germany think that...,” followed by six items tapping into social distance, see Table 11). Responses were assessed on a 7-point Likert scale ranging from 0 (*do not agree at all*) to 6 (*completely agree*).

Fear of Discovery Scale

People keep secrets because they fear negative consequences for the self (e.g., shame, ostracism) once the concealed information is exposed to other people (Smart & Wegner, 2000). Fear of discovery is the emotional response elicited by the imagined or real threat of a personal secret being discovered by others. This response is characterized by (1) the subjective experience of fear of the secret being discovered, (2) sympathetic responses (e.g., increased heart rate) to thoughts about the secret being discovered, (3) worrying about the secret being discovered, (4) attempts to prevent others from finding out about the secret, and (5) the subjective appraisal of these reactions as distressful or burdensome. The Fear of Discovery Scale (Table 11, developed by the authors) consists of five subscales that represent the aforementioned aspects with two items each, rated on a Likert-type scale from 0 (*do not agree at all*) to 6 (*completely agree*). Participants only received the Fear of Discovery Scale in case they chose “yes” when asked whether they want to keep their sexual interest in children a secret from at least one person (forced choice), and were then instructed to complete the scale with regard to this secret. Only items that achieved a minimum score of 9 on a rating scale ranging from 0 (no content validity) to 10 (high content validity) among three senior scientists from our faculty were used in the final questionnaire. The scale was furthermore pretested in a sample of psychology students ($N = 21$) who were instructed to report their feelings, thoughts, and behaviors with respect to a personal secret of their own choice (such as a shameful aspects of one’s body, personality, sexuality, or an experience from their past that they want to keep others from knowing) and achieved very high internal consistency scores ($\alpha = .90$).

Brief Symptom Inventory-53

The Brief Symptom Inventory-53 (original English version by Derogatis & Spencer, 1982, German translation by Franke, 2000) with its nine subscales Somatization, Obsessive-compulsive, Interpersonal sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation, and Psychoticism, and its global score is a commonly used instrument in clinical practice and research (Derogatis & Savitz, 2000). Participants filled out 53 items on a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*very strongly*) regarding psychological and

physical problems that they might have experienced during the last week. Internal consistency for the German version was high with $\alpha = .96$ for the global severity index (Geisheim et al., 2002). Convergent validity was demonstrated via inter-correlations with established questionnaires such as the Beck Depression Inventory ($r = .74$ for the global severity index), and the scale could be used to reach effect size estimates for CBT among $N = 617$ patients (Geisheim et al., 2002).

UCLA (University of California, Los Angeles) Loneliness Scale Revised

The UCLA Loneliness Scale revised is a shortened (12 items) German language version (Bilsky & Hosser, 1998) of Russell, Peplau, and Cutrona's (1980) original UCLA Loneliness Scale. Participants indicated their level of agreement with each item (e.g., "My social relationships are superficial," "I feel isolated from others") on a 5-point Likert scale from 0 (*very often*) to 4 (*never*). A later version of the original scale (D. W. Russell, 1996) showed high internal consistency ($\alpha > .89$) and retest reliability over the course of 1 year ($r = .73$), as well as acceptable convergent validity, as indicated by correlations with other measures of loneliness and related concepts (e.g., $r = -.56$ for social support satisfaction). In its 12-item German version, the questionnaire demonstrated similarly high reliability (internal consistency $\alpha = .90$, split half reliability $r = .89$; Bilsky & Hosser, 1998). Correlations between the UCLA loneliness score and sociodemographic variables (e.g., age, living alone vs. living with other people) were significant and indicate the validity of the scale (Bilsky & Hosser, 1998). In a study conducted with child pornography users and child sex offenders from the German Prevention Project Dunkelfeld, the scale displayed high reliability ($\alpha = .92$, Neutze, Grundmann, Scherner, & Beier, 2012).

Social Desirability Scale -17

Based on the Social Desirability Scale (Crowne & Marlowe, 1960), Stöber (1999) developed an updated version to measure tendencies to produce socially desirable (yet unlikely) responses among German-speaking subjects (e.g., "I never hesitate to go out of my way to help someone in trouble"). Answers are given on a binary scale (forced choice between true and false). Stöber's (1999) version of the scale displayed acceptable reliability (internal consistency $\alpha > .72$ and retest reliability $r = .82$ within 4 weeks) and was significantly correlated with an older German translation of Crowne and Marlowe's (1960) scale ($r > .67$).

Rosenberg Self-Esteem Scale

The Rosenberg Self-Esteem Scale used in this survey (Ferring & Filipp, 1996) is a German adaptation from Rosenberg's (1965) original scale. Ten items relating to positive and negative attitudes towards the self (e.g., "On the whole, I am satisfied with myself" vs. "I feel I do not have much to be proud of") are answered on a 4-point Likert scale ranging from 0 (*do not agree at all*) to 3 (*completely agree*). Items relating to negative feelings are reversely coded, so that higher (overall) scores represent higher levels of self-esteem. Previous analyses showed high internal consistency ($\alpha > .81$) and split half reliability ($r > .81$, Ferring & Filipp, 1996). The scale demonstrated significant correlations with measures of optimism, self-efficacy, and affective-motivational variables (e.g., $r > .54$ for hopelessness, Ferring & Filipp, 1996).

Fear of Negative Evaluation – 5

Fear of negative evaluation stands for "the tendency to dread being evaluated unfavorably by others" (Kemper, Lutz, & Neuser, 2012, p. 343) and represents the cognitive component of social anxiety (Neuser, 2003). Kemper et al. (2012) provided a translated 5-item short version of the original 30-item English version (Watson & Friend, 1969) of the scale. Items included, for example, "I worry that I will say or do the wrong things" and "When I am talking to someone, I worry about what the other person may be thinking about me." A 4-point Likert scale from 0 (*almost never correct*) to 3 (*almost always correct*) is used. The German short scale showed an internal validity of $\alpha > .84$ in clinical and non-clinical samples (Kemper et al., 2012). In the 30-item English version (Watson & Friend, 1969), a retest reliability of $r = .78$ was achieved. Lending validity to the scale Watson and Friend (1969) found that "individuals high on [fear of negative evaluation] became nervous in evaluative conditions, and seemed to seek social approval" and that the scale "showed correlations with other relevant measures" (p. 456).

Therapy Motivation Scale

We developed a 4-item measure to assess participants' willingness to seek professional help (e.g., medical doctor or psychologist) during a crisis. Items are displayed in Table 11 and were rated on a 7-point Likert scale ranging from 0 (*do not agree at all*) to 6 (*completely agree*). Negatively formulated items were recoded so that higher scores represent a higher therapy motivation.

Bumby Child Molest Scale

This scale contains a list of beliefs that people who have offended against children might use to legitimize their behavior (e.g., “Sexual activity with children can help the child to learn about sex”), rated on a 4-point Likert scale ranging from 0 (*strongly disagree*) to 3 (*strongly agree*, Bumby, 1996). We used a 28-item short German version of the scale (Rambow, Elsner, Feelgood, & Hoyer, 2008). Bumby’s (1996) original scale showed “convergent and discriminative validity, freedom from a socially desirable response bias, and utility in assessing the efficacy of a cognitive restructuring treatment component” (p. 37). The German short scale demonstrated an internal consistency of $\alpha = .96$ among a sample of incarcerated sexual offenders (Gonsior, 2002).

Subscale Emotion-Oriented Coping from the Coping Inventory for Stressful Situations

This subscale assesses a person’s tendency to react with emotion, self-preoccupation, and wishful thinking in situations of stress (in contrast to problem-focused approaches, see Endler & Parker, 1990 for the original version of the scale). We used a modified 8-item German version by Kälin (1995). Items (e.g., “I become very tense”) are rated on a 5-point Likert scale ranging from 0 (*very untypical*) to 4 (*very typical*). Internal consistency was demonstrated among child pornography users and child sex offenders with pedophilia ($\alpha = .76$) and detected offenders scored higher on emotion-oriented coping than undetected offenders (Neutze et al., 2012).

Coping Self-Efficacy Subscale of the Self-Efficacy Scale Related to Minors

The Coping Self-Efficacy Subscale assesses beliefs regarding one’s capability to control sexual urges in various moods or situations (e.g., “even if a minor wishes to be close to me” or “even if I feel lonely”) rated on a 4-point Likert scale from 0 (*not at all true*) to 3 (*exactly true*, Neutze et al., 2012). We deleted one item of the original 20-item set (“even if I need several attempts before succeeding”), because it implies a prior loss of control over one’s sexual urges. The scale was used among patients with pedophilia from the Berlin Prevention Project Dunkelfeld where it displayed high internal consistency ($\alpha = .94$, Neutze et al., 2011). Furthermore, Neutze et al. (2011) reported a significant positive correlation with a scale assessing the tendency to use sex with children as a coping strategy ($r = .47$).

4.3.3 Results

A descriptive analysis of participants' responses on perceived social distance, fear of discovery, and therapy motivation can be found in Table 11. In general, participants reported high levels of perceived social distance and fear of discovery. Perceived social distance was notably higher than actual social distance found in public stigma surveys (Jahnke et al., 2015). This bias was particularly large when extremely punitive reactions were concerned. For example, 64% of the current sample believed that most people in Germany think that non-offending PWP should better be dead, while only 14% of the German participants in the aforementioned survey actually agreed to this item (note that comparison data may not be representative; cf. Jahnke et al., 2015). Also, the majority of participants reported to be afraid to be discovered as pedophilic and to experience distress because of it. With regard to therapy motivation, PWP appeared to be ambivalent (52% would seek professional help even if it meant that they have to talk about their sexual interests to a stranger, but only 36% believed that a health care professional would understand their problems).

We compared participants' scores with data from the average population or other available relevant comparison groups (Table 12). People in the current sample of PWP that were not incarcerated or recruited from therapeutic groups reported similar levels of psychopathology on the Brief-Symptom Inventory-53 than the ones found among patients with pedophilia in the Berlin Prevention Project Dunkelfeld, which recruits participants seeking therapeutic support, but much higher levels than members of the average population.

Table 11. Items and descriptive overview (*M*, *SD*, percentage of item agreement, Cronbach's α) of newly developed questionnaires

Scale (item)	<i>M</i>	<i>SD</i>	agree
Perceived Social Distance Scale ($\alpha = .84$)	4.81	0.91	-
Would have these persons as friends.	0.72	1.20	4.81
Would accept these persons in my neighborhood.	0.63	0.89	1.92
Would accept these persons as colleagues at work.	0.91	1.07	3.85
Would talk to them.	1.64	1.22	7.69
These persons should be incarcerated.	4.81	1.32	83.65
These persons should better be dead.	3.96	1.54	63.46
Fear of Discovery Scale ($N = 100^*$) ($\alpha = .89$)	3.97	1.31	-
I'm afraid that others may discover my secret.	5.16	1.41	83.65
It scares me that others might know about my secret.	4.86	1.59	81.73
When thinking about others discovering my secret I become nervous and feel my heart beat rise.	3.96	1.95	60.58
The thought of others finding out about my secret causes physical discomfort.	3.82	1.91	58.65
I worry a lot about what will happen if others find out about my secret.	3.88	1.92	56.73
I cannot shake off thoughts about the possibility of my secret being discovered.	2.95	1.94	41.35
I avoid talking about subjects that are related to my secret.	3.40	2.11	50.00
I try to act in a way that no one can find out that I carry a secret.	4.28	1.87	68.27
It is stressful for me to keep my secret.	3.33	1.94	46.15
Having this secret is distressing to me.	4.03	1.96	62.50
Therapy Motivation Scale ($\alpha = .84$)	2.91	1.68	-
I would confide in a health care professional.	3.36	2.14	57.69
I would seek professional help even if it means I have to talk about my sexual interests in children to a stranger.	3.21	2.22	51.92
I think that a health care professional will understand my problems.	2.61	2.03	35.58
I think that it is very likely that a health care professional reacts negatively when I reveal my sexual interests in children.	3.55	1.77	55.77

Note. All scales range from 0 to 6.

* note that 4 participants reported that they did not try to keep their pedophilic interests a secret from anybody and therefore did not complete the Fear of Discovery Scale.

Understanding Stigmatization of People with Pedophilia

Table 12. Reliability and outcome levels as compared to other reference samples (*t*-test, *N* = 104)

			Comparison group			test statistics	Effect size
	<i>M</i>	<i>SD</i>	Sample (reference)	<i>M</i>	<i>SD</i>	<i>t</i> (<i>df</i>)	<i>d</i>
Brief-Symptom Inventory-53 ³ ($\alpha=.97$)	0.90	0.70	<i>N</i> = 46 patients with pedophilia from Berlin Prevention Project Dunkelfeld (Beier et al., 2013)	0.96	0.56	0.51 (148)	0.09
			<i>N</i> = 300 members of the average population (Franke, 2000)	0.28	0.23	13.42 (402)**	1.19
Fear of Negative Evaluation Scale-5 ² ($\alpha=.88$)	1.18	0.78	<i>N</i> = 2603 members of the general population in Germany (Kemper, Lutz, & Neuser, 2012)	1.14	0.72	0.55 (2705)	0.05
Rosenberg Self-Esteem Scale ³ ($\alpha=.89$)	2.63	0.88	<i>N</i> = 92 members of ad-hoc sample (Ferring & Filipp, 1996)	2.29	0.44	3.35 (194)**	0.49
Subscale Emotion-Oriented Coping from the Coping Inventory for Stressful Situations ³ ($\alpha=.84$)	1.63	0.80	<i>N</i> = 505 young Swiss professionals (Kälin, 1995, statistics retrieved from Beier et al., 2013)	1.89	0.68	3.44 (607)**	0.35
			<i>N</i> = 46 patients with pedophilia from Berlin Prevention Project Dunkelfeld (Beier et al., 2013)	2.18	0.67	4.07 (148)**	0.75
UCLA Loneliness Scale ³ ($\alpha=.91$)	1.88	0.95	<i>N</i> = 3284 members of the general population in Germany (Bilsky & Hosser, 1998)	1.01	0.95	9.19 (3386)**	0.92
Bumby Child Molest Scale ³ ($\alpha=.92$)	1.47	0.50	<i>N</i> = 18 incarcerated child sexual abusers with pedophilia in Germany (Borchers, 2007)	1.94	0.56	3.62(120)**	0.89
Coping Self-Efficacy Subscale of the Self-Efficacy Scale Related to Minors ² ($\alpha=.96$)	2.09	0.81	<i>N</i> = 196 undetected child sex offenders with pedophilia or hebephilia from the Berlin Prevention Project Dunkelfeld (Neutze, Grundmann, Scherner, & Beier, 2012)	0.95	0.63	13.47** (298)	1.57
			<i>N</i> = 149 detected child sex offenders with pedophilia or hebephilia from the Berlin Prevention Project Dunkelfeld (Neutze et al., 2012)	0.89	0.70	12.57**(251)	1.59
Social Desirability Scale-17 ¹ ($\alpha=.74$)	0.44	.21	<i>N</i> = 91 psychology students (Stöber, 1999)	.37	0.48	1.35 (193)	0.19

p* < .05; *p* < .01, ¹scale ranges from 0 to 1, ² scale ranges from 0 to 3, ³scale ranges from 0 to 5.

Moreover, participants showed lower levels of emotion-focused coping than a norm population of young Swiss professionals and patients with pedophilia from the Berlin Prevention Project Dunkelfeld. Compared to the general population, participants in this sample did not differ with respect to their scores on the Fear of Negative Evaluation Scale-5

and even showed higher levels of self-esteem than individuals in another ad-hoc sample. On the UCLA Loneliness Scale, PWP from our sample reported higher levels of social isolation than the average population. Attitudes towards sexual activities with children as assessed by the short form of the Bumby Molest Scale in our sample were far less offense-supportive than among incarcerated pedophilic child sexual abusers. Self-efficacy related to minors was much higher in this online sample of PWP than among detected and undetected offenders with pedophilia or hebephilia (child sexual or child pornography offenders) from the Berlin Prevention Project Dunkelfeld. Finally, participants in this study did not significantly differ from psychology students with respect to their propensity to give socially desirable responses.

Bivariate intercorrelations (Table 13) showed that perceived social distance was significantly linked only to fear of discovery. Fear of discovery was correlated to lower levels of emotional functioning, that is, higher scores on the Brief-Symptom-Inventory-53, the Fear of Negative Evaluation-5, and the Emotion Scale of the Coping Inventory for Stressful Situations, as well as lower scores on the Rosenberg Self-Esteem Scale (all correlations at least $r = .32$). Furthermore, there was a significant positive correlation ($r = .44$) between fear of discovery and (reduced) social functioning as measured by the UCLA Loneliness Scale. Neither the Perceived Social Distance Scale nor the Fear of Discovery Scale was significantly linked to the Bumby Scale or the Coping Self-Efficacy Subscale of the Self-Efficacy Scale Related to Minors. Notably, the Rosenberg Self-Esteem Scale, the Emotion Scale of the Coping Inventory for Stressful Situations, and the UCLA Loneliness Scale were strongly inter-correlated and showed the same correlation pattern with other variables.

A number of socio-demographic variables and social desirability were also linked to stigma and outcome variables (e.g., people who are more educated report less emotional coping and less fear of discovery), confounding the link between them. To assess the effects of stigma on each of our independent variables while statistically controlling for these potential confounds, we conducted hierarchical regression analyses with socio-demographic variables, social desirability, and type of pedophilia (i.e., exclusive vs. non-exclusive) entered in block one, and stigma variables in block two (perceived social distance and fear of discovery, see Table 14 and 15 for results). The first set of predictors (specifically, age, relationship status, and/or social desirability) was significant only for the Fear of Negative Evaluation-5 and Emotion Subscale of the Coping Inventory for Stressful Situations.

Table 13. Overview of intercorrelations (Two-tailed, $N = 104$)

Scale	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1 PSDS															
2 FODS ^a	.24*														
3 age	-.05	-.12													
4 education ^b	-.09	-.22*	.22*												
5 relation. ^b	.12	.09	-.20*	-.04											
6 SDS-17	-.06	.05	-.23*	.01	.20*										
7 pedophilia type ^b	.04	-.13	-.04	.04	-.20*	-.18									
8 BSI-53	.06	.51**	-.18	-.07	-.16	.10	-.17								
9 FNE-5	-.13	.43**	-.32**	-.08	-.14	.19*	-.13	.53**							
10 RSES	-.16	-.32**	.28**	.13	.12	-.17	.00	-.59**	-.65**						
11 COSI-ES	-.08	.32**	-.30**	-.22*	-.04	.42**	-.18	.55**	.60**	-.57**					
12 UCLA LS	.12	.44**	-.13	-.09	.25**	-.04	-.07	.64**	.43**	-.54**	.43**				
13 Bumby MS	.01	-.02	.13	-.07	-.04	.13	.04	.08	.17	.00	.15	.01			
14 TMS	-.18	-.01	.03	-.08	-.17	-.04	-.17	-.20*	-.05	.11	-.16	-.28**	-.19		
15 SESM-C	-.03	-.15	-.03	.17	-.01	-.21*	-.05	-.14	-.15	.09	-.26**	-.19	-.29**	.17	
16 Convict. ^b	.19	-.00	.04	-.04	-.15	.05	.04	.10	.03	-.15	.17	.23*	.24*	-.17	-.27**

Note. PSDS = Perceived Social Distance, FODS = Fear of Discovery Scale, education (0 = no Abitur, 1 = Abitur, Abitur = German higher education certificate), relation. = relationship status (1 = none, 2 = in relationship), SDS-17 = Social Desirability Scale-17, pedophilia type (1 = dominant attraction to children, 2 = no dominant attraction to children), BSI-53 = Brief Symptom Inventory-53, FNE-5 = Fear of Negative Evaluation-5, RSES = Rosenberg Self-Esteem Scale, COSI-ES = Emotion Subscale of the Coping Inventory for Stressful Situations, UCLA LS = UCLA Loneliness Scale, Bumby MS = Bumby Molest Scale, TMS = Therapy Motivation Scale, SESM-C = Coping Self-Efficacy Subscale of the Self-Efficacy Scale Related to Minors, Convict. = convicted of child pornography offenses or child sexual abuse (0 = no conviction, 1 = previous convictions)

^a $N = 100$, as four participants reported that they did not keep their pedophilia a secret from anybody and therefore, did not complete the Fear of Discovery Scale; ^b Point-biserial correlations.

Stigma variables significantly explained between 7% (Emotion Subscale of the Coping Inventory for Stressful Situations) and 24% (Brief-Symptom-Inventory-53) of variance for emotional functioning ($ps < .05$) above and beyond the predictors from the first block. For social functioning (UCLA Loneliness Scale), adding the stigma variables to the set of initial predictors lead to a significant increase of 19% in explained variance. Neither the variables in the first block nor the second block were significant predictors for cognitive distortions (Bumby Child Molest Scale and Coping Self-Efficacy Subscale of the Self-Efficacy Scale Related to Minors) and motivation to seek therapy (with the exception of social desirability, which predicted higher coping self-efficacy). Fear of discovery was significantly negatively linked to social and emotional functioning. Finally, perceived social distance was associated with less fear of negative evaluation – which was contrary to the hypothesized direction of this link. As binary correlations showed perceived social distance to be significantly linked to fear of discovery, but not to fear of negative evaluation ($r = -.13$, n.s.), it can be concluded that perceived social distance acted as a suppressor variable between fear of discovery and fear of negative evaluation. The already high correlation between fear of discovery and fear of negative evaluation was therefore even higher than directly observed ($r = .43$) when controlling for perceived social distance.

Table 14. Predictors of emotional functioning: Results of hierarchical multiple regression analysis

	Brief Symptom Inventory-53 ^a		Fear of Negative Evaluation-5 ^b		Rosenberg Self-Esteem Scale ^c		Emotion Subscale of the Coping Inventory for Stressful Situations ^d	
	β	<i>SE</i> β	β	<i>SE</i> β	β	<i>SE</i> β	β	<i>SE</i> β
Step 1								
Age	-0.08	0.01	-0.20*	0.01	0.16	0.01	-0.12	0.01
Educational level ^c	0.04	0.13	0.04	0.14	0.04	0.18	-0.17*	0.15
Type of pedophilia ^c	-0.15	0.13	-0.09	0.15	-0.01	0.19	-0.11	0.15
Relationship status ^c	-0.23*	0.18	-0.22*	0.20	0.13	0.26	-0.16	0.21
Social Desirability	0.06	0.32	0.15	0.35	-0.16	0.45	0.38***	0.36
Step 2								
Perceived Social Distance	-0.06	0.07	-0.24**	0.08	-0.11	0.10	-0.11	0.08
Fear of Discovery	0.53***	0.05	0.47***	0.05	-0.27**	0.07	0.27**	0.06

Note. $N = 100$

^a $R^2 = .10$ for Step 1 ($p = .08$), $\Delta R^2 = .24$ for Step 2 ($p < .001$)

^b $R^2 = .16$ for Step 1 ($p < .01$), $\Delta R^2 = .21$ for Step 2 ($p < .001$)

^c $R^2 = .10$ for Step 1 ($p = .06$), $\Delta R^2 = .09$ for Step 2 ($p < .01$)

^d $R^2 = .29$ for Step 1 ($p < .001$), $\Delta R^2 = .07$ for Step 2 ($p < .05$)

^e = dummy coded

* $p < .05$; ** $p < .01$; *** $p < .001$.

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Table 15. Predictors of cognition, social functioning, and therapy motivation: Results of hierarchical multiple regression analysis

	UCLA Loneliness Scale ^a		Bumby Child Molest Scale-5 ^b		Coping Self-Efficacy Subscale of the Self-Efficacy Scale Related to Minors ^c		Therapy Motivation Scale ^d	
	β	<i>SE</i> β	β	<i>SE</i> β	β	<i>SE</i> β	β	<i>SE</i> β
Step 1								
Age	-0.03	0.01	0.23*	0.00	-0.17	0.01	-0.04	0.02
Educational level ^e	0.00	0.19	-0.10	0.11	0.18	0.17	-0.10	0.37
Type of pedophilia ^e	-0.09	0.19	0.05	0.11	-0.11	0.18	-0.12	0.37
Relationship status ^e	-0.30**	0.26	-0.06	0.15	0.04	0.24	0.15	0.52
Social Desirability	-0.03	0.45	0.19	0.26	0.28**	0.42	-0.12	0.90
Step 2								
Perceived Social Distance	-0.01	0.10	-0.03	0.06	0.02	0.09	-0.17	0.20
Fear of Discovery	0.45***	0.07	-0.01	0.04	-0.14	0.06	-0.01	0.14

Note. *N* = 100

^a $R^2 = .10$ for Step 1 ($p = .09$), $\Delta R^2 = .19$ for Step 2 ($p < .001$)

^b $R^2 = .06$ for Step 1 ($p = .32$), $\Delta R^2 = .00$ for Step 2 ($p = .96$)

^c $R^2 = .11$ for Step 1 ($p = .06$), $\Delta R^2 = .02$ for Step 2 ($p = .39$)

^d $R^2 = .06$ for Step 1 ($p = .35$), $\Delta R^2 = .03$ for Step 2 ($p = .22$)

^e = dummy coded

* $p < .05$; ** $p < .01$; *** $p < .001$.

4.3.4 Discussion

Within the FESAP, we have combined findings from stigma research on other groups (Rusch et al., 2005a), positions from the minority stress theory (Meyer, 2003), and etiological theories from sexual offending research (T. Ward & Beech, 2006) to create a systematic set of assumptions about possible stigma consequences for PWP. We have gathered empirical data to explore the hypothetical links between societal attitudes towards this group (as perceived by them), psychological functioning, and risk factors for child sexual abuse. Some of our analyses supported the hypotheses from the FESAP while others were not in line with our previous assumptions. Results indicated that fear of being discovered as a person with pedophilia was indeed negatively associated with social and emotional functioning, but neither with cognitive variables nor the motivation to seek therapy. The expected positive link between perceived social distance and child sexual abuse risk factors could not be shown (but note that there were marginally significant associations between perceived social distance and previous sexual offending against children, $r = .19$, $p = .06$, and therapy motivation, $r = -.18$, $p = .07$).

Stigma-Related Stress among PWP

The PWP who participated in this study – 73% of whom have never been convicted for child sexual abuse or child pornography offenses – reported high levels of perceived social distance. Comparing participants' responses with results from a large public stigma survey from Germany (Jahnke et al., 2015), PWP appear to overestimate the already high level of discrimination intention towards their group in the population. For instance, a majority believed that most German people would agree to incarcerate PWP in the absence of a crime, while in fact this seems to be a minority opinion (Jahnke et al., 2015). Consequently, many individuals in our sample experienced fears of their sexual interests being discovered by others, prompting a large number of participants to employ strategies to avoid suspicion (e.g., by not talking about pedophilia-related topics with others). PWP may therefore lack opportunities to verify their assumptions about how the majority actually perceives them, but instead base their conclusions on their experiences with a small, but possibly very vocal, number of people or media expressing high levels of stigmatizing attitudes. Considering that negative outcomes are associated with the individual's perception of stigma, this observation may pose a chance to reduce stigma-related effects by informing PWP about their overestimation of public stigma. Nevertheless, actual public stigma is still high (Jahnke et al., 2015), and punitive attitudes towards PWP have been found to be positively related to social desirability (Imhoff, 2015), indicating that extreme stances towards this group are perceived as the social norm that individuals need to follow in order to make a good impression.

Contrary to studies finding an association between awareness of stigma and impaired functioning (e.g., P. W. Corrigan et al., 2006), perceived social distance in this survey was not found to predict cognitive distortions, emotional or social functioning, or motivation to seek therapy. Just because PWP acknowledge public stigma they do not necessarily believe or internalize it (see also Rusch et al., 2005a). According to our results, fear of discovery is a more appropriate indicator for how much PWP are affected by public stigma.

Social and Emotional Functioning

With regard to social and emotional functioning, we found that people in our sample presented more deficits than people from the general population (with the exception of self-esteem, fear of negative evaluation, and emotion-focused coping), but at the same time higher functioning than participants from clinical and/or forensic samples of PWP. Moreover, we could show that the more PWP experienced fear that others may find out about their sexual

interests, the more emotional and social problems are reported, even when controlling for potential confounds like social desirability, educational level, and age. This is in line with the assumptions from our framework, which has been informed by similar experiences of LGB people (Meyer, 2003). Therefore, similar to these sexual minority groups, higher rates of mental disorders among PWP may result from, or be exacerbated by, the stressful experience of belonging to a stigmatized group. The more PWP in our sample experienced fear of discovery, the more likely they were to indicate other factors that are hypothesized to be precursors of psychological dysfunctions (such as emotional coping and lower self-esteem, see Hatzenbuehler, 2009). For social functioning, participants with higher scores of fear of discovery also tended to report more problems related to loneliness, which corresponds to results from other sexual minority groups (Westefeld, Maples, Buford, & Taylor, 2001).

Cognitive Distortions

The FESAP also postulates a link between stigma-related stress and cognitive distortions that could not be confirmed in this research. One explanation could be that individuals with a sexual interest in children who belong to online communities or social circles of other PWP have found a way to overcome their “*isolated minority syndrome*” (Fog, 1992) and have learned appropriate ways to deal with their sexuality. In any case, PWP in this study appeared to have enough critical distance from common stereotypes about themselves to not lose their expectations of control and competence with regard to refraining from sexual acts with children. Another limitation is the applicability of the Bumby Molest Scale which was designed for offender populations and may have produced reactance in some participants. Given these restrictions, there were, however, meaningful correlations between scores on the Bumby scale and various other variables (e.g., previous convictions), supporting convergent validity of this scale even in this community sample.

Motivation to Seek Therapy

Our initial assumptions regarding the links between stigma-related stress and the motivation to pursue therapy were not confirmed empirically. Although about half of the participants appeared to be hesitant about talking to mental health practitioners (and doubted that practitioners were capable to understand their problems), their willingness to confide in a physician or psychotherapist does not seem to depend on fear of discovery or perceived social distance. More research is needed to elucidate whether this holds true for PWP with higher levels of psychopathology or living in countries with stricter reporting laws as well.

Limitations and Outlook

There are a number of factors that limit the validity and generalizability of the reported results. First of all, due to the correlational design, there is no proof for a causal relationship between stigma-related stress and the variables tested in this article. Longitudinal designs are needed to clarify the temporal order of the relationship between stigma-related stress and outcome variables such as loneliness or self-esteem. Also, because all measures were given in the same order to each participant, order effects might have occurred.

Moreover, we did not include questions pertaining to actual experiences of discrimination (e.g., threats of violence upon being discovered as having pedophilia). Although such events may not frequently occur among PWP, who mostly appear to take many precautions to keep their stigmatized identity a secret, they may nevertheless have a large impact on their lives. Hence, such experiences should be assessed in future studies in order to achieve a more complete picture of stigma-related stress among PWP.

Another important and novel aspect of the study is that the participants have been recruited from online communities instead of offender populations. Thus, we can provide the field with information about a target population whom we currently know very little about. This strategy, however, possibly entails a selection bias, as participants who volunteered for participation are likely to have different characteristics (e.g., higher education) than PWP who did not take part in the survey. Nevertheless, this is, to the best of the authors' knowledge, the first cross-sectional study to provide insight into how PWP experience and react to the stigma towards their sexual interests.

In summary, this research indicates that a number of assumptions derived from our framework appear to be valid and worthy of further consideration. Empirically testing an association between stigma-related stress and actual sexual offending risk among PWP, however, remains a difficult challenge. Due to the illegal nature of such acts, honest responding is likely to be compromised even in settings with a high degree of anonymity (e.g., online surveys), as a failure to guard anonymity (e.g., if the server is hacked or law enforcement is pressing charges) could lead to substantial social and legal repercussions. As such limitations do not exist for convicted offenders with pedophilia, researchers may test whether stigma-related variables (e.g., fear of discovery or actual experiences of discrimination) have any predictive value for sexual recidivism. For those who do not offend or have not been detected offending, researchers should focus on minimizing the potential risk of open self-reports, which may also

include negotiating a guarantee of non-prosecution from law enforcement authorities despite incriminatory information that may be obtained during the survey. Also, authors of future surveys might consider including questions that are not legally relevant, but could be used as proxies for actual offending (e.g., “I would watch child pornography, if I knew that I would not be prosecuted”) and estimating the degree of honest responding by comparing reported offense rates with offense rates obtained by using randomized response techniques (Hoffmann, Schmidt, Waubert de Puiseau, & Musch, 2015; Warner, 1965).

Regardless of whether future research substantiates the hypotheses that stigma-related experiences contribute to sexual offending risk, the severe stigmatization of PWP does have a number of implications for clinical health management practices. Mental health care professionals should be aware of the negative public reactions towards PWP (that clients may perceive as being even more hostile than they actually are), which may in turn trigger fears to be discovered. Devising strategies to help the person cope with the stigma (A. Williams, Moore, Adshead, McDowell, & Tapp, 2011) should be an adjunctive therapy goal that is likely to have at least a positive indirect influence on dynamic child sexual abuse risk factors (Whitaker et al., 2008) such as low self-esteem, ineffective coping, and social isolation (but note that these efforts should remain an important element of clinical practice even in the case that stigma-related stress is not discovered to increase sexual offense rates).

Furthermore, our findings emphasize that there exists a subgroup of PWP with considerably less problems regarding the psychological functioning deficits usually found among clinical and/or forensic samples. This discovery could contribute to a reframing of overly pessimistic attitudes concerning this group, as they are not uncommon among clinicians and researchers (e.g., T. Ward & Siegert, 2002, who wrote about “pure pedophiles” that this group “is likely to exhibit a multitude of offence-related deficits [i.e. cognitive distortions about sex with children, impaired attachment, emotion regulation, and coping deficits],” p. 339). Note, however, that our sample is not representative for PWP in general and that samples drawn from other sources potentially present different characteristics.

In light of our findings, researchers and practitioners should, nevertheless, be aware that elevated rates of psychopathology or other social or emotional deficits might, at least in part, be due to public stigma and the high levels of stress and anxiety that are associated with it. As this most probably does not only apply to PWP, de-stigmatization of mental illness or sexual minority interests in general, should remain on the agenda of any humanitarian society.

5. Challenging Stigmatization of People with Pedophilia

5.1 Study IV - Stigmatizing Attitudes towards People with Pedophilia and their Malleability among Psychotherapists in Training.

Abstract

Offering counseling and psychotherapy to patients with pedophilia is considered an essential part of sexual abuse prevention by many experts in the field. Yet, professionals' willingness to offer treatment might be compromised by stigmatizing attitudes towards these patients. In the present study, we developed and tested a 10-min online intervention (including educational material and a video about a person with pedophilia) to reduce stigma and increase motivation to work with this particular patient group. Psychotherapists in training were either assigned to the anti-stigma intervention group ($n = 68$) or the control group ($n = 69$) that received information about violence-free parenting. In the anti-stigma condition, agreement with the stereotypes controllability and dangerousness, anger, reduced pity and social distance were significantly reduced after the intervention, compared to the control group, while motivation to work with this group remained unchanged. The effects persisted, though slightly reduced in size, for perceived controllability, anger and social distance at follow-up. Our results suggest that stigmatizing attitudes, negative affective responses and social distance regarding PWP among psychotherapists in training can be positively influenced by a low-cost intervention. Practical implications of these findings for high quality health care and child sexual abuse prevention are discussed.

5.1.1 Theory

Child sexual abuse, defined as a sexual contact offense between an adult and a minor, is highly prevalent worldwide (Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). According to a recent meta-analysis, about 13% of girls and 6% of boys have experienced sexual abuse during their childhood (Barth, Bermetz, Heim, Trelle, & Tonia, 2012). As the experience of child sexual abuse is known to be associated with a large range of negative consequences for the affected children's mental and physical health (Briere & Elliott, 2003) and high costs for the community (Shanahan & Donato, 2001), research has been dedicated to find new and effective ways of child sexual abuse prevention (e.g., Zeuthen & Hagelskjær, 2013).

Many experts argued that focusing on the identification, counseling and treatment of potential offenders may be a very helpful and worthwhile approach to significantly reduce the occurrence of child sexual abuse (Beier, Ahlers, et al., 2009; Beier, Neutze, et al., 2009; Finkelhor, 2009; Osterheider et al., 2011). Although not all people who are pedophilic (i.e., have a sexual attraction to prepubescent children; Dombert et al., 2015; Seto, 2008, 2012), commit such acts, pedophilia is nevertheless one of the most important risk factors for child sexual abuse (Hanson & Bussiere, 1998). This makes PWP an obvious target for child sexual abuse prevention (e.g., psychotherapy). Yet, psychotherapists may not be willing to and/or may not feel qualified enough to contribute to these efforts.

In a German survey, more than 95% of the responding psychotherapists were unwilling to work with patients diagnosed with pedophilia for various reasons, some of them relating to negative feelings and attitudes towards this patient group (Stiels-Glenn, 2010). In a recent public health survey of 352 clinical practitioners (medical doctors, psychologists, psychotherapists and other health care personnel) in Finland, 65% rated their skills and knowledge, and 38% their personal attitudes as poor or insufficient concerning the treatment of PWP (Alanko et al., 2015). Conversely, in a survey conducted and published by a US-based network of mental health specialists and people with a sexual interest in children, a large number of PWP named the expectation to be treated in a stigmatizing way by the professional as one of the primary reasons for their previous reluctance to seek help (Kramer, 2011, August 17). Therefore, reducing stigma against PWP among health care professionals must be considered an important prerequisite for timely child sexual abuse prevention and treatment targeting PWP.

A stigma is defined as a negatively valued attribute that makes its carrier “different from others, [...] in the extreme, a person who is quite thoroughly bad, or dangerous, or weak” (Goffman, 1963, p. 3). People respond to stigmatized others on a cognitive, emotional, and behavioral level (P. W. Corrigan et al., 2012; Rusch et al., 2005a), also identified as stereotypes (e.g., the belief that someone is dangerous), prejudice (e.g., agreeing with the belief that someone is dangerous and/or feeling angry towards another person) and discrimination (e.g., refusing to talk or work with someone). Stigma against people with a mental illness is a widespread problem with serious adverse consequences for the stigmatized individuals, including, most notably, reducing quality of life and self-esteem (B. G. Link et al., 2001), and creating an obstacle for high quality health care (P. Corrigan, 2004). To prevent the harmful effects of stigmatization to take its toll on people with a mental illness, a multitude of stigma reduction interventions have been tested (Dalky, 2012; Heijnders & Van Der Meij, 2006). Such programs have focused primarily on attitudes towards patients suffering from schizophrenia or mental illness in general (Dalky, 2012), and none of them have yet addressed concerns regarding PWP (see also Jahnke & Hoyer, 2013). Despite this, the abundant literature on the effectiveness of previous anti-stigma programs can and should inform the development of new programs directed at other stigmas.

P. W. Corrigan, River, et al. (2001) suggested three strategies to categorize the literature on interventions targeting stigma of mental illness: protest, education, and contact. Protest campaigns center on “highlight[ing] the injustices of various forms of stigma and chastise offenders [i.e., stigmatizers] for their stereotypes and discrimination” (P. W. Corrigan & Shapiro, 2010, p. 910). However, it was found that such campaigns seem to be ineffective or even have a worsening effect on people’s attitudes (P. W. Corrigan & O’Shaughnessy, 2007), what may be interpreted as a sign of psychological reactance (P. W. Corrigan, River, et al., 2001). Educational strategies challenge common stereotypes and misperceptions, separating (stigmatizing) myths from reality (P. W. Corrigan, River, et al., 2001). Empirically, attitudes towards people with mental illness have been discovered to be more favorable among the more educated (B. G. Link et al., 1987), and educational interventions have been shown to decrease mental illness stigma (Penn, Kommana, Mansfield, & Link, 1999), at least in the short term (P. W. Corrigan et al., 2002). The largest and most stable effects concerning more positive attitudes towards people with a mental illness, however, appear to be achieved by enabling contact between members of the general public and people with a mental illness (P. W. Corrigan, River, et al., 2001). In general, people who report being familiar with people

with a mental illness showed a more favorable reaction to this group (Angermeyer & Dietrich, 2006; P. W. Corrigan, Edwards, et al., 2001; B. G. Link & Cullen, 1986).

Pedophilia belongs to the most stigmatized and rejected mental disorders (Feldman & Crandall, 2007). Fourteen percent of the participants in a large and heterogeneous German sample agreed that PWP should better be dead and 39% recommended imprisonment, even though the instruction emphasized that the individual in question had never committed a sexual (or other) crime (while only 3% or 5%, respectively would respond similarly when alcohol abusers are concerned; Jahnke et al., 2015). Among an English-speaking sample, as much as 27% agreed that PWP should better be dead and 49% recommended imprisonment (compared to 9% or 6%, respectively demanding similarly drastic measures for sexual sadists, or 21% and 8%, respectively, when people with antisocial tendencies are concerned; Jahnke et al., 2015). Moreover, many members of the population falsely believe that pedophilia is a controllable disorder in the sense of Weiner (1985), implying that PWP can exert, at least to some degree, volitional control over whom they feel sexually attracted to (Jahnke et al., 2015). Hence, these individuals may not see pedophilia as a true mental disorder (see also Imhoff, 2015), and are thus unable or unwilling to afford it the same level of concern or deservingness of treatment that they do to other mental disorders. Even more problematic, the public seems to be uninformed about the conceptual differences between pedophilia and child sexual offending, assuming that the vast majority of, or even all PWP irrevocably engage in sexual activities with minors (Feelgood & Hoyer, 2008; K. McCartan, 2004; K. F. McCartan, 2010), although this is not the case. While we have very little information about PWP who never commit sexual crimes, this group must be expected to exist and to potentially make up a large proportion of PWP as a population (Goode, 2010; G. Schmidt, 2002).

Given the huge stigma directed at them, we expect many PWP to be reluctant about disclosing their sexual interests and potentially related problems to other people, including health care professionals. Although people with mental health training generally hold more positive attitudes towards people with a mental illness than those without special training (Peris et al., 2008), they are not immune to stigmatizing attitudes that exist in their social environment and may be less motivated or capable to offer high quality treatment as a result (Schulze, 2007). In a German sample of psychotherapists, only very few participants agreed to be willing to treat PWP and a number of them justified this decision with negative attitudes towards this group (Stiels-Glenn, 2010). Thus an intervention targeting such overly pessimistic or stigmatizing views could help increasing their willingness to offer therapy. While it needs to be addressed

that reluctance to treat PWP could be due to numerous other reasons, most prominently a lack of knowledge or experience in the field (Stiels-Glenn, 2010), an anti-stigma intervention could nevertheless be effective in sensitizing practitioners to the needs and problems of such clients. This in turn might motivate therapists to engage in specialized training about the treatment of PWP, or to acquire the knowledge that has previously been missing. Also, very importantly, this could help practitioners to establish a better therapeutic relationship with their patients (which may in turn promote therapy success; Martin, Garske, & Davis, 2000).

At this point, we would like to address ethical concerns that fellow researchers or practitioners might see in creating an anti-stigma intervention for the stigma against PWP: We do not think that child sexual abuse is acceptable in any way, nor do we believe that PWP never present any danger to children. On the contrary, we feel that our efforts to de-stigmatize pedophilia among health care professionals can contribute to the goal of protecting children from sexual abuse. In this respect, health care providers, such as psychotherapists, can make a huge contribution to children's safety if they accept and approach PWP in a respectful way without condoning behaviors that are against the law and/or might put children at risk of harm (Jahnke & Hoyer, 2013; Jahnke et al., 2015; Seto, 2012). In line with these assumptions, recent data from a German prevention project (Beier et al., 2014) revealed that CBT approaches could indeed change dynamic risk factors for sexual offenses against children among $n = 53$ undetected PWP (while no changes occurred for waiting list controls, $n = 22$). With regard to child sexual offending, 20% of previous offenders continued abusive behaviors, while 0% of the non-offenders with pedophilia started offending during the one-year treatment project (note that significant decreases in offending could not be detected due to low base rates).

The present study

We argue that a stigma reduction program for psychotherapists that addresses stigma against PWP can be helpful to correct stereotyped assumptions about PWP especially with regard to dangerousness and controllability, reduce negative feelings and social distance towards PWP, and increase willingness to offer therapy and to specialize in treatment of PWP. To test these hypotheses in the most rigorous way, we designed a randomized controlled trial, where a sample of psychotherapists received an online link to either the anti-stigma intervention or received information about an unrelated program on responsible parenting (control group). To maximize the effectiveness of the intervention, we combined educational and contact strategies. The need for an educational focus in the intervention is documented in Beier,

Hartmann, & Bosinski (2000) who detected a massive lack of qualified psychotherapists for patients with pedophilia in Germany. According to these authors, curricula for psychotherapists in training place little, if any, weight on the diagnosis and treatment of sexual disorders. In order to provide a sense of contact with a real individual behind the label “pedophilia” whilst guaranteeing safety and anonymity for this person, we included a video about a young man with a sexual interest in children. As recent evidence indicates (Clement et al., 2012; Reinke, Corrigan, Leonhard, Lundin, & Kubiak, 2004; Ritterfeld & Jin, 2006), the presentation of a person with a mental illness on video-tape (indirect contact) is helpful in reducing stigma, though typically yielding smaller effect sizes compared to direct face-to-face contact (P. W. Corrigan et al., 2012).

5.1.2 Methods

Participants

Psychotherapists in training were approached at eight German CBT institutes and received invitation letters to our study via their respective postgraduate institute ($N = 137$). In some cases, they were additionally contacted by a member of the research staff during psychotherapy courses. All participants gave informed consent. Participants were mostly female (82.5%) and between 24 and 53 years old ($M = 30.34$, $SD = 5.39$). Some affirmed having had contact with PWP in their personal life (7.4%) or professionally as, for instance, a member of the treatment staff in a hospital or clinic (18.2%). The majority of participants did not have children of any age (78.8%) or below the age of consent in Germany, which is 14 (82.4%). According to student statistics from one of the participating institutes (IAP-TUD GmbH), the participants in our sample compare to other psychotherapists in training with respect to age, gender, and parental status. In order to avoid making a sizeable number of participants identifiable (and thus creating ethical problems as well as compromising willingness to give truthful responses), we did not assess further information, such as the name of the institution that each participant belonged to or detailed information regarding their level of training.

Procedure

Questionnaires and interventions were implemented online using the software package SoSci Survey (Leiner, 2013). Data were collected before the anti-stigma /control intervention (pretest), directly after the intervention (posttest), and after a time period of more than one

week but less than two months (follow-up). The two data sets were linked by a code that participants created themselves. For the follow-up survey, psychotherapists in training received login information one week after the pre/post-test invitations had been sent out, (again, via their postgraduate institutes). Participants received no payment. Sixty-eight psychotherapists in training were assigned to the anti-stigma intervention group and 69 to the control group. Among the psychotherapists in training who completed pre- and post-test assessments, 35.8% (29.4% in the anti-stigma condition and 42.0% in the control condition) dropped out before the follow-up test or did not comply with the required intermission period of at least one week between the first two assessments and the follow-up test. The time interval between post assessment varied considerably, ranging from one week to 64 days ($M = 18.33$, $SD = 12.78$).

Anti-stigma and control intervention

The education component of the anti-stigma intervention consisted of short texts challenging typical myths about pedophilia by describing it as a condition that one can neither choose nor change (controllability stereotype), and that, for many PWP, does not lead to child sexual abuse or child pornography offenses (dangerousness stereotype). Further texts provided general information about diagnostic criteria and therapeutic interventions. Video-based contact was implemented using excerpts from the Austrian documentary “Outing” (Moser, 2012) where a young male student with an unpixelated face talks about his sexual interest in children and his therapeutic experiences (mins: 02:14 – 03:38; 08:25 – 09:23; 15:45 - 16:47). Video footage included, for instance, the following statement, “In the years before [my stationary psychotherapy] I thought about killing myself regularly. Mainly because of my pedophile fantasies.” Another short section that we used showed the man talking to his psychotherapist about his desire to be accepted by others and his intention to never commit sexual offenses with children (mins: 42:39 - 45:04).

Ideally, a control condition should share as many characteristics with the intervention group as possible. We designed a control condition that was similar to the anti-stigma condition in duration, content, and structure by providing information related to child well-fare and therapy. The contact component consisted of a short clip produced and broadcasted by a major German TV channel (Zweites Deutsches Fernsehen, 2012). More specifically, participants in the control condition received information about violence-free education and a course specifically designed for parents (“Starke Eltern, starke Kinder” [“Strong parents, strong

children”]) to teach family conflict-management skills and promote violence-free parenting. The footage included short interviews with the treatment staff, the parents, and the children that were involved in this program (e.g., one mother says “I was so angry that the only thing I could do was to lock myself in my bedroom and hope for someone else to come and calm down me and the child”).

Both experimental conditions were similar in length (anti-stigma intervention: 937 words and 6 mins of video footage; control condition: 874 words and 5:08 mins of video footage), and would take approximately 9:45 mins (anti-stigma intervention) or 8:38 mins (control condition) to complete for a reader with an average reading speed (i.e., about 250 words per min; Jackson & McClelland, 1975).

Instruments

The stigma inventory

The stigma inventory measures stereotypes (controllability and dangerousness), affective responses (sympathy and anger) and discriminatory intention (social distance) as different aspects of stigma against PWP (see Table 16 for items). The scales assessing anger, perceived controllability, and social distance were taken from a recent study by Jahnke et al. (2015), where the latter two have shown high reliability (Cronbach’s $\alpha \geq .82$; the variable anger consisted of only one item). The newly developed 4-item dangerousness scale showed acceptable reliability in this survey at pretest ($\alpha = .70$) and in an earlier testing on psychotherapy students (results available from the authors), while scores at posttest and follow-up were lower and require cautious interpretation ($\alpha = .66$ and $.61$ at posttest and follow-up, respectively). Low scores on the dangerousness scale do not imply that the respondents believes PWP to be harmless, but indicate awareness of the fact that a sexual interest in children does not necessarily lead to corresponding sexual and criminal behavior. Every item could be rated on a 7-point Likert scale (0-6) ranging from *do not agree at all* to *completely agree*. Throughout the questionnaire, PWP are described as *people with a dominant sexual interest in children*.

Therapy Motivation Scale

We developed a Therapy Motivation Scale to assess therapists’ willingness to treat PWP who have never (item 1) or have already (item 2) committed a sexual crime or to participate in

training to gain more knowledge about the treatment of PWP (item 3), respectively. Internal consistency of the scale was calculated for pretest, posttest, and follow-up data and proved to be consistently high ($\alpha = .85, .83, .84$). Participants were asked to indicate their agreement with these statements on a 7-point Likert scale (0-6) with response categories ordered from *do not agree at all* to *completely agree*.

Assessing participants' satisfaction with the anti-stigma program

As part of the formative evaluation process, we explored participants' satisfaction with the anti-stigma program using a number of simple items concerning the adequateness of the information content, the interestingness of the texts and the video, the personal gain in knowledge, and the relevance for one's own professional work (e.g., "How would you rate the information content of the texts?" with a 3-point response scale - *too low, optimal, too high*). There were no corresponding questions in the control group.

Statistical analysis

To account for selective dropout across intervention groups and time, we fitted multilevel mixed models (Skrondal & Rabe-Hesketh, 2004). These models have recently gained popularity because they make much weaker assumptions than traditional procedures for dealing with missing values, particularly selective dropout (e.g., complete case analysis in repeated measurement ANOVA and LOCF (see Schafer & Graham, 2002)). Using the expectation-maximization (EM) algorithm (Little & Rubin, 2002) they allow, if saturated for the joint effect of group and time, for the occurrence of group-specific dropout across time and consider the full data; i.e., information from all assessments of a patient irrespective of potential missings at other assessments. We used the XTMIXED procedure of Stata, version 12.1 (Stata Corp., 2012), fitted models with two dummy variables for the main effect of time, one for the main effect of group and two for the joint effect of time and group. Standard errors of regression coefficients were estimated with the robust Huber-White sandwich method, and random intercept models were fit to consider individual heterogeneity in outcomes.

Based on the saturated model we computed marginal predictions for both within subject effects and between subject effects (anti-stigma intervention vs. control intervention). Statistical significance was defined at the two-sided 5% level. We did not lower the alpha threshold for each outcome, as we tested separate hypotheses (see also Bender & Lange, 2001; Perneger, 1998).

5.1.3 Results

As expected due to randomization, there were no significant between-group differences at baseline for age ($t(125.897) = 1.721, p = .088$), gender ($\chi^2(1) = .39, p = .501$), having children below the age of 14 ($\chi^2(1) = .623, p = .658$), and the time interval between post assessment and follow-up assessment ($t(86) = -.078, p = .938$). Descriptive analyses of outcome variables at pretest, posttest, and follow-up level can be found in Table 17. A comparison of outcome variables showed no significant differences between control group and intervention group at pretest level (all t 's < 1.052 , all p 's $> .295$; see Table 17). Further analyses showed that there are also no significant differences between the control group and the treatment group at pretest level and with respect to age, gender, parental status, and time interval when non-completers are excluded from the analysis.

Participants' acceptance of the anti-stigma program was excellent, with the majority of participants agreeing that the written information (72.1%) and the video (86.8%) were highly interesting. Further, many agreed that the program has helped them to improve their knowledge (29.4% low or very low improvement, 33.8% moderate improvement, 36.8% high or very high improvement).

It was common for participants to rate the provided information as relevant for their professional work (14.7% low or very low relevance, 23.5% moderate relevance, 61.7% high or very high relevance). The quantity of information that we delivered within this 10-min intervention was perceived as optimal by 85.3%, whilst 13.2% would have preferred to have received more information. Only one person reported that he or she would have preferred less information.

Pretest levels of agreement to each item from the stigma inventory are displayed in Table 16. Compared to the responses from the general public reported in Jahnke et al., 2015, this sample of psychotherapists in training held considerably less stigmatizing views towards PWP (with, e.g., less than 3% agreeing that sexual interests in children is something that one can choose, and only 40% reporting to feel anger when they think of a person with pedophilia). With more than 40% of this sample indicating willingness to accept PWP in their neighborhood, and only a very small minority demanding drastic interventions (such as imprisonment) for PWP that have never committed a criminal offense, social distance also appeared to be much lower compared to the aforementioned results from the general public. Furthermore, a large part of our sample (80%) reported to be willing to treat PWP who have never offended before, and

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about half as much would also be willing to treat PWP who have committed a sexual crime in the past. Lastly, with 79% agreeing with the respective item, the motivation to attend vocational courses in order to learn more about the treatment of PWP was equally high.

Table 16. Agreement (in percent) with items at pretest level ($N = 137$)

Item	agree	uncertain
Controllability:		
A dominant sexual interest in children is something that one can choose.	2.19	6.57
People with a dominant sexual interest in children have taken a deliberate decision to have these interests.	2.19	5.11
People have the choice whether they have a dominant sexual interest in children or not.	5.84	9.49
Dangerousness:		
Many people with a dominant sexual interest in children never have sexual contact with a child.	49.64	32.12
Somebody with a dominant sexual interest in children is a perverted sexual predator.	9.49	16.79
A dominant sexual interest in children will sooner or later lead to child sexual abuse.	18.25	22.63
People with a dominant sexual interest in children can control their sexual behavior towards children.	49.64	26.28
Affective reactions:		
When I think of a person with a dominant sexual interest in children I feel sympathy.	37.23	21.9
When I think of a person with a dominant sexual interest in children I feel anger.	40.15	17.52
Social distance^a:		
Would have these persons as friends.	21.90	21.9
Would accept these persons in my neighborhood.	40.88	18.25
Would accept these persons as colleagues at work.	48.18	14.6
Would talk to them.	80.29	10.95
These persons should be incarcerated.	2.92	13.14
These persons should better be dead.	0.73	3.65
Motivation to work with PWP:		
I am willing to offer psychotherapy to people with a dominant sexual interest in children, who have never committed a sexual crime.	79.56	9.49
I am willing to offer psychotherapy to people with a dominant sexual interest in children, who have committed a sexual crime.	37.96	16.79
I would like to attend vocational courses to treat people with a sexual interest in children.	78.83	7.3

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

Table 17. Descriptive analysis of observed and model-based outcome variables with *t*-test for group differences at pretest level

Variable	Control group (<i>n</i> = 69)				Treatment group (<i>n</i> = 68)				Between-group differences (pre-test)	
	Pre-test	Post-test	FU ¹	FU ²	Pre-test	Post-test	FU ¹	FU ²	<i>t</i> -test	<i>p</i>
Control.	<i>M</i> (<i>SD</i>) 1.01 (1.14)	<i>M</i> (<i>SD</i>) 1.02 (1.16)	<i>M</i> (<i>SD</i>) .98 (1.08)	<i>M</i> 1.06	<i>M</i> (<i>SD</i>) .95 (.99)	<i>M</i> (<i>SD</i>) .45 (.60)	<i>M</i> (<i>SD</i>) .53 (.53)	<i>M</i> .62	<i>t</i> (<i>df</i>) .35 (135)	<i>p</i> .727
Danger.	2.32 (.96)	2.37 (.89)	2.11 (.92)	2.17	2.10 (.99)	1.72 (.97)	1.78 (.92)	1.84	1.27 (135)	.205
Symp.	2.81 (1.51)	3.00 (1.57)	3.25 (1.53)	3.16	3.01 (1.46)	3.84 (1.46)	3.71 (1.41)	3.50	- .80 (135)	.425
Anger	3.07 (1.97)	3.04 (1.94)	2.53 (1.85)	2.51	2.75 (1.61)	1.88 (1.61)	1.69 (1.40)	1.96	1.05 (130.536)	.295
SD	2.02 (1.36)	1.95 (1.35)	1.95 (1.24)	2.06	2.06 (1.08)	1.62 (1.00)	1.68 (1.08)	1.80	- .19 (129.442)	.851
MT	4.15 (1.53)	4.08 (1.59)	3.88 (1.59)	3.87	4.03 (1.65)	4.15 (1.54)	4.05 (1.53)	3.93	0.43 (135)	.672

Note. All scales range from 0 (“do not agree at all”) to 6 (“completely agree”), FU = Follow-up, Control. = Controllability, Danger. = Dangerousness, Symp. = Sympathy, SD = Social Distance, MT = Motivation to offer therapy

¹Because of drop-outs, only *n* = 40 (control group) and *n* = 48 (intervention group) completed the follow-up assessment

² predicted values

We conducted analyses for changes within the control group and the intervention group individually, and regarding the interaction of both groups based on mixed effect models (Table 18). As the outcome variables anger, social distance, and motivation to work with PWP deviated substantially from the normal distribution, we conducted the same analysis for both the original dataset and a second version of the dataset in which we had employed logarithmic square transformations in order to achieve normality. As both analyses yielded similar results for social distance, we only report results for the original dataset, as they are easier to interpret. For the two other variables, we report results based on log-transformed data.

Looking at within-group differences from pretest to posttest, there was a significant effect indicating a reduction of agreement with stereotypes, of negative affective responses, and social distance in the anti-stigma group. There was no change regarding the motivation to work with PWP. The differences between baseline measures and follow-up measures for the anti-stigma group were less pronounced, but effects remained significant for all outcome variables except motivation to work with PWP.

Table 18. Model-based (mixed effect models) coefficients, significance values, confidence intervals, and effect sizes for the change in main outcomes for control group ($n = 69$) and intervention group ($n = 68$)

Outcome	Assessment ¹	within control group			within treatment group			treatment x control group					
		Coef	<i>p</i>	95% CI	<i>d</i>	Coef.	<i>p</i>	95% CI	<i>d</i>	Coeff.	<i>p</i>	95% CI	<i>d</i>
Controllability	Posttest	.01	.80	[-.10, .13]	.01	-.50	< .01	[-.66, -.34]	-.47	-.51	< .01	[-.70, -.31]	-.48
	Follow-up	.05	.60	[-.14, .24]	.05	-.33	< .01	[-.52, -.14]	-.31	-.38	< .01	[-.65, -.11]	-.36
Dangerousness	Posttest	.05	.41	[-.07, .17]	.05	-.38	< .01	[-.52, -.24]	.39	-.43	< .01	[-.62, -.24]	-.44
	Follow-up	-.14	.25	[-.38, .10]	-.15	-.26	< .01	[-.46, -.07]	-.27	-.12	.44	[-.43, .19]	-.13
Sympathy	Posttest	.19	< .05	[.01, .37]	.13	.82	< .01	[.61, 1.04]	.56	.64	< .01	[.36, .91]	.43
	Follow-up	.35	.07	[-.03, .72]	.23	.48	< .01	[.18, .79]	.33	.14	.57	[-.34, .62]	.09
Anger*	Posttest	.07	.53	[-.14, .27]	.05	-.64	< .01	[-.89, -.38]	-.52	-.70	< .01	[-1.03, -.38]	-.57
	Follow-up	-.11	.41	[-.37, .15]	-.09	-.57	< .01	[-.81, -.33]	-.46	-.46	< .05	[-.82, -.11]	-.38
Social Distance	Posttest	-.07	.12	[-.16, .02]	-.06	-.45	< .01	[-.55, -.35]	-.37	-.38	< .01	[-.51, -.24]	-.31
	Follow-up	.04	.73	[-.18, .26]	.03	-.27	< .01	[-.44, -.09]	-.22	-.30	< .05	[-.58, -.02]	-.25
Motivation to work with PWP*	Posttest	-.01	.80	[-.09, .07]	-.01	-.04	.43	[-.15, .06]	-.05	-.03	.64	[-.16, .10]	-.04
	Follow-up	.10	.20	[-.05, .25]	.13	.05	.55	[-.12, .23]	.07	-.05	.69	[-.27, .18]	-.06

Note. Coeff. = Coefficient for change from base level for factor levels, CI = confidence interval, PWP = people with pedophilia.

¹Outcome variables at posttest or follow-up were compared to pretest levels as reference.

* Results based on log-transformed data.

In the control group, sympathy scores rose significantly from pretest to posttest (and failed short of reaching significance in the follow-up assessment with $p = .07$), while all other outcome variables did not change in a significant way. Between-group comparisons indicated statistically significant differences between anti-stigma and control group in the outcome variables perceived controllability (from pretest to posttest and follow-up), perceived dangerousness (only from pretest to posttest), sympathy (only from pretest to posttest), anger, and social distance (both from pretest to posttest and follow-up). Across all significant outcomes, participants who had received the anti-stigma intervention were less likely to agree with stereotypes, reported a more favorable affective response, and less social distance than participants from the control group. According to Cohen's guidelines, significant effects were small to medium-sized. Further statistical analyses also revealed that having a child under the age of 14 did not impact the effectiveness of the intervention for all tested outcome variables.

5.1.4 Discussion

The present study was designed to test the effect of an anti-stigma intervention on attitudes towards PWP and the motivation to offer mental health services among psychotherapists in training. Results revealed a stigma-reducing effect of the intervention on all outcomes (but not on motivation to work with PWP) compared to the control group. Most effects remained significant until the follow-up, although slightly diminished. Furthermore, the participating psychotherapists in training were overall satisfied with the program and considered it to be interesting, informative, and of high relevance for their professional work. Taking into account the brevity, simple applicability, and low costs of the intervention, this is a very promising result.

The anti-stigma program was partially successful in correcting stereotyped assumptions about PWP. Regarding participants' baseline-level beliefs concerning controllability of pedophilia, we found that the majority of our sample did not agree that pedophilia is something that one can choose. Nevertheless, people in the anti-stigma group were even less likely to believe in the controllability of sexual interests in children after receiving the intervention compared to the control group. While the effect remained significant until the follow-up assessment, the practical relevance of this result is unclear, as, at least in this sample of psychotherapists in training, only a very low number of participants held beliefs regarding controllability that needed correction from a stigma reduction perspective. The program may, however, have succeeded in making some participants more certain of their previous (correct) beliefs.

Participants' ratings regarding the actual threat that PWP pose to children were mixed. While most participants understood pedophilia and sexual abuse as distinct phenomena that are not necessarily related (which is in line with scientific evidence; Dombert et al., 2015; Seto, 2008), a considerable number was uncertain or did not agree. Although the anti-stigma program helped to correct the stereotyped mix-up of legal and psychopathological terms, the effects were short-termed. The fact that not all effects remained stable until the follow-up assessment is, however, not an uncommon finding in the literature on stigma reduction (Holzinger, Dietrich, Heitmann, & Angermeyer, 2008; but note that the failure to detect an effect at follow-up may have been due to low reliability of the scale). To sustain the effects, long-term (or repeated) multi-faceted interventions are needed, particularly since attitudes that have developed over a long time tend to be stable, so new information is often remembered in a way that is consistent with previous beliefs (P. W. Corrigan & Penn, 1999; Dalky, 2012; Rusch et al., 2005b). We suggest including the evaluated online intervention as one component of a broader educational schedule about pedophilia (e.g., in psychotherapy training). Additionally, collaborating with experienced mental health professionals who are involved in therapy of PWP could offer a more interactive experience as well as the opportunity to address individual concerns.

The study furthermore showed that the affective responses sympathy and anger and the discrimination intention social distance towards PWP could be changed with an anti-stigma intervention. This is of high importance, as negative affective reactions and discrimination intentions are likely to complicate the development of a reliable and empathic therapeutic relationship. Maintaining an appreciative and respectful mindset towards PWP despite their risk of committing sexual offenses against children is a competence that is certainly necessary (although not necessarily sufficient) for high quality treatment.

This view is in line with our finding that the anti-stigma program, unexpectedly, failed to influence willingness to offer therapy and to specialize in treatment of PWP. While this effect could have been due to an inability of our instruments to detect such changes (see below for an in-depth discussion of floor and ceiling effects), it is also possible that stigma has only a subordinate effect on a therapist's decision to offer or decline treatment compared to other variables. More research addressing the reasons for rejecting to offer therapy for PWP, such as a lack of knowledge about this group (Alanko et al., 2015; Stiels-Glenn, 2010), is needed to help reduce treatment barriers. In this regard, we would propose an intervention addressing stigma and providing evidence-based training for the treatment of PWP. Future research

should also consider that a lack of motivation to offer treatment to PWP might be triggered by psychotherapists' fears to be stigmatized themselves.

It could be a sensible approach for future stigma research to ask whether participants would be willing to offer therapy, given that they had the necessary knowledge and the option to be supervised by an expert in this field. Participants' ratings concerning their motivation to work with PWP may also underestimate the typical rejection rate of PWP seeking treatment, as trainees may not, or only in rare cases, be given permission by their employers or psychotherapy institutes to decline treatment, which may promote a less selective attitude than the one that a typical self-employed psychotherapist working in the public health system might have. Also, psychotherapists in training may be more responsive to unusual cases (that they view as training opportunities) than experienced psychotherapists. These reasons (among others that will be discussed below, e.g., self-selection bias, social desirability) may explain why Stiels-Glenn's results paint a bleaker (and probably more realistic) picture of outpatient treatment availability for PWP in Germany (with only 4.7% of responding psychotherapists willing to offer treatment).

One of the major strengths of this research lies in the randomized controlled approach that makes it possible to assign attitude change to the anti-stigma program. In addition, the implementation of a follow-up assessment enabled an evaluation of the stability of these effects. Furthermore, the presented anti-stigma intervention is, to our knowledge, the first attempt to apply evidence-based stigma reduction strategies to challenge stigmatization of PWP. To achieve optimal results, the program combined educational and contact strategies of stigma reduction that have been shown to be the most advantageous avenue to reduce stigma, with contact most likely being the more important component of the two (P. W. Corrigan et al., 2012; Rusch et al., 2005b). Indirect contact established via a video, as in this study, has advantages in terms of broad dissemination at a cost-effective level but is inferior to direct contact with regard to effect sizes (P. W. Corrigan et al., 2012). In this context, however, direct contact would have been likely to create problems from a practical and ethical standpoint, as a person with pedophilia might be highly suspicious of disclosing to a group of strangers, even psychotherapists (and justifiably so, given recent results on the pervasiveness of extreme stigma against PWP provided by Jahnke et al., 2015). Therefore, we consider indirect contact via videotape, like in the present study, to be the best (and most feasible) strategy to challenge stigma against PWP.

Yet, this study has some limitations that need to be addressed. As of now, the intervention program was tested only in a sample of psychotherapists in training, which limits generalizability of the results of this study. The sample we assessed is not representative for psychotherapists in training and cannot be used to derive general conclusions for this population (or other mental health specialists). Furthermore, the data indicated that our sample differed systematically from the majority of their fellow students and colleagues. Despite their (relatively) young age and short professional career, almost 20% of our study participants reported prior experiences with PWP. Also, most psychotherapists in training were not averse to work with PWP and showed neutral or moderately positive attitudes towards this group at pretest level. Hence, our data strongly suggest a sampling bias (Bayar, Poyraz, Aksoy-Poyraz, & Arikan, 2009), with psychotherapists being more likely to take part in the experiment if they already had a high personal or professional interest in the topic or already had relatively positive attitudes towards PWP. Psychotherapists in training who are strongly biased against PWP, or against even the subject matter in the control condition, however, might be motivated to not answer the survey due to disinterest or frustration with the topics presented. This sampling bias may not only threaten generalizability but also internal validity through floor or ceiling effects (as a decrease or increase in a dependent variable cannot be detected if participants already pile up at the low or high end of the scale). Therefore, we consider it likely that administering the anti-stigma program to an unselected sample of psychotherapists (e.g., during a psychotherapy course or an information session for the treatment staff of a hospital) would lead to an even greater decrease of stigma. Put into a special position by strict patient confidentiality laws in Germany, a psychotherapist might be among the few people, to whom a person with pedophilia could disclose his (or her) sexual interests, even when the person has committed undetected sexual offenses in the past. While anti-stigma interventions educating the general public about PWP could have merit, targeting a specific professional group whose attitudes, affective and behavioral reactions substantially determine to what extent PWP engage in professional help can be considered of key importance “in terms of the broad stigma change picture” (P. W. Corrigan et al., 2012, p. 967). Yet, police officers, judges, or other professionals working in the criminal justice system, mental health professionals like physicians or nurses, or relatives of a patient with pedophilia could also be considered meaningful target groups for stigma change. More research is needed to find out if this program is similarly effective for these groups.

Furthermore, like many controlled stigma reduction experiments, this study does not provide a measure for an actual behavioral change (P. W. Corrigan et al., 2012; Dalky, 2012). It is, for

instance, not clear whether participants who completed the intervention would show more empathy to a real client with pedophilia or establish a stronger therapeutic alliance with this person in a real therapeutic setting. Further studies would be needed to determine whether the anti-stigma intervention has any measureable real-life consequences (such as more treatment adherence or client and/or therapist satisfaction).

Other methodological limitations concern the lack of standardization and experimental control in this online experiment (e.g., no control over monitor size, sound quality, the participants' physical and psychological condition, or activities he or she might be engaged in during the assessment such as eating or listening to music) and the coordination of follow-up assessments. Yet, since participants were randomly selected to anti-stigma and control group and there was no difference regarding the time interval from posttest to follow-up test between groups, these two standardization problems seem to be relatively innocuous for internal validity.

Another unexpected result of our study was the observation that sympathy significantly increased in the control group from pretest to posttest, while their endorsement of stereotypes, other reported affective responses, and social distance remained unchanged. As the control condition was designed to not influence stigma towards PWP this effect deserves an explanation, given that this was not a chance finding or methodological artifact. It is possible that drastic opinions, such as the idea that somebody would want another person to be dead because of his or her sexual preference, may have prompted participants to feel more empathic towards PWP, while other not prejudicial ideas remained unchallenged.

Decreasing participants' tendency to give social desirable responses is of particular importance in every study that is based on self-ratings. Young psychotherapists are likely to recognize being generally empathetic, open-minded and non-judgmental towards people with mental disorders as an ideal they ought to fulfill to be respected and successful as mental health practitioners. While we cannot rule out that the mostly favorable reactions towards PWP among this sample of psychotherapists in training are due to social desirability bias, we approached this issue by assessing attitudes in a web-based format that is usually associated with a higher perceived anonymity compared to traditional pen-and-paper questionnaires (Kays et al., 2012; P. Ward et al., 2012).

In many countries (e.g., the US, the UK, and Canada) it is much more likely that treatment will be offered post offense, in part because of mandatory reporting. German law, on the other

hand, does not require psychotherapists to report past offenses. In fact, doing so would be against the law for a therapist, and the act would be treated as a serious breach of secrecy. Therefore, at the moment our study is arguably more relevant for German practitioners. Yet, there exists a subgroup of PWP who do not sexually abuse children and some of whom are clearly worried about offenses that they have not yet committed, but are at risk of committing (Cantor, 2014; Schaefer et al., 2010). This group might be eligible for treatment before an offense occurs even in countries with mandatory reporting laws.

Most psychotherapists, however, are trained too little to offer high quality therapy to patients with pedophilia, and the intervention presented here cannot (and is not meant to) substitute this lack of knowledge. Nevertheless, we believe that psychotherapists who are sensitized to the public health dilemma of PWP are likely to react with more empathy and understanding when a client with pedophilia asks for help (and more willing to assist the client in the search of a more qualified psychotherapist if needed). At present, specialized community-based treatment programs for PWP are, however, limited in number and most only offer group sessions (Beier, Ahlers, et al., 2009; Beier, Neutze, et al., 2009). More treatment options and more/better qualified psychotherapists are clearly required to help PWP deal with their sexual interest in ways that are not illegal and/or harmful to children.

6. General Discussion

6.1 Summary of the Main Findings

6.1.1 Overview

The overarching aim of this dissertation was to shed light on the blind spot of stigma research that is stigma against PWP. The research focus was both conceptual and empirical, as a theoretical model for the study of public attitudes as well as PWP's perception of and reaction to stigma was developed to guide subsequent data collection. To provide a wide knowledge base on this hitherto neglected research area, the studies presented in this dissertation targeted a broad range of topics related to stigma research, including public stigma, self-stigma, and interventions to reduce stigma. To these ends, we used a variety of methods (literature review, surveys, and controlled experiments) in multiple settings (face-to-face contact or online research), recruiting various participant groups (nonprobability samples of people from the general population in several countries, self-identified German-speaking PWP, and German psychotherapists in training). In the following section, the main findings of all studies are summarized.

6.1.2 Previous Literature

A thorough search of the literature of stigma against PWP revealed a lack of systematic studies. Nevertheless, the few studies that could be identified hinted that pedophilia is highly stigmatized (with one study even providing evidence that it might be more stigmatized than 39 other conditions, except for antisocial personality disorder) and that stigma negatively affected PWP (some even to the point of considering suicide). Yet, these findings could only be considered preliminary and, for conceptual and methodological reasons, required cautious interpretation. In fact, most studied samples were small and highly selective (e.g., surveying only university students). Also, the question of how participants would react to pedophilia as a specific type of sexual interest - and not the sexually abusive behavior towards minors which is often referred to under the same term - was not addressed in any of the reviewed studies. The review furthermore identified a lack of studies assessing stigma towards PWP among subgroups especially relevant for the management of pedophilic disorder, particularly mental health professionals.

6.1.3 Public Stigma

Studies I and II indicated that PWP face a higher stigma among the German population and English-speaking MTurk workers than other severely rejected groups (people who abuse alcohol, sexual sadists, and people with antisocial tendencies). The low numbers of participants reporting to be willing to accept non-offending PWP and the relatively high numbers who would agree that these people should be dead or locked away underlined the notion that pedophilia is indeed among the most stigmatized human characteristics. In contrast to previous studies identified in the literature review, participants were instructed to think about pedophilia as a psychological rather than a legal phenomenon. Taken together, these two studies sampled a total of $N = 1055$ participants. Both samples were heterogeneous with respect to participants' ages, gender, and socioeconomic backgrounds.

Study I furthermore showed that lower levels of education and higher RWA scores were correlated with stigma against PWP, which is in line with previous studies of stigma against other groups (e.g., Angermeyer & Dietrich, 2006; Whitley & Lee, 2000). Contrary to previous studies in other populations (e.g., Angermeyer & Dietrich, 2006), lower age was associated with *higher* social distance towards PWP. As was typically found for the two other groups as well, attributions of controllability led to increased anger and decreased pity for PWP (Weiner et al., 1988). People who react with higher anger and lower pity and who have a stronger belief that such pedophilic interests are very dangerous have a stronger desire for social distance towards PWP, which is similar to findings from past studies regarding the stigma of mental illness (B. G. Link et al., 1999; Siltan et al., 2011). The strongest predictors of social distance towards PWP were high RWA, anger, and reduced pity.

6.1.4 Stigma-Related Stress and Associated Problems

Study III provided evidence regarding how an ad hoc sample of self-identified PWP perceives and reacts to stigma. The data indicated that PWP overestimated social distance, as compared to the results from Study I and II. Moreover, the majority in our online sample experienced fears that their sexual interests could be discovered by other people, and only about four percent reported that they were not trying to conceal this fact from at least one other person. There were some indications for self-stigma that supported hypotheses from the FESAP (see Chapter 4.3.1 for a detailed description): The more PWP agreed to experience fear of discovery, the more problems they reported on an emotional or social level (e.g., more psychopathological symptoms, increased loneliness and emotion-focused coping, and less

self-esteem). However, the stigma experience did not seem to affect cognitive distortions or PWP's motivation to seek treatment.

6.1.5 Effectiveness of a Stigma-Reduction Intervention

Results from Study IV revealed that stigma towards PWP can be changed with an education and contact based anti-stigma intervention among psychotherapists in training. Contrary to previous studies on stigma towards PWP, this investigation employed a randomized controlled experimental design. Participants who received the anti-stigma intervention showed less agreement with stereotypes, less negative affective reactions, and more willingness to accept PWP on different levels of interpersonal contact directly after the intervention compared to the control group. When participants were contacted again for the follow-up assessment approximately three weeks after receiving the intervention, the stigma reduction effects remained significant for the controllability stereotype, anger, and social distance compared to the control group. Contrary to previous expectations, the motivation to offer treatment to PWP could not be influenced by the anti-stigma intervention. Also, German psychotherapists in training from Study IV held more favorable (baseline) attitudes towards PWP than people from the general public, with the great majority indicating willingness to treat at least non-offending PWP. Yet, there was still a sizeable number of trainees reporting negative affective responses like anger, while less than half of the sample agreed to feel sympathy for PWP.

6.2 Limitations and Outlook

6.2.1 Overview

There are a number of characteristics regarding the studies' design or methodology that impact the interpretation and generalizability of the presented results. The three main constraints (ad hoc-sampling, self-report data, cross-sectional design) are presented in the following section, each followed by recommendations on how to overcome these limitations in future studies.

6.2.2 Ad Hoc Sampling

It should be noted that none of the findings within this dissertation were based on representative samples or subsamples. Study I to IV used ad hoc samples to investigate their respective study questions. This means that sampling for these studies did not rely on a random sampling process. Instead, participants were included in the study because of their accessibility, which critically limits the generalizability of the findings.

In Study I, pedestrians walking by the research team in a busy shopping street in two German cities were approached. As the results showed, young and highly educated participants were clearly oversampled. Also, people who spent time in the area might have been wealthier or might have had more free time on average than other people from the general population (or differ from them with respect to other variables). There were a multitude of potential confounding factors that might have influenced the likelihood to be a participant in these studies as well as the responses, such as prosocial orientation (especially since no financial compensation was provided), levels of distrust, traumatic sexual experiences, or comfortableness with questions related to sexuality and sexual deviance in general. It cannot be ruled out that people who agreed to participate in the study after having been invited by a member of the research staff differed systematically from those who declined.

Participants in Study II were Internet users working on the online platform MTurk. Even if these workers were representative of all MTurk users, the sampling procedure led to an exclusion of people who did not have access to the Internet or did not work for MTurk. For instance, MTurk workers have been described as younger, more educated, and more likely to be unemployed than US citizens in general (Shapiro et al., 2013). Again, people uncomfortable with the studied subjects might have declined participation. Therefore, findings cannot be generalized on the level of the average population in the respective

countries. Nevertheless, both Study I and II have sampled groups of people that were more heterogeneous with respect to sociodemographic characteristics than typical undergraduate samples (Shapiro et al., 2013).

Study III targeted adults with a sexual interest in children and was carried out online. Because pedophilia appears to be rare among women and some of the established scales that were used in this research were clearly directed at male respondents (by, e.g., referring to erections instead of corresponding sexual processes in women), only male participants were included. Therefore, results were by default not representative for PWP, as the experiences of women with pedophilia, even if they were only a small fraction among PWP, were not assessed. Other factors may have further impaired generalizability of results. Firstly, not everybody has access to the Internet or uses it on a regular basis. Internet users have been found to be younger, more educated, and to have a higher socioeconomic status than non-users (Chen & Wellman, 2004), and using the Internet to recruit PWP may have oversampled people with these characteristics. Furthermore, as it is problematic to pay money to participants whose identities are unknown, PWP did not receive financial rewards for their participation. PWP who volunteered to participate under these conditions were probably more socially oriented, more interested in research, or more convinced that the research serves “a greater good” than PWP who declined. Also, PWP who engaged in the Internet forums that were targeted might differ from other PWP on a number of other characteristics. A strongly self-help focused forum (like the jungsforum.org) might have attracted less PWP who are well-adjusted. A forum intended as a platform for political activism might have disproportionately attracted users with pedophilia who share certain views on social issues. While some websites openly campaign for “children’s rights” to have sexual contacts with adults (e.g., www.krumme13.org), others attempt to reduce the stigma related to pedophilia by informing the public that their members successfully resist sexual urges towards children (e.g., www.virped.org).

Yet, although not providing representative data, ad hoc samples of PWP may still be useful to study a number of aspects concerning PWP. Study III of this dissertation, for example, did not aim at establishing population estimates for PWP with regard to their perception of stigma or attitudes towards sex with children but instead tested theoretically driven hypotheses about associations between different variables (however, note that it is possible for the sample to be “so uncharacteristic of the population that even relationships among variables are inaccurately represented”; Meyer & Wilson, 2009, p. 29). Ad hoc samples are also helpful to repudiate common views about characteristics of PWP (e.g., “severe axis II pathology”; L. J. Cohen &

Galynker, 2002, p. 282) that may in fact only be true for small subsamples like incarcerated child sex offenders with pedophilia (Seto, 2008). In fact, findings from Study III suggested that PWP from this sample are better adjusted than clinical or forensic populations of PWP, emphasizing the heterogeneity and diversity among PWP that was frequently overlooked by scientists and practitioners (Okami & Goldberg, 1992; Seto, 2008).

For Study IV, trainees were invited via their CBT training institutes. Findings indicated a selection bias among volunteers with respect to baseline attitudes towards PWP and professional interest in pedophilia. Psychotherapists in training recruited for Study IV reported unexpectedly high rates of previous professional or personal contacts with PWP, considering the fact that participants were relatively young and only at the start of their professional career as therapists. Thus, they may not be representative for German psychotherapists in training.

Studies I (members of the average adult population in Germany), II (members of the average adult population in the US), and IV (German psychotherapists in training) should be replicated using probability sampling methods in the future. However, standards of probability sampling are arguably very hard to reach for the target population of Study III (community men with pedophilia). In fact, the only possible way to recruit a representative sample of PWP would include screening thousands of people from representative panels or a randomized subset of the population (Dombert et al., 2015). With an estimated prevalence of 3% - 5%, one would expect to find 30 to 50 people with sexual interest in children among a group of 1,000 representatively selected men (and considerably smaller numbers of men with an exclusive sexual attraction to children; Dombert et al., 2015). Given the high costs of this procedure, receiving sufficient funding is unlikely. As a second-best option, researchers should endeavor to replicate their findings using different samples of PWP while controlling for as many potential confounding variables (e.g., social desirability, age, educational level) as possible.

6.2.3 Self-Report Data

Studies I to IV were based on self-reports. Despite providing an easy access to people's attitudes, feelings, and experiences, investigations relying on self-report measures impose challenges for interpretation. To name one challenge, it is possible that responses were biased by social desirability. In Study I, II, and IV, participants rated their attitudes towards PWP (and in the case of Study I and II other stigmatized groups as well). Typically, a tendency to

give socially desirable responses is linked to patterns of responding that indicate favorable attitudes towards stigmatized groups. Yet, as a recent study by Imhoff (2015) showed, prejudicial reactions towards PWP might be more common among participants scoring high on a scale assessing social desirability bias. Therefore, Study I and II may have overestimated rather than underestimated levels of stigma towards PWP. In the case that social desirability had an opposite effect on reactions towards the three other studied groups, relative differences between stigma towards PWP and the comparison groups in Study I and II might have been overestimated. On the other hand, psychotherapists in training who participated in Study IV may have downplayed negative reactions towards PWP. As future therapists, they might have felt obligated to report having positive attitude towards all patients, even though their private feelings might have been more conflicted.

While social desirability bias cannot be ruled out for any research based on self-reports, there are a number of straightforward ways to reduce its impact. For all studies presented within this thesis, social desirability bias was counteracted by guaranteeing anonymity for all participants. This strategy also involved including only a small set of sociodemographic variables in order to avoid making participants indirectly identifiable. Results from a recent study indicated that participants feel that their anonymity needs are better protected by online research compared to paper pencil studies (P. Ward et al., 2012), which further supports the validity of Study II, III, and IV, which were all conducted in an online setting. Moreover, Study III employed a social desirability scale to control this effect.

Another problem of self-report based attitude measures in stigma research is that they may not be reliable indicators for actual behavior. It is unclear whether people who responded favorably to, for example, accepting a person with pedophilia as a friend, would actually befriend a person they find out has pedophilia. Also, psychotherapists' real-life behavior might diverge from their reported intention once they are actually confronted with the task of treating a person with pedophilia. For these reasons, future stigma research would benefit from the inclusion of measures beyond self-report (i.e., implicit or behavioral measures; e.g., Teachman et al., 2006). For example, investigators could assess psychotherapists' real-life decision to invite a patient to therapy sessions depending on the types of symptoms (e.g., depression, schizophrenia, or pedophilia) this patient has mentioned in a previous telephone call. This design can be carried out as an experimental study when health care professionals are randomly assigned to study groups based on which problems the "patient", who is in fact an actor and a study confederate, specifies during the call.

Beside actual behavior, researchers may also assess subtle bodily (e.g., heart rates) or behavioral signs of sympathy, such as the tendency of study participants to mimic individuals on videotape, depending on whether or not these people are presented as having pedophilia (Yabar, Johnston, Miles, & Peace, 2006). Studying stigma with a multi-method approach including a variety of measurement types would considerably increase our knowledge of stigma processes, which could in turn be used to inform efforts to combat stigma.

6.2.4 Cross-Sectional Design

Due to the cross-sectional and correlational survey design of Study III, data from this investigation could not be used to infer causal statements. To rule out possible alternative explanations, we controlled for confounding variables like educational level, social desirability, or family status. Nevertheless, it is always possible that the reported findings (e.g., the link between PWP's fear of discovery and psychopathological symptoms) might have been explained by an unknown third variable, or that the direction of the cause differed from the one that was hypothesized. Hence, to clarify the nature of the associations, experimental or at least longitudinal data are required. Such study designs need to be carefully planned and executed in order to avoid or overcome ethical problems and recruitment constraints.

To establish only the temporal sequence of cause and effect (showing that, e.g., fear of discovery at age 18 preceded emotional problems in the years to come), researches should rely on longitudinal surveys. However, if PWP refuse to provide their addresses or other forms of establishing a long-term contact, drop-out in longitudinal studies is likely to be excruciatingly high.

Randomized-controlled experiments represent the gold standard for making causal inferences. To assess self-stigma experimentally, experimenters might consider randomly assigning PWP to a low stigma group and a high stigma group, depending on the information that participants receive regarding the public's attitudes towards them (e.g., "Less than 1% of the public agrees that PWP should better be dead" vs. "80% of the public agrees that PWP should better be dead") and assessing PWP's responses to this information (e.g., fear of discovery, motivation to disclose, self-esteem). Alternatively, PWP could be confronted with videos or texts showing examples of either empowering and supportive public responses (low stigma group) or highly negative and stigmatizing material (high stigma group). While the first variant is problematic as it involves some form of experimental deception, the second might pose less

ethical problems, as it could be argued that PWP are likely to be aware of the existence of both types of public reactions. Yet, problems arise due to the difficulty of recruiting sufficient numbers of PWP (especially in community settings; see also 6.4.3 for a detailed discussion). Also, if research like the experimental study described above is carried out online and PWP drop out before the end of the data collection, they may never receive information about the nature of the experiment (and the degree, if any, of deception involved).

Another promising variant for future studies on the assumptions from the FESAP involves creating an anti-self-stigma program for PWP that could also be administered online or for patients attending group therapy (like from the Berlin Prevention Project Dunkelfeld; Beier, Ahlers, et al., 2009). These interventions may involve psychoeducative strategies, cognitive restructuring, and acceptance and commitment-based approaches (for an overview on current self-stigma reduction strategies for people with a mental illness, see Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012). If a program (or a treatment component within a larger frame of therapy) explicitly focused on strengthening stigma resilience effectively reduces psychopathologic symptoms or other social and emotional problems in PWP (compared to other forms of treatment or waiting list controls), this would provide compelling evidence for the adverse effects of stigma, as suggested by the FESAP. These efforts should be preceded by a comprehensive analysis of stigma resilience among PWP, as such an account is currently missing (see also Chapter 6.3.3).

6.3 Merging Stigma and Forensic Literature: Contributions to Future Research

6.3.1 Overview

The work presented in this thesis is not the first to propose links between public stigma, stigma-related experiences, and subsequent problems (including a rise in offense risk) among PWP (see also Fog, 1992; Seto, 2012). Nevertheless, this dissertation presents the most exhaustive and systematic model on stigma against PWP to-date. The model presented in Chapter 4.3 has a high heuristic value because it combines insights from different research fields that are usually regarded as separate. Albeit suffering from a particularly harsh stigma, PWP have not received much attention from stigma theorists. Furthermore, sex offender research has so far tended to overlook the potential role of stigma in the etiology of child sexual abuse.

Both stigma theory and child abuse research have a long empirical history and stand on solid empirical ground individually. As unified in one model, these two separate literatures fit together like parts of a puzzle and give rise to a considerable amount of thought-provoking ideas, some of which are presented in this chapter. The following sections give an overview on (1) possible future research endeavors that may be informed or improved by incorporating ideas from the FESAP, and (2) stigma aspects which have not yet been included in – but can be seen as meaningful additions to – the FESAP. These new aspects of stigma involve stigma research on other groups (e.g., people with other paraphilias), resilience, consequences of disclosure, and stigma by association.

6.3.2 Ideas for Future Research Based on the Framework for the Effects of Stigma-related Stress among People with Pedophilia

Adopting a stigma perspective puts common assumptions about pedophilia on their heads: Instead of early psychological disturbances creating both the sexual interest in children and additional problems (see, e.g., Maniglio, 2011; T. Ward & Beech, 2006), the link between psychosocial disturbances and pedophilia may also be explained by experiences or expectations of rejection (or other stigma-related stress factors) leading to psychological problems in later life. As the scientific community currently lacks longitudinal or experimental data that would help determine causality with more certainty, both assumptions appear equally plausible and deserving of further research.

Thus, the FESAP opens up new possibilities to study pedophilia and underscores the importance of addressing stigma as a potential confounding variable. For instance, a number of researchers attempted to generate knowledge about pedophilia by comparing characteristics of child sexual offenders who are diagnosed with pedophilia with other groups (e.g., demographically similar community men; L. J. Cohen, McGeoch, Gans, et al., 2002). In some cases, potential confounding effects of stress brought on by the prison environment are controlled for by choosing a comparison group of other incarcerated offenders (Cantor et al., 2008). The problem with such case-control studies lies in the assumption that child sexual offenders and other offenders behind bars (especially those who have been prosecuted for non-sexual crimes) are subject to comparable amounts of stress and inmate violence, which appears highly unlikely (Jewkes, 2005; Vaughn & Sapp, 1989). Sexual offenders, especially those who have offended against children, are at the bottom of the prison hierarchy and, supposedly, suffer more from stigma and discrimination than, for instance, burglars (Vaughn & Sapp, 1989). Moreover, the stigma of feeling sexually attracted to children is likely to have acted as a source of stress even before first-time offending or incarceration. Assessing such experiences as well as general stress levels among offender groups with and without pedophilia might help to statistically control for such confounds. It is essential to clarify if the differences found between inmate groups are explained directly by pedophilia or indirectly because PWP are treated differently by those who know about their sexual interests.

The FESAP also underscores the importance of the community or mental health professionals in helping PWP refrain from having sex with children or watching child abusive images. As a modern descendant of labeling theory, the FESAP helps to see PWP in a different light by emphasizing their humanity and focusing on adverse societal processes that PWP are confronted with. By taking Seto's (2012) warning seriously that PWP "will remain hidden if they continue to be hated and feared, which would impede efforts to better understand this sexual orientation and thereby prevent child sexual exploitation" (p. 235), the FESAP encourages an unprejudiced debate about PWP. Thereby, the framework shifts scientific attention from currently popular control-focused research paradigms (i.e., identifying sexual interests against the will of PWP; see, e.g., van Leeuwen et al., 2013) to more supportive and cooperative approaches that center on the question how society or mental health practitioners can provide an environment in which PWP dare to disclose their sexual interests. Hence, the FESAP may help researchers develop and justify more humanitarian strategies to prevent sexual offending among PWP.

6.3.3 Stigma Research Beyond the Framework for the Effects of Stigma-related Stress among People with Pedophilia

Other stigmatized groups

To date, the FESAP provides the most comprehensive and systematic presentation of stigma-related problems for people with a sexual interest in children. These considerations, however, may also be relevant for researchers interested in stigma towards other paraphilias, especially those linked to criminal offenses (e.g., sexual sadism or necrophilia). Ideas from the FESAP may also be relevant for the social reintegration of sexual offenders (irrespective of whether they have pedophilia or not), as both the public and the offender tend to overestimate the frequency of sexual recidivism and underestimate the effects of treatment (Fortney et al., 2007). In one study, about half of a sample of sexual offenders in outpatient treatment reported to have experienced threats, property damage, or attacks when others found out about their criminal past (Brannon, Levenson, Fortney, & Baker, 2007). These “negative reactions can create unhealthy and maladaptive environments” that “seem to make the offender’s reintegration into society more difficult” as well as “lead to dynamic risk factors that have been associated with increased recidivism” (Brannon et al., 2007, p. 376). As a systematic scientific framework to study such associations is currently missing, research efforts might be informed by the FESAP.

Resilience

Another factor that deserves scientific attention is stigma resilience among PWP. While early stigma theories assumed that self-stigma is an automatic response to being stigmatized, modern theorists acknowledged that not every stigmatized individual reacts the same way (P. W. Corrigan & Watson, 2002). Despite potential social disadvantages, stigmatized individuals are not passive “victims,” but are able to find ways of coping with their situation. As a consequence, not every person who is stigmatized may feel devalued, depressed, or anxious. This process has been shown to exist for many stigmatized groups (Rusch et al., 2009).

For instance, Rusch et al. (2009) found that “cognitions associated with resilience to stigma [among people with a mental disorder] may facilitate use of out-patient services and be more relevant to help-seeking than the level of perceived stigma per se” (p. 552). These cognitions include rejecting stigma as unfair and identifying strongly with one’s stigmatized group (Rusch et al., 2009). Accordingly, people with a mental disorder who identified with their

support group showed enhanced resistance to stigma, were more likely to reject stereotypes about their group, and benefited of more social support (Crabtree, Haslam, Postmes, & Haslam, 2010). Stigma resistance, the rejection of stereotypes, and support were also linked to higher self-esteem (Crabtree et al., 2010). Among LGB people, resilience has been found to help withstand stressful stigma-related experiences and maintain a positive self-image (Meyer, 2003). A number of stigmatized individuals may even react with righteous anger to stigmatizing views of themselves (P. W. Corrigan & Watson, 2002), which for some might lead to very different behavioral consequences (e.g., political activism).

Results from study III gave some indication of resilience among PWP as well. For instance, the tested sample of PWP did not show worse emotional outcomes with regard to emotion-focused coping, fear of negative evaluation, and self-esteem than control populations. Contrary to what would have been expected for this stigmatized group, self-esteem among PWP was even higher than among an ad hoc (non-patient) sample (Ferring & Filipp, 1996). Furthermore, a high perceived social distance did not predict problematic outcomes on any scale used within this study. Perhaps this unexpected finding could be explained by resilience as many participants were active users of online self-help circles. In the future, studies using the FESAP to investigate links between perceived stigma and negative outcomes should consider assessing resilience variables such as group identification or rejection of stereotypes to elucidate how individuals can successfully deal with the stigma attached to pedophilia.

Disclosure

Confiding in other people can be an important strategy to manage a stigmatized identity and might contribute to higher resilience among stigmatized people. Many participants in Study III reported that keeping their pedophilia a secret was distressing to them. Opening up about their sexual identity may reduce inhibition of distressing thoughts and feelings, which, “over time, [...] serves as a cumulative stressor on the body, increasing the probability of illness and other stress-related physical and psychological problems” (Pennebaker, 1990, p. 21). Yet, others may not always react positively. For these reasons, making decisions about whether or not to disclose one’s sexual identity is a difficult choice for all people with sexual interests that deviate from the heterosexual norm. While potential benefits of disclosing pedophile sexual interests include enhancing social control and social support, it might also lead to violence, discrimination, and deprivation of support.

Yet, apart from qualitative interview studies (e.g., Freimond, 2013), little is known about how people react when they learn that their spouse, child, friend, or other acquaintance is sexually interested in children. However, given that lay theories on pedophilia stress the role of child sexual abuse, lack of empathy during childhood, and lack of parental guidance (Furnham & Haraldsen, 1998), parents of PWP may start blaming themselves, even if they in fact had been caring and considerate as caregivers. Also, parents may suspect other people (e.g., teachers, other family members) of having sexually abused their son or daughter during childhood, even when he or she denies such experiences. Furthermore, conflicting feelings towards the person with pedophilia are likely to occur. Family members and friends may, for instance, react shocked, concerned, betrayed, or disappointed. They may conclude that the relative with pedophilia is a threat to the children in the family and exclude this person from family meetings where children are present. Interestingly, in Freimond's (2013) study, seven of the nine interviewees with sexual interest in children specifically decided to confide in friends instead of family members.

Furthermore, especially younger and more educated PWP are likely to use the Internet as an outlet to talk about their sexual interests and related problems. The eponymous protagonist of the Czech documentary *Daniel's World* (Holý, 2014) about the life of a young man with pedophilia recounted that the community of PWP, whom he came in contact with through online forums, have helped him more in coming to terms with his sexual identity than his sexologist. For an unknown number of PWP, such communities may even represent the sole environment where they dare to open up about their sexuality, and (as in Daniel's case) such interactions may have a lasting effect on PWP's attitudes and behaviors. Considering the growing importance of online communication in the lives of many individuals with sexual interests that are in conflict with society's norms (Holt et al., 2010), furthering our understanding of the extent and the consequences of PWP disclosing online would constitute a worthwhile research effort.

Associative stigma

Notably, stigma does not only negatively affect the lives of the stigmatized but also those of the people close to the stigmatized (P. W. Corrigan & Kleinlein, 2005). This form of devaluation is also known as associative stigma (P. W. Corrigan & Kleinlein, 2005) or "stigma by association" (e.g., Östman & Kjellin, 2002). In an interview study with relatives of patients treated in psychiatric wards, the majority reported problems in at least one of the assessed

variables for stigma by association (Östman & Kjellin, 2002). For instance, relatives agreed that the patient's disorder had affected their relationship with others or caused psychological problems among relatives themselves (Östman & Kjellin, 2002). In another study, a little less than half of the relatives did not tell anyone that the patient was hospitalized or limited such conversations to a small number of people (Phelan, Bromet, & Link, 1998). Health care practitioners who treat people with mental disorders may also be affected by associative stigma (Verhaeghe & Bracke, 2012).

Knowing that a closely associated person is sexually interested in children may become a huge source of stress and conflict and create helplessness and a need for counseling. Because of shame or concerns for the safety of the person with pedophilia, PWP's loved ones may have even fewer opportunities to talk about this issue than relatives or friends of people with, for instance, schizophrenia or depression. Therefore, affected family members or other significant people from the social environment of the person with pedophilia should receive guidance about how to be supportive and how to deal with potential feelings of fear, anger, or self-accusation. Many parents may be relieved to know that not all PWP have suffered from childhood trauma or bad parenting (Seto, 2008), despite what many lay people believe (Furnham & Haraldsen, 1998). Such offers could be provided by mental health experts or counselors but also web sites or leaflets. For PWP, knowing that there is an expert that his family or friends can talk to might increase the likelihood of disclosing. A broader knowledge base regarding the reactions, fears, and needs of people who come to share the secret of someone's pedophilic interest could also help inform new counseling or treatment strategies. As scientific knowledge about the struggles and needs of PWP's loved one's is, however, very limited at this moment, research should be conducted to assess these needs as well as the recipients' willingness to welcome assistance in this matter.

6.4 Stigma Reduction and a New Management of Pedophilia

6.4.1 Overview

There have been a number of calls for action to reduce stigma against people with a mental illness (De Mendonça Lima, 2004; World Health Organization, 2001) and a growing research interest in developing interventions to change negative attitudes towards these groups (Dalky, 2012). While designing anti-stigma programs is a straightforward strategy to combat stigma, there are other equally important efforts that scientists should undertake to help decrease stigma against PWP. These strategies involve (1) attributing greater importance to community samples of PWP (unless there is a straightforward reason why only clinical or forensic samples are required for the purpose of the study), and (2) making an effort to avoid inadvertent stigmatization in scientific writing. The following subchapters go into more detail how each strategy could contribute to the greater goal of decreasing stigma and provide clear and concise recommendations.

6.4.2 Target Groups for Stigma Reduction Interventions

As Study IV within this dissertation revealed, an anti-stigma intervention targeting stigma towards PWP has shown promising results among psychotherapists in training. Similar education and contact based interventions can be tailored to different populations. Meaningful target groups are discussed below.

Mental Health Professionals

At present, PWP are confronted with a lack of specialized treatment in Germany and many other countries. Patients from the Berlin Prevention Project Dunkelfeld traveled a mean distance of 205 km to participate in the weekly sessions, with those living more than 100 km away having to travel 334 km on average (Beier, Ahlers, et al., 2009). As data from Study III indicated, about half of the sample of self-identified PWP were unwilling to or unsure about contacting a mental health professional in times of need, and only a third believed that the professional would be able to understand their problems. Furthermore, while a pedophilic disorder requires the patient to be at least 18 years old and 5 years older than the children he or she feels sexually attracted to, many PWP recall a start of their sexual fantasies in adolescence. Despite technically not being eligible for a diagnosis of pedophilic disorder, a person in late stages of puberty or after puberty who begins to become aware of such sexual fantasies (and the stigmatizing assumptions associated with them) may be in urgent need of

help. These considerations underscore the importance of educating mental health professionals about pedophilia and providing more and better options for outpatient therapy (also including options for PWP below the age of 18).

Professionals from the mental health sector and counselors should be better informed about PWP and make health resources available whenever possible. Very importantly, curricula for the medical or therapeutic professions should place more weight on the diagnosis and treatment of pedophilia and other paraphilias, and address the role of stigma in the disclosure process. In case that professionals strongly oppose the idea of treating a person with pedophilia (due to, e.g., inexperience, insecurities, or even deep seated aversion for having been affected by child sexual abuse themselves) they should at minimum be prepared to help the client find a therapist who is better suited to offer treatment.

People Working in the Justice Sector

People from the justice sector and the police need to be aware of stigma against PWP in order to treat them respectfully and protect their rights, even when they are accused of sexual offenses involving children. The protection of PWP involves treating breeches of confidentiality, such as a therapist illegally exposing his client's sexual interest, seriously. Members of the justice sector should also conduct efforts to ensure that speculations about the actual or supposed sexual interests of a defendant in a child sexual abuse case are treated confidentially, as disseminating such information may endanger this person's safety and lead to massive social disadvantages. PWP that are threatened or attacked because of their sexual interest should receive the help they need, sending a clear sign that violence based on somebody's sexual interests is not tolerated, even if the person is sexually interested in children (see Seto, 2008, for examples of physical violence against PWP). Lastly, it has been shown that students tend to perceive defendants as less credible in child sexual abuse cases than in robbery cases (McCauley & Parker, 2001) and recommend longer prison sentences for defendants in child abuse cases whom they believed to have pedophilia (Lam et al., 2010). These clear and unfair disadvantages are likely to further reduce PWP's motivation to be open about such interests and seek therapeutic help.

The Media

Media representatives, journalists, and related professions should be educated about pedophilia and the negative effects that may ensue from stigma. For many years,

sensationalist news stories have perpetuated stigmatizing assumptions involving PWP, as many media professionals tended to portray pedophilia in an unrealistic and derogatory way and/or to give an exaggerate account of sexual offenses involving children. In fact, since the mid-80s, medial interest in child sexual abuse has been growing steadily (Jenkins, 1998), despite the reality that the actual danger of child sexual abuse has been stable or even declining in many countries (Finkelhor & Jones, 2006; Kury, Obergfell-Fuchs, & Woessner, 2004). The excessive coverage of child abuse cases involving “stranger danger” (Kitzinger & Skidmore, 1995), high degrees of brutality, and murder incited increased public outrage (Kitzinger, 1996). At the same time, media reports about sexual abuse hardly differentiated between different types of offenses and different types of offenders and their many diverse (sexual and non-sexual) motivations (see also Chapter 2.2.1). Subsequently, terms like “pedophile,” “child molester,” and “monster” have become interchangeable for most people, or appear to be only minute distinctions (Sampson, 1994). Having been exposed to a myriad of reports about the sexual crimes of actual or supposed PWP, it is no wonder that the community is relatively steadfast in their belief that PWP are extremely dangerous for children and not willing to seek treatment, reinforcing their decision to withhold friendship and contact from this group.

Hence, the community and especially media representatives need to be better informed about the conceptual differences between pedophilia and child sexual abuse. The fact that each individual with pedophilia can make the choice to abstain from criminal sexual behavior even if it means that this person’s sexual fantasies will remain largely unfulfilled, is an important message for PWP and their social environment. Short anti-stigma interventions for journalist or spokespeople could help correct common myths about PWP. Mental health experts may contribute to these efforts by providing resources for journalists that portray PWP in balanced and realistic ways.

6.4.3 Recruiting Community Men with Pedophilia

To establish generalizable theses about PWP as a population, studying samples that are representative for this group is indispensable. This is especially important when the study focuses on estimating unbiased population prevalence of a particular characteristic (e.g., mental disorders or attitudes; see also Meyer & Wilson, 2009). However, as has been explained before, probability samples of PWP are very difficult to achieve. In the absence of such studies, researchers should increase their awareness of the problems associated with

different sampling strategies and the degree of inadvertent stigmatization that may ensue from such procedures. Earlier chapters mention that generalizing findings derived from PWP in forensic or clinical institutions on all PWP is likely to result in an inaccurate characterization, namely because respondents, in addition to their pedophilic interests, are characterized by an inability to abstain from criminal sexual behavior or by other comorbid disorders. It is to be expected that PWP who do not offend or were able to avoid detection and who do not need or want to receive treatment because of their sexual interest differ fundamentally from the aforementioned subsamples. In fact, the current situation for pedophilia is reminiscent of times when “generalizations about the inevitable psychological dysfunctionality of homosexuality [were] based on samples composed exclusively of emotionally disturbed subjects” (Suppe, 1981, p. 70). Therefore, assessing community samples of PWP is needed to truly understand the etiology and characteristics of pedophilia. Below, problems and risks of studying PWP in a community setting are explored, followed by recommendations for studying this group online.

Pedophilia as a sensitive research topic

Researching sensitive issues presents high challenges on an ethical and methodological level. Lee and Renzetti (1990) defined a sensitive topic as “one which potentially poses [...] a substantial threat” to researched and researcher, “the emergence of which renders problematic [...] the collection, holding, and/or dissemination of research data” (p. 512). The benefits of conducting sensitive research need to outweigh the risks for the researchers and the participants. However, these benefits and risks are often difficult to determine in advance (Dickson-Swift, James, & Liamputtong, 2008).

Pedophilia may be considered a sensitive issue because of its private, sexual nature, and the stigma associated with it. In case that a participant reveals to have had (undetected) sexual contact with children or watched child pornography, this person is furthermore put at risk of prosecution because of his or her involvement in a scientific study.

As results from this dissertation indicate, PWP are highly aware of their stigma. Among all respondents from Study III, almost everyone tried to keep their sexual interest a secret from at least one other person, and a substantial number reported going to great lengths to prevent others from knowing despite the fact that having this secret appeared to be a distressing experience for many. Participating in a study on pedophilia might become a stressful and

potentially harmful experience unless the researcher is aware of these risks and takes the necessary precautions.

Because of their (oftentimes) controversial nature, researching sensitive topics may be risky for researchers and their respective institutes as well. There are a number of accounts from researchers who have found themselves at the center of public outrage because of their research on pedophilia or related topics (e.g., Rind, Bauserman, & Tromovitch, 2000). In one incident, the media scandalized the fact that child sex offenders would get paid for their participation in a study although this is an ethical and often necessary procedure to recruit participants (Hanson, Letourneau, Olver, Wilson, & Miner, 2012; Seto, 2008). Such reactions are likely to have a “chilling effect on researchers and institutions” (Seto, 2008, p. x; please note that corresponding book section is paginated in Roman numerals) and to complicate future funding. Another researcher who planned to conduct interviews with community PWP was told that “I was not allowed to interview them in my office because I must not facilitate their presence on campus”, forcing her to “meet unknown men in locations including their homes” (Goode, 2010, pp. 47).

Online Research on PWP

In recent years, the World Wide Web has created new possibilities for PWP to build communities while staying relatively anonymous (Holt et al., 2010). These new outlets provide new opportunities for recruiting PWP and carrying out research. As pedophilia is a relatively rare (and usually well hidden) sexual interest, online research greatly facilitates reaching volunteers who may not live in proximity of the research institute. For PWP, online research also drastically decreases the costs and risks of participation. They are neither required to reveal their identity nor to show their face to strangers and can remain more in control of the situation, making online research a valuable tool to reach large numbers of PWP. For Study III, the research team was able to collect data from $N = 104$ participants within only eight weeks. Nevertheless, conducting research on pedophilia online presents a number of challenges that researchers should be aware of before starting their investigations.

Carrying out online research in line with general ethical principles is problematic, mostly because of a lack of official research standards for this relatively new and fast changing medium. In particular, “eliciting informed consent, negotiating access agreements, assessing the boundaries between the public and the private, and ensuring the security of data transmissions” remain challenging (British Sociological Association, 2002, pp. 5-6).

Therefore, researchers who use online research “should ensure that they are familiar with ongoing debates on the ethics of Internet research, and might wish to consider erring on the side of caution in making judgments affecting the well-being of online research participants” (British Sociological Association, 2002, p. 6).

While achieving complete anonymity on the Internet “seems to be a wishful thinking” (Weber & Heinrich, 2012, p. 20), using anonymity systems (e.g., Tor) or pseudonyms help conceal the participant’s identity. PWP in online forums are likely to be well-versed in protecting their personal information, as these topics have been found to be frequently discussed among such communities (Holt et al., 2010). Besides, when participants are already involved in self-help forums for PWP (e.g., [jungsforum.net](#) or others), participating in online research on pedophilia might not add much to the risk they are already taking. Nevertheless, researchers should make efforts to minimize any (additional) risk. This involves using software that protects sensitive data (e.g., via encryption) but also avoiding to collect information about illegal behavior unless the researcher can be sufficiently sure that revealing such acts in the survey will not lead to criminal prosecution (as, e.g., in the case that the police confiscates the researcher’s computer).

Scientists should also be transparent about their background and aims and be prepared to receive phone calls or e-mails from PWP inquiring about the researcher’s personal attitudes once the data collection has started. It could be helpful for the research staff to plan what they want to respond when a person with pedophilia asks about child sexuality or the morality of “intergenerational” sex. As has been mentioned before, scientists should educate themselves about potential goals and agendas of the forums they want to include in their study. While this knowledge could help anticipate the debates and discussions that are likely to ensue among forum members, it also has consequences for the interpretation of the results, as different forums are likely to attract PWP with different characteristics.

Another critical factor for recruitment success is whether the researcher is able to win the trust of her or his research subjects. Cooperating with active forum users with pedophilia who could in turn invite members of their community to participate in the research can be a helpful avenue to motivate PWP who would otherwise feel at risk of repercussions. Naturally, building such relationships requires a long term effort and should be mutually beneficial for researchers and PWP (but note that PWP may of course also work as scientists, as in the case of M. Geradt who co-authored one of the studies that this dissertation is based on). While

researchers gain access to hard-to-reach populations, PWP could profit by receiving information about new debates and developments in research. Furthermore, while scientists, regardless of their sexual identity, should remain in full control of the study goals, exchange with PWP from the community helps sensitize the research team to the needs and concerns of the people they want to study, thus creating new ideas for future research endeavors.

Yet, I believe that the most important factor that determines whether or not a researcher gains access to this population is his or her capacity to treat individuals with pedophilic interests as people. If scientists do not take care to approach this group in a respectful and non-stigmatizing way, members of the target population are likely to react warily or even deter other potential participants from taking part in the study by producing angry forum posts. Needless to say, researchers should not forget preparing a comprehensive list of therapists or counselors that participants with mental health problems could contact.

6.4.4 Recommendations for Writing about Pedophilia

Although knowledge is an important agent of stigma reduction, this does not mean that people educated about PWP do not hold stigmatizing assumptions. In fact, even mental health professionals and scientists who are most likely aware of the distinction between having a pedophilic sexual interest and committing sexual crimes involving children tend to present PWP in problematic ways. Some of these stigmatizing tendencies in scientific writing are presented in the following paragraphs, along with recommendations on how to avoid them.

Increasing Sensitivity to Labels

The Publication Manual of the American Psychological Association (American Psychological Association, 2010) advises academic authors to be sensitive to labels. Writing about participants in a way that they “tend to lose their individuality” and are “broadly categorized as objects” (p. 72) should be avoided. Instead, it is more sensitive to adopt a “person first” writing style, as in, for instance, “patients with bipolar disorder” (American Psychological Association, 2010). Thus, the term “pedophiles” should be replaced with descriptions like “people with a sexual interest in children,” PWP (as in this dissertation), or “minor-attracted people” as a term that PWP appear to prefer as a label (Kramer, 2011, August 17). When referring to PWP, these guidelines are, however, rarely considered (see, e.g., L. J. Cohen & Galynker, 2009; Murray, 2000; van Leeuwen et al., 2013), even among authors who, apart from that, write about PWP in a differentiated and empathetic manner (e.g., Beier, Neutze, et

al., 2009; Cantor, 2014). Also, the general term “pedophilia” should be avoided when study participants are drawn exclusively from forensic samples of child sexual abusers. Despite being a common practice in the forensic literature, this use of the concept is not only problematic in terms of validity and generalizability but also stigmatizing for PWP who have never committed criminal acts. Thus, in such cases, terms like “offenders with pedophilia” or “PWP who have committed child sexual abuse” may be cumbersome, but provide a much higher degree of clarity.

Avoiding Derogatory Descriptions

Furthermore, PWP are often portrayed in derogatory ways. For instance, a number of authors wrote that PWP have brain “deficiencies” or “abnormalities” (e.g., Cantor et al., 2008; Schiffer et al., 2007) instead of describing structural or functional brain differences between PWP and control subjects in neutral terms. It is unnecessary and stigmatizing to reason or imply that a mere difference (in, e.g., left-handedness, scores on non-clinical personality scales, brain anatomy, or other) is abnormal or signaling a deficit due to the “other” participant group having pedophilic sexual interests (which is neither a crime nor, in itself, pathological).

The scientific literature on pedophilia also perpetuated a negative picture of PWP by being focused primarily on topics related to child sexual offending and social control. Albeit acknowledging that PWP who do not offend theoretically exist, even the accompanying literature to the DSM-IV-TR clinical classification (American Psychiatric Association, 2000) completely overlooked this group in its description of clinical features. Instead, the text offered a longer list of (allegedly) typical criminal or deceitful activities and cognitive distortions, even though the claim that PWP are more violent or manipulative than other people is not backed up by empirical evidence (see also Kramer, 2011; but note that the DSM-5 accompanying text is a large improvement over its predecessor in this respect).

Moreover, many authors directly or indirectly implied that people with a sexual interest in children are deeply defective (e.g., suffering from a “complex interaction of disturbances of the emotional, cognitive and sexual experience”; quotation taken from Wiebking & Northoff, 2013, p. 350) and have huge difficulties preventing themselves from committing crimes. To provide another example, pedophile attraction is often reduced to its sexual component, as if being sexually interested in children would exclude deep feelings of love and commitment towards desired children. In contrast, for some PWP these aspects are even more important

than sexual acts (G. Schmidt, 2002) – an idea that does not seem to be contested in today’s academic circles when homosexual, bisexual, or heterosexual orientations are concerned (Diamond, 2003). Yet, when tender or sentimental feelings that PWP may have towards children (usually termed “emotional congruence with children”; see Finkelhor & Araji, 1986 or Chapter 2.3.2) are discussed in the literature, they are often depicted as something abnormal or very negative. For example, McPhail, Hermann, and Nunes (2013) described emotional congruence as an “exaggerated affective and cognitive affiliation with children and childhood that is posited to be involved in the initiation and maintenance of sexual offending against children” (p. 737). Another author speculated that emotional congruence with children is usually “due to arrested development, either through retardation, immaturity, or low self-esteem” (Rowan, Rowan, & Langelier, 1990, p. 79). While many researchers may be understandably upset about sexual offenders justifying their criminal actions with love for children, devaluating *all* notions of strong tender feelings towards children is disrespectful and stigmatizing towards PWP and does not contribute to a better understanding of their experiences. After all, it might also be possible that some PWP may refrain from having sexual contacts with children not despite of their loving affection, but because of it (as documented by, e.g., Holý, 2014, in his portrayal of Czech PWP).

6.5 Final Conclusions

G. Schmidt (2002) described the (male) person with pedophilia as stuck in the tragic dilemma of either living out “a form of sexuality that [...] is in conflict with a central social covenant based upon sexual self-determination and consensual sexuality” or “denying himself the experience of love and sexuality” (pp. 476). Taking the present research into consideration, the dilemma appears intensified, as the person with pedophilia is ostracized even in the case of law-abiding behavior.

Despite the fact that no one can choose to be sexually attracted to children any more than one can choose to have depression or a bisexual orientation, the understanding and presentation of pedophilia by the public often implies a degree of deliberate evil that would attach to very few other conditions. The biggest confusion seems to lie in the failure to distinguish between having a particular condition and showing an overt behavior that might partially be caused by that condition. Although PWP are a highly diverse population, many people from the general public seem to assume that virtually none of them are capable or willing to cope with their sexual impulses in ways that do not cause harm to children.

Despite the fact that research on stigma effects on PWP is still at a very early stage, it is hard to imagine such a strong negative public response not having any negative effects on PWP. This dissertation broke new ground by investigating links between stigma-related stress and other adverse consequences for the individual with pedophilia (and, indirectly, also for children). More research is needed to substantiate the hypothesis that fear of discovery has a detrimental effect on PWP’s emotional and social level of functioning, with special care taken to clarify the causal nature of this phenomenon. It is possible that the prejudice and discrimination surrounding pedophilia are an important issue not only with respect to the human rights of individuals with pedophilia but also to children’s safety, which might indirectly be compromised by public stigma towards PWP.

These conclusions suggest that PWP have little reason to be hopeful in our society. Yet, as research from this dissertation has also uncovered, there is reason for tentative optimism. As one study showed, stigmatizing assumptions might be alleviated by developing and implementing anti-stigma interventions for mental health professionals, journalists, and other groups. Moreover, while this phenomenon needs yet to be explored in further detail, many PWP can be expected to have found ways to cope with the stigma surrounding their sexual

interests, as has been documented for other stigmatized groups (e.g., people from the gay and lesbian community) as well.

With the Internet paving the way for researchers interested in the experiences of PWP drawn from community samples, there is also hope that the scientific community will become more and more familiar with portrayals of PWP that challenge common stereotypes. In a few years from now, the image of these individuals as deeply disturbed people primarily motivated by insatiable urges to engage in sexual activities with children may continue to falter, giving rise to innovative studies focusing on pedophilia as a phenomenon worthy of study in and of itself. If PWP from community settings become aware of researchers' growing acceptance, this may boost their motivation to participate in studies. Such a development could in turn increase the feasibility and representativeness of many research endeavors dedicated to the study of pedophilia in a non-forensic context. This may set in motion a self-reinforcing process of de-stigmatization, growing interest in PWP's experiences, and growing trust between researchers and PWP. In the wake of these new and promising developments, it remains to be seen whether researchers will overcome their blind spot and realize the merits of acknowledging and studying stigma against PWP - not least of all the potential to prevent child sexual offending.

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8. Appendix

The following pages show previously unpublished material in German language that was used within the four studies presented in this thesis. This collection contains the original version of the stigma inventory measuring cognitive beliefs and stereotypes, affective reactions, and discriminatory behavioral intentions regarding PWP (or people who abuse alcohol) that was used in Study I and, in parts, in Study IV. Also included is the Perceived Social Distance Scale, the Fear of Discovery Scale, and the Therapy Motivation Scale for PWP (all Study III), as well as the four-item dangerousness scale, educational material for the anti-stigma and the control condition, and the Therapy Motivation Scale for psychotherapists (all Study IV).

8.1 The Stigma Inventory (in German)

Bitte antworten Sie möglichst spontan und ohne lange nachzudenken – es gibt kein „richtig“ oder „falsch“. Lesen Sie sich die folgenden Aussagen durch und kreuzen Sie für jede Aussage jeweils die Antwort an, die am besten auf sie zutrifft. Bitte beachten Sie, dass die Aussagen im nun folgenden Fragebogen zu Forschungszwecken erstellt wurden und nicht notwendigerweise die Meinung des Forscherteams widerspiegeln.

Zunächst soll es um Menschen gehen, **die (sexuell hauptsächlich an Kindern interessiert sind/nahezu täglich große Mengen Alkohol trinken).**

	Stimme nicht zu			Stimme voll zu			
	0	1	2	3	4	5	6
(Sexuelles Interesse hauptsächlich an Kindern/Nahezu täglich große Mengen Alkohol zu trinken,) ist etwas, was man sich aussucht.							
(Menschen mit sexuellem Interesse hauptsächlich an Kindern/ Menschen, die nahezu täglich große Mengen Alkohol trinken,) haben sich bewusst dafür entschieden.							
Menschen haben die Wahl, ob sie (sexuell hauptsächlich an Kindern interessiert sind/nahezu täglich große Mengen Alkohol trinken) oder nicht.							

Inwiefern sind Menschen, **die sexuell hauptsächlich an Kindern interessiert sind/die nahezu täglich zu große Mengen Alkohol trinken, generell** für andere Menschen gefährlich?

	Stimme nicht zu			Stimme voll zu			
	0	1	2	3	4	5	6
Menschen, die (sexuell hauptsächlich an Kindern interessiert sind/nahezu täglich große Mengen Alkohol trinken), sind eine Gefahr für Kinder.							
Menschen, die (sexuell hauptsächlich an Kindern interessiert sind/nahezu täglich große Mengen Alkohol trinken), sind eine Gefahr für Jugendliche.							
Menschen, die (sexuell hauptsächlich an Kindern interessiert sind/nahezu täglich große Mengen Alkohol trinken), sind eine Gefahr für Erwachsene.							

Appendix

Beim Gedanken an Menschen (*mit sexuellem Interesse hauptsächlich an Kindern/die nahezu täglich große Mengen Alkohol trinken,*) fühle ich...

	Stimme nicht zu			Stimme voll zu			
	0	1	2	3	4	5	6
... Angst							
... Mitleid (Study I and III) / Mitgefühl (Study IV)							
... Wut							

Nun geht es um Lebensbereiche, in denen Sie sich vorstellen können, mit bestimmten Menschen zusammen zu sein und Lebensbereiche, aus denen Sie diese lieber heraushalten wollen. Wie ist das mit Personen, die (*sexuell hauptsächlich an Kindern interessiert sind/nahezu täglich große Mengen Alkohol trinken*), **aber noch nie eine Straftat begangen haben**?

	Stimme nicht zu			Stimme voll zu			
	0	1	2	3	4	5	6
Mit diesen Personen würde ich eine Freundschaft eingehen.							
Diese Personen würde ich in meiner Nachbarschaft akzeptieren.							
Diese Personen würde ich als Arbeitskollegen akzeptieren.							
Ich würde mich mit diesen Personen unterhalten.							
Diese Personen sollten eingesperrt werden.							
Diese Personen wären besser tot.							

8.2 Perceived Social Distance Scale (in German)

Hier geht es nicht um Ihre persönlichen Ansichten zu diesem Thema! Bitte geben Sie nur an, was sie glauben, wie **die meisten Deutschen** auf diese und die folgenden Fragen antworten würden. Nun geht es um Lebensbereiche, in denen **andere** sich vorstellen können, mit Menschen, die sexuell hauptsächlich an Kindern interessiert sind, **aber noch nie eine Straftat begangen haben**, zusammen zu sein und Lebensbereiche, aus denen sie diese lieber heraushalten wollen.

Ich glaube, die meisten Leute in Deutschland denken:

	Denkt fast niemand			Denken fast alle			
	0	1	2	3	4	5	6
„Mit diesen Personen würde ich eine Freundschaft eingehen.“							
„Diese Personen würde ich in meiner Nachbarschaft akzeptieren.“							
„Diese Personen würde ich als Arbeitskollegen akzeptieren.“							
„Ich würde mich mit diesen Personen unterhalten.“							
„Diese Personen sollten eingesperrt werden.“							
„Diese Personen wären besser tot.“							

8.3 Therapy Motivation Scale for PWP (in German)

Manche Menschen, die sexuell an Kindern interessiert sind, haben psychische Probleme, die mit diesem Interesse in Zusammenhang stehen. Es könnte z.B. sein, dass sie darunter leiden, stigmatisiert zu werden, sich depressiv oder ängstlich fühlen, oder den Eindruck haben, ihre sexuellen Bedürfnisse nicht kontrollieren zu können. Wenn das bei Ihnen so ist oder in Zukunft so wäre, **wie bereit wären Sie, sich professionelle Hilfe (z.B. bei einem Arzt oder Psychologen) zu suchen?**

	Denkt fast niemand			Denken fast alle			
	0	1	2	3	4	5	6
Ich würde mich einem professionellen Helfer anvertrauen.							
Ich würde mir professionelle Hilfe suchen, auch wenn es bedeutet, dass ich mit einer fremden Person über mein sexuelles Interesse an Kindern sprechen muss.							
Ich denke, dass ein professioneller Helfer mein Problem nachvollziehen kann.							
Ich halte es für wahrscheinlich, dass ein professioneller Helfer negativ reagieren würde, wenn ich von meinem sexuellen Interesse an Kindern berichte.							

8.4 Fear of Discovery Scale (in German)

Die meisten Menschen haben etwas, was Sie vor einigen, oder sogar allen anderen Menschen verbergen möchten. Dies kann z.B. eine unangenehme oder peinliche Erfahrung in der Vergangenheit, einen Gesetzesbruch oder anderes Fehlverhalten, oder schambehaftete Aspekte der eigenen Persönlichkeit oder des eigenen Körpers betreffen. Auch persönliche (z.B. sexuelle) Vorlieben und Abneigungen werden von manchen Menschen bewusst vor anderen verborgen. Bitte geben Sie an, was in Bezug auf Ihr sexuelles Interesse an Kindern auf Sie zutrifft.

0	Haben Sie ein wichtiges Geheimnis, von dem Sie auf keinen Fall möchten, dass es allgemein bekannt wird?	ja <input type="checkbox"/>	nein <input type="checkbox"/>
---	---------------------------------------------------------------------------------------------------------	--------------------------------	----------------------------------

Appendix

Wenn ja, bitte beantworten Sie die folgenden Fragen mit Bezug auf Ihr Geheimnis.
Lesen Sie sich die folgenden Aussagen durch und kreuzen Sie für jede Aussage jeweils die Antwort an, die am besten auf sie zutrifft.

	Stimme nicht zu			Stimme voll zu			
	0	1	2	3	4	5	6
Ich habe Angst davor, dass andere von meinem Geheimnis erfahren.							
Es macht mir Angst, dass andere von meinem Geheimnis wissen könnten.							
Beim Gedanken, dass andere von meinem Geheimnis erfahren könnten, werde ich nervös und bekomme Herzklopfen.							
Der Gedanke daran, dass andere mein Geheimnis herausbekommen könnten, löst bei mir körperliches Unbehagen aus.							
Ich mache mir viele Gedanken darüber, was passiert, wenn mein Geheimnis herauskommt.							
Ich kann Gedanken an eine mögliche Entdeckung meines Geheimnisses nicht abschütteln.							
Ich vermeide Gesprächsthemen, die mit meinem Geheimnis zu tun haben.							
Ich versuche mich so zu verhalten, dass niemand auf die Idee kommt, ich könnte ein Geheimnis verbergen.							
Es ist anstrengend für mich, mein Geheimnis zu bewahren.							
Dieses Geheimnis zu haben, belastet mich.							

8.5 Four-Item Dangerousness Scale (in German)

	Stimme nicht zu			Stimme voll zu			
	0	1	2	3	4	5	6
Viele Menschen, die sexuell hauptsächlich an Kindern interessiert sind, haben nie sexuellen Kontakt zu einem Kind.							
Jemand, der sexuell hauptsächlich an Kindern interessiert ist, ist ein perverser Triebtäter.							
Sexuelles Interesse hauptsächlich an Kindern führt früher oder später zu sexuellem Kindesmissbrauch.							
Menschen, die sexuelle hauptsächlich an Kindern interessiert sind, können ihr Verhalten gegenüber Kindern kontrollieren.							

8.6 Therapy Motivation Scale for Psychotherapists (in German)

Im Folgenden geht es Ihre Bereitschaft, Menschen mit pädophilen Neigungen zu behandeln.

	Stimme nicht zu			Stimme voll zu			
	0	1	2	3	4	5	6
Ich bin bereit, Menschen psychotherapeutisch zu behandeln, die sexuell hauptsächlich an Kindern interessiert sind, aber noch nie eine Sexualstraftat begangen haben.							
Ich bin bereit, Menschen psychotherapeutisch zu behandeln, die sexuell hauptsächlich an Kindern interessiert sind und bereits eine Sexualstraftat begangen haben.							
Ich kann mir vorstellen, Fortbildungsveranstaltungen zu besuchen, um Menschen mit sexuellem Interesse an Kindern zu behandeln.							

8.7 Educational Material (in German)

8.7.1 Anti-Stigma Intervention

Was ist Pädophilie?

Pädophilie ist nach ICD-10 eine **Störung der Sexualpräferenz**. Im DSM-IV-TR ist Pädophilie durch folgende Kriterien charakterisiert (S. 631¹):

- A. Über einen Zeitraum von mindestens 6 Monaten wiederkehrende intensive sexuell erregende Phantasien, sexuell dranghafte Bedürfnisse oder Verhaltensweisen, die sexuelle Handlungen mit einem präpubertierenden Kind oder Kindern (in der Regel 13 Jahre und jünger) beinhalten.
- B. Die Person hat das sexuell dranghafte Bedürfnis ausgelebt, oder die sexuell dranghaften Bedürfnisse oder Phantasien verursachen deutliches Leiden oder zwischenmenschliche Schwierigkeiten.
- C. Die Person ist mindestens 16 Jahre alt und mindestens 5 Jahre älter als das Kind oder die Kinder nach Kriterium A.

Im Folgenden werden in die Definition pädophiler Neigungen auch Personen einbezogen, die das B-Kriterium nicht erfüllen, d. h. die die pädophilen Bedürfnisse nicht ausgelebt haben und keinen Leidensdruck durch die Neigung selbst erleben.

Zur Prävalenz der Pädophilie in der Allgemeinbevölkerung liegen keine zuverlässigen Angaben vor. Je nach Definition und Erhebungsinstrument liegen die Schätzungen für pädophile Neigungen bei 0,2 bis 9%.

¹ Saß, H., Wittchen, H.-U., Zaudig, M. & Houben, I. (2003). *Diagnostisches und Statistisches Manual Psychischer Störungen -Textrevision- DSM-IV-TR*. Göttingen: Hogrefe.

„Ich habe mir das nicht ausgesucht“

Ähnlich wie hetero-, homo- oder bisexuelle Menschen stellen Menschen mit Pädophilie ihre sexuelle Neigung gewöhnlich zu Beginn der Pubertät fest. Sowohl die Präferenz für ein bestimmtes *Geschlecht* (wie bei Hetero- und Homosexualität) als auch die Präferenz für ein bestimmtes *Alter* (wie bei Pädophilie) sind stabile Dimensionen der sexuellen Neigung, die nicht verändert werden können. Dies belegen beispielsweise frühere verhaltenstherapeutische Versuche, bei Menschen mit homosexuellen Neigungen durch Rekonditionierung eine heterosexuelle Orientierung zu etablieren. Ebenso wie bei der Rekonditionierung von Menschen mit Pädophilie führten diese Versuche allenfalls zu kurzfristigen Veränderungen im sexuellen Arousal, ohne jedoch die zugrunde liegende Präferenz zu verändern.

Ähnlich wie bei anderen sexuellen Neigungen ist auch die Entstehung der Pädophilie bislang wenig verstanden. Es existieren verschiedene Ansätze, die teilweise als veraltet und wenig empirisch belegt gelten (z. B. die Konditionierungshypothese) oder die Faktoren als Ursache postulieren, die nicht bei allen Betroffenen gefunden werden und daher nur unzureichende Erklärungen liefern (z. B. sexueller Missbrauch in der Kindheit). Auch Zusammenhänge der sexuellen Präferenz mit pränatalen und neurobiologischen Besonderheiten werden diskutiert.

Gemeinsam ist den verschiedenen Erklärungsmodellen, dass die Entwicklung der pädophilen Neigung auf Faktoren zurückgeführt wird, die außerhalb der Kontrolle des Individuums liegen. So wie sich homo- oder heterosexuelle Menschen ihre sexuelle Präferenz nicht ausgesucht haben, sind auch Menschen mit Pädophilie für ihre sexuelle Neigung nicht verantwortlich - wohl aber für ihr Verhalten.

Pädophilie = Kindesmissbrauch?

Pädophilie wird oft mit sexuellem Kindesmissbrauch gleichgesetzt. Während Pädophilie als psychologischer Begriff eine Störung der sexuellen *Präferenz* beschreibt, ist sexueller Missbrauch von Kindern hingegen ein juristischer Begriff für eine *Straftat*. Nicht alle Sexualstraftaten an Kindern werden jedoch von Menschen mit Pädophilie begangen, und umgekehrt führt Pädophilie nicht zwingend zu sexuellem Kindesmissbrauch. Zwar ist Pädophilie unter verurteilten Sexualstraftätern einer der bedeutsamsten Risikofaktoren für einschlägige Rückfälle. Phallometrischen Messungen zufolge haben jedoch nur 30-50% der Straftäter, die wegen sexuellen Kindesmissbrauchs verurteilt wurden, pädophile Neigungen, und es gibt viele andere Ursachen, die zu sexuellem Kindesmissbrauch führen können (z. B. Mangel an altersadäquaten sexuellen Beziehungen, substanzbedingte Verhaltensehemmung).

Zudem ist nicht bekannt, wie viele Menschen mit Pädophilie überhaupt straffällig werden. Es gibt nachweislich Personen, die ihre pädophilen Neigungen auf Fantasien beschränken können, ohne je sexuellen Kontakt zu einem Kind zu haben. Andere suchen freiwillig therapeutische Hilfe auf, um sexuelle Übergriffe zu vermeiden. Das belegt z. B. die hohe Nachfrage im Berliner Präventionsprojekt „Kein Täter werden“, das für diese Zielgruppen eine Behandlung anbietet. Die Angst vor negativen Reaktionen oder Indiskretion hält jedoch auch viele Betroffene davon ab, therapeutische Hilfe in Anspruch zu nehmen.

Therapiemöglichkeiten

Derzeit geht man davon aus, dass die pädophile Neigung selbst nicht geändert werden kann. Therapeutische Interventionen setzen daher vor allem an der Verringerung sexuellen Arousals und der Erhöhung der Selbstkontrollfähigkeiten der Betroffenen an, um sexuelle Übergriffe zu verhindern. Dafür wird ein kombiniertes Vorgehen aus kognitiver Verhaltenstherapie und pharmakologischer Behandlung empfohlen.

Wichtige Prinzipien in der **kognitiven Verhaltenstherapie** der Pädophilie sind:

- Akzeptanz der sexuellen Präferenz und Bewusstmachen ihrer Stabilität
- Bearbeitung kognitiver Verzerrungen
- uneingeschränkte Verantwortungsübernahme für das eigene sexuelle Verhalten
- schrittweise Prävention sexuell missbräuchlichen Verhaltens (analog zur Suchtbehandlung):
 1. Risikosituationen erarbeiten (z. B. allein mit Kindern sein)
 2. scheinbar irrelevante Entscheidungen identifizieren (Annäherungen an Fehlverhalten, die noch keinen Übergriff darstellen, z. B. Masturbation zu Fantasien mit Kindern)
 3. Strategien zur Vermeidung von Risikosituationen erarbeiten
 4. Coping-Strategien zum adäquaten Umgang mit nicht vermeidbaren Risikosituationen und Fehlverhalten entwickeln
- Erhöhung von Empathie, Impulskontrollfähigkeiten und sozialen Kompetenzen

Die **pharmakologische Behandlung** zur Verringerung des sexuellen Arousal beinhaltet meist testosteronhemmende Medikamente, teilweise werden auch SSRIs eingesetzt. Eine dauerhafte Option zur Reduktion des Sexualtriebs ist die chirurgische Kastration.

Die Effektivität psychologischer Interventionen zur Behandlung der Pädophilie wird kontrovers diskutiert. Da Menschen mit Pädophilie für präventive Behandlungen aufgrund der beschriebenen Ängste schwer zugänglich sind, existieren kaum Therapie-Evaluationen an bislang nicht straffällig gewordenen Betroffenen. Zudem sind nur wenige Psychotherapeuten zur Behandlung von Menschen mit Pädophilie bereit. Erste Ergebnisse aus dem Therapieprojekt „Kein Täter werden“ zeigen jedoch positive Effekte der Präventivbehandlung auf kognitive Risikofaktoren sexuellen Kindesmissbrauchs.

Zusammenfassung

- Pädophilie ist durch wiederkehrende sexuell erregende Phantasien, Bedürfnisse oder Verhaltensweisen charakterisiert, die sich auf präpubertäre Kinder beziehen.
- Wie hetero- oder homosexuelle Menschen auch haben sich Menschen mit Pädophilie ihre sexuelle Neigung nicht ausgesucht.
- Menschen mit Pädophilie werden nicht zwingend zu Sexualstraftätern. Umgekehrt haben viele Sexualstraftäter keine oder keine überdauernden pädophilen Neigungen, selbst wenn sie Sexualdelikte an Kindern verübt haben. Es gibt Betroffene, die freiwillig eine Behandlung aufsuchen, um sexuelle Übergriffe zu vermeiden. Ängste oder Erfahrungen mit negativen Reaktionen halten jedoch auch viele Betroffene von einer Behandlung ab.
- Die Behandlung der Pädophilie umfasst meist eine Kombination aus kognitiver Verhaltenstherapie und medikamentöser Behandlung. Es sind jedoch nur sehr wenige Psychotherapeuten zur Behandlung von Menschen mit Pädophilie bereit.

8.7.2 Control intervention

Was ist gewaltfreie Erziehung?

Das Recht auf gewaltfreie Erziehung wurde im November 2000 vom Deutschen Bundestag im „Gesetz zur Ächtung der Gewalt in der Erziehung und zur Änderung des Kindesunterhaltsrechts“ verankert. Im Bürgerlichen Gesetzbuch wird dazu festgehalten:

„Kinder haben ein Recht auf gewaltfreie Erziehung. Körperliche Bestrafungen, seelische Verletzungen und andere entwürdigende Maßnahmen sind unzulässig.“

(§ 1631 Abs. 2 BGB)

Obwohl sich die Tendenz zu Gewalt in der Erziehung in den letzten zwei Jahrzehnten insgesamt verringert hat, sind vor allem leichtere Körperstrafen nach wie vor verbreitete Erziehungsmaßnahmen. Gewalt in der Erziehung ist für die betroffenen Kinder mit zahlreichen negativen Konsequenzen im emotionalen Erleben und im Verhalten verbunden. Um Familien in der gewaltfreien Erziehung zu unterstützen, sieht der Gesetzgeber daher das Angebot von Erziehungshilfen wie z. B. Bildungs- und Beratungsleistungen vor (§ 16 Abs. 1 SGB VIII). Ein Beispiel für ein solches Unterstützungsangebot ist der vom Deutschen Kinderschutzbund angebotene Elternkurs **Starke Eltern – Starke Kinder®**.

Starke Eltern - Starke Kinder®: Ziele, Inhalte und Aufbau

Der Kurs Starke Eltern - Starke Kinder® (kurz SESK®) richtet sich an Eltern, die ihre Erziehungskompetenz verbessern möchten und Unterstützung bei der Bewältigung des Familienalltags und bei Erziehungsschwierigkeiten suchen. Übergeordnetes **Ziel** ist es, Eltern für kindliche Bedürfnisse und Rechte zu sensibilisieren und einen sicheren, respektvollen und reflektierten Erziehungsstil zu entwickeln. Im Sinne gewaltfreier Erziehung gehört hierzu insbesondere der Verzicht auf physische, sexuelle und psychische Gewalt gegenüber Kindern.

Teilziele und Inhalte des Kurses sind:

- Stärkung des Selbstvertrauens von Eltern und Kindern
- Verbesserung der Eltern-Kind-Beziehung und der familiären Kommunikation
- Unterstützung bei der gewaltfreien Bewältigung von Konflikten und Familienalltag
- Möglichkeiten zum Austausch mit anderen Eltern
- Information zu Erziehung und Kinderrechten

Den Inhalten liegt ein sogenanntes anleitendes Erziehungsmodell zugrunde, das systemische, kommunikationspsychologische und familientherapeutische Ansätze kombiniert. Daraus werden verschiedene **Erziehungsmethoden** abgeleitet, die den Eltern zur Erreichung der Erziehungsziele vermittelt werden.

Dazu gehören:

- Bewusstmachen und Modellieren klarer Werte
- Feedback geben und erhalten
- Ermutigung, Anerkennung und Vertrauen
- aktives, empathisches Zuhören, Verbalisierung von Gefühlen, Formulieren von Ich-Botschaften und gemeinsame Suche nach Lösungswegen
- Vereinbarungen treffen und einhalten

Der **Aufbau** des Kurses gliedert sich in 8 bis 12 Einheiten zu je ca. zwei Stunden. Nach einem kurzen theoretischen Abschnitt werden die Inhalte durch Rollenspiele u. a. Übungen veranschaulicht und trainiert.

Wirksamkeit des Kurses

Die Wirksamkeit des Kurses Starke Eltern – Starke Kinder® wurde 2002 und 2009 evaluiert. Infolge der Kursteilnahme zeigten sich zahlreiche positive Veränderungen sowohl auf Seiten der Eltern als auch auf Seiten der Kinder.

Beide Studien zeigen, dass die Kursteilnahme bei den **Eltern** zu mehr Selbstwirksamkeit, Zufriedenheit und Entlastung in der Kindererziehung führt. Entwürdigende Erziehungsmethoden wie Beschimpfung oder Ohrfeigen kamen infolge der Kursteilnahme seltener zur Anwendung. Das Familienklima verbesserte sich, der Anteil an gemeinsam verbrachter Zeit von Eltern und Kind erhöhte sich. Zudem verbesserten die Kursteilnehmer im Vergleich zur Kontrollgruppe u. a. ihre Kompetenzen in empathischem Zuhören und im Treffen verbindlicher Absprachen. Auch gelang es den Teilnehmern nach dem Kurs besser, die positiven Seiten ihres Kindes wahrzunehmen.

Kinder, deren Eltern am Kurs teilgenommen haben, beurteilten die Erziehung ihrer Eltern nach dem Kurs positiver. Sie nahmen bei ihren Eltern mehr Geduld, Toleranz, Wärme und Unterstützung wahr. Zudem berichteten Kinder in geringerem Maße von Problemen mit Gleichaltrigen, was sich mit der Einschätzung der Eltern deckt, das Sozialverhalten der Kinder habe sich infolge des Kurses verbessert.

Fortbildung

Berufstätige mit einer abgeschlossenen Ausbildung im psychologischen oder pädagogischen Bereich haben die Möglichkeit, sich zum Kursleiter für Starke Eltern – Starke Kinder® und weiterführend auch zum Trainer für die Ausbildung von Kursleitern fortzubilden.

Die **Kursleiterschulung** ist eine mindestens viertägige Fortbildung, die zur Durchführung von SESK®-Kursen berechtigt. Ausgebildete Kursleiter können den Elternkurs dann beispielsweise bei Trägern der Kinder- und Jugendhilfe, Familienzentren oder in Einrichtungen des Gesundheits- oder Bildungswesens anbieten. Interessierte benötigen:

- eine abgeschlossene psychologische oder pädagogische Ausbildung
- Berufserfahrung in der Elternarbeit
- Erfahrung als Gruppenleiter von Erwachsenengruppen

Die **Trainerschulung** berechtigt zur Ausbildung von Kursleitern für SESK®-Kurse. Für diese weiterführende Fortbildung sind folgende Kriterien zu erfüllen:

- ein abgeschlossenes Studium in Psychologie, Pädagogik oder Sozialpädagogik
- Berufserfahrung in der Elternarbeit
- Erfahrung als SESK®-Kursleiter
- Anbindung an den Deutschen Kinderschutzbund (DKSB)
- Kompetenz zur Anpassung der Kurse für verschiedene Einsatzbereiche und Institutionen, z. B. Kindertagesstätten, Schulen, Gesundheitswesen etc.

Neben den je nach Einsatzbereich individuell vorgenommenen Anpassungen der Kurse gibt es auch ausgearbeitete Erweiterungen des Kurses für die Anwendung bei bestimmten Zielgruppen. Dazu gehören beispielsweise der SESK®-Kurs „Ganz praktisch“, der für Eltern aus niedrigeren Bildungsschichten entwickelt wurde sowie Elternkurse für Patchwork- und Stieffamilien und Kurse in türkischer und russischer Sprache.

Die Fortbildungen werden von den DKSB-Landesverbänden durchgeführt. Bis 2010 wurden ca. 12.000 Kursleiter und ca. 100 Trainer ausgebildet.

Zusammenfassung

- Gewaltfreie Erziehung beinhaltet den Verzicht auf körperliche Strafen, psychische Verletzungen und andere entwürdigende Erziehungsmaßnahmen. Das Recht von Kindern auf gewaltfreie Erziehung ist gesetzlich verankert.
- Der Elternkurs Starke Eltern – Starke Kinder® richtet sich an Eltern, die ihre Erziehungskompetenz verbessern möchten. Ziel ist es, Eltern in der Entwicklung eines sicheren und respektvollen Erziehungsstils und der gewaltfreien Konfliktbewältigung zu unterstützen.
- Die Teilnahme am Kurs verbessert die Kompetenzen der Eltern in gewaltfreier Erziehung, erhöht ihre Selbstwirksamkeit und verbessert die Eltern-Kind-Beziehung. Auch Kinder beurteilen die Erziehung ihrer Eltern nach der Kursteilnahme positiver.
- Der Deutsche Kinderschutzbund bietet für Berufstätige im pädagogischen oder psychologischen Bereich Kursleiter- und Trainerschulungen für SESK®-Kurse an.

9. Confirmation

Hiermit versichere ich, dass ich die vorliegende Arbeit ohne unzulässige Hilfe Dritter und ohne Benutzung anderer als der angegebenen Hilfsmittel angefertigt habe; die aus fremden Quellen direkt oder indirekt übernommenen Gedanken sind als solche kenntlich gemacht. Die Arbeit wurde bisher weder im Inland noch im Ausland in gleicher oder ähnlicher Form einer anderen Prüfungsbehörde vorgelegt.

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Datum, Unterschrift