# Renaming Pedophilia to Minor-Attracted Persons to Minimize Stigma-related Barriers and Challenges Mental Health Professionals Face with Treating this Population

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**Dedication**

This work is dedicated to the child I once was—

the little girl who was neglected, abused, frightened, hungry, and cold,

yet somehow found a way to survive.

You carried burdens no child should ever know,

and still you held on long enough for me to become who I am today.

Every page of this dissertation is a testament to the strength that grew from suffering,

the resilience born from neglect,

and the hope that somehow survived even in hunger, fear, and loneliness.

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that you were worthy,

and that you deserved so much more than the world gave you.

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## Abstract

This study examined how stigma surrounding terminology creates barriers and challenges for mental health clinicians who provide treatment to individuals who experience sexual attraction to minors and explored whether replacing the term “pedophile” with the term “minor-attracted persons” (MAPs) may reduce these barriers. Stigma influences both those seeking help and the clinicians responsible for providing care, limiting disclosure, restricting treatment engagement, and straining therapeutic relationships. The purpose of this qualitative descriptive study was to explore clinicians lived experiences with stigma-related barriers and to determine whether renaming the condition could meaningfully influence treatment dynamics. The study was guided by the Theory of planned behavior, which provided a framework for understanding how clinicians’ attitudes perceived social expectations, and perceived control influence their intentions and actions when treating this population. A purposive sample of licensed mental health clinicians (N = 16) from the Northwestern Pennsylvania region participated in the study. Eligible participants were required to be licensed mental health professionals with direct experience providing treatment to individuals diagnosed with pedophilia or who experience sexual attraction to minors. Recruitment occurred through direct email outreach, and data were collected through sixty-minute, semi-structured interviews conducted via videoconferencing. Interviews were audio-recorded, transcribed verbatim, and analyzed using thematic analysis to identify patterns related to the research questions. Participants were also given the option to review their transcripts for accuracy. Findings revealed that clinicians face substantial stigma-related barriers, including fear of professional judgment, legal uncertainty, emotional discomfort, and limited specialized training. These factors shaped therapeutic rapport and influenced willingness to treat. Participants offered mixed views on the renaming: some perceived it as a

supportive, person-first term that may reduce stigma, while others believed terminology alone cannot overcome deeply rooted societal attitudes or resolve ethical and legal complexities. The study concluded that renaming may offer modest benefits by softening initial impressions, but significant reductions in stigma-related barriers require broader systemic changes, including enhanced education, clearer treatment guidelines, and increased professional support. Recommendations for future research include examining how terminology interacts with clinical decision-making, policy, training, and prevention-oriented treatment approaches.

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## Chapter 1: Introduction

Pedophilia is defined as a sexual attraction to children (Berlin, 2014; Jahnke et al., 2021). Pedophiles have a psychosexual disorder associated with a sexual interest and prior attempts to engage in sexual acts with prepubescent children (Münch et al., 2020). The DSM-V-TR (2022) classifies pedophilia as a mental health disorder in which an individual has acted on sexual urges towards a minor and/or has had sexual fantasies involving a minor. The prevalence for pedophilia is difficult to discern as reported statistics are typically based on self-reported or noted criminal activities (Savoie et al., 2021). However, experts suggested that an estimated 5% of all males are attracted to younger children (Lievesley et al., 2022; Parr & Pearson, 2019).

The term pedophile continues to have significant barriers and challenges for, not only the mental health clinicians treating pedophiles, but also those struggling with the disorder (Grady et al., 2018; Walker et al., 2022). Mental health clinicians' barriers include navigating the ethical and legal complexities surrounding mandatory reporting laws, balancing their duty to protect the public, particularly children, with maintaining a therapeutic alliance and confidentiality with the client, and limited access to specialized training in treating pedophilic disorders, leading to inadequate clinical approaches and misunderstandings about effective treatment options, and societal prejudice, as working with pedophiles can provoke personal and professional judgment (Jahnke et al., 2015; Levenson & Grady, 2019a). Barriers for pedophiles seeking treatment include fear of legal consequences, a lack of qualified mental health providers available, and a fear of being judged or ostracized, leading to secrecy and reluctance to seek help (Jahnke et al., 2015). Mandatory reporting laws further complicate the issue, as individuals may avoid treatment out of fear that disclosing their thoughts or behaviors could lead to legal repercussions, even if no criminal activity has occurred (Levenson & Grady, 2019b). These barriers not only

hinder individuals from seeking early intervention but also contribute to the perpetuation of untreated conditions, increasing the risk of harm.

Research documents that many of these barriers and challenges are related to the stigma that is attached to pedophilia (Grady et al., 2018; Harper et al., 2021; Jahnke et al., 2021; Jara & Jeglic, 2021; Lehmann et al., 2021; Levenson et al., 2020; Lievesley, Harper et al., 2020; Lievesley, Swaby et al., 2022; Stelzmann et al., 2022). Stigma surrounding pedophilia is pervasive and affects both mental health clinicians and individuals with pedophilic tendencies. For clinicians, there is a significant social and professional stigma tied to working with people who have pedophilic disorders. Many clinicians fear being judged by their peers or the public for providing care to these individuals, which can lead to reluctance in treating them or even bias during treatment (Jahnke et al., 2015). This stigma may be rooted in the moral condemnation of pedophilia and the misconception that those with pedophilic interests are inherently dangerous or will inevitably commit sexual offenses, even though many do not act on their impulses (Roche et al., 2022; Seto, 2012). For individuals with pedophilic tendencies, the stigma is even more pronounced. They are often viewed as morally depraved or evil, regardless of whether they have engaged in illegal activities or not. This intense social stigma fosters fear of being ostracized, publicly shamed, or reported to authorities (Jahnke et al., 2015). Many individuals with pedophilic inclinations report feelings of isolation, self-loathing, and despair due to the widespread societal rejection they face (Jimenez-Arista & Reid, 2023; Levenson & Grady, 2019b). The stigma also exacerbates internalized shame, contributing to mental health problems such as depression and anxiety, which can remain untreated due to fear of exposure.

An effort to address the pervasive level of stigma attached to pedophilia was made by introducing the term “minor-attracted persons” (MAPs) in place of pedophile (B4U-ACT, 2020,

2023). This attempt to rebrand started with a professor at Old Dominion University who posted a comment on Facebook, arguing that it was not necessarily immoral for adults to be sexually attracted to kids and suggested the phrase minor-attracted persons to overcome the stigmas associated with the term pedophile (Cole, 2021; Crane, 2021). A MAPs designation was recognized through the B4U-ACT (2020), where a small group of mental healthcare providers, therapists, and researchers allied to promote an understanding regarding society's negative attitudes towards MAPs, even those that remain non-offending (B4U-ACT, 2020, 2023). Walker's comments sparked a debate among experts in such fields as psychology, psychiatry, and social work and the term MAPs began to be used in some professional arenas even though it has not been committed as an official diagnostic term by the American Psychological Association.

Critics of this renaming argue that MAPs are defined in various, and at times conflicting, ways: as a category for anyone with sexual attractions toward children, as a synonym for pedophilia, or even as a sexual identity, orientation, or minority group. Some of the Map's literature strongly asserts that stigmatizing sexual interest in children is a major cause of child sexual abuse and therefore suggests that such interests should be socially and culturally normalized. However, these claims lack empirical support and conflict with child protection goals (Farmer et al., 2024).

There are only a handful of studies that have examined the perceptions of the term MAPs in those who are sexually attracted to children (Farmer et al., 2024; Freimond, 2013; Walker, 2019). The results of these studies present somewhat conflicting results. In studies by Freimond (2013) and Walker (2019), those who were sexually attracted to children reported the term MAPs to be liberating and an improvement from the term pedophile. Additionally, the term

MAP was perceived as more accurate and less stigmatizing because it didn't mean they were actual offenders. However, research by Farmer et al. (2024) showed that, while the term MAPs has gained a level of legitimacy, pedophiles themselves do not consider it less stigmatizing and prefer the term pedophile or hebephile (Farmer et al., 2024). The above studies were all done from the perspective of a person who was sexually attracted to children. Studies on perceptions of the term MAPs in clinicians who treat this population are even scarcer. Parr and Pearson (2019) examined practitioner's perspectives and found that some of the same level of stigmatization exists even with the renaming. For example, clinicians reported there was a level of professional risk and fear of losing other patients even if they were treating non-offending MAPs. Additionally, there was considerable confusion on reporting laws when it came to MAPs. Parr and Pearson (2019) called for more research on how the term MAPs specifically affects those who are trying to treat these people to provide better treatment avenues.

Current treatment recommendations for pedophilia suggest using a combination of psychotherapies, like cognitive behavioral therapy (CBT), mindfulness, and mindfulness-based cognitive therapies (MBCT), accompanied with pharmacological interventions (B4U-ACT, 2020, 2023; Landgren et al., 2022; Levenson & Grady, 2019a). However, clinicians who work with patients have done so based on traditional education and training models focused on pedophilia, not MAPs, which doesn't account for the possible differences between the two groups (L. Cohen et al., 2018). Furthermore, research suggests examining treatment effectiveness for pedophilia and MAPs separately is warranted (Jahnke et al., 2021; Sorrentino & Abramowitz, 2021). Understanding clinician's perceptions of the term MAPs is even more important to further understand the above problems.

Our understanding of how mental health clinicians understand MAPs as compared to pedophilia is in its infancy (B4U-ACT, 2020; Cantor, 2014; Jahnke, 2018). The little research that is available points to the term MAPs having some of the same level of stigma-related barriers and challenges for both the person themselves and the treating clinicians. However, further examination from the clinician's perspective is needed to better understand if the renaming may provide professionals with a positive means for successful treatment. This renaming to "minor-attracted persons" could have significant implications for mental health clinicians, potentially reducing stigma and facilitating more effective therapeutic relationships. Clinicians may be more willing to engage with individuals who identify as MAPs, as the new terminology could reduce the negative connotations and stigma often associated with the label "pedophile" (Jahnke et al., 2015). This renaming could foster a more open and non-judgmental therapeutic environment, encouraging individuals with pedophilic inclinations to seek help without fear of being condemned or misunderstood (Levenson & Grady, 2019a).

**Statement of the Problem**

The research problem addressed by this proposed study was the stigma-related barriers and challenges mental health clinicians encounter when treating this population (B4U-ACT, 2020, 2023; Jahnke et al., 2021; Münch et al., 2020). There is mounting evidence that clinicians, plagued by concerns of professional reputational damage, moral discomfort, and inadequate training, are reticent to engage with clients expressing pedophilic desires (Levenson & Grady, 2019a; Parr & Pearson, 2019). The label "pedophile" evokes strong connotations of criminality and societal condemnation, which in turn may hinder therapeutic rapport and obstruct the cultivation of a non-judgmental, compassionate stance. The shift to MAPs, however, seeks to recast these individuals not as inherently criminal, but as individuals in need of psychological

intervention, thus potentially reducing professional and social stigma (B4U-ACT, 2020; Walker, 2019). By reframing the clinical narrative, clinicians might feel more secure in their professional roles and more open to fostering early interventions and more robust therapeutic outcomes (Levenson & Grady, 2019a; Lievesley et al., 2020). If this problem is not addressed the persistence of stigma-related barriers and challenges surrounding MAPs could lead to ongoing reluctance among mental health professionals to provide care, thereby leaving individuals with pedophilic tendencies without adequate mental health support, leaving them at increased risk of mental health deterioration, further isolation, and potentially dangerous behaviors (Jahnke et al., 2015; Levenson et al., 2020). Additionally, the stigma-related barriers and challenges surrounding the treatment of pedophilia could lead mental health professionals to experience moral distress and professional isolation when working with this population (Farmer et al., 2024).

**Purpose of the Study**

The purpose of this qualitative descriptive study was to explore how mental health clinicians experience and describe the stigma-related barriers and challenges they encounter when providing care to individuals identified as minor-attracted persons (MAPs), and to examine their perceptions of whether rebranding the term “pedophilia” as “minor-attracted persons” may reduce these stigma-related barriers and improve therapeutic relationships and treatment effectiveness. The research focused on unpacking clinicians' perspectives, particularly regarding how this terminological shift may recalibrate the dynamics of stigma-related barriers and challenges and influence treatment efficacy.

The recruitment process began by direct email outreach to qualified mental health professionals in the Northwestern Pennsylvania region. The email detailed the study’s purpose,

eligibility criteria (licensed mental health professionals with experience treating individuals diagnosed with pedophilia), and instructions for how to express interest in participating. When a participant emailed the researcher with expressed interest in participating in the study, informed consent was obtained, and participants scheduled their semi-structured interviews, which were conducted via Zoom.

During the 60-minute, audio-recorded interview, participants were asked about their experiences with stigma-related barriers and challenges when treating individuals diagnosed with pedophilia and their perspectives on whether renaming pedophilia as MAPs could reduce those barriers. To ensure accuracy, the interviews were audio recorded and transcribed verbatim. As recommended by Sandelowski (2000), participants were given the option to review their transcripts to ensure accuracy and provide clarifications if necessary.

Using Braun & Clarke's (2019) six-step thematic analysis, the study distilled recurring themes and patterns, offering insights into how this renaming could tangibly influence therapeutic practices. The final step involved interpreting the themes within the context of existing literature on stigma-related barriers and challenges and mental health treatment for individuals diagnosed with pedophilia. The findings were compiled into a comprehensive report that outlined how the renaming may influence clinical practices and stigma-related barriers and challenges reduction. Qualitative descriptive research was particularly suitable for this study, as it allowed for an accurate depiction of clinicians' experiences and perspectives, while minimizing researcher interpretation (Kim et al., 2017; Sandelowski, 2000, 2010). The study aimed to generate practical insights that can reshape clinical approaches and break down the stigma-related barriers to care, ultimately facilitating more effective treatment (Farmer et al., 2024; Levenson & Grady, 2019b).

## Introduction to Theoretical Framework

The theory of planned behavior (TPB), initially conceptualized by Ajzen (1991), has been adopted as the foundational theoretical lens for this study due to its profound ability to elucidate and anticipate human actions within social environments. Since its inception in the 1980s, TPB has maintained significant prominence in contemporary discourse, especially in deconstructing the interplay between attitudes, subjective norms, and perceived behavioral control, and how these dimensions shape individual intentions and, consequently, actions (Ajzen, 1991). At its core, the TPB postulates that individuals are more predisposed to perform a given behavior when they exhibit favorable attitudes toward the action, experience strong perceived social endorsement (subjective norms), and perceive a robust degree of agency or control over executing the behavior (Ajzen, 2011). This framework has seen extensive application across a broad array of disciplines, spanning the health sciences, psychological inquiry, and social behavior research, as it offers a methodologically sound foundation for scrutinizing behavioral trends and decision-making pathways (Ajzen, 2020; R. Martin, 2017; Rossmann, 2020, 2021).

The relevance of TPB to the current study was irrefutable, as it served as an essential scaffolding for unraveling how mental health practitioners navigate the intricate landscape of treating individuals identified as MAPs. Specifically, TPB illuminated the complex web of subjective norms, perceived behavioral control, and personal attitudes that converge to influence clinicians' intentions toward employing evidence-based practices (EBPs) when working with this highly stigmatized group. Within this framework, the study probed the extent to which clinicians' professional behaviors were conditioned by the nuanced social pressures, moral considerations, and professional mandates they encountered, and how their perceived ability to surmount these barriers informed their engagement in clinical care (Ajzen, 2011). The lens of

TPB became indispensable in scrutinizing the potential ramifications of renaming pedophilia as MAPs, particularly in terms of how such renaming recalibrates clinicians' therapeutic approaches and the multifaceted psychological, social, and professional factors that modulate their engagement with this population. This theory provided the study with a robust analytical tool for investigating the psychosocial forces at play and understanding how these variables coalesce to drive or deter clinician involvement in treating a deeply marginalized and contentious demographic.

**Introduction to Research Methodology and Design**

The proposed study adopted a qualitative methodology, which was particularly suited to disentangle the intricate nuances of human experiences and perceptions, especially within the context of multifaceted social phenomena. Qualitative research, by its nature, seeks to delve beneath the surface of problems, drawing upon the lived realities of participants to extract meaning and insight. This approach resonated strongly with the core aim of this study, which was to explore the perspectives of mental health professionals navigating the stigma-related challenges and barriers of working with individuals labeled as MAPs. Qualitative inquiry allowed for the generation of rich, textured data that illuminates the "how" and "why" of human behavior. Such a methodology was indispensable in this context, where deep, descriptive, and non-numerical insights were required to reveal the underlying stigma-related barriers and challenges faced by clinicians in providing effective care.

A descriptive research design was selected for this study, as it allowed for the accumulation of comprehensive information by way of an array of qualitative techniques, such as interviews and focus groups. This design was particularly well-suited to research areas that remain underexplored, enabling a more nuanced investigation into the lived experiences of

professionals working with individuals diagnosed with pedophilia or minor attraction (Braun & Clarke, 2019; Kim et al., 2017). Within the domain of healthcare research, descriptive methods are often leveraged to yield in-depth insights from individuals possessing direct, practical experience with the issue at hand (Neergaard et al., 2009). The integration of qualitative methodology with a descriptive research design was an optimal pairing for this investigation. Together, they facilitated an open, yet incisive exploration of the subjective realities of mental health practitioners.

Purposive sampling strategy was used to identify participants to recruit. Purposive sampling was particularly well-suited to descriptive qualitative research because it enabled the deliberate selection of participants who possessed nuanced insights or direct experiences pertinent to the study, thereby ensuring the acquisition of deeply informative and contextually rich data. Furthermore, this approach allowed for a judicious allocation of research resources by concentrating on individuals capable of providing the most pertinent and insightful contributions, thus facilitating a more profound exploration of the underlying phenomenon (Campbell et al., 2020; Palinkas, L.A., et al., 2015). The data collected from this purposive sample of licensed mental health care clinicians with experience working with pedophiles or persons with a minor attraction proceeded through 60 minute semi-structured, audio recorded interviews via Zoom. The ensuing analysis employed thematic methods, allowing the researcher to distill recurrent themes and patterns that, in turn, responded to the overarching research questions (Venkatesh Aravindh & Thirupathi, 2019).

**Research Questions**

The proposed study was guided by the following research questions, which were developed using the purpose statement and theoretical framework.

***RQ1***

How do mental health professionals describe the stigma-related barriers and challenges they face when providing treatment for individuals labeled as pedophiles, particularly in relation to the stigma associated with pedophilia?

***RQ2***

How do mental health professionals perceive that renaming pedophilia as minor-attracted persons could help overcome these stigma-related barriers and challenges in treatment, and what impact do they believe this renaming could have on therapeutic relationships and treatment efficacy?

**Significance of the Study**

The proposed study will potentially contribute to scholars and practitioners in the fields of mental health and clinical psychology by addressing a critical gap in the literature surrounding the renaming of pedophilia as "minor-attracted persons" and its potential to alleviate entrenched stigma while enhancing treatment efficacy. Existing research underscores the pervasive stigma faced by clinicians tasked with treating individuals diagnosed with pedophilic disorders, a stigma that often fosters reluctance to engage, perpetuates cognitive biases, and ultimately diminishes the effectiveness of therapeutic interventions (Jahnke et al., 2015; Levenson & Grady, 2019a). By probing how this renaming might recalibrate clinicians' perceptions and facilitate more effective therapeutic dynamics, this study aspired to offer practical insights with profound implications for future clinical training paradigms and intervention protocols. These insights could transform the clinical environment into one that fosters greater support and therapeutic success for both practitioners and clients (Farmer et al., 2024). This contribution is particularly pressing, given that mental health professionals frequently experience heightened emotional

fatigue and moral dissonance when working with stigmatized populations, leading to compromised care quality and practitioner burnout (Levenson et al., 2020).

Beyond its immediate clinical applications, this study promised to inject fresh perspectives into the broader discourse on the role of terminology in shaping public perceptions, professional ethics, and policy in mental health. The shift from "pedophile" to MAPs represents more than a mere lexical adjustment; it is emblematic of a potential cultural and ethical reorientation with far-reaching consequences for therapeutic practices, societal norms, and even legal frameworks. Through an examination of clinicians' responses to this renaming, the study interrogated whether this terminological shift had the capacity to cultivate a more humane, non-punitive therapeutic atmosphere, and whether such a shift might alleviate the internalized stigma and psychological distress long endured by individuals with pedophilic tendencies (B4U-ACT, 2020, 2023; Harper et al., 2021). Moreover, the exploration of the effectiveness of this renaming holds the potential to influence policy reform and inform the development of clinical guidelines that delicately balance ethical obligations to treatment with the imperatives of public safety. In doing so, the study could offer a new conceptual framework for navigating the complexities of this highly stigmatized disorder, with implications for both clinical practice and public policy (Levenson & Grady, 2019a).

## Definitions of Key Terms

### *Descriptive Research Design*

A type of qualitative research design that aims to describe a phenomenon in detail, providing an accurate account of individuals' experiences, attitudes, or perceptions. This design is often used when little prior research exists on a topic, allowing researchers to generate new insights and understanding (Braun & Clarke, 2019).

### *Evidence-Based Practice (EBP)*

EBP refers to an approach to problem-solving and decision-making in clinical mental healthcare settings whereby the most credible and trustworthy evidence available is used, in combination with clinical experience and the consideration of patient preference, to guide informed decisions, care, and treatment. EBP describes practice grounded in research to improve efficacy (Landgren et al., 2022). EBPs are widely used in healthcare settings to ensure effective interventions.

### *Mental Health*

Mental health describes an individual's psychological, emotional, and social well-being, including behaviors, thoughts, feelings, and coping mechanisms (Lievesley et al., 2022).

### *Minor-Attracted Persons (MAPs)*

A MAP is an individual who repeatedly and frequently experiences sexual attraction and arousal toward minors under the legal age of consent (Lievesley et al., 2022). The term is often used to reduce the stigma associated with labels such as "pedophile" and to encourage a compassionate approach to care and treatment.

### *Pedophilia*

Pedophilia is a psychiatric disorder characterized by the DSM-5, involving recurrent intense sexual fantasies and behaviors involving sexual activity with prepubescent children for at least six months. Most territories consider pedophilic behavior a criminal offense (Sorrentino & Abramowitz, 2021).

***Phenomenon***

In research, a phenomenon refers to a specific, observable event, experience, or situation being studied. It often focuses on how individuals perceive or are impacted by experiences within a given context.

***Qualitative Methodology***

A research approach that focuses on understanding complex phenomena from the perspectives of participants, often through the collection of non-numerical data such as interviews, observations, and text. This method aims to explore the "how" and "why" of human behavior and experiences rather than measuring relationships or statistical outcomes (Rudd et al., 2021).

***Sexual Abuse***

Sexual abuse involves an individual's nonconsensual exploitation, sexually suggestive language, emotional exploitation, threats, and/or physical harm (Sorrentino & Abramowitz, 2021).

***Stigma***

A social phenomenon where individuals are devalued, discriminated against, or subjected to negative stereotypes based on a particular characteristic or condition. In this context, stigma refers to the negative perceptions and social judgments faced by individuals with pedophilic tendencies, as well as the clinicians who treat them (Jahnke et al., 2015; Levenson & Grady, 2019b).

***Thematic Analysis***

A qualitative data analysis method used to identify, analyze, and report patterns (themes) within data. It involves coding the data to find recurring ideas, concepts, or behaviors and

organizing these into broader themes to answer the research questions (Venkatesh Aravindh & Thirupathi, 2019).

### *Willingness to Treat*

Willingness to treat refers to a provider's voluntary compliance or agreement to deliver clinically significant care to a patient **(**Augarde & Rydon-Grange, 2022).

## Summary

This study set out to critically examine how the renaming of pedophilia as "minor-attracted persons" could reconfigure the stigma-related barriers and challenges entrenched within mental health practice. Through the application of a qualitative descriptive approach, this research aimed to unravel the intricate layers of clinicians' lived experiences, dissecting the multifaceted challenges and shifting perceptions regarding this controversial renaming. The study aspired to address a gap in existing research by probing whether a shift in nomenclature might minimize the stigma-related barriers and challenges that mental health professionals face. These findings hold the potential to reframe clinical training and intervention strategies, thus enhancing the capacity of mental health professionals to offer more robust, stigma-reducing care for this population. On a broader scale, the research delved into the ethical dilemmas and policy ramifications linked to renaming efforts, offering critical insights that may inform the restructuring of future clinical guidelines and public health strategies.

## Chapter 2: Literature Review

The purpose of this qualitative descriptive study was to explore whether the renaming of the term "pedophile" to "minor-attracted persons" (MAPs) alleviates the stigma-related barriers and challenges faced by mental health clinicians in their treatment of this population. The problem addressed in this study was whether this renaming minimizes these barriers and challenges or if these barriers remain for clinicians, regardless of the terminology used. This investigation addressed the question of whether this terminological shift mitigates the professional and ethical challenges inherent in providing care to individuals with pedophilic tendencies or if these challenges persist unchanged, irrespective of the renaming effort. Mental health practitioners frequently grapple with intricate ethical quandaries, pervasive societal prejudices, and an insufficient depth of specialized training, all of which can hinder their willingness and capability to offer effective therapeutic intervention for individuals exhibiting sexual attraction to minors (Jahnke et al., 2015; Levenson & Grady, 2019b). These dynamics may perpetuate treatment gaps and reinforce stigma-related barriers and challenges within clinical contexts, raising critical questions about the efficacy of renaming as a tool for stigma reduction.

Research indicates a lack of empirical study and the presence of treatment gaps concerning the services and attention provided to MAPs due in large part to the stigma associated with MAPs and reluctance to treat on behalf of clinicians (Levenson & Grady, 2019a; Lievesley et al., 2022; Sathyanath et al., 2023; Schaefer et al., 2022). Consequently, MAPs remain an underserved patient population—a care gap likely perpetuating the risk of sexual abuse presented to minors (Sorrentino & Abramowitz, 2021). Limited and existing research focuses primarily on healthcare professionals' experiences, perceptions, and willingness to treat

MAPs (Lievesley et al., 2022). In correlation, suicidal ideation rates are higher among MAPs (Sorrentino & Abramowitz, 2021). Hence, outcomes for this population of MAPs presented the potential of not only improving the well-being and psychological health outcomes of MAPs but also minors while reducing the risk of abuse posed to minors. Jara and Jeglic (2021) call for the need for increased research and implementation concerning prevention strategies, such as targeting high-risk individuals by providing them with coping and treatment resources while reducing stigmatization among healthcare providers to minimize stigma-related barriers to effective treatment (Jara & Jeglic, 2021; Moss et al., 2021).

Chapter two, the literature review, provided a synthesis of empirical research on the topic as a basis within which to contextualize the findings of this study and offers support evidencing the gap in existing knowledge and the need for future research regarding the re-wording by mental health clinicians treating MAPs, and intent to treat. This literature review began by describing the search strategy employed and the chosen theoretical framework guiding the proposed study, the theory of planned behavior (Ajzen, 1991). Next, the literature review explored what is known in correspondence to primary topics informing the context of this study, which include defining pedophilia and MAPs, stigma and social perception of pedophilia, renaming the term pedophilia as MAPs, barriers to treatment for pedophilia and MAPs, therapeutic approaches to pedophilia and MAPs, the impact of stigma on mental health professionals, and the ethical and legal considerations in treating pedophilia and MAPs. Chapter two concluded with a summary of literature evidencing the need for future research, and a transition to chapter three, the methods chapter.

A comprehensive Boolean search methodology was applied to identify relevant literature. The following search terms and phrases, listed below, were used across several databases,

including Google Scholar, the university library database, ERIC, NCBI, PubMed, the Cochrane Database, and APA. For each search phrase, the first number represented the total number of results generated across all databases for all time, while the second number reflects the results limited to publications from 2018 onward. Only peer-reviewed, empirical literature published after 2018 was selected for review, except for foundational works relevant to the theoretical framework.

1. Theory of planned behavior: 4 million (all time), 23,000 (since 2018).
2. Current evidence-based practice AND minor-attracted persons: 121 (all time), 76 (since 2018).
3. Current legal plans AND minor-attracted persons AND medical AND mental health AND legal channels: 53 (all time), 23 (since 2018).
4. Minor-attracted persons AND treatment standards: 499 (all time), 270 (since 2018).
5. Pedophilia AND treatment AND barriers: 16,000 (all time), 4,000 (since 2018).
6. Pedophilia AND evidence-based practice: 59 (all time), 18 (since 2018).
7. Pedophilia AND legal plans: 18,000 (all time), 5,000 (since 2018).

Despite the vast expanse of literature concerning a variety of psychological and behavioral topics, the research specifically addressing minor-attracted persons remains conspicuously sparse, revealing a pronounced and critical gap in scholarly inquiry. To mitigate this shortfall, the search strategy was broadened to encompass the term "pedophilia." This adjustment generated a more substantial body of results, yet even within this broader scope, there persists a notable dearth of comprehensive syntheses, such as meta-analyses or systematic reviews, that rigorously examine evidence-based treatment practices for this highly stigmatized population. These observations underscored a pressing and unfulfilled need for further empirical

exploration, signaling a vital area for future research to ensure the development of more robust and effective therapeutic interventions.

**Theoretical Foundation**

The theoretical foundation chosen as most relevant and appropriate in guiding the proposed study's data collection, interpretation of findings, and contextualization was the theory of planned behavior (TPB). The TPB was developed during the 1980s by Ajzen (1985, 1991) and explained human behavior as the result of intention. The theory is useful for describing human behavior in different social contexts because the TPB assumes an individual's behavior is driven by their intention. In other words, intention to engage in a behavior is the most significant determining factor of whether that individual will engage. Moreover, the TPB posits that three predominant factors most significantly determine an individual's intention to engage in a behavior: a) Attitude, b) subjective norms, and c) perceived behavioral control (Ajzen, 1985, 1991; Ajzen & Driver, 1992). Attitude refers to an individual's felt psychological perspective toward a behavior and that individual's beliefs concerning the meaning associated with the behavior. Attitudes may be either positive or negative, and the TPB posits that as an individual's attitude toward a behavior is more positive, that individual is more likely to intend to engage in a behavior. Conversely, as an individual's attitude is more negative towards a behavior, that individual is less likely to intend to engage in a behavior and, therefore, less likely to engage in the behavior (Ajzen, 1985, 1991; Ajzen & Driver, 1992).

Subjective norms refer to societal perceptions and beliefs associated with behavior, which influence an individual's intention to perform or engage in a behavior. Said differently, subjective norms refer to the social pressure or expectations placed on an individual concerning engaging in behavior based on group perspectives and beliefs toward that behavior. For example,

subjective norms can include social or peer, family, and societal perceptions towards behavior. Often, subjective norms are influenced by broader cultural values, perspectives, and beliefs. Subjective norms influence an individual's intention to engage in a behavior because individuals seek belonging and acceptance from their surrounding social circles. Therefore, if an individual is contextualized by subjective norms of their peers, family, or culture of belonging that disapprove of behavior, the TPB posits that that individual will be less likely to intend to engage in the behavior because of the risk of disapproval and a lack of acceptance by their family, social, and societal circles of belonging (Ajzen, 1985, 1991; Ajzen & Driver, 1992).

Perceived behavioral control refers to an individual's perception of the degree to which they can engage in the behavior with ease and capability. Hence, The TPB posits that as an individual perceives that they will be able to engage in a behavior with greater ease, they are more likely to intend to engage in the behavior. External factors, as well as internal psychological factors, may facilitate or hinder an individual's perceived behavioral control. For instance, barriers to engaging the behavior in the external world may minimize an individual's perception of behavioral control, while aspects that make engaging the behavior more easily facilitated will contribute to an increase in perceived behavioral control, which will, consequently, increase the likelihood that the individual will intend to engage in the behavior and therefore perform the behavior. Factors influencing behavioral control in the context of acting on minor attraction may include but not be limited to legal barriers, interference from family members or friends, and/or the risk of repercussions (Ajzen, 1985, 1991; Ajzen & Driver, 1992).

The TPB has been applied throughout various fields, including but not limited to social psychology, healthcare, and business marketing, to understand and even predict behaviors influencing work outcomes, health outcomes, and psychological well-being. The theory of

planned behavior has been used to understand individuals' and patients' likelihood of engaging in health-beneficial and health-detrimental behaviors such as exercise habits, eating habits and dietary practices, smoking, and consumer choices, the latter of which has been applied to the field of business marketing. Because of the versatility of the theory of planned behavior in terms of application and its consistent, long-term validation, the TPB is known to be a trustworthy and valuable framework for use in empirical research and the designing of evidence-based practice interventions and solutions aimed at understanding and promoting behavioral change (Ajzen, 1985, 1991; Ajzen & Driver, 1992). Because the proposed study specifically asserted the lack of research concerning how evidence-based practices (EBP) are related between the treatment of minor-attracted persons and mental healthcare providers, which focuses on the behavior of EBP application and the intent to treat MAPs, the TPB was a fitting and highly appropriate theoretical framework for guiding the data collection of the proposed study and interpreting and contextualizing the results within the existing literature.

One of the aspects that distinguished Ajzen's (1985) early development of the TPB from other behavioral theories is that while other traditional frameworks recognized most human behavior as primarily goal-directed, with the end goal being the primary motive incentivizing intent to behave and thus behavior, Ajzen (1985) recognized three deeper psychological factors as motivating behavioral intention and thus behavior. These psychological factors of social norms, perceived behavioral control, and attitude describe an individual's motivation and, therefore, intent to behave based on deeper psychological needs. For this reason, the theory of planned behavior became more widely applicable and trustworthy because these psychological needs bridged disciplines, as opposed to goal-oriented intentions, which are often more industry or discipline-specific (Ajzen, 1985; Ajzen & Driver, 1992). Conversely, such fundamental

human psychological needs, such as the desire for belonging and acceptance, drive behaviors manifest in a variety of ways across disciplines. Ajzen (1991) pinpointed these deeply rooted psychological influences, and consequently, the theory has been applied across disciplines to understand not only human behavior but also to inform various stages of formally and institutionally applied change models based on the predictions of human behavior (Ajzen, 2020; J. J. Martin, 2017; Rossmann, 2021, 2020).

Moreover, the theory has been adapted and has evolved. For instance, Rossmann (2020 , 2020) developed what is known as the theory of reasoned action, informed by assumptions and tenets of the theory of planned behavior. However, Rossmann's (2021) theory was not chosen as the most appropriate or relevant guiding theoretical framework for the proposed study because it emphasizes the influence of logic and reason alone as the guiding motivators of human behavior. Contrary, Ajzen's (2020) theory, as clarified in his recent Frequently Asked Questions publication, understands mental components and socio-emotional components as motivators of human behavior. In this way, Ajzen's (1991) framework takes a more holistic and comprehensive perspective on the factors driving and motivating human behavior, making it more reliable, trustworthy, and applicable to a variety of disciplines, human personality types, and contexts, understanding that some individuals may be more fully motivated by analytical reasoning, such as perceived through behavioral control, while others may be more motivated by the influence of here and social perceptions, due to a need for social acceptance (Ajzen, 2020).

As evidence of the TPB theory's reputability and validated application, Bosnjak et al. (2020) document that the theory of planned behavior has been empirically scrutinized and over 4,000 published research papers, specifically referenced in the graphic database of the websites. This makes the theory of planned behavior one of the most widely applied social and behavioral

science theories of the 19th and 20th centuries. More specifically, Godin and Kok (1996) conducted an early evaluation of the theory of planned behavior concerning its reliability when used to predict intention. The researchers' results indicated that the theory performed extremely statistically significantly well when used to explain intention.

Variables of attitude toward action and perceived behavioral control were the most significant factors explaining intention variation. The researchers concluded that the theory of planned behavior was significantly effective in explaining intention based on perceived behavioral control and attitude. However, a weakness of the theory was that its efficiency in predicting intention of behavior varied between categories of health-related behaviors. Thus, these findings implied that the theory's accuracy and strength in predicting intention and behavior may vary specifically when applied to health-related behaviors (Godin & Kok, 1996). However, because it continues to be one of the most validated behavioral theories contextually relevant to the proposed study, it was chosen as the most trustworthy and relevant guiding theoretical framework for application herein (Ajzen, 1991). Therefore, the proposed study offered useful insight contributing to understanding the theory of planned behavior's reliability when applied to quantitative mental health, social, and psychological studies. The next section of the literature synthesized what is empirically known on the proposed study topic.

**Defining Pedophilia and Minor-Attracted Persons (MAPs)**

Pedophilia is conceptualized in clinical discourse as a psychiatric condition characterized by a chronic and preferential sexual attraction toward prepubescent children, typically those younger than 13 years of age. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V-TR) classifies pedophilic disorder based on the presence of recurrent, intensely arousing sexual fantasies, urges, or behaviors involving prepubescent children, persisting for a

minimum duration of six months, and causing significant distress or functional impairment (American Psychiatric Association, 2022). A nuanced distinction exists between the cognitive and emotional phenomena underlying pedophilia and the behavioral enactment of such impulses—namely, offending—which constitutes engagement in illegal or morally transgressive actions (Seto, 2008). This distinction emphasizes the need to separate diagnosis from criminal actions, focusing on prevention and mental health support instead of linking attraction directly to harmful behavior.

The term "minor-attracted persons" (MAPs), in contrast, encompasses a broader taxonomy of individuals who experience sexual or romantic inclinations toward individuals below the legal age of maturity. This category includes prepubescent attraction (pedophilia), pubescent attraction (hebephilia), and attraction to post-pubescent adolescents (ephebophilia) (Blanchard et al., 2009; Martijn et al., 2020, 2021). The introduction of this terminology represents a paradigm shift aimed at mitigating societal stigma and engendering an environment conducive to therapeutic engagement, wherein individuals are not solely defined by their attraction but recognized holistically (Levenson & Grady, 2019a). The usage of "MAP" emphasizes person-first language, which underscores the individual's humanity beyond their orientation, aligning with contemporary ethical imperatives in mental health care.

The heterogeneity within this population is pronounced, encompassing divergent psychological profiles, behavioral patterns, and ethical frameworks. For example, a subset of MAPs self-identifies as non-offending, consciously refraining from acting upon their attractions due to moral convictions or fear of legal repercussions (Stevens & Wood, 2019). These individuals often grapple with profound internalized stigma, heightened susceptibility to depression and anxiety, and pervasive fear of societal ostracism—factors that collectively

disincentivize the pursuit of professional support (Grady & Levenson, 2021). Conversely, offending MAPs, who have committed legally proscribed acts, are often the primary focus of research and treatment efforts, which emphasize recidivism prevention, behavioral management, and legal accountability (Seto, 2008).

Pedophilia is frequently conflated with child sexual abuse in public discourse, a reductionist perspective that obscures critical distinctions and perpetuates stigmatization (Levenson & Grady, 2019b; Seto, 2008). Emerging research underscores the importance of acknowledging that not all individuals with pedophilic attractions engage in abusive behavior (Farmer et al., 2024;  Schaefer et al., 2022). Discerning a distinction between the two definitions of pedophilia versus MAPs can change society and professional counselors' perceptions towards those afflicted with these conditions. The significance of such an examination may impact the stigmatization that such terms have and produce a changed perspective of those professionals in assisting these individuals with treatment measures (Lievesley et al., 2020). This recognition is essential for cultivating a balanced approach to clinical and societal responses—one that prioritizes preventive strategies, mental health interventions, and the enhancement of public safety while addressing the complex needs of this population. By adopting a nuanced framework, practitioners and researchers can eschew the polarizing narratives that dominate public opinion and instead focus on evidence-based strategies that foster well-being and minimize harm.

**Stigma and Social Perception of Pedophilia**

Stigmatization describes a mental barrier to adequate and sufficient treatment towards minor-attracted persons, and existing research suggests that the media contributes to the presence of stigma in a way that prevents the advancement of treatment approaches and guidelines (Glina et al., 2022; Ischebeck et al., 2024). For example, journalism has long contributed to stigmatizing

pedophilia at the expense of continuing research and treatment development (Glina et al., 2022; Ischebeck et al., 2024). Furthermore, a lack of post-incarceration and reintegration protocols, programs, and resources exist for offenders attempting to reintegrate into society after incarceration. The lack of such resources is thought to contribute to reincarceration and the perpetuation of offenses committed by minor-attracted persons due to a lack of treatment addressing the psychological well-being of perpetrators (Canada et al., 2022; Simmons et al., 2021).

The public stigma associated with minor-attracted persons and pedophilia, perpetuated by media coverage, strongly correlates with negative behavioral and emotional consequences for MAPs seeking treatment and health. Specifically, it is found that increased exposure to negative portrayals of pedophilia by the media correlates with self-esteem among MAPs and reduced help-seeking due to the fear of negative stigmatization and marginalization (Stelzmann et al., 2022). Although pedophilic acts are a public health threat, Stelzmann et al.'s (2022) research is in alignment with the theory of planned behavior (Ajzen, 1991) that underscores the influence that social and societal norms have on behavioral intent—in this case, explicitly help-seeking behavior. As negative social norms surround minor-attracted persons, intent to seek help deteriorates due to the negative stigmatization associated with the condition (Ajzen, 1991; Stelzmann et al., 2022).

Stigma surrounding minor attraction and pedophilia has been widely recognized as a significant barrier to research, clinical engagement, and treatment access. Levenson and Grady (2019a) emphasized that individuals with pedophilic interests often fear seeking professional help due to intense societal condemnation and legal repercussions, which contributes to underreporting and lack of treatment. Lievesley et al. (2022) found that even trained clinicians

may harbor moral discomfort and negative biases toward this population, which hinders open dialogue and therapeutic rapport. Schaefer et al. (2022) noted that the stigmatization of minor-attracted persons leads to widespread social isolation, internalized shame, and a reluctance to access preventive mental health care. Similarly, Sorrentino and Abramowitz (2021) highlighted how stigma not only impedes treatment but also deters empirical investigation, creating a research vacuum that limits evidence-based practice. Together, these findings demonstrate that stigma is a foundational obstacle to both clinical care and scientific advancement in this area. Addressing this topic will likely contribute to the development of more effective treatment approaches, protocols, successful mental health care outcomes, and improvements in public safety and well-being. Hence, a need exists within empirical research to examine not only the impacts on victims but also the impacts on MAPs and devise legal approaches and frameworks that allow for the effective, non-stigmatized treatment and provision of services to MAPs (Jackson et al., 2022). Furthermore, the synthesis of the literature suggests that additional legal barriers to effective treatment of minor-attracted persons include factors such as mandatory reporting, age-related consent laws, laws concerning child pornography, laws concerning civil commitment, notification, and registration laws, and treatment options that are overall, limited (Christofferson, 2019; Moorti & Cuklanz, 2023).

**Barriers to Treatment of Pedophilia and MAPs**

Medical and mental health care barriers guiding the effective treatment and the development of treatment standards concerning minor-attracted persons suggested throughout the scant literature describe current empirical suggestions and recommendations towards treatment. Because literature is sparse on the topic, a review of research on the topic of MAPs and the application of evidence-based practices towards treatment, as well as mental healthcare

practitioners' intention to treat, revealed that one of the most prominent mental healthcare barriers to effective treatment and development of treatment standards seems to be stigma. The strong stigma associated with minor-attracted persons is thought to inhibit many mental health care providers from discussing, researching, and proactively addressing the topic (Levenson & Grady, 2019a; McCoy, 2017; Schaefer et al., 2022).

Mental health care and medical barriers to treatment of minor-attracted persons found throughout the literature include but may not be limited to stigma and discrimination, inaccessible services, reporting and legal requirements, ethical complications, a limitation of research and evidence-based practice guidelines guiding providers, and a lack of social support networks. For example, research suggests a significant amount of discrimination and stigma from mental health care providers towards minor-attracted persons, which not only may inhibit MAPs from seeking help and from disclosing their attraction but can also inhibit the willingness to treat and intention to treat among mental health care providers, the latter of which further minimizes effective treatment (Levenson & Grady, 2019b; Schaefer et al., 2022). The more stigma and discrimination mental health care providers attached to the condition of minor attraction, the less willing these individuals may be to address and see patients suffering from this condition, which further contributes to the condition being problematic within society. Because of this stigma, minor-attracted persons may experience a limitation of services available and limited access to services. Stigma and a lack of funding and research on the topic may minimize the affordability and accessibility of services.

Additionally, mental healthcare providers may encounter ethical challenges when attempting to provide treatment and support to these individuals. These ethical challenges may include legal complications and moral issues (Levenson & Grady, 2019a; Schaefer et al., 2022).

For example, providers may be under pressure to provide non-discriminating support and treatment care to an individual in a confidential setting while simultaneously experiencing legal pressure to disclose potential threats of offense to protect the safety of potential victims. This can place significant pressure on providers addressing this population, thereby hindering many mental healthcare providers from engaging in the domain in the first place (Levenson & Grady, 2019a; Schaefer et al., 2022). As described previously, a scarcity of research on the topic, due in large part to stigma, has resulted in not only a lack of education and guidance relating to treatment standards of minor-attracted persons, which may otherwise assist mental health care providers in being more comfortable with providing treatment but also, contributes to a lack of public education on the topic and thus a cyclical perpetuation of associated stigma. This perpetuation of associated stigma is thought to contribute to a lack of social networks concerning the treatment of MAPs for both minor-attracted persons themselves and mental health care professionals intending to provide treatment to this population (Levenson & Grady, 2019b; Schaefer et al., 2022).

Research suggests that medical and mental health care barriers to effective treatment of MAPs also arise from the fact that pedophilia and child sexual abuse are framed, in part, by cultural contexts, even though it is a global phenomenon and issue (Bayram et al., 2021). Moreover, child sexual abuse is a worldwide issue surrounded by and characterized by complex psychological, emotional, financial, and legal ramifications (Bayram et al., 2021; Global Prevention Project, 2023; Heasman & Foreman, 2019; Sreenivasan et al., 2023). This makes addressing the issue extremely sensitive, complex, and culturally specific; consequently, treatment guidance must consider the cultural, legal, ethical, and societal contexts. For this reason, a lack of unanimous treatment protocol and frameworks exist, and current suggestions

are framed according to overarching cultural stigma, context, and other factors. Additionally, as mentioned previously, because of stigma, a lack of cohesive and comprehensive treatment plans exists (Sreenivasan et al., 2023). Most treatment concerning minor-attracted persons relates to legal ramifications and punitive reinforcement. Some literature exists concerning prevention, while the least relates to treating perpetrators' psychological conditions and well-being and non-offending MAPs (Bayram et al., 2021; Heasman & Foreman, 2019; Sreenivasan et al., 2023).

Finally, research conducted by Parsonson and Alquicira (2019) found that self-care and social support are extremely important factors in perpetuating psychological and mental well-being among offending minor-attracted persons, thereby suggesting that those without effective self-care coping strategies and support circles may face more tremendous barriers to adequate or effective treatment. Hence, research such as this suggests the complex and interwoven way factors influence the mental healthcare barriers to viable treatment for this population. Münch et al. (2020) found that although pedophilia is generally conceptualized as a condition harmful to others, it is equally harmful to affected persons due to the negative psychosocial consequences and repercussions to self-esteem often associated with the condition—the latter of which is known to become a barrier to effective treatment due to the minimized potential for help-seeking behavior. Similarly, Pirelli et al. (2020) identified that burnout and compassion fatigue can be barriers to continuing treatment provisions towards sexual offenders by mental health care providers.

Barriers to the development of changed legal structures concerning the treatment of minor-attracted persons relate to ethical and safety concerns, such that many communities and individuals wish to uphold current strict legislation regarding reporting requirements, while others suggest that these requirements hinder self-disclosure and effective treatment engaged in

and received by minor-attracted persons (Mundy, 2020; Walker, 2021; Wilson, 2021). Consequently, legal barriers to treatment include but are not limited to unanimously accepted classifications and legal definitions, the protection of confidentiality and privacy, stigmatization among health care providers and the public, reporting laws, limited accessibility and options concerning treatment, consequences, they lack and limitation of guiding research and effective frameworks (Mundy, 2020; Walker, 2021; Wilson, 2021).

**Therapeutic Approaches and Outcomes to Pedophilia and MAPs**

This section of the literature review described positive outcomes associated with treating minor-attracted persons found throughout the literature reviewed. As with the literature reviewed in previous subsections, empirical evidence describing treatment approaches and outcomes concerning minor-attracted persons is extremely sparse compared to the empirical literature on other topics within the behavioral and Health Sciences. However, a review and synthesis of existing evidence-based practice and treatment outcomes of minor-attracted persons, in addition to pedophiles, revealed that positive outcomes experienced by this population about treatment include improvement in mental health outcomes, reduced risk of offending, and improved coping or self-management skills (Bekkers et al., 2023; Levenson & Grady, 2019a). Improvements in psychological condition and symptoms are important because it is thought to decrease the risk of offending while improving the overall well-being and quality of life of affected individuals. Improved psychological symptoms may include but not be limited to reductions in depression, anxiety, and suicidal ideation, and in tandem, improvements in self-confidence, reintegration into social circles, and reduced levels of self-stigmatization (Bekkers et al., 2023; Levenson & Grady, 2019a). For instance, some studies have found significant, positive psychological improvements, such as decreases in depression and improvements in behavioral control associated with the use

of pharmacological interventions and cognitive behavioral therapy in combination (Gannon, 2021; Pfaus, 2022; Scarpazza et al., 2023).

The improvement of self-management skills and coping mechanisms has been observed in a few studies concerning positive outcomes of cognitive behavioral therapy when used among minor-attracted persons (Bekkers et al., 2023; Levenson & Grady, 2019b; Pfaus, 2022). Cognitive behavioral therapy has been shown to lead to an increase in positive coping mechanisms, increased awareness of potential triggers of maladaptive behavior or child sexual engagement, and increased voluntary avoidance of those triggers, as well as increased boundary setting and impulse control among MAPs (Bekkers et al., 2023; Levenson & Grady, 2019a; Pfaus, 2022). Furthermore, increased integration into community and peer support groups is suggested to also aid in the minimization of detrimental behavior among MAPs, although research in this area is scant (Bekkers et al., 2023; Levenson & Grady, 2019a; Pfaus, 2022). Although increased peer and community support is thought to contribute to improvements in behavioral attention, specifically the intention to engage in positive, adaptive behavior due to the attached positive social norms and perceived social belonging and acceptance, many MAPs lack otherwise helpful social integration and support groups due to a lack of resources and fear of stigmatization or self-disclosure (Bekkers et al., 2023; Levenson & Grady, 2019b; Pfaus, 2022).

Levenson and Grady (2019a) report characteristics and markers of useful, significantly positive therapeutic outcomes concerning MAPs, including an increase in non-judgmental attitudes among therapists and maps, increased knowledge about attraction to minors among therapists and MAP, and holistically viewing individuals. For therapists, this includes viewing clients in a whole-person-centered way instead of focusing only on their pathology. Concerning patients, this refers to a reduced self-stigmatization (Levenson & Grady, 2019a). Likewise,

positive outcomes of online support group therapeutic approaches can include an increased sense of social belonging and acceptance and, therefore, a more positive self-perspective, a more hopeful outlook, and an increased perpetuation of help-seeking behavior, as opposed to a reluctance to seek help in cases in which MAPs experience severe social isolation and self-stigmatization (Bekkers et al., 2023). Bekkers et al.'s (2023) research findings involving a thematic analysis showed that the provision of bonds of trust, social control, and education provided through online forums and support networks specifically for MAPs resulted in a reduction of stigma, improved coping mechanisms, and overall, provided the majority of MAPs with what was perceived to be a stepping stone towards seeking professional care and assistance, as well as the provision of an informal supportive social environment to encourage prevention and adaptive coping behaviors (Bekkers et al., 2023; Pfaus, 2022).

Pharmacological interventions have also been found to be significantly useful, resulting in statistically significant minimizations in adverse outcomes and symptom severity associated with minor attraction. Pfaus (2022) documents dangers related to cancel culture, emphasizing that cancel culture contributes to the vilification of sex researchers, dampening research conducted on the topic and contributing to the under-service toward this in-need population of MAPs. Moreover, in the same study, Pfaus (2022) describes research findings indicating that most frontline approaches to pharmacological intervention used among sex offenders, sex addicts, and not minor-attracted persons are significantly effective in reducing maladaptive behavior. Similarly, Fix and Shepherd (2019) describe how stigmatizing and negative perceptions toward child sexual abuse on a societal level block research pathways and, ultimately, block effective treatment and prevention of childhood sexual abuse. On the contrary, the continuation of research and the implementation of effective treatment approaches has been

initially shown to result not only in treatment outcomes that improve the well-being of MAPs and the safety of minors but also the improvement of familial dynamics, marriages, and the repair of marriages that have otherwise been damaged through childhood sexual abuse (Koelling, 2021). Such research suggests the need to encourage a shift in perception among researchers and practitioners concerning the investigation of effective treatment approaches, intent to treat, and evidence-based practice relating to MAPs.

For example, Martijn et al. (2021) described the phenomenon of minor attraction in terms not only of sexual desire but also romantic attraction, offering insight into the complex psychological experiences of perpetrators and non-offending minor-attracted persons, and, therefore, the complex psychological needs of these individuals concerning treatment avenues (Martijn et al., 2021). Martijn et al. (2020) also suggested in an earlier research study that one of the most important aspects of treatment targeting MAPs is the importance of trauma healing to foster these individuals' ability to develop emotional capacity and intimacy, as opposed to maladaptive and safety compromising sexual desires (Burns, 2023; Nurbayani et al., 2022). Moreover, furthering research on the topic and improvement of treatment provisions may lead to a dismantling of previous preconceptions concerning MAPs, such as gender and sexual orientation stereotypes associated with MAPs (Lawrence & Willis, 2021; Lievesley & Lapworth, 2021; Zielona-Jenek, 2020) and may lead to a minimization of misdiagnosis (Ferreira et al., 2021). For instance, it is common for pedophilia to sometimes be misdiagnosed as obsessive-compulsive disorder and vice versa (Ferreira et al., 2021).

Because the volume and diversity of treatment plans towards minor-attracted persons documented within empirical literature is scant. Consequently, the documentation among empirical literature of the outcomes and impact of current treatment plans towards minor-

attracted persons is also lacking (Landgren et al., 2022). However, the literature suggests the efficacy of pharmacological interventions (Landgren et al., 2022). For instance, one of the few meta-analyses documenting the outcome of treatment towards pedophilic individuals indicated that the use of pharmacological interventions, specifically testosterone-lowering drugs, was statistically significantly associated with a reduction in both psychiatric experiences and symptoms of pedophilia, as well as a reduction in adverse coping mechanisms and behaviors such as child sexual abuse (Landgren et al., 2022). A synthesis of literature also reveals that intended, positive outcomes of treatment toward minor-attracted persons include but are not limited to the risk reduction of offense, improvements in the mental health status of affected individuals, the enhancement of positive, adaptive self-coping and management strategies, legal compliance, the provision of accountability, the closing of research gaps, and the reduction of stigmatization and social isolation attached to an experienced by minor-attracted persons (Guo et al., 2020; Walker, 2019).

Concerning minimizing the public health threat that minor-attracted persons present, a primary objective or outcome of treatment concerns reducing the risk of offenses committed. The documented, intended outcomes of treatment are interwoven and mutually influential, such that improvements in the mental health state experienced by minor-attracted persons and the enhancement of adaptive coping mechanisms and self-management behaviors are thought to contribute to a reduction of the risk of offense, such that minor-attracted persons will be more adequately armed to manage their behavior and make sound decisions (Guo et al., 2020; Landgren et al., 2022; Walker, 2019). As a result, it is speculated that these individuals will comply with legal requirements more appropriately (Guo et al., 2020; Landgren et al., 2022; Walker, 2019). Also, by increasing the amount of education and training provided to

practitioners in a way that is aimed at reducing associated stigma, effective accountability, monitoring, and providers' legal compliance is thought to increase, thereby allowing for more effective treatment delivery and the conducting of research that can close current gaps and understanding. Overall, emerging approaches, routes, and avenues of research suggest that the primary goal involves reducing the stigma associated with minor-attracted persons among mental healthcare providers so that research can continue to be conducted and treatment can continue to be provided to minor-attracted persons in a way that comprehensively addresses roots of the issues and improves the well-being of both patients and the safety of otherwise potential victims (Guo et al., 2020; Landgren et al., 2022; Walker, 2019).

Despite the lack of research concerning the positive and intended outcomes of current treatment plans, research indicates that ineffective treatment plans towards minor-attracted persons can increase internalized social stigmatization and, consequently, a reduction in psychological well-being among minor-attracted persons (Walker, 2019). Additionally, survey research suggests that the likelihood of labeling or attaching pedophilic stigmatization towards individuals by public and mental health care provider perception is increased among LGBTQ populations, regardless of whether the LGBTQ individual is a minor-attracted person (Walker, 2019). Consequently, the same research suggests that because of this increased likelihood of stigmatization towards sexually marginalized communities and LGBTQ individuals, LGBTQ individuals are more likely to experience social isolation, internalized stigmatization, insecurity, lack of confidence, and feelings of being misunderstood, all of which can contribute to a lack of help-seeking behavior related to a variety of psychological conditions (Walker, 2019). Such findings suggest that the intended outcomes of current treatment plans ought to be to reduce the stigmatization and misunderstanding associated with various sexually marginalized populations.

As mentioned previously, digital, artificial intelligence-driven solutions to treatment may aid in increasing the positive outcomes associated with treatment, such that affected individuals may be more apt to seek help from AI-driven platforms, knowing that their self-reporting or conversations are not being documented by the individual, directly (Guo et al., 2020).

Consequently, such treatment options guided by artificial intelligence may reduce the psychological distress experienced by minor-attracted persons, thereby improving the likelihood of treatment continuance and subsequent outcome progress, including developing effective management strategies and coping mechanisms (Elchuk et al., 2022). Elchuk et al. (2022) found that as minor-attracted persons studied perceived an increase in social support for their treatment and healing from providers and family members, suicidal ideation decreased, alongside other psychological health markers.

Research also suggests that possible intended outcomes of treatment vary somewhat depending on whether treatment is being administered to offending or non-offending minor-attracted persons (L. J. Cohen et al., 2019; Stevens & Wood, 2019; Walker et al., 2022). The research defines non-offending minor-attracted persons as individuals who suppress their attraction to minors. Because of a lack of research on the topic, empirical research documenting the effects of coping mechanisms employed by non-offending minor-attracted persons is minimal and thus leads to a gap in informed practice that could otherwise aid in designing interventions for minor-attracted persons that emphasize and perpetuate the use of these coping mechanisms (L. J. Cohen et al., 2019; Stevens & Wood, 2019; Walker et al., 2022). Circling back to a discussion of the intended outcomes of treatment, as they vary between non-offending and offending minor-attracted persons, research thus suggests that the intended treatment outcomes of offending minor-attracted persons are to primarily reduce adverse behaviors, with

the intent of improving the safety of potential victims (L. J. Cohen et al., 2019; Stevens & Wood, 2019; Walker et al., 2022). The outcomes of treatment concerning non-offending minor-attracted persons are primarily aimed at improving the psychological condition of patients, such that they experience an increase in confidence, improved coping mechanisms, reduced suicidal ideation, and improved mental health markers. Although these intended treatment outcomes may differ, research suggests that the treatment of both offending and non-offending individuals ought to equally consider the mental health of patients addressed since mental health status is understood to contribute to behavioral intention (L. J. Cohen et al., 2019; Stevens & Wood, 2019; Walker et al., 2022).

Another key objective of treatment towards minor-attracted persons referenced informally throughout the literature is treating trauma as a means by which to treat the condition of being minor-attracted (McKillop & Price, 2023; Robinson et al., 2021). More recent research highlights the need for trauma-informed practitioners in this field (Grady & Levenson, 2021), underscoring the fact that the experience of childhood trauma often increases the risk of psychological distress and the development of pathological conditions such as pedophilia later in life (Grady & Levenson, 2021; Schaefer et al., 2022). Specifically, Grady and Levenson (2021) found that 75% of minor-attracted persons evaluated had experienced emotional and verbal abuse during childhood, while 78% had experienced bullying by siblings or peers.

This section describes what is known regarding existing evidence-based practice relating to minor-attracted persons (Gannon, 2021; Levenson & Grady, 2019a; Scarpazza et al., 2023; Stelzmann et al., 2022). Literature documenting evidence-based practice recommendations concerning the treatment and management of MAPs is extremely sparse, pointing to a need for future research and a need to increase education provided to healthcare providers and minimize

public and healthcare provider stigmatization. However, the literature reviewed in this section revealed positive outcomes associated with the effective treatment of minor-attracted persons, specifically concerning the use of cognitive behavioral therapy and pharmacological interventions, both of which have been shown to reduce negative psychological experiences, reduce the risk of offending, and improve MAPs' implementation of positive coping mechanisms. Additionally, online social support forums effectively bridge MAPs' sense of isolation and intent to reach out for professional help and treatment.

**Impact of Stigma on Mental Health Professionals**

Limited and existing research focuses primarily on healthcare professionals' experiences, perceptions, and willingness to treat MAPs (Lievesley et al., 2022). Support within communities for treating minor-attracted persons (MAPS) has not been examined, and the limited research on this topic focuses on primary healthcare professionals' experiences, perceptions, and willingness to treat this population (Lievesley et al., 2022). The impact for mental health professionals when treating MAPs can include mandatory reporting and concerns with providing effective treatment.

Mandatory reporting can be a legal barrier to effective treatment of minor-attracted persons because many local jurisdictions require mental health care professionals, including those in the domains of education, psychotherapy, and traditional health care, to report suspicious activity such as child abuse, neglect, and sexual abuse (Bonagura et al., 2022; Christofferson, 2019; Moorti & Cuklanz, 2023). These reporting requirements often require such professionals to report suspected conditions, such as the condition of being minor attracted, regardless of whether or not an offense is suspected of having been committed. Such requirements concerning reporting can place conflicting pressures upon providers regarding

respecting an individual's confidentiality and privacy to provide effective treatment and support, in contrast to reporting the individual for the safety and concern of others.

Additionally, these known reporting requirements can inhibit a minor-attracted person's likelihood of openly disclosing their condition and struggle for fear of being reported and facing accusations that may or may not be accurate (Bonagura et al., 2022; Christofferson, 2019; Moorti & Cuklanz, 2023). Additionally, age consent laws vary according to local governments and define ages at which sexual activity is legally permissible. If an individual is underage, according to the local jurisdiction, even if both individuals engaging in a sexual act consented to the act, the act is still generally considered a criminal offense.

Christofferson (2019) once explored the efficacy and viability of various preventative treatment options for minor-attracted persons to determine patients' confidence, comfort, and educational knowledge levels with various treatment options to determine their efficacy, accessibility, and viability. Study findings revealed a wide variance between individuals' likelihood of engaging in treatment options and were therefore inconclusive concerning the efficacy of various treatment options. This was thought to be because most treatments require self-reporting. At the same time, this demonstrates a mental barrier to effective treatment and underscores an illegal barrier to treatment, considering the implications of self-reporting (Christofferson, 2019). It appears that more clear treatment guidelines concerning the psychological well-being of minor-attracted persons have been developed concerning non-offending individuals, as opposed to offending individuals, the latter of which the focus of research remains on public, external prevention and negative repercussions rather than a treatment of the psychological experiences of these individuals (Tenbergen et al., 2021).

Tenbergen et al.'s (2021) research signifies the need for legal frameworks to be reorganized to allow practitioners to increase the focus allocated to developing intervention and treatment protocols for both offending and non-offending groups. Moss (2019) reports research findings indicating that in one community examined, higher levels of maladaptive coping mechanisms among minor-attracted persons were associated with a minimized intent to seek help among MAPs and that increased internalized stigmatization levels were also positively associated with a decrease in intention to seek help—findings that align with the assumptions of the TPB positing that increased negative social norms and attitudes predict a reduction of behavioral intent.

Appel (2022) asserts that the effective treatment of minor-attracted persons is surrounded by various ethical and legal complexities, considering that sexual contact between minors and adults is prohibited based on child welfare laws. However, technological advancements may present circumventions to previous challenges related to a reluctance to seek help among MAPs due to governing laws (Appel, 2022) since technological platforms may provide anonymous and confidential treatment assistance to individuals without the need to confide in another individual, and thus without the fear of incarceration due to help-seeking behavior (Nurbayani et al., 2022). The provision of treatment and surrounding ethical and legal debates ensue as scholars and practitioners alike demonstrate a variety of sometimes opposing opinions concerning how treatment ought to be approached and how it ought to be delivered (Ewald, 2023; Sakib, 2022; Sobko et al., 2024).

**Renaming Pedophilia as Minor-Attracted Person**

Academic works written on the topic of pedophilia and minor-attracted persons have focused on how these terms define and stigmatize a person (Ischebeck et al., 2024; Jahnke et al.,

2021). However, some researchers noted that the renaming of the term pedophilia to minor-attracted persons has not been accepted in professional circles and is often met with controversy (Farmer et al., 2024; Jara & Jeglic, 2021). Despite pro-pedophile activism and supportive professionals working with MAP, the term MAPs continue to surface in scholarly and policy discourse in association with pedophilia resulting in media and public backlash (Dearden, 2023). Other experts perceived the change would provide a neutral and non-stigmatizing alternative to the term "pedophile" (Bindel, 2023; McKillop & Price, 2023). Currently, the use of the term MAPs has only been accepted by small groups of academics in such fields associated with psychology, sexual abuse prevention, or pedophilia treatments.

Controversy over the idea of renaming the term pedophilia has caused a rigorous amount of discontent, scandal, and accusations of endorsing child sexual abuse (Farmer et al., 2024). Critics of changing the term pedophilia to MAP are concerned that it normalizes pedophilia while conflating sexual attraction to children and trivializing the use of the concerns associated with the actions of this term (Svrluga, 2021). These same critics accused proponents of changing the term to MAPs as an attempt to normalize pedophilia and create an acceptance of such actions (Coulter & Newman, 2021; Walker, 2021).

**Ethical and Legal Considerations in Treating Pedophilia and MAPs**

This section described what is known about current standards outlining the treatment of minor attractive persons. Because of the significant lack of research on the topic of minor-attracted persons in pedophilia and large, there is currently no unanimously accepted guiding theoretical framework applying to the prevention of pedophilia, nor is there a set, uniformly accepted set of treatment standards for minor attractive persons (Lievesley & Harper, 2020). However, scholars describe various treatment recommendations, many of which share similar

themes and approaches. For instance, Lievesley et al. (2020) describe the need for practitioners to address the psychological well-being of both offending and non-offending minor-attracted persons with the same level of importance as behavioral prevention, considering that psychological distress is thought to be as significant of a public health threat as offenses. Psychological distress among minor-attracted persons can increase the risk of suicide, suicidal ideation, depression, and even a lack of help-seeking behavior, which can consequently increase the risk of offenses committed (Grady et al., 2018; Lievesley et al., 2020). This section first explores medical and mental healthcare barriers to treatment standards of minor-attracted persons and second describes legal barriers to treating minor-attracted persons.

A review of current literature revealed that the presence and implementation of universal legal standards concerning treating minor-attracted persons in medical, mental health, and legal channels has yet to be devised (Selmani-Bakiu & Ratkoceri, 2021). In other words, currently, no standard legal plans are still specifying the treatment of minor-attracted persons across both mental health and legal channels (Selmani-Bakiu & Ratkoceri, 2021). However, a synthesis of current standards and recommendations across channels reveals that most practitioners and scholars agree that prevention and education are imperative to minimize the burden that society faces concerning the abuse of victims and the lack of treatment provided to minor-attracted persons (Levenson & Grady, 2019a; Melton et al., 2017; Selmani-Bakiu & Ratkoceri, 2021). Prevention and education require patient, community, and practitioner education to mobilize effective therapeutic interventions, supervision, civil commitment, and therapeutic approaches (Selmani-Bakiu & Ratkoceri, 2021). Additionally, legal scholars suggest that increased advocacy and support are imperative to prevention, effective reporting, monitoring, protection, and continuing research (Melton et al., 2017). Emerging research is more prominently guided by the

intent to develop education and interventions that overcome stigma among providers to increase prevention by effectively treating the psychological conditions and experiences of minor-attracted persons (Levenson & Grady, 2019a).

Disagreements and conflicting perspectives concerning classifications and legal definitions on the topic of pedophilia, minor-attracted persons, and offenses committed therein can create challenges to effective legal frameworks guiding the treatment management of minor-attracted persons and behaviors (Mundy, 2020, 2022; Walker, 2021). Specifically, conflicting perspectives and definitions characterizing help-seeking individuals, risk-presenting individuals, and offending versus non-offending individuals can cause complications in streamlining treatment approaches. Similarly, conflicting views concerning privacy and confidentiality and ethical considerations guiding treatment can lead to incongruencies in treatment delivery and confusion among practitioners when navigating challenging situations characterized by conflicting pressures (Mundy, 2020, 2022; Walker, 2021). Furthermore, as mentioned throughout all previous subsections of this literature review, stigmatization from both the public and practitioners attached to minor-attracted persons and the broader topic of sexual abuse and pedophilia can contribute to a reluctance to approach research and revise legal frameworks involving minor-attracted persons. Also, as mentioned previously, mandatory reporting laws require professionals to report not only suspicious behavior but also the condition of pedophilia and minor-attraction, which can create conflicting objectives between legal plans intending to reduce stigmatization and increase confidentiality in which the treatment and services are provided, and legal plans intended to improve the safety of minors through increased monitoring and reporting protocols (Mundy, 2020, 2022; Walker, 2021). Conflicting objectives, disagreements, and complications such as this, together, not only contribute to confusion and

lack of evidence-based education informing public perception but also contribute to barriers in conducting future research that ultimately are detrimental to effectively addressing the issue (Mundy, 2020, 2022; Walker, 2021).

Swaby and Lievesley (2022) assert the fact that stigmatization has contributed to a detrimental research gap, such that both offending and non-offending minor-attracted persons hold significant insight that could otherwise close research gaps performing effective treatment approaches and interventions aimed at alleviating the psychological struggles experienced by minor-attracted persons, which could, as a result, contribute to an alleviation of the public health threat they pose. Swaby and Lievesley (2022) found that the most significant factors preventing MAPs from coming forward and seeking help included stigmatization, fear of incarceration, and fear of social isolation. Additionally, these research findings highlight the distress many minor-attracted persons likely live within and the need for adaptive coping mechanisms as a key component of treatment. Hence, while this section outlines barriers to legal plans addressing minor-attracted persons, it becomes clear that, in turn, stigmatization and a lack of research are legal barriers to otherwise creating more effective legal guidance and plans concerning treatment, prevention, and even appropriate management and monitoring strategies.

Similarly, a lack of self-reporting, due to distorted self-perceptions and self-grooming, has been found to lead to ineffective monitoring, management, and treatment. In other words, the stigmatization and psychological distress experienced by minor-attracted persons leave them prone to the phenomenon of grooming (Winters & Jeglic, 2022), a self-coping mechanism whereby these individuals convince themselves of the harmlessness of their behavior and motivations, justify their actions or deny any harm done to children as a coping mechanism to mitigate the otherwise severe psychological consequences of decreased self-esteem, self-

stigmatization, and decreased sense of dignity (N. Cohen & Katz, 2021; Mundy, 2022; Winters & Jeglic, 2022).

Finally, the lack of research and cohesive legal guidelines or plans concerning minor-attracted persons has led to a lack of practitioner guidelines and conclusions concerning effective program approaches and implementations for minor-attracted persons (N. Cohen & Katz, 2021). However, a review of existing programs revealed that over 33% of programs reviewed are interdisciplinary, meaning that the programs addressed legal and psychological treatment considerations toward minor-attracted persons. The integration and use of a holistic approach toward treatment are documented to be statistically significantly correlated with more positive treatment outcomes, such as improved adaptive coping mechanisms and reduced incidence of offenses (N. Cohen & Katz, 2021), thereby suggesting that the use of interdisciplinary approaches to treatment may improve legal outcomes while improving public safety (Cant et al., 2022; Nematy et al., 2023; Nielsen et al., 2020).

As described previously, consistent, recognized future legal plans for dealing with and treating minor-attracted persons are inclusive, incohesive, and unspecified. Existing legal guidelines specify various protocols for managing offenses committed by minor-attracted persons, such as sentences and incarceration (Mundy, 2020; Walker, 2021; Wilson, 2021). Additionally, current legal requirements concerning the management of minor-attracted persons, regardless of whether they have committed an offense, require practitioners to report suspected individuals and individuals characterized by the condition to regal and mental health care authorities (Mundy, 2020; Walker, 2021; Wilson, 2021).

This section of literature explored what is known regarding current existing legal plans for minor-attracted persons in medical, mental health, and legal channels. The reviewed literature

suggested that current legal systems are being challenged to devote increased funding to and implement policy initiatives aimed at overturning traditional stigma associated with and preventing the treatment of MAPs (Levenson & Grady, 2019b; Melton et al., 2017; Selmani-Bakiu & Ratkoceri, 2021). Outcomes of current inadequate treatment plans may perpetuate the stigmatization associated with MAPs due to a focus on the behaviors resulting from the condition, as opposed to the psychological experiences and well-being of MAPs (Landgren et al., 2022). Barriers concerning legal plans for minor-attracted persons include the presence and pervasiveness of social stigma, reliance on self-reporting, and the reluctance of practitioners to work with MAPs (Wilson, 2021).

**Research Gaps and Future Directions**

The literature reviewed in this chapter evidenced the need for future research concerning the terms pedophilia and minor-attracted persons and whether these renaming factors influence mental health professionals' willingness to treat this population. Overall, the fact that the literature on the topic was extremely sparse reveals the need to conduct additional research on the topic and also reveals the likely reluctance of scholars and practitioners to study this population and the sensitive issues associated (Levenson & Grady, 2019a; Lievesley & Lapworth, 2021; Melton et al., 2017; Selmani-Bakiu & Ratkoceri, 2021). The study's guiding theoretical framework, the theory of planned behavior (Ajzen, 1985, 1991), posits that an individual's attitudes, surrounding social norms, and perceived behavioral control contribute to an individual's intent to engage in behavior. The tenets of this theory were demonstrated by the literature reviewed, which overall strongly indicated that social stigmatization, or social norms, contribute to a reluctance of mental health therapists to intend to treat individuals considered to be pedophiles or minor-attracted persons. Additionally, this social stigmatization has been found

to positively correlate with a reluctance among MAPs to seek help or intend to behave in a help-seeking way. Thus, the literature explored revealed a gap in current knowledge concerning treatment support for communities of minor-attracted persons. Research is extremely limited and focuses primarily on healthcare professionals' perceptions, experiences, and willingness to treat the population when using the term pedophilia and/or pedophile. However, it is not yet known if this renaming from the term pedophilia to MAPs addresses this stigma-related barriers for mental health clinicians that influence the willingness to treat (Lievesley et al., 2022). Thus, to contribute to closing this gap in research, the proposed study focused on investigating whether the renaming from the term pedophilia to minor-attracted persons help to minimize the stigma-related barriers and challenges mental health professionals face when treating this population.

**Summary**

This qualitative study aimed to determine the relationship between EPBs and with the intent to treat MAPs with mental health clinicians and measure the degree to which the demographic characteristics of mental health clinicians moderate it. This chapter, the literature review, provided a synthesis of what is known within existing literature regarding the purpose of the proposed study as a basis for contextualizing the research findings and supporting the proposed study's purpose. Chapter two described the search methods used to uncover 90 empirical publications relating to the topic. A Boolean search of literature was completed using various search engines and search phrases related to each research question. The search results revealed a significant lack of research on the topic, with some search phrases populating fewer than 100 results for all time and when constrained to studies published after 2018. Only peer-reviewed literature was included in the literature review, and only recent literature published after 2018 was included, except for seminal work relating to the study's guiding theoretical

framework, the theory of planned behavior (Ajzen, 1985, 1991). The theory of planned behavior posits that an individual's behavior is predicted by intention and that intention to behave is predicted by attitude, social norms, and perceived behavioral control. This guiding theoretical framework was useful in explaining the proposed study's relationship between variables, specifically the intent to treat MAPs on behalf of mental health care providers. A review of existing literature initially validated the TPB, considering the high stigmatization associated with MAPs and the corresponding reluctance to treat MAPs on behalf of mental healthcare providers.

The literature reviewed in this chapter explored three themes aligning with the proposed study's research questions. The first theme concerning treatment standards concerning minor-attracted persons was an overwhelming lack of literature (Lievesley & Harper, 2020). Literature findings revealed that many minor-attracted persons internalize the social stigma associated with the condition, which can diminish psychological well-being (Lievesley et al., 2020). Additionally, the literature indicated that mental health care and medical barriers contribute to a lack of unanimously accepted treatment protocol (Levenson & Grady, 2019b; Schaefer et al., 2022). The second literature review topic related to existing legal plans for minor-attracted persons in medical, mental health, and legal channels. Recent literature suggests that scholars and practitioners of progressive research are urging shifts to current legal systems to implement policy initiatives aimed at overturning traditional stigma associated with and preventing the treatment of MAPs (Levenson & Grady, 2019b; Melton et al., 2017; Selmani-Bakiu & Ratkoceri, 2021). Finally, the third topic explored within the literature related to what is known regarding current evidence-based practice for minor-attracted persons (Gannon, 2021; Levenson & Grady, 2019a; Scarpazza et al., 2023; Stelzmann et al., 2022). Again, an overwhelming lack of literature was found, evidencing the gap the proposed study intends to fill, which is that it is not yet known

how evidence-based practices are related between the treatment of minor-attracted persons and mental health clinicians, as well as what challenges influence the treatment (Lievesley et al., 2022). Chapter three, the methods chapter, described the proposed qualitative, descriptive study's methodology (Rudd et al., 2021; Venkatesh Aravindh & Thirupathi, 2019; Xiaofeng & Zhenshun, 2020) intended data collection and analysis procedures.

# Chapter 3: Research Methodology

The term pedophile continues to have significant barriers and challenges for, not only the mental health clinicians treating pedophiles, but also those struggling with the disorder (Grady et al., 2018; Walker, 2021). The research problem addressed by this proposed study was the stigma-related barriers and challenges mental health clinicians encounter when treating this population (B4U-ACT, 2020, 2023; Jahnke et al., 2021; Münch et al., 2020; Schmidt & Niehaus (2022). The purpose of this qualitative descriptive study was to investigate whether the renaming of "pedophile" as "minor-attracted persons" can reduce the stigma-related barriers and challenges that mental health clinicians frequently confront when providing care to this population. To address this research problem, the proposed study employed a qualitative descriptive methodology, which was well-suited for exploring complex, underexamined social phenomena through participants lived experiences (Braun & Clarke, 2019; Neergaard et al., 2009). This chapter presented the study's methodological framework, including the population and sampling strategy, data collection procedures, analysis plan, ethical considerations, and strategies to ensure the study's trustworthiness and rigor. Each section was organized to provide a systematic overview of how the study addressed the stated research problem.

## Research Methodology and Design

The proposed study used a qualitative descriptive research methodological approach. A qualitative methodology is appropriate because the study seeks to explore the lived experiences and perceptions of mental health clinicians when treating individuals identified as minor-attracted persons. Qualitative research is best suited for investigating how individuals experience social phenomena, allowing for the capture of rich, detailed, and contextualized data that cannot be easily quantified (Braun & Clarke, 2019; Creswell & Poth, 2018; Newhart & Patten, 2023). A

descriptive qualitative design specifically enables the collection of data that offers straightforward, unembellished accounts of participants' experiences (Neergaard et al., 2009). This design is particularly useful when studying topics that have received limited prior exploration, such as the stigma-related challenges clinicians face when working with MAPs. A descriptive design supports the goal of developing an in-depth understanding without imposing theoretical frameworks or requiring extensive interpretation beyond participants' own words (Skinner, 2020).

A quantitative methodology was considered but ultimately determined to be less appropriate for this study. Quantitative research involves testing hypotheses, measuring variables, and analyzing statistical relationships between factors (Skinner, 2020; Venkatesh Aravindh & Thirupathi, 2019). Because the current research questions sought to understand clinicians' subjective experiences rather than measure or predict specific variables, a quantitative approach would have limited the ability to explore the complexity and nuance of stigma-related barriers. Additionally, alternative qualitative designs were reviewed. A phenomenological approach, which seeks to understand the essence of a lived experience (Moustakas, 1994), was considered. However, phenomenology requires participants to reflect deeply on a specific lived experience, often emphasizing the subjective meaning-making process (Moustakas, 1994). In contrast, this study aimed to describe clinicians' broader experiences with stigma rather than to analyze the deeper existential meaning of those experiences. These factors made a descriptive design more appropriate. A grounded theory approach, which aims to generate a new theory grounded in collected data (Charmaz, 2014), was also evaluated. Grounded theory is typically employed when the goal is to develop theoretical models about social processes (Charmaz,

2014). Since the present study sought to explore and describe perceptions rather than to build new theory, grounded theory was not chosen.

The qualitative method and descriptive design directly addressed the identified problem by allowing the researcher to explore, in detail, the stigma-related barriers and challenges that mental health clinicians face when treating individuals labeled as minor-attracted persons. Because this population is highly stigmatized, a descriptive design was especially appropriate as it allowed clinicians to share their experiences and perspectives in their own words, without imposing theoretical or interpretive filters. This aligned with the purpose of the study, which was to understand both the clinicians' experiences with stigma and their perceptions of whether rebranding the term "pedophile" to "minor-attracted person" can help reduce these barriers and improve therapeutic outcomes. The descriptive approach enabled the researcher to gather rich, first-hand data that answers RQ1 by capturing how clinicians described the stigma and challenges they face, and RQ2 by uncovering how they perceived the potential impact of rebranding on clinical engagement and treatment effectiveness. In short, this methodology ensured that the research remained grounded in the lived realities of clinicians, which was essential for understanding the practical and ethical complexities of treating this population.

**Population and Sample**

The target population for this study encompassed mental health care professionals in the United States, including licensed professional counselors (LPCs), licensed clinical social workers (LCSWs), licensed psychologists, and psychiatrists. According to the National Center for Health Workforce Analysis (2023), there are over one million behavioral health providers employed in the U.S., encompassing various disciplines within mental health care. These clinicians are trained

to diagnose, treat, and manage mental health conditions, including but not limited to depression, anxiety disorders, trauma-related disorders, and paraphilic disorders.

The selected population was appropriate for this study because the research problem, purpose, and research questions specifically sought to understand the experiences of professionals who encounter the unique stigma-related barriers when treating individuals identified as minor-attracted persons (MAPs). Mental health clinicians are uniquely positioned to provide insight into these experiences, given their clinical expertise, ethical obligations, and exposure to stigma within therapeutic settings (Grady et al., 2018; Walker, 2021).

A purposive sample of 16 mental health professionals practicing in the Northwestern Pennsylvania region was recruited. Eligible participants met the following inclusion criteria The participants were: (a) at least 18 years of age, (b) held an active clinical license (e.g., LPC, LCSW), (c) had a minimum of two years of experience providing mental health services, (d) had experience providing care to individuals who are identified as MAPs and (e) were willing to participate in an audio-recorded, Zoom meeting. Participants also obtained at least a minimum of a master's degree in a mental health-related field (e.g., clinical psychology, counseling psychology, social work, or a related discipline) or a doctoral degree (PhD or PsyD) in psychology or psychiatry. Acceptable licensure included, but was not limited to, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Psychologist, or Medical Doctor (MD) specializing in Psychiatry.

Demographic information including age, gender identity, race and ethnicity, highest degree obtained, professional license type, and years of practice, was collected to characterize the sample. Participants were not excluded based on gender, ethnicity, sexual orientation, or

other demographic variables, in alignment with ethical research practices (Creswell & Poth, 2018).

Individuals who did not hold an active clinical license, those who had less than two years of post-licensure experience, or those without a master's or doctoral degree in a qualifying mental health discipline were excluded from the study. Similarly, pre-licensed interns, graduate students, and individuals practicing under supervision without independent licensure were not eligible to participate. Purposive sampling was appropriate for this study because it allowed the deliberate selection of individuals who had direct experience with the phenomenon of interest—treating MAPs and encountering stigma-related barriers (Campbell et al., 2020; Palinkas et al., 2015). By focusing on clinicians with at least two years of practice experience, the study minimized the risk of data skewing due to professional inexperience.

The sample size of 16 participants is consistent with qualitative research recommendations (Guest et al., 2006). Guest et al., (2006) found that thematic saturation in qualitative interviews often occurs within the first 12 participants, with basic themes typically emerging after six interviews. Further, Francis et al. (2009) and Anderson and Lamp (2022) recommend that qualitative studies predefine a stopping criterion based on saturation, noting that 10–15 interviews are sufficient for studies examining specific professional experiences within relatively homogeneous populations. Given the specificity of the sample and the focused nature of the research questions, it was anticipated that data saturation—the point at which no new themes or significant information emerge— would be reached within the proposed sample range.

Participants were recruited through direct email outreach to mental health care clinicians known to provide services to individuals identified as MAPs. After obtaining site approval, the researcher identified providers within the local geographic region using the list of approved sex

offender treatment providers for Pennsylvania (PA) found online. Next, recruitment emails describing the study's purpose, eligibility criteria, and participation requirements were distributed. The emails included a link to an online screening survey hosted through Google Forms.

Interested individuals completed the screening survey to confirm eligibility. Eligible participants were then sent a confirmation email containing a link to an informed consent using Docusign. After informed consent was received, participants were sent another email and invited to schedule a semi-structured, audio-recorded interview conducted over Zoom. Prior to each interview, the researcher reviewed the informed consent with each participant. During the interviews, only the audio component was recorded, and participants were assigned alphanumeric identifiers (e.g., P1, P2) to protect confidentiality. All data, including audio recordings and transcripts, will be securely stored on an encrypted, password-protected USB device in accordance with ethical research standards (Boros, 2018; U.S. Department of Health and Human Services, 2022).

**Instrumentation**

Participant demographic information was collected through a brief survey administered prior to the qualitative interview. The demographic survey gathered data on variables including age, gender identity, race and ethnicity, highest degree obtained, field of study, type of professional license held, and years of independent clinical practice. These variables were selected to help characterize the sample and to provide important contextual information for interpreting the qualitative findings. Table A summarizes the demographic variables that were collected. Collecting demographic data ensured that the sample's characteristics were

transparently reported and aided in evaluating the transferability of the study's findings to similar clinical populations (Creswell & Poth, 2018).

**Table 1**

*Participant Demographic Data Description*

| *Variable* | *Description* | *Response Format* |
|---|---|---|
| Age | Participant's current age (must be 18 years or older) | Open-ended (numerical) |
| Gender Identity | How the participant identifies their gender | Multiple choice + "Other" option |
| Race and Ethnicity | Participant's self-identified race and/or ethnicity | Multiple choice + "Other" option |
| Highest Degree Obtained | Highest level of education completed (e.g., Master's, Doctorate) | Multiple choice |
| Field of Study | Field in which highest degree was earned (e.g., Psychology, Social Work) | Open-ended |
| Type of Professional License | Active licensure held (e.g., LPC, LCSW, Licensed Psychologist, Psychiatrist) | Multiple choice |
| Years of Independent Practice | Number of years practicing independently (post-licensure) | Open-ended (numerical) |

In addition to the demographic survey, a semi-structured interview guide (see Appendix G) was created by the researcher as the primary instrument for qualitative data collection. The semi-structured guide included approximately 15 key questions aligned with the RQs. Follow-up and probing questions were utilized throughout the interviews to ensure rich and detailed participant responses. The interview guide was intentionally structured to collect data directly related to the research problem, purpose, and research questions, to ensure strong alignment across the study's components.

**Study Procedures**

After obtaining site permission to recruit participants from the Pennsylvania Sex Offenders Assessment Board (see Appendix A), the researcher obtained approval from the Institutional Review Board (IRB) prior to initiating participant recruitment (see Appendix B). After both site permission and IRB approval were secured, recruitment of the sample began. Contact information for potential participants was gathered from the public directory listings at

the Pennsylvania Sexual Offenders Assessment Board website. General recruitment invitation emails were sent to prospective participants and included a description of the study's purpose, the eligibility criteria, and a summary of what participation entailed.

Each recruitment email (see Appendix C) included a link to an online, five question screening survey where potential participants confirmed they met the inclusion criteria (see Appendix D). For a participant to be eligible they had to answer with a "yes" to all five screening questions: (a) Are you over the age of 18 years? (b) Are you a licensed mental health professional? (c) Do you have at least two years of experience providing mental health care in a clinical setting? (d) Do you currently provide care to individuals identified as either pedophiles or minor-attracted persons (MAPs)? and (e) Are you willing to participate in a Zoom interview that will be audio recorded and last approximately 60 minutes? Eligible participants were contacted via email and provided with an informed consent (see Appendix E) they signed and returned using DocuSign. Once received, an eligibility email (see Appendix F) was sent to the participant. These participants were invited to schedule a semi-structured interview through Zoom. The researcher requested that the participants provide a selection of available dates and times, and upon confirmation, the participant was sent a Zoom invitation link for the agreed-upon session.

At the beginning of each interview, the researcher reviewed the informed consent document and confirmed that participants understood the information provided. The researcher then reminded the participant that the interview was being audio recorded. At the conclusion of the interview, the researcher asked the participant if they had any additional comments or clarifications to add. After the recordings were transcribed, participants were invited to review

the automatically transcribed interview data to ensure the accuracy of the transcription, enhancing the credibility of the data collected.

To preserve and protect participant confidentiality, alphanumeric identifiers (e.g., P1, P2) were assigned to each participant at the time of recruitment. No identifying information was recorded during the interviews, and all demographic and interview data was de-identified prior to analysis. This process ensured that confidentiality was upheld while maintaining the integrity of the qualitative data collection process. All data collected from the interviews, including audio recordings and transcripts, was saved to a single encrypted USB drive. The signed informed consent forms were saved separately to a different encrypted USB drive. This separation ensured that identifying information was not linked to interview data. The USB drive containing the informed consent forms was securely stored in the researcher's locked home office, while the USB drive containing the interview recordings and transcripts was stored in the researcher's locked work office.

**Data Analysis Plan**

The data analysis plan, which was used for this study, included thematic analysis, following Braun and Clarke's (2019) six-step guide. The six steps of the guide include familiarization, initial quote creation, category development, theme identification, and final report production. In this section, each of these steps were described alongside plans for data preparation, storage, and inductive coding methodologies specific to the analysis of the gathered transcription data.

The first step of data analysis included the task of preparing the information by garnering the transcribed interviews directly from the Zoom platform. After downloading, the participant's transcripts were replaced with an alphanumeric identifier, such as P1 or P2. After ensuring the

deidentification of all personal information from the transcripts, the process of data cleaning was conducted, which involved comparing the transcripts with the audio recordings to correct any grammatical or transcription errors. Each transcript was compared to the audio recording to ensure that all information was transcribed accurately and ready for thematic analysis procedures. After the data preparation and storage process, familiarization was conducted. The process of familiarization involves reading and rereading the transcripts multiple times to ensure that the researcher was deeply embedded within the transcriptions and participants' responses (Braun & Clarke, 2019). A process of familiarization, involving reading and rereading the transcripts, was conducted twice to ensure that the researcher was deeply embedded with the participant's reflections.

The second step of data analysis procedures involved initial coding, which entailed targeting and tagging repeating words and phrases as they occurred across each transcript (Braun & Clarke, 2019). For this process, the researcher marked each time a phrase or word was repeated and labeled this as a code. For example, if the participant commonly mentioned the word barriers, then the corresponding code would be *barrier*. This process was referred to as inductive coding, in which the identified information was derived directly from the text instead of using pre-named identified codes (Braun & Clarke, 2019). Initial coding occurred three times across all transcripts to ensure that all information was tagged appropriately and included.

The third process included category development, which entailed the task of combining codes of similar topics and values into singular categories (Braun & Clarke, 2019). As a rule, all categories contained a minimum of two or more codes, supplied in an appropriate definition, and coincided with participant quotes. Following these procedures ensured a straightforward method of thematic analysis that could be replicated by other researchers while also ensuring that all

codes are represented within each category. After all categories were developed, the fourth process of theme identification proceeded. Theme identification involved combining categories, based on pattern analysis, into groups, referred to as themes (Braun & Clarke, 2019). Each theme contained a minimum of one or more categories. All categories were reviewed twice to ensure that there was no missing information represented in the final themes.

The final process of thematic analysis involved the production of the report, which entailed the task of providing accurate phrases to describe each theme and associated definitions and describing a narrative format of the perceptions of individuals who provided their responses in semi-structured interviews (Braun & Clarke, 2019). Using thick descriptions, participant posts were supplied, and correspondence with each team to ensure that the findings were inherently relevant to the participant's reflections. The final report, in the case of this dissertation, included Chapter 4, which narratively described, alongside appropriate tables, the initial code, categories, and themes. Finally, Chapter 4 also described the implications and recommendations, coinciding with prior empirical and theoretical research, which aligned with the thematic findings discussed.

In qualitative research, the researcher serves as the primary instrument for data collection and interpretation (Babchuk, 2016; Creswell & Poth, 2018; Rademaker & Polush, 2022). As such, the researcher's perspectives, background, and assumptions potentially influenced the collection, coding, and analysis of the data. To minimize potential bias and enhance trustworthiness, the researcher engaged in reflexivity throughout the study. This entailed the practices of maintaining a reflexive journal to document personal reflections, emerging biases, decision-making processes, and methodological choices (Berger, 2015). Reflexive notes were reviewed regularly to ensure that interpretations remain grounded in participants' actual words and experiences, rather than the researcher's preconceived notions. The researcher practiced

bracketing by intentionally setting aside prior knowledge and assumptions during the interview and analysis phases to preserve the authenticity of participants' narratives (Tufford & Newman, 2012).

**Assumptions**

Assumptions refer to aspects that must be true for the research to be considered valid and reliable but cannot be demonstrated to be true and are thus trusted as true due to measures taken to increase the reliability of the study (Rudd et al., 2021; Venkatesh Aravindh & Thirupathi, 2019; Xiaofeng & Zhenshun, 2020). The proposed study assumed that participants recruited answered the interview questions regarding intent to treat and apply evidence-based practice honestly, accurately, and to the best of their abilities so that the data could be trusted as reliable. The proposed study also assumed that participants' self-reported information would be related to the context of this study. Finally, the study assumed that the use of inductive thematic analysis would provide the necessary responses to answer the research questions.

**Limitations**

Limitations are factors that constrain the study, often due to circumstances beyond the researcher's control, such as sample size, available data, or funding (Rudd et al., 2021; Venkatesh Aravindh & Thirupathi, 2019; Xiaofeng & Zhenshun, 2020). In qualitative descriptive research, limitations typically relate to the scope and depth of participant perspectives captured at a single point in time. One limitation of this study was that participants' reflections were based on their current perceptions and may not have accounted for changes in their views or experiences over time. Although the study sought rich, detailed descriptions, it did not aim to establish causality, predict outcomes, or assess changes longitudinally.

Another limitation involved the use of a relatively small, purposively selected sample drawn from a specific local geographic area. While this approach enhanced the depth and contextual relevance of the findings, it limited the transferability of results to broader populations of mental health clinicians. The experiences described by participants were potentially influenced by regional cultural, organizational, or policy factors that are not generalizable to other settings. The researcher chose to focus on a local setting to maximize feasibility, cost-effectiveness, and relevance to clinical practice in the studied area.

Additionally, limitations inherent to qualitative inquiry include the potential influence of researcher bias and participant self-reporting. Participants' narratives in qualitative research may be shaped by memory inaccuracies or social desirability concerns. To mitigate these risks, the researcher engaged in reflexive practices, maintained an audit trail, and offered participants the opportunity to review their transcribed interviews for accuracy (Berger, 2015; Creswell & Poth, 2018). Regardless of these measures, the possibility of interpretive bias and selective memory could not be fully eliminated. Despite these limitations, this study is expected to generate meaningful insights into the stigma-related barriers encountered by mental health clinicians treating minor-attracted persons, thereby contributing to the emerging body of qualitative research on this important topic.

**Delimitations**

Delimitations are conditions and parameters intentionally set by the researcher to focus the study and ensure manageability, such as through the selection of specific populations, settings, or time frames (Rudd et al., 2021; Venkatesh Aravindh & Thirupathi, 2019; Xiaofeng & Zhenshun, 2020). In this study, several delimitations were established based on theoretical alignment, relevance to the research problem and purpose, and feasibility considerations. This

study was delimited to licensed mental health professionals, including LPCs, LCSWs, licensed psychologists, and psychiatrists who completed at least two years of independent clinical practice. Pre-licensed clinicians, graduate students, and clinicians practicing under supervision were excluded. Experienced, independently licensed clinicians were considered to have more firsthand knowledge of stigma-related barriers in treating minor-attracted persons (MAPs) than other practitioners. By focusing on this group, the study ensured that participants provided informed, practice-based insights. These activities supported the research problem, which addressed barriers faced by clinicians, the purpose statement that sought to explore those barriers, and the research questions that targeted clinicians' lived experiences. This delimitation also aligned with prior literature emphasizing the importance of examining the views of seasoned professionals when studying stigma and treatment challenges (Grady et al., 2018; Walker, 2021).

The study was geographically delimited to mental health professionals practicing within a specific local region rather than drawing from a national sample. Limiting the geographic scope increased the feasibility and practicality of participant recruitment while enabling a deeper contextual understanding of localized stigma dynamics. While this choice limited broader transferability, it enhanced the study's focus and aligned with the qualitative descriptive approach's emphasis on rich, context-bound data. This decision supported the problem statement's focus on barriers in clinical practice settings and reflects existing literature noting regional variability in stigma-related experiences (Jahnke, 2018).

The study was delimited to exploring the experiences and perceptions of clinicians only and did not include the perspectives of individuals identified as minor-attracted persons (MAPs) or other professional groups (e.g., law enforcement, general medical practitioners). Restricting the sample to clinicians ensured the study remained tightly aligned with its problem, purpose,

and research questions, which specifically sought to examine clinician-related stigma barriers. This delimitation followed the theoretical framework underpinning the study's focus on provider-based barriers rather than client experiences and was consistent with recommendations in the literature to examine professional perceptions independently (Münch et al., 2020).

The study focused exclusively on perceptions regarding stigma-related barriers associated with renaming terminology (e.g., "minor-attracted persons") rather than investigating treatment outcomes, intervention effectiveness, or broader societal attitudes. Focusing narrowly on terminology-related stigma barriers allowed for a manageable scope and provided an in-depth exploration of an underexamined aspect of clinician experiences. This boundary ensured that the research directly addressed the stated problem, fulfilled the purpose of investigating stigma-specific barriers, and answered the research questions centered on clinicians' perceptions of terminology renaming (B4U-ACT, 2020).

**Ethical Assurances**

This study obtained approval from the National University Institutional Review Board (IRB) prior to any participant recruitment or data collection. The IRB review ensured that all study procedures complied with ethical guidelines for conducting research with human subjects, including principles outlined in The Belmont Report (U.S. Department of Health and Human Services, 2022). A summary of ethical issues and safeguards discussed here can be seen in Table 2.

**Table 2**

*Summary of Ethical Issues and Safeguards*

| *Ethical Issue* | *Safeguard Implemented* |
|---|---|
| IRB Approval | The study obtained approval from the National University Institutional Review Board (2019) to ensure compliance with ethical research guidelines. |
| Minimal Participant Risk | Participants were advised that they may experience minor emotional discomfort but were informed they can skip questions or withdraw at any point without penalty. Mental health support resources were provided to each participant post-interview. |
| Confidentiality Measures | Participant identities were protected using alphanumeric codes. Interview data and consent forms were stored securely on encrypted USB drives and kept in locked locations. |
| Researcher Bias Management | The researcher engaged in reflexive journaling, applied bracketing strategies, and conducted peer debriefing sessions to mitigate bias and maintain objectivity. |

The anticipated risk to participants was minimal. Participants were asked to discuss their professional experiences treating individuals identified as minor-attracted persons (MAPs). While minimal emotional discomfort may occur when discussing topics related to stigma or controversial populations, no physical risk or major psychological harm was expected. If participants experienced emotional discomfort, they were reminded that they could decline to answer any questions and could withdraw from the study at any time without penalty. Additionally, a list of mental health support resources was provided at the conclusion of each interview in the event that participants desired additional support (Appendix H).

Participant confidentiality was protected using alphanumeric identifiers (e.g., P1, P2) assigned at the time of recruitment. No personally identifying information was recorded in interview transcripts or reports. Audio recordings and transcripts were stored securely on a password-protected, encrypted USB drive, and consent forms were stored separately on a second encrypted USB drive. Both drives were kept in locked, secure locations: one in the researcher's home office (consent forms) and one in the researcher's work office (interview data). All electronic data will be retained securely for three years after the conclusion of the study and then permanently destroyed in accordance with IRB requirements.

In qualitative research, the researcher serves as the primary instrument for data collection and interpretation (Berger, 2015; Creswell & Poth, 2018; Rademaker & Polush,). As such, the researcher's background, experiences, and biases had the potential to influence data collection, analysis, and interpretation. It was critical to acknowledge and address these influences to maintain the trustworthiness and credibility of the study.

The researcher is a survivor of incest, which may have sensitized personal perceptions related to topics of childhood trauma, stigmatized populations, and the broader context of treating minor-attracted persons. Awareness of this lived experience was crucial, as it carried the potential to influence data interpretation, either through heightened emotional responses or unconscious bias. To address this, the researcher engaged in ongoing reflexivity throughout the study. Reflexive journaling was maintained from recruitment through data analysis to document personal reflections, reactions, and emerging biases (Berger, 2015; Tufford & Newman, 2012).

Additionally, the researcher employed bracketing strategies by intentionally setting aside personal experiences and assumptions to remain grounded in participants' perspectives rather than pre-existing beliefs (Tufford & Newman, 2012). Member checking was also incorporated,

whereby participants had the opportunity to review their interview transcripts for accuracy, ensuring that the data reflect their intended meaning rather than the researcher's interpretation. Peer debriefing with a qualified qualitative research advisor was used periodically to enhance objectivity and maintain fidelity to the participants lived experiences. By acknowledging personal history, maintaining a structured reflexive process, and employing bracketing and peer consultation strategies, the researcher actively worked to minimize bias and ensure that the study findings authentically represented participants' experiences.

**Summary**

Chapter three, the methodology chapter, described the proposed study's methodology, design, data collection and analysis procedures, considerations of trustworthiness and validity, and ethical considerations. Chapter 3 detailed that the target population for this study encompassed mental health care professionals in the United States, including licensed professional counselors (LPCs), licensed clinical social workers (LCSWs), licensed psychologists, and psychiatrists. A purposive sample of 16 mental health professionals practicing in the Northwestern Pennsylvania region was recruited. Instrumentation consisted of a brief survey to collect demographic data and a semi-structured interview guide for collecting the qualitative data. All data was collected from interviews and included audio recordings and transcripts. All data was saved to a single encrypted USB drive. Chapter 3 detailed the methods of recruitment, data collection, and data analysis. Employing a qualitative methodology and descriptive design in the project allowed for gaining deep description and understanding from mental health professionals regarding the targeted social phenomenon. Thematic analysis guided the analysis of participants' reflections, which was presented narratively in the following chapter, Chapter 4. Chapter 4, the next chapter, as part of this dissertation, detailed the findings of the

study, methods of data collection and analysis, and any changes, if any, that occurred and deviation from the proposed chapter 3.

# Chapter 4: Findings

The research problem addressed by this proposed study was the stigma-related barriers and challenges mental health clinicians encounter when treating this population (B4U-ACT, 2020, 2023; Jahnke et al., 2021; Münch et al., 2020). This problem was addressed through the study's purpose of exploring how mental health clinicians experience and describe the stigma-related barriers and challenges they encounter when providing care to individuals identified as minor-attracted persons (MAPs), and to examine their perceptions of whether rebranding the term "pedophilia" as "minor-attracted persons" may reduce these stigma-related barriers and improve therapeutic relationships and treatment effectiveness. Data were collected through sixteen semi-structured, in-depth interviews (IDIs) with mental health professionals who had experience or perspectives related to providing treatment for individuals who experience minor attraction. Participants were recruited using purposive sampling to ensure diversity in professional roles, levels of experience, and clinical settings. Each interview was conducted via a secure online platform and lasted between 45 and 75 minutes. An interview guide was used to elicit participants' views on language, stigma, professional training, ethical considerations, and therapeutic engagement. All interviews were audio-recorded with participants' consent and subsequently transcribed verbatim. Field notes were maintained throughout the data collection process to capture contextual observations and preliminary analytic reflections. This chapter presented each of the six themes in detail, using participants' direct quotations to illustrate how they navigate these tensions in practice.

## Trustworthiness of the Data

Several strategies were employed to enhance the credibility and trustworthiness of the findings. Reflexivity was central throughout the research process, with the researcher

maintaining a reflexive journal to record analytic decisions, personal reflections, and potential biases. This practice supported confirmability through transparency and critical self-awareness, consistent with the interpretivist stance of the study. Credibility was strengthened through prolonged engagement with the data, iterative review of transcripts, member checking (Appendix 1), and regular comparison across cases to ensure that themes were grounded in participants' accounts. Transferability was achieved through providing participants' demographic data and detailed descriptions of the research.

Dependability was achieved through maintaining an audit trail that would allow the reconstruction of the study. The audit trail was maintained to document coding decisions and theme development, providing a clear record of the analytic process. Additionally, peer debriefing with the supervisory team was used to discuss emerging interpretations and enhance analytical rigor. Due to the sensitivity of the topic, careful attention was given to preserving participants' intended meanings through repeated reading and context-sensitive interpretation. Collectively, these strategies contributed to a trustworthy representation of stigma-related barriers and challenges mental health clinicians encounter when treating this population (B4U-ACT, 2020, 2023; Jahnke et al., 2021; Münch et al., 2020). Participant demographics included current age, how the participant identified their gender, self-identified race or ethnicity, highest level of education completed, the field in which highest degree was earned, active licensure held, number of years practicing independently post-licensure as seen in Table 3 presents this data by participant.

**Table 3**

*Participant Demographic Summary (P1–P16)*

| *Participant* | *Age* | *Gender* | *Race/Ethnicity* | *Highest Degree* | *Field of Study* | *License* | *Years Independently Licensed* |
|---|---|---|---|---|---|---|---|
| P1 | 43 | Male | Black | Master's | Social Work | LCSW | 12 |
| P2 | 32 | Male | White | Master's | Clinical Mental Health Counseling | LPC | 8 |
| P3 | 45 | Female | Black | Master's | Social Work | LCSW | 15 |
| P4 | 27 | Female | White | Master's | Clinical Mental Health Counseling | LPC | 3 |
| P5 | 51 | Female | White | PhD | Forensic Psychology | Psychologist | 22 |
| P6 | 39 | Male | White | Doctorate | Clinical Psychology | Psychologist | 10 |
| P7 | 34 | Female | Hispanic | Master's | Marriage and Family Therapy | LMFT | 7 |
| P8 | 48 | Male | Black | Master's | Counseling Psychology | LPC | 16 |
| P9 | 41 | Female | Asian American | Doctorate | Counseling Psychology | Licensed Psychologist | 13 |
| P10 | 36 | Male | White | Master's | Social Work | LCSW | 9 |
| P11 | 29 | Female | White | Master's | Clinical Mental Health Counseling | LPC | 4 |
| P12 | 46 | Female | Black | Master's | Social Work | LCSW | 18 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| P13 | 38 | Male | Latino | Doctorate | Forensic Psychology | Licensed Psychologist | 11 |
| P14 | 44 | Male | Asian American | Master's | Marriage and Family Therapy Counselor | LMFT | 12 |
| P15 | 52 | Female | White | Doctorate | Education and Supervision | LPC-Supervisor | 24 |
| P16 | 33 | Male | White | Master's | Clinical Psychology | Psychologist (Provisional) | 3 |

## Results

### *RQ1: Mental Health Professionals' Perspectives of MAP-Related Stigma and Treatment Barriers*

Participants' accounts revealed that stigma operates across personal, social, and institutional levels and profoundly shapes clinicians' attitudes, perceived norms, and sense of control in treating individuals with minor attraction. The label pedophile carried an immediate moral and emotional charge that affected not only how clinicians viewed their clients but also how they perceived their own professional identities. Many participants described visceral reactions of discomfort or apprehension when first encountering clients who disclosed minor attraction. This emotional response reflected negative attitudes toward the behavior, the first component of the TPB.

These internal reactions often generated feelings of moral tension, whereby clinicians wanted to uphold empathy and clinical neutrality but struggled against instinctive aversion and fear of misjudgment. As one participant noted, even uttering the word pedophile produced physical tension and unease. This struggle between empathy and self-protection illustrates how

stigma infiltrates personal attitudes, shaping not only beliefs about clients but also beliefs about one's professional self.

Over time, and with reflective practice, some clinicians were able to reframe their attitudes through experience, supervision, and exposure. This shift from moral discomfort to clinical curiosity represented an attitudinal realignment that made compassionate engagement more feasible. In TPB terms, direct experience and professional reflection served as corrective mechanisms that reshaped underlying beliefs, strengthening positive attitudes toward providing care. This finding aligns with research by Christofferson (2019) and Jahnke et al. (2021), both of whom found that experience and specialized training reduce stigma and increase therapeutic confidence. The present study extended this understanding by emphasizing that attitudinal change is not automatic but rather develops through deliberate reflection supported by empathic professional cultures.

However, findings indicated that individual attitude change was often constrained by subjective norms, the second TPB component, referring to the perceived expectations and judgments of others. Across accounts, participants described strong normative pressures within their professional environments discouraging engagement with MAP clients. Colleagues' comments, workplace gossip, and even supervisory silence communicated that such work was professionally undesirable or reputationally risky. Several participants recounted experiences of being subtly or overtly criticized for showing compassion toward this population. These normative influences created what Ajzen (1991) describes as "social pressure," which in turn suppressed clinicians' intention to engage. The findings resonated with Parr and Pearson (2019) and Lievesley et al. (2022), who found that clinicians frequently navigate professional cultures where showing empathy toward MAP clients is misinterpreted as moral leniency. The current

study contributed to this literature by empirically demonstrating how these collective norms function as a regulatory system that sustains stigma within therapeutic spaces.

Institutional cultures further reinforced these social norms. Participants frequently described organizational climates characterized by avoidance, liability concerns, and moral distancing. Some agencies discouraged or redirected cases involving MAP clients, while others lacked clear protocols for handling them. These conditions amplified clinicians' sense of isolation and moral uncertainty. The lack of institutional support thus became a form of structural stigma that restricted perceived behavioral control, the third component of the TPB. When clinicians felt unsupported, ill-equipped, or vulnerable to professional consequences, their perceived ability to provide effective care diminished. This limitation directly affected their behavioral intentions, even when their attitudes toward the population were neutral or positive. This echoed findings from Levenson and Grady (2019a) and Schaefer et al. (2022), who observed that institutional avoidance contributes to clinicians' reluctance to engage. However, the current study extended this by highlighting how these organizational constraints function as "control beliefs" within TPB, limiting clinicians' perceived autonomy and efficacy.

Participants also identified gaps in training and education that compounded these barriers. Many reported that graduate programs and continuing education offered little to no guidance on how to ethically and clinically treat individuals who experience minor attraction. This educational deficit constrained perceived control, leaving clinicians to navigate high-stakes ethical decisions such as balancing confidentiality and risk reporting without sufficient frameworks. The absence of clear training or policy guidance reinforced the belief that such clients were "too risky" or "untreatable," effectively discouraging engagement. These results were consistent with Jahnke et al. (2021) argued that limited formal training perpetuates

avoidance and fear in clinical practice. Yet this study deepened that insight by demonstrating how educational scarcity not only reduces competence but also shapes clinicians' cognitive and emotional readiness to act, further confirming the predictive value of perceived behavioral control within the TPB model.

At a deeper level, the findings illustrated that stigma functions not only as an external barrier but as an internalized system of self-regulation within clinicians and their professional networks. Even experienced clinicians who expressed confidence in working with MAP clients reported that their comfort was sometimes met with skepticism or moral suspicion from others. The result was a culture of professional silence that perpetuated avoidance and reinforced social boundaries between "acceptable" and "unacceptable" forms of clinical empathy. These observations aligned with Levenson and Grady's (2019) notion of "stigma by association" and extend it by showing that such stigma also shapes clinicians' sense of identity and belonging within their profession.

Through the lens of the Theory of planned behavior, these findings demonstrated that stigma undermines clinicians' intention to engage with MAP clients by negatively influencing all three determinants of behavior: it fostered negative or ambivalent attitudes, reinforces unsupportive social norms, and erodes perceived control. Without targeted interventions that challenge these interlocking forces, clinicians are likely to continue experiencing hesitation, moral tension, and self-censorship when working with this population. In this sense, stigma functions as a structural inhibitor that shapes both the psychology and sociology of clinical decision-making. This study thus confirmed prior conclusions that stigma is the central obstacle to effective treatment (Levenson & Grady, 2019a; Lievesley et al., 2022), but extended the literature by demonstrating, through TPB, how these mechanisms interact dynamically to

constrain clinicians' behavioral intentions, providing a theoretical and empirical bridge between individual psychology and professional culture.

### *RQ2: Mental Health Professionals' Perspectives of MAP-Related Clinical*

The second research question examined whether and how language change could mitigate the barriers described above. Participants' responses revealed that renaming pedophile to minor-attracted person (MAP) operates as both a cognitive and behavioral intervention that can influence attitudes, norms, and perceived control within the TPB model.

At the attitudinal level, clinicians described MAPs as a more neutral, humanizing term that separates identity from behavior. Many explained that the term allowed them to think about clients as people rather than as extensions of public stereotypes. Several noted that using MAPs helped them remain emotionally grounded, enabling empathy without compromising ethical boundaries. The linguistic shift thus facilitated a reframing of belief structures: where pedophile evoked fear and revulsion, MAPs invoked curiosity, compassion, and professional responsibility. This finding aligned with prior research by Freimond (2013) and Walker (2019), who found that person-first language allows clinicians to maintain therapeutic neutrality and reduce the automatic moralization that accompanies stigmatized terms. It also echoed Jahnke's (2018) work showing that linguistic framing directly shapes emotional response and willingness to engage. Other studies demonstrated in medical contexts that person-first terminology increases empathy and reduces implicit bias, effects that were mirrored here in clinicians' reflections on therapeutic tone.

However, this attitudinal shift also represented a subtle divergence from existing literature. Farmer et al. (2024) found that individuals who identify as minor-attracted did not always experience MAPs as less stigmatizing, suggesting that the benefits of renaming may be

more significant for clinicians than for clients. The current study built on this distinction by showing that while MAPs enhance clinicians' emotional regulation and cognitive reframing, it does not necessarily alter broader societal stigma. This nuance extended prior work by Levenson and Grady (2019b) and Lievesley et al. (2022), who emphasized the pervasiveness of structural stigma, by revealing that the linguistic benefit may function primarily at the micro (therapeutic and interpersonal) level rather than the macro (societal) level.

Participants also observed that this change in terminology had relational consequences. Clients appeared less guarded and more willing to disclose sensitive material when clinicians used MAPs instead of "pedophile." This finding supported the work of Jahnke (2018) and Harper et al. (2021), who found that reduced linguistic stigma fosters openness and decreases client shame. By signaling respect and safety, person-first terminology encouraged dialogue that might otherwise have been silenced by stigma. In Ajzen's (1991) framework, such shifts in perception can strengthen behavioral intentions by reinforcing positive feedback loops: improved relational experiences foster more favorable attitudes, which in turn encourage continued engagement.

At the level of subjective norms, the use of MAPs helped some clinicians navigate professional and social discomfort. Several participants reported that introducing the term in discussions with colleagues reduced defensiveness, creating space for more measured, constructive dialogue. Using MAPs also served as a linguistic cue that reframed conversations from moral debate to clinical reflection. This finding paralleled the recommendations of B4U-ACT (2020, 2023), which advocates for nonjudgmental, person-centered language as a tool for professional education and stigma reduction. Like Parr and Pearson (2019), participants described how the terminology lowered conversational barriers in certain contexts, allowing

clinicians to discuss minor attraction more freely. However, reactions among professionals were far from uniform. Some participants described colleagues rolling their eyes or dismissing the term as overly cautious or politically correct. Others worried that adopting the term could be perceived as "softening" or "excusing" behavior, thus risking public mistrust. These divergent reactions reflected what Lievesley et al. (2022) termed the "normative ambivalence" surrounding linguistic reform, where language that promotes empathy for one group may simultaneously evoke suspicion from another.

In TPB terms, this demonstrated that subjective norms can both enable and inhibit behavioral intention depending on the social group in question. The finding supported Ajzen's (2011) assertion that normative pressures act as both facilitators and constraints of intention. It also extended existing literature by revealing that even well-intentioned linguistic shifts can become a site of moral negotiation within professional cultures. As in prior research by Levenson and Grady (2019a), clinicians in this study remained acutely aware of how their peers might interpret their stance toward MAP clients, with terminology often functioning as a moral signal of professional identity.

Perceived behavioral control was also affected by linguistic choice. Clinicians reported that adopting MAPs helped them regulate their own emotional responses during therapy and discussions. The neutrality of the term allowed them to maintain composure and focus on treatment rather than moral evaluation. This emotional regulation increased their sense of control over difficult conversations, making them feel more competent and less overwhelmed. Conversely, using pedophile was described as emotionally charged and potentially destabilizing, eliciting defensiveness in both clinician and client. Thus, language functioned as a psychological tool that shaped clinicians' confidence in managing challenging therapeutic interactions. This

aligned with Ajzen's (1991) framework, which positions perceived control as a key determinant of behavioral intention, and complements findings by Christofferson (2019), who reported that structured training and linguistic clarity improved clinicians' confidence when treating MAP clients.

Participants also linked language reform to broader behavioral outcomes, particularly in relation to early intervention and prevention. Several suggested that the availability of a less stigmatizing label could make individuals more willing to seek help before crises or offenses occur. This observation strongly aligned with the prevention-oriented framework advanced by Grady et al. (2018) and B4U-ACT (2020), both argue that destigmatizing terminology is essential to creating accessible pathways for care. Clinicians in this study saw renaming not only as symbolic but as a potential harm-reduction strategy that lowers barriers to help-seeking, an interpretation consistent with Stelzmann et al. (2022), who found that fear of moral condemnation remains one of the strongest deterrents to treatment engagement among minor-attracted persons.

Despite these perceived benefits, participants consistently emphasized that language change alone cannot dismantle stigma. They viewed MAPs as a valuable entry point but not a solution in itself. For some, the term risked misunderstanding or even backlash in the wider community, where the distinction between attraction and offending is poorly understood. Without concurrent public education and institutional endorsement, clinicians feared that adopting the term might inadvertently undermine professional credibility or invite misinterpretation. This ambivalence echoed the warnings of Farmer et al. (2024), who cautioned that linguistic reform without cultural groundwork can be perceived as normalization or denial of harm. Similarly, Parr and Pearson (2019) and Levenson and Grady (2019a) found that clinicians

often hesitate to use language that diverges from public discourse for fear of professional backlash. The current study therefore extended these insights by applying a theoretical explanation: in TPB terms, MAPs can positively influence attitudes and perceived control, but its broader normative impact remains limited by persistent societal stigma and lack of institutional reinforcement.

Across participants' reflections, one unifying idea emerged: while language is a powerful facilitator of empathy, it must be paired with institutional support and reflective practice to produce lasting change. Clinicians repeatedly stated that "language matters, but trust matters more." They recognized that the success of any linguistic reform depends not only on what is said but on how it is enacted through consistent ethical behavior, transparent communication, and a willingness to confront shared discomfort. Through the lens of the Theory of planned behavior, this underscored that sustainable behavioral change among clinicians requires an integrated approach that simultaneously addresses attitudes, reshapes professional norms, and strengthens perceived control through education and support.

In sum, the findings from the second research question revealed that the renaming of pedophile to minor-attracted person can positively influence clinicians' intentions to engage with this population by reshaping their internal beliefs, moderating social pressures, and enhancing their sense of efficacy. However, the ultimate effectiveness of this linguistic change depends on the broader social and institutional contexts in which clinicians operate. This interpretation aligned with Ajzen's (2020) assertion that intentions are socially situated and contingent upon environmental support. When positive attitudes are reinforced by supportive norms and adequate resources, clinicians are more likely to act on their ethical commitment to care. When these supports are absent, even the most compassionate intentions may falter.

Thematic analysis of participant accounts yielded six major themes, each reflecting a different dimension of how language, stigma, and professional context intersect in clinical practice. The first theme, language as gateway, illustrated how clinicians view terminology as a key factor shaping tone, safety, and therapeutic engagement. The second theme, Clinician Discomfort, examined the persistent emotional and moral unease that surrounds this population, even when more neutral language is used. The third theme, Training, Experience, and Support, highlighted the lack of formal preparation and institutional guidance that leaves many clinicians feeling unprepared. The fourth theme, Mandatory Reporting Tensions, explored how ethical and legal obligations complicate therapeutic relationships and decision-making. The fifth theme, Stigma Blocking Care, broadened the focus to the systemic and societal forces that limit access to treatment. Finally, the sixth theme, Trust and Alliance, centered on the relational foundation of effective therapy, emphasizing empathy, honesty, and safety as essential to treatment success.

Together, these themes depicted the complex interplay between professional responsibility, public perception, and the personal challenges clinicians face when providing care to MAP clients. Each theme was presented in detail below, supported by direct participant quotations to illustrate the nuances of clinicians' lived experiences.

**Theme 1: Language as Gateway**

The first theme, language as gateway, captured how clinicians viewed terminology as a relational tool that shapes tone, safety, and engagement. Across accounts, language was portrayed not simply as vocabulary, but as a relational tool that shapes tone, safety, and engagement. Several participants emphasized that the term MAPs help separate attraction from behavior, reducing the automatic conflation of identity with offending. As P1 noted, "I think

"MAPs" is less stigmatizing. "Pedophile" has a very negative connotation that often equates attraction with offending behaviors. MAPs helps separate the identity from the action."

For many clinicians, this distinction carried emotional as well as professional weight. They described "pedophile" as a word saturated with media imagery, public outrage, and moral condemnation that makes open discussion difficult. As P2 explained: "Honestly, it sits a lot better with me. "Pedophile" is just loaded. It's what you see on the news, you know? MAPs feels more clinical, less accusatory." Here, MAPs was viewed as a term that lifted the negative connotations associated with "pedophile," making it easier to begin difficult conversations without defensiveness or fear, a sentiment that several other clinicians echoed. Participants frequently linked person-first language to a reduction in shame, emphasizing that subtle shifts in wording could transform the initial dynamic of a session. P9 observed that "MAPs is a better term in clinical practice. It focuses on the person first, which reduces shame and allows for more open dialogue. 'Pedophile' carries so much judgment that it often shuts down the conversation before it starts." Likewise, P11 noted that using MAPs "puts the focus on the person, not just the attraction," adding that clients appeared "less shamed" and more willing to engage when the term was used.

Many clinicians also reflected on their own internal responses to terminology, explaining that neutral language helps sustain composure and empathy during sessions involving highly stigmatized material. P3 described this:

> The word 'pedophile' is so emotionally charged, even for me as a provider. MAPs feels more neutral, and it allows for a conversation without that immediate defensive reaction. It's easier to talk about risk management and coping strategies when the person isn't feeling attacked. (P3)

For some, the use of neutral language enhanced the emotional regulation capacities of both clinician and client, allowing difficult content to be discussed safely. Several participants emphasized that gentler wording reinforces a person-centered approach by avoiding labels that sound final or condemnatory. As P4 explained, “I think it’s gentler, and it helps me approach the client as a person, not just a label. ‘Pedophile’ feels harsh and final.” Others linked this directly to empathy in practice. P13 reflected, “It’s much more client-centered and it keeps me focused on empathy. ‘Pedophile’ is so stigmatizing it almost guarantees silence. MAPs, while not perfect, helps clients feel seen as people first.”

Many participants also saw language as a gateway beyond the therapy room and indicated the possibility that it may impact help-seeking behavior. They suggested that a less stigmatizing label could influence whether and how soon people seek treatment. P1 expressed this view clearly: “I think it could potentially increase early intervention because people might be more willing to seek help if they’re not immediately labeled as dangerous or criminal.” Similarly, P13 noted that “society sees the label ‘pedophile’ as so stigmatizing that people won’t come forward,” adding that MAPs “lowers the barrier to accessing care.”

Clinicians frequently described this pathway in concrete terms: reducing fear of judgment, they said, could translate directly into earlier intervention. As P2 explained, “I think people might come in earlier before something harmful happens. Like, if you don’t feel labeled as a monster, maybe you’re more likely to seek therapy.” Others agreed that feeling safe enough to disclose attraction without automatic danger-labeling was key. P3 added, “I think it might encourage earlier intervention. Like, if someone feels they can identify as a MAP without being automatically labeled dangerous, maybe they’ll seek help before they’re in crisis.”

Some clinicians also observed that this effect extended to their peers. Softer language appeared to make early-career practitioners less hesitant to engage. P4 commented, “I think it could encourage people to come forward earlier, and it might make new clinicians like me less hesitant to engage.” Participants often connected these patterns to prevention, stressing that safety begins with the ability to ask for help before harm occurs. P5 summarized this point: “It could normalize early intervention. If we want to prevent harm, we need people to feel safe asking for help before they act.”

Across interviews, clinicians repeatedly indicated that language may impact the timing of treatment initiation. P13 explained, “It can encourage earlier intervention. People who feel stigmatized delay treatment, but MAPs creates just enough space for them to seek help before things escalate.” P11 reinforced this by saying, “MAPs doesn’t excuse anything, it just makes it easier for clients to seek help, and that’s what prevents harm in the long run.”

At the same time, many participants acknowledged limits to what terminology can achieve. Several pointed out that while word choice might ease entry into therapy, it does not alter core therapeutic methods. P7 remarked, “It might help some clients come forward sooner, but I don’t think it changes treatment itself. Therapy still focuses on coping strategies, risk management, and reducing shame.” Others suggested that the main effect may lie in initial rapport rather than in ultimate outcomes. As P12 put it, “If anything, MAPs might make some clinicians feel better, but I don’t think it really changes outcomes.”

Participants also discussed variability in how colleagues respond to the term, describing a profession divided between cautious acceptance and outright skepticism. As P16 noted, “Some roll their eyes at MAPs and see it as unnecessary. Others use it to make conversations easier. It’s pretty split.” While many endorsed MAPs as a helpful in-session tool, others questioned whether

it truly reduces stigma beyond clinical contexts. P1 explained, “I think it reduces stigma somewhat, especially in professional discussions. But I think the general public still struggles with the idea.”

Several clinicians described this effect as highly context-specific. Within therapy or among informed peers, the language seemed to help; outside those settings, it often failed to translate. As P3 said, “It helps reduce stigma, at least in the therapy room. Outside of that, in society, not so much yet.” Participants like P15 emphasized this distinction: “I support using MAPs in therapy. It creates a space where clients can feel less judged. That said, I’m pragmatic, I know society may never accept it, but within the therapy room, it has value.” Others echoed that sense of situational usefulness, describing MAPs as an effective clinical term that nevertheless faces public resistance. P5 summarized, “It reduces stigma in treatment settings, but it hasn’t caught on publicly. I think that’s where the real barrier is societal acceptance.”

Not all participants were comfortable with the terminology itself. Some viewed it as a linguistic overcorrection that risks minimizing the seriousness of the topic. P6 stated:

> Honestly, I don’t like it. I get the idea is to reduce stigma, but I think it risks sugarcoating something very serious. ‘Pedophile’ is harsh, yes, but it captures the reality of what we’re talking about. MAPs feels like rebranding for comfort rather than clarity.

Others shared concerns about public perception, suggesting that the term might make professionals seem evasive. P12 commented, “It makes people suspicious of us as professionals. They feel like it avoids the truth and makes our field look like it’s hiding something.” P8 echoed this, warning that “calling it MAPs makes it sound softer, like we’re trying to normalize it,” which could “risk losing public trust. If we look like we’re sugarcoating, we’re going to lose credibility.” A few clinicians noted that such skepticism is reinforced within professional

settings, where colleagues fear that adopting MAPs could be misinterpreted. As P16 said, “I’ve heard colleagues say using MAPs makes us look like we’re excusing something dangerous.” Similarly, P12 observed that “in my workplace, most people don’t even use MAPs. Using it sometimes makes you look like you’re soft on crime.”

Even among clinicians open to the term, participants agreed that its influence rarely extends beyond professional boundaries. P14 explained, “I think it can reduce stigma in the therapy setting, but I doubt it changes much in the public eye.” Others shared concern that the public might interpret MAPs as an attempt to downplay risk. As P6 observed:

> Maybe it reduces stigma in academic or clinical circles, but I don’t think the public is ready for it. In fact, I think some people see the term and feel like professionals are trying to normalize or excuse harmful attractions. That can backfire. (P6)

P7 expressed a similar view: “It probably reduces stigma in the therapy room, but I’m not sure about the bigger picture.” In the end, several participants reflected on this dual reality whereby language fosters openness within therapy but may simultaneously heighten suspicion outside it. As P16 summarized, “Maybe it reduces stigma in therapy, but outside of that, I think it increases suspicion. People don’t trust new labels, especially for something this sensitive.”

Overall, participants depicted terminology as a meaningful but bounded tool that can shape tone, openness, and accessibility, but not the deeper structure of therapeutic work. For many, using MAPs allowed for calmer, more empathic engagement and, in some cases, earlier disclosure or treatment-seeking. Yet clinicians also recognized that language alone cannot resolve societal stigma or professional unease, and that its impact remains context-dependent, most visible within therapy rooms and supervision spaces rather than in public discourse.

Across accounts, terminology emerged less as a solution than as a gateway: it can signal respect and safety, but sustaining trust and progress depends on the clinician's capacity for honesty, empathy, and continued dialogue. While language offered clinicians a way to soften discussions, it did not eliminate the underlying unease that surrounds this client group. The next theme explored how such discomfort manifests within professional contexts.

**Theme 2: Clinician Discomfort**

Clinical discomfort formed a second theme. While many clinicians viewed language as a useful entry point for reducing stigma, they also emphasized that changes in terminology did not erase the deeper discomfort surrounding this client group. Building on the previous theme, participants described how emotional, moral, and professional unease persisted even when the term MAPs was used, shaping how openly they could engage with both colleagues and clients. This discomfort often surfaced in supervision meetings and workplace conversations, where clinicians feared saying the "wrong thing" or being judged for showing too much empathy. In this sense, the challenge extended beyond linguistic sensitivity and reflected the broader tension between professional responsibility and social stigma that continues to shape clinical practice.

Several clinicians explained that even among colleagues, discussions about minor attraction could quickly become tense, and the terminology used often determined whether those conversations continued or shut down. For some, using the term MAPs provided a way to navigate that tension more constructively, softening the initial defensiveness that often arises when the word pedophile is mentioned. As P1 explained, "Colleagues are more open to discussions when MAPs is used. It seems to soften the immediate defensiveness."

Clinicians described MAPs as a kind of linguistic buffer that made it possible to address a difficult subject without triggering the moral or emotional reactions that can halt dialogue. As P3

observed, “MAPs takes some of the emotional charge out of the conversation.” For many, this shift in terminology was less about political correctness and more about creating psychological space for calm, reflective discussion. Participants suggested that the word itself seemed to invite a more measured tone, reducing the instinctive recoil or moral judgment that can accompany the word pedophile.

Others reflected on how this change in terminology affected not only colleagues but also their own internal state during clinical work. The language used in sessions they explained could directly influence their ability to stay composed and present with clients. P2 described this dynamic candidly: “If I say ‘pedophile,’ I feel myself tense up. When I use MAPs, it helps me stay grounded and focus on the person, not just the label.”

More experienced participants, who had worked longer with this population, tended to express less personal discomfort. Yet they even acknowledged that softer language could play a useful role in facilitating conversations among peers who were newer to the topic or less accustomed to its sensitivities. As P5 noted, “My comfort has always been fairly high, but MAPs helps colleagues talk about this population without shutting down. It lowers the defensiveness.” In this sense, language served not only as a communication tool with clients but also as a bridge among professionals, easing collective tension and promoting openness in spaces where silence or avoidance had previously dominated.

Several clinicians noted that language not only helps facilitate discussion but also supports their ability to remain composed and empathetic during therapy. Many described how certain terms could either trigger emotional reactions or help maintain professional distance and focus. The word MAPs, in particular, was said to allow for greater calm and presence when discussing sensitive material. As P9 explained, “MAPs feels less loaded, which helps me stay

grounded and empathic. For colleagues, I've seen mixed reactions. Some embrace it, others dismiss it, but I think over time, acceptance will grow."

While participants acknowledged this potential for increased composure and empathy, they also made clear that such benefits were not universal. Some clinicians reported skepticism from peers who viewed MAPs as unnecessary or politically motivated. The term, in these cases, was seen less as a helpful reframe and more as an overcorrection. P4 described this dynamic succinctly, recalling that "my colleagues sometimes roll their eyes when they hear the word MAPs, like it's just political correctness." These reactions underscored a recurring theme: that comfort with terminology often reflects underlying attitudes toward the population itself.

Several participants emphasized that word choice alone cannot resolve deeper discomfort or moral unease. For them, stigma operated at a level beyond semantics, tied to long-standing societal fears and the emotional weight of the topic. As P6 noted, "If someone's uncomfortable with this population, calling them MAPs isn't going to fix that. It might help colleagues talk about it more easily, but it doesn't solve the underlying stigma." This perspective reflected a broader understanding that linguistic changes may open doors to dialogue but cannot by themselves dismantle ingrained prejudice or fear.

A few clinicians expressed ambivalence, seeing both sides of the debate. They recognized that while gentler terminology could help foster openness, it also risked appearing to downplay the gravity of the issue. P7 illustrated this tension clearly, explaining that "On one hand, MAPs does sound less harsh and might make clients feel more comfortable. On the other hand, I can see how it might feel like we're softening something serious. So, I don't fully lean either way." For these participants, the value of MAPs depended largely on context. While it was considered a useful conversational tool, it could also feel misplaced if interpreted as minimizing harm.

For others, resistance to the term revealed an even deeper moral conflict within professional spaces. Some clinicians described colleagues who equated softened language with moral leniency, leading to frustration or distrust. P8 explained that "If anything, the MAP term makes some colleagues more frustrated, because they feel like it's avoiding the reality. I'm more comfortable sticking with clinical accuracy, even if it's harsh." This participant went further, suggesting that stigma itself can sometimes be rationalized as necessary: "People don't want to excuse this behavior. And as clinicians, we're human too." These accounts highlighted the tension between professional compassion and the societal impulse toward condemnation that many clinicians said they must navigate consciously in both discussion and practice.

Across accounts, participants described how differing professional attitudes created a persistent climate of unease and self-consciousness in clinical settings. Several clinicians spoke of an "unspoken tension" that permeated team discussions or supervision groups when the topic of minor attraction arose. For some, the discomfort stemmed not only from the sensitivity of the subject but also from a perceived lack of collective empathy within professional circles:

> Even with colleagues, there's this kind of unspoken vibe that these clients aren't worth the effort, which is tough to hear. I know colleagues who would flat-out refuse to take a referral if they heard the client was a MAP. So, there's pressure there, but I try to remind myself that my role is to help, not to judge. (P2)

Many clinicians traced these reactions back to broader societal narratives surrounding pedophilia, noting that public fear and moral condemnation often seep into professional environments. They described how this influence shapes tone, language, and comfort levels even in clinical spaces intended to be nonjudgmental. P3 reflected on this connection between public stigma and professional discomfort:

> Society pretty much views them as monsters, and that trickles down into how we, as clinicians, talk about them. I've been in team meetings where colleagues would say, 'Oh, I'd never work with that population,' and you can feel the stigma in the room. (P3)

The same participant later on added that stigma was not just a matter of personal bias but an institutional norm that affected the culture of care. Organizational attitudes, workplace gossip, and even subtle gestures were indeed described as reinforcing avoidance:

> The biggest barrier is actually on the system side, like colleagues making comments or intake staff rolling their eyes. Clients pick up on that stuff. Personally, I've never turned anyone away, but I'd be lying if I said it hasn't been uncomfortable sometimes. (P3)

Additionally, clinicians frequently spoke of the tension between personal values and professional expectations, describing an ongoing effort to balance empathy for clients with the need to maintain credibility among peers. This balancing act often left them questioning how their compassion might be perceived. P4 described the tension succinctly:

> They definitely make me second-guess myself. I worry that colleagues would judge me for being 'too soft' if I showed compassion, but I also don't want to come across as judgmental to the client. It's like being pulled in both directions. (P4)

Such reflections revealed how professional discomfort was not simply about the clients themselves, but also about the social dynamics within therapeutic and institutional settings.

For some clinicians, this internal conflict extended beyond day-to-day interactions and into broader advocacy efforts. P5 shared that these professional and societal narratives often made it difficult to promote understanding or expand access to care, saying, "They make it harder to advocate. When society views someone as irredeemable, it's tough to justify why treatment matters. But I've seen lives change with therapy, so I push back on those narratives."

Participants like P5 described advocacy as a necessary and emotionally taxing act of resistance against entrenched stigma that could leave them feeling professionally isolated.

Others identified risk-aversion and avoidance as systemic barriers that discouraged engagement altogether. Clinicians described workplace norms that implicitly signaled that working with MAP clients was "too risky," which left even willing providers hesitant. As P6 explained:

> Colleagues sometimes act like anyone with these attractions is beyond help. That attitude seeps in, even if I try to resist it. Honestly, I've turned down a referral or two in the past because I didn't feel prepared or supported. And within my clinics, there's this unspoken message that these clients are 'too risky' or 'too difficult.' (P6)

Participants also commented on how these reactions can surface even in clinical education and supervision. Simply raising the topic, they said, could generate visible discomfort among peers or supervisors. P4 observed, "I've noticed that even bringing up the possibility of working with MAPs in supervision makes people kind of tense up. There's this idea that you shouldn't even touch those cases unless you're specialized, which can feel discouraging." Such remarks highlighted how stigma reproduces itself within the structures designed to train and support clinicians, limiting open dialogue about complex ethical and emotional issues.

This professional discomfort was not limited to mid-career clinicians. Some participants described encountering similar reactions early in their training, shaping how they learned to navigate professional identity and advocacy. As P5 recalled, "Early in my career, colleagues questioned why I would even want to work with 'those people.' I've had pushback from administrators who worried about 'liability.' None of that stopped me, but it's an ongoing barrier." This reflection illustrated how institutional apprehension can discourage early-career

clinicians from engaging with this population, potentially perpetuating the shortage of trained professionals in the field.

Across accounts, participants described clinician discomfort as extending far beyond individual hesitation. Rather, it was seen as a product of collective and systemic forces including societal stigma, institutional caution, and professional norms, that implicitly discourage involvement with MAP clients. While some clinicians found that language adjustments like MAPs could make conversations easier, most emphasized that genuine openness requires more than a linguistic shift. Instead, they called for greater systemic support, reflective supervision, and an ongoing willingness among professionals to confront their own and their peers' discomfort as a step toward more compassionate, effective care. This discomfort was often compounded by limited training and institutional support, as participants described in the following theme.

**Theme 3: Training, Experience, and Support**

Participants described widely varying levels of experience in working with individuals who experience minor attraction. For many, such cases represented only a small portion of their overall caseloads, but they were often remembered as among the most complex and emotionally demanding. As P12 noted, "I've worked mostly in hospitals and outpatient clinics. Over the years, I've treated a handful of clients with these attractions, but it's never been the majority of my work." Others described encountering these clients sporadically across diverse clinical contexts, which prompted reflection on how best to approach such work:

> My caseload has always been pretty mixed, but I've had a handful of clients, maybe six or seven over the years, who disclosed being attracted to minors. Some were mandated by

> the courts, others came in voluntarily. It's not the bulk of my work, but enough that I've had to really think about how I approach it. (P3)

Several participants recalled feeling unprepared when these cases first arose, particularly early in their careers. P4 shared:

> I haven't directly had a ton of MAP clients. I did have one case where a teenager disclosed being attracted to younger kids, which was honestly really difficult for me at the time because I didn't feel trained for it. (P4)

Experiences like this highlighted the gap between academic preparation and clinical reality, especially in moments that demanded both ethical precision and emotional steadiness.

At the other end of the spectrum, a few clinicians reported extensive professional experience with this population, particularly those working in forensic or mandated treatment contexts. P5 described:

> I've been working in forensic mental health for over 22 years. My primary caseload has been individuals mandated for treatment after sexual offenses, but I've also worked with voluntary clients who identified as MAPs. I've probably treated a couple hundred in that time. (P5)

Even so, this clinician emphasized the structural limitations of the field, adding, "There aren't enough specialized providers, so clients fall through the cracks."

Across participants, there was widespread agreement that graduate training rarely addressed minor attraction in any depth. Many said their first encounters with MAP clients came unexpectedly in practice, leaving them to rely on supervision or continuing education. As P2 explained:

> We really didn't cover this in grad school, so most of what I've learned has come from supervision and continuing education. I've done some workshops on sexual offending behavior, but nothing super in-depth specifically about MAPs. We don't get this in school, and yet we're seeing these clients. (P2)

Supervision was described as the primary source of learning for many clinicians, often compensating for the lack of structured academic preparation. P7 put it succinctly: "Most of what I know has come from supervision and case consultations. It's definitely not something grad school prepared me for." Similarly, P11 shared, "I've gone out of my way to seek supervision and readings that help me support MAP clients."

A number of participants mentioned completing limited training in areas such as risk management or sexual-offending behavior, though few considered themselves specialists. As P16 explained, "I've had some training in risk management, but no deep specialization." Experienced clinicians, such as P4, emphasized how this lack of guidance can leave new practitioners feeling vulnerable: "Early-career clinicians need support with this. We want to help, but it's scary to feel like we're walking a tightrope."

Even those with backgrounds in forensic or offender treatment acknowledged the need for ongoing self-directed learning. P1 commented:

> I've had some specialized training in sexual offender treatment but not extensive. I rely heavily on supervision, consultation, and continuing education when working with this group. In fact, I don't remember any special mention of minor attraction in grad school. All my training has been in the form of CE's. (P1)

Another clinician echoed the same experience of informal, practice-based learning, describing the process as largely experiential rather than structured:

> I wouldn't call myself a specialist, but I've done some continuing ed workshops, mostly focused on sexual offending behavior. I've also leaned on supervision a lot, especially early on. You kind of learn by doing with these cases, because there's not a ton of formal training out there. (P3)

Many clinicians reiterated that this experiential, "learn-as-you-go" approach was far from ideal, emphasizing that trial-and-error learning can heighten anxiety and ethical uncertainty. P6 noted: "We didn't learn much about it in grad school, and most of my knowledge has come from continuing education or trial-and-error in practice. Honestly, it's a tough area." Others echoed this sentiment, as P12 reflected, "Most of my experience has been learning through cases and consultation."

Several participants contrasted this lack of preparation with the complexity of the work itself, arguing that changes in terminology alone cannot substitute for robust training. P8 observed, "I honestly don't think it changes treatment at all. The risk factors are the same, the therapeutic approach is the same. Changing the word doesn't fix the stigma or the behavior." Others, like P7, suggested that while terminology might play a minor role in easing engagement, competence ultimately depends on training and support: "I don't think just changing the word is enough, but I also see why it might help in some cases. What matters more is the support clinicians have to actually work with this population."

A number of clinicians expressed concern that softened language could obscure the need for rigorous skills-based preparation. P6 cautioned, "We can't just try to soften the language and hope the stigma goes away. We need to acknowledge the discomfort and address it head-on. What will help is more training, better supervision, and realistic conversations about risk."

Calls for improved education and systemic support were common across interviews. Participants emphasized the need for training that addresses both technical and emotional aspects of the work, encouraging self-reflection and nonjudgmental discussion. As P13 noted, "We need training that emphasizes person-first language, along with supervision groups where clinicians can openly discuss their discomfort without judgment." P1 expanded on this point, adding,

> Training is essential. Providers need more and better education to separate attraction from behavior. Also, normalizing professional discussion of MAPs in supervision would help. Stigma is a definite barrier so we, as providers, should be setting the example by learning more and actively reducing our own bias. These clients deserve access to care without fear of judgment. Language matters, but so does the willingness of providers to examine their own biases. (P1)

Several clinicians stressed that opportunities for open professional dialogue are key to countering isolation and fear. P7 remarked, "I think a lot of clinicians avoid the topic altogether, and that makes the stigma worse. We need spaces where people can process their reactions without judgment." Others emphasized the emotional strain of this work, calling for realistic preparation to help clinicians manage discomfort while maintaining compassion. P3 shared:

> Not just training on the DSM criteria, but real training on how to sit with the discomfort. If we, as providers, shut them out because of stigma, we're not only failing them but also failing to protect potential victims. (P3)

Participants also emphasized the importance of humanizing perspectives as part of clinical education. P2 explained, "These clients are human beings. They deserve a chance at treatment like anyone else. The language helps, but it's also about us as clinicians being willing to check our own biases." Others called for training that balances empathy with practical tools for safety

and risk management. As P8 advised, “Don’t hide behind new terms. Acknowledge the discomfort, be clear about safety, and give clinicians practical tools for risk management.”

Across accounts, participants agreed that ongoing professional learning is essential for improving care for MAP clients. They called for structured supervision, continuing education, and open discussion as the most effective ways to build both competence and confidence. P9 summarized this perspective: “Training is key, especially training that addresses personal biases and stigma. I’d also recommend more open discussions in supervision groups, so clinicians don’t feel isolated in this work.” P11 added, “We need better training and open dialogue. Stigma thrives in silence, so creating spaces where clinicians can talk about their discomfort is important.”

Finally, participants reiterated that without adequate preparation and institutional backing, stigma will continue to limit both access to treatment and clinicians’ willingness to engage. As P14 concluded, “I’d just say that whatever term we use, clinicians need to feel supported. Without that, stigma will always be a barrier.”

Overall, participants portrayed clinical work with individuals who experience minor attraction as an area defined by both professional uncertainty and personal commitment to ethical care. While most clinicians encountered such cases only occasionally, they described them as uniquely complex, requiring sensitivity, transparency, and specialized guidance. Across accounts, the lack of formal training emerged as a central obstacle that leaves many practitioners learning reactively rather than proactively. Participants emphasized that meaningful progress depends not merely on adopting new terminology, but on developing structured education, supportive supervision, and open professional dialogue. Together, these accounts highlighted a shared recognition that competence and compassion must evolve in tandem if clinicians are to

meet the needs of this highly stigmatized population with confidence and care. Alongside discomfort and limited preparation, clinicians also grappled with the ethical and emotional demands of mandatory reporting, which is explored in the next theme.

**Theme 4: Mandatory Reporting Tensions**

A fourth theme focused on mandatory reporting tensions, which was described by participants as one of the most challenging and anxiety-provoking aspects of working with clients who experience minor attraction. They spoke about the emotional burden of balancing confidentiality, safety, and liability, with each decision carrying significant ethical and personal weight. As noted by P6, "Mandatory reporting has been the biggest challenge. Deciding whether a disclosure meets the threshold for reporting is incredibly stressful, because the stakes are so high either way."

Clinicians reflected that part of what makes these decisions so difficult is the blurred line between thought and behavior. Many emphasized that while the law is clear in theory, its application in practice is rarely straightforward. The need to distinguish between fantasy, risk, and action creates persistent uncertainty. This was explained by P7 who mentioned that "I've had to really think through what's risky behavior versus just thoughts. That line isn't always clear, and it can feel heavy when you're making those decisions."

This ambiguity often extends beyond legal interpretation and into the clinician's internal experience. Several participants indeed described the tension between wanting to support clients without judgment and fearing the potential consequences of missing a reportable concern. P8 illustrated: "The biggest challenge is separating the attraction from behavior. Clients are afraid to talk about it, and honestly, sometimes I'm afraid to hear it. Liability is always in the back of my mind."

Others spoke of a persistent fear of error and the weight of personal responsibility. P4 reflected on this anxiety, stating, “My own fear of doing the wrong thing. Like, if a client tells me something risky, am I going to miss a reporting obligation?” Even with supervision, uncertainty often lingered long after decisions were made. As the same participant recalled, “I had to decide whether what the client shared rose to the level of a mandated report. I consulted with my supervisor, but I still felt uneasy for weeks afterward.”

In addition, participants recalled specific cases that tested their judgment and highlighted the complexity of maintaining both safety and therapeutic trust. P3 shared in this regard:

> I had a client who was actively struggling with impulses, and I had to navigate confidentiality versus safety. It was a gray area, and it really tested my judgment. I also worry about documentation, what I put in the chart, who might read it later. (P3)

Some participants described circumstances where reporting became unavoidable, acknowledging the professional and emotional strain of that decision:

> One instance involved mandatory reporting. A client disclosed ongoing risk behaviors that required me to break confidentiality. That situation was ethically challenging because it risked losing the therapeutic relationship that actually took a very long time to build. I reached out to 2 different colleagues for their input before reporting too. (P1)

Others said that in moments of doubt, they preferred to err on the side of caution, choosing to report rather than risk omission. As expressed by P12, “I’ve reported clients before, even if I wasn’t 100% sure, because I’d rather be safe than sorry.” More experienced clinicians, particularly those in supervisory roles, described these dilemmas as inherent in the work. P15 shared, “I’ve had to make difficult judgment calls, and I always encourage supervisees to err on the side of safety while still supporting the client.”

Several participants also noted the fear of liability that accompanies these decisions, observing that the pressure to "get it right" can sometimes overshadow compassion. As P16 described:

> [There is a] fear of liability. These cases feel like walking a tightrope. You want to help, but you also have to protect yourself and others. I'd recommend focusing less on rebranding and more on training clinicians in risk management and ethics. That's where the real work is. (P16)

To manage these challenges, many clinicians said they focus on transparency from the very beginning of treatment. They emphasized that setting clear expectations about confidentiality helps prevent misunderstandings or feelings of betrayal later on. As P9 noted, "When you're clear about boundaries and upfront with clients about confidentiality limits, it can be navigated responsibly." Similarly, P13 emphasized that "Reporting is always a concern, but being upfront with clients about those limits helps."

However, even with such transparency, participants still observed that clients' awareness of mandatory reporting obligations often shaped their behavior in therapy. Some indeed described an atmosphere of guardedness, where clients feared saying too much. P14 summarized this dynamic simply: "The fear and secrecy. Clients are often terrified of saying too much." For some clinicians, this fear directly interfered with the therapeutic relationship, creating a tension between honesty and self-protection. As P15 explained, "The biggest challenge is trust, helping them believe that therapy is a safe space. Fear of reporting makes many clients very guarded."

Across accounts, participants portrayed mandatory reporting as a delicate balance between ethical duty and therapeutic alliance. While all agreed that safety must remain the priority, they described the emotional strain and uncertainty that accompany these decisions, as

well as the impact such policies have on clients' willingness to seek or sustain treatment. These professional challenges were intensified by stigma, which participants identified as a barrier to care at every level.

**Theme 5: Stigma Blocking Care**

A fifth theme related to how stigma can block proper care. Participants consistently described stigma as a pervasive barrier that prevents individuals with minor attraction from accessing or engaging fully in treatment. The stigma was seen as operating at multiple levels, including within the wider community, inside treatment organizations, and even among mental health professionals themselves. Clinicians emphasized that this stigma not only marginalizes clients but also places pressure on providers to either avoid or distance themselves from this population:

> The biggest challenge is managing community and organizational stigma. Even colleagues sometimes view these clients as "untreatable," which adds pressure as well as frustration. They create an environment where these clients are often pushed away rather than supported. Working with this population requires intentional advocacy to ensure they get treatment without judgment, but this is a balancing act. (P1)

This participant's reflection captured how stigma is not limited to public discourse but also embedded within institutional culture. Several clinicians echoed that professional spaces can reinforce bias through subtle behaviors, language, and organizational norms that implicitly discourage treatment. These dynamics create an atmosphere where advocacy feels risky, and where clinicians must deliberately push back against exclusionary attitudes just to provide equitable care.

Participants further explained that societal perceptions of danger and deviance continue to shape how both clinicians and clients view treatment. For some, discussions about this population still carry assumptions of risk or moral failure, making genuine empathy difficult to sustain in professional circles. As shared by P8: “Society views these individuals as dangerous, period. And that perception can’t just be erased with a new term. In staff meetings, if this population comes up, people still use words like ‘predator’ or ‘dangerous.’”

Such language, participants noted, has a ripple effect, as it sustains fear within systems of care and signals to clients that they are unlikely to be met with understanding. This perception of universal judgment, in turn, discourages help-seeking before crises occur.

Several participants spoke directly about the emotional state of clients who fear disclosure. They described how many individuals who experience minor attraction enter therapy carrying a deep sense of shame and anxiety, worried that honesty might trigger legal or ethical consequences. P2 explained: “Clients are scared to even say the words out loud. There’s also the fear of, like, “If I share this, are you going to call the cops on me?” So, building trust takes a long time.”

Clinicians described these fears as both rational and deeply internalized. The association between attraction and criminality is so strong in the public imagination that even clients who have not acted on their attractions assume they will be treated as dangerous or immoral. As a result, many engage in partial disclosure or remain silent altogether. Providers observed that this secrecy hinders accurate assessment and meaningful progress in therapy, since genuine conversation cannot happen in an atmosphere of fear. P3 elaborated on the tension between client shame and clinician discomfort, illustrating the bidirectional nature of stigma in therapeutic relationships:

> Honestly, just getting them to trust me. There's so much shame wrapped up in it. Clients are terrified they'll be judged or reported. And to be transparent, I had to work through my own knee-jerk reactions, too. I remember the first client who disclosed, I froze for a second. Over time, I've gotten more comfortable, but those initial sessions can be really tough. (P3)

This account underscored how stigma affects both sides of the clinical encounter. Indeed, providers must not only manage clients' fears but also confront their own emotional reactions and social conditioning. Participants shared that these reactions were common and had to be actively acknowledged to avoid disrupting the therapeutic relationship. They noted that building trust required patience, transparency, and a conscious effort to separate attraction from harmful behavior. Despite these obstacles, several clinicians identified potential openings for progress. Some noted that efforts to reduce stigma through language changes, public education, and open professional dialogue can help make treatment more accessible and preventive. P9 shared in this regard: "I think it makes treatment more accessible. If people feel less judged, they're more likely to seek therapy earlier, which is better for prevention and support."

**Theme 6: Trust and Alliance**

A final theme related to the value of trust and alliance. Participants repeatedly emphasized that trust and psychological safety are the cornerstones of effective treatment with individuals who experience minor attraction. Across accounts, clinicians described the therapeutic alliance as fragile, deeply influenced by fear, shame, and stigma. Many participants stressed that their first and most important task is to create an environment in which clients feel safe enough to speak honestly without fear of judgment, rejection, or punishment.

> When I use "MAPs," clients seem to feel safer opening up. When "pedophile" is used, I've seen clients shut down. I have even had one argue with me when I used "pedophile" because they felt the word was synonymous with offending. (P1)

While terminology emerged as one of many tools that clinicians use to foster connection, participants clarified that its significance lies in its impact on trust, not in semantics alone. Using language that feels safer to clients was described to signal openness and respect, helping to establish the foundation for honesty early in treatment. Participant P2 shared in this regard: "I think it lowers stigma a bit, at least in professional circles. Clients I've worked with responded positively when I used MAP instead of pedophile. It didn't erase all the shame, but I noticed more openness."

These small linguistic adjustments often served as early indicators of a clinician's empathy. Participants indeed described clients gradually relaxing, making eye contact, or disclosing more once they sensed that the therapist would not recoil or judge them.

> When I've used the term MAPs, clients seem more willing to open up. When "pedophile" comes up – sometimes in their own words – they tend to shut down or avoid eye contact. It's like the word itself carries all the weight of stigma. (P3)

Others like P5 noted that using a less stigmatized term helped set a tone of emotional containment and acceptance, which in turn strengthened rapport: "Clients who hear "MAPs" feel safer. When 'pedophile' is used, you can watch them shut down. Language is powerful."

For some clinicians, the effect was immediate and profound, with clients expressing visible relief that the therapist could acknowledge their experiences without condemnation. These moments often marked the beginning of genuine therapeutic connection, as shared by P15: "MAPs has absolutely helped. I've had clients break down in relief when I used it. It made them

feel they weren't being defined solely by their attraction." Participants described these early breakthroughs as essential for alliance-building. When clients no longer feared immediate rejection, they could begin to discuss risk, shame, and coping strategies more openly:

> Clients have told me directly that they felt relief when I used MAPs instead of pedophile. It made them feel less like a monster and more like a person who could get help. Clients feel safer, and that safety is essential for effective treatment. Using MAPs isn't about excusing behavior, it's about creating space for people to get help before things escalate. If we can reduce stigma, we can actually reduce harm in the long run. (P9)

Still, participants were careful to point out that language does not function uniformly. While *MAPs* facilitated openness for some clients, others found it unnecessary or even off-putting. Clinicians described a range of reactions that often depended on personal history, self-perception, and the client's relationship to shame or identity. For some individuals, the newer term felt empowering or safer; for others, it felt artificial or overly cautious. P7, for instance, explained that these differences highlighted the importance of flexibility and the clinician's ability to meet each client where they are, rather than adhering rigidly to one linguistic choice: "Yes, I think using MAPs has helped some clients open up a bit more, but I've also had clients who preferred just being straightforward and using the word pedophile. It depends on the individual."

Furthermore, clinicians noted that when clients preferred direct terminology, it was often because they wanted transparency and authenticity in the therapeutic space. These clients associated plain language with honesty and respect, suggesting that what mattered most was not the term itself, but whether it aligned with their sense of truth and autonomy. Others like P6, however, valued softer or person-first language because it reduced anxiety and allowed them to

participate without feeling immediately judged: “Some clients seemed relieved when I used “MAPs,” but I’ve also had others roll their eyes and say it felt like I was minimizing their struggle. So, it’s a mixed bag.” As this participant implied, language choice can become a delicate balancing act between sensitivity and candor. What feels validating to one client may feel minimizing to another, underscoring that trust often depends on the clinician’s attunement to subtle emotional cues and willingness to adapt moment by moment.

Other participants added that, for many clients, the specific words used mattered far less than the broader sense of safety, acceptance, and presence conveyed by the therapist. They explained that clients were often more concerned about the therapist’s reaction including tone of voice, body language, or perceived judgment than about terminology itself. For many, the most pressing fear was not the label but the risk of being reported, rejected, or misunderstood. This awareness led clinicians to view trust and safety as inseparable from therapeutic effectiveness, regardless of the language chosen, as noted by P8: “Clients are usually more worried about being reported than what term I use. Some seemed fine with MAPs, but I didn’t see it change the core issues.”

P8’s reflection captured a recurring theme that genuine connection is established not through words but through the therapist’s emotional steadiness and ethical clarity. Participants described how many clients carefully watch for subtle cues including tone, body language, or facial expression that might signal disapproval or disgust. Even brief moments of hesitation could be interpreted as rejection, quickly eroding the fragile sense of safety that therapy requires. Clinicians spoke of needing to monitor their own reactions closely to ensure that clients felt fully accepted. P16 expanded on this idea, emphasizing that clients’ primary concerns often revolved around the clinician’s judgment, or the potential consequences of disclosure, rather than the

terminology used: “The couple of clients I’ve had didn’t seem to care which word I used. They cared more about whether I would judge them or report them.” This observation reinforced the notion that while language might open a door to conversation, it cannot replace the foundation of relational trust. What mattered most to clients was the felt sense that their therapist could tolerate difficult material without withdrawing, judging, or overreacting. Participants therefore emphasized that their central responsibility was to cultivate a consistent, nonjudgmental environment in which clients could risk honest disclosure without fearing punishment or abandonment.

Establishing this sense of security was widely regarded as the first and most vital step in treatment. Clinicians explained that trust does not emerge spontaneously but must be built carefully through repeated experiences of safety, empathy, and reliability. Trust, therefore, was described as the true foundation of progress. Participants emphasized that clients often arrive in therapy burdened by intense shame and fear of rejection, and that creating a secure environment takes time, patience, and consistency, as noted by P11: “The hardest part is their fear of being rejected or punished for seeking help. I spend a lot of time building trust and reassuring them that therapy is a safe space.” P9 echoed this and similarly shared that “clients often come in very guarded, afraid that if they share honestly, they’ll be reported or judged. Building that trust takes time.” With this in mind, reassurance was described as an ongoing process that unfolded gradually through repeated interactions. Clinicians portrayed these early sessions as emotionally delicate spaces in which even small details, such as word choice or a therapist’s facial expression, carried enormous significance. A single unintended sign of discomfort could confirm a client’s worst fears and set back weeks of progress. Participants described this process as gradual and effortful, requiring a careful balance between empathy and professional transparency

to maintain both safety and therapeutic boundaries. P13 shared: “The biggest challenge is overcoming the shame they carry. Clients often come in assuming they’ll be judged immediately, so I focus a lot on rapport building.”

Some participants reflected that stigma extends beyond clients’ internal experiences and into the broader mental health system, shaping both access to care and provider attitudes. They described how societal fear and moral judgment surrounding this population often lead to limited referrals, discomfort among clinicians, and even avoidance of cases. For clients, this climate of stigma can make the idea of reaching out for help feel risky or hopeless, as illustrated by P11: “I’ve had clients say they almost didn’t reach out because they assumed no one would help them. And among clinicians, there’s a lot of discomfort that can make referrals tricky.” Such reflections illustrated how trust must often be built in the shadow of systemic barriers. Even before therapy begins, clients may enter treatment assuming they will not be believed or supported. For many clinicians, acknowledging these barriers openly became part of establishing trust by reassuring clients that their fears were valid, yet also showing that the therapy room could be a space of acceptance and accountability.

Other clinicians noted that genuine trust also depends on maintaining clear ethical boundaries, particularly concerning issues of safety and reporting. They explained that while empathy and nonjudgment are essential, avoiding direct conversations about risk can undermine credibility. Transparency about the limits of confidentiality, rather than avoiding difficult topics, was in this sense described as crucial for preserving both safety and trust:

> Be honest. Don’t hide behind new words. Focus on safety and clear boundaries instead of worrying about terminology. We shouldn’t overthink language here. The real issue is risk and safety. That’s where our energy should go. (P12)

Furthermore, participants consistently emphasized that flexibility and responsiveness to clients' preferences were central to sustaining this delicate balance. Allowing clients to determine the language used in sessions was seen as a practical expression of respect and collaboration, helping them feel more ownership over the process. P14 shared in this respect that "I usually let clients set the language we use." For this participant, such flexibility was not simply a linguistic choice but an acknowledgment that the client's comfort and agency are vital to establishing mutual trust: "It's not the biggest factor, the trust I build matters more."

Others echoed this view, stressing that while terminology might initiate connection, what sustains it is the clinician's capacity for steadiness, empathy, and authentic engagement over time. The ongoing demonstration of acceptance, even in moments of tension or discomfort, was described as the core mechanism of trust-building. P16 shared: "I'd just say that language matters, but trust matters more. Clients will open if they feel safe, regardless of what word we use. That's where we should put our energy." P15 agreed and similarly explained that "language is a tool, not a solution by itself. MAPs helps open the door, but what keeps the door open is the clinician's willingness to engage without judgment. That's the real key."

**Summary**

This chapter outlined the results obtained from sixteen in-depth interviews with mental health professionals who have experience or perspectives related to providing treatment for individuals with minor attraction. Through thematic analysis, six major themes were identified: Language as Gateway, Clinician Discomfort, Training, Experience, and Support, Mandatory Reporting Tensions, Stigma Blocking Care, and Trust and Alliance. Collectively, these themes captured clinicians' complex experiences of navigating stigma, balancing empathy with ethical responsibility, and managing professional and emotional challenges within their work.

The findings highlighted how language and stigma interact to shape both therapeutic processes and professional attitudes, and how systemic and institutional barriers further complicate engagement with this population. Participants also underscored the importance of professional training, reflective supervision, and the establishment of trust as essential components of effective care. The next chapter discussed these findings in relation to the existing literature and the study's theoretical framework, offering interpretations and implications for practice, policy, and future research.

## Chapter 5: Discussion, Recommendations, and Study Summary

The research problem addressed by this proposed study was the stigma-related barriers and challenges mental health clinicians encounter when treating this population (B4U-ACT, 2020, 2023; Jahnke et al., 2021; Münch et al., 2020). The purpose of this qualitative descriptive study was to explore how mental health clinicians experience and describe the stigma-related barriers and challenges they encounter when providing care to individuals identified as minor-attracted persons (MAPs), and to examine their perceptions of whether rebranding the term "pedophilia" as "minor-attracted persons" may reduce these stigma-related barriers and improve therapeutic relationships and treatment effectiveness. To address this research problem, the study employed a qualitative descriptive methodology, which is well-suited for exploring complex, underexamined social phenomena through participants' lived experiences (Braun & Clarke, 2019; Neergaard et al., 2009). Specifically, 16 licensed mental health clinicians participated in semi-structured, in-depth interviews designed to capture their perceptions, experiences, and reflections on working with individuals who experience minor attraction.

The findings presented in Chapter 5 examined the results that the researcher described in Chapter 4. The current chapter's discussions examine the project's finding in the broader context of existing literature and the study's guiding theoretical framework, the theory of planned behavior (Ajzen, 1991). Chapter 4 detailed six major themes that captured clinicians' complex experiences: Language as Gateway, Clinician Discomfort, Training Experience and Support, Mandatory Reporting Tensions, Stigma Blocking Care, and Trust and Alliance. Together, these themes illustrated how stigma and language intersect to shape clinicians' emotional responses, ethical decision-making, and therapeutic engagement. The discussions presented in Chapter 5 are

built upon those previous findings by interpreting them in relation to the two research questions that guided the inquiry:

RQ1. How do mental health professionals describe the stigma-related barriers and challenges they face when providing treatment for individuals labeled as pedophiles?

RQ2. How do mental health professionals perceive that renaming pedophilia as minor-attracted persons could help overcome these stigma-related barriers and challenges, and what impact might such renaming have on therapeutic relationships and treatment efficacy?

Drawing on the theory of planned behavior, the current chapter's discussions examined how clinicians' attitudes, subjective norms, and perceived behavioral control interacted to influence their willingness and ability to engage with MAP clients. In doing so, the present analysis situated the findings within existing empirical and theoretical scholarship on stigma, language, and clinical ethics. This analysis identified areas where the present study's results align with or extend previous research (Jahnke, 2018; Levenson & Grady, 2019a; Lievesley et al., 2022), and where new insights emerge regarding the mechanisms by which stigma operates within clinical contexts.

The current chapter discussions were organized by research questions. The first section explored clinicians' experiences of stigma-related barriers and their influence on behavior through the lens of TPB. The second section examined perceptions of linguistic change as a potential intervention to reduce stigma and promote therapeutic engagement. Chapter 5 concluded by discussing the broader implications of these findings for clinical practice, training, and policy, and by identifying directions for practice and future research aimed at fostering more stigma-informed, prevention-oriented models of care. The chapter closed with a concluding section, emphasizing the main findings and value of the study.

## Discussion

The findings of this study provided several important implications for clinical practice, professional training, and broader social discourse. Although the term MAPs was not accepted by all clinician participants, the results suggested that language plays a meaningful role in shaping how clinicians perceive and engage with this population. Participants emphasized that terminology could influence initial tone, reduce defensiveness, and foster empathy, thereby serving as a relational gateway to therapeutic openness. However, they also cautioned that linguistic shifts alone cannot dismantle deeper layers of stigma or moral discomfort. These insights have implications for how future-term clinical practices, training/professional development processes, and policies in mental health organizations can approach the treatment of individuals who experience minor attraction.

The purpose of this qualitative descriptive study was to explore how the renaming of "pedophile" to "minor-attracted persons" (MAPs) might alleviate stigma-related barriers experienced by mental health clinicians in their work with individuals who experience minor attraction. Two research questions guided this inquiry: (1) How do mental health professionals describe the stigma-related barriers and challenges they face when providing treatment for individuals labeled as pedophiles? and (2) How do mental health professionals perceive that renaming pedophilia as minor-attracted persons could help overcome these stigma-related barriers and challenges, and what impact might such renaming have on therapeutic relationships and treatment efficacy?

The Theory of planned behavior (TPB) provided the theoretical foundation for interpreting these findings. According to Ajzen (1991), behavior is guided by three key factors: attitudes toward the behavior, subjective norms surrounding that behavior, and perceived

behavioral control, which together shape one's behavioral intentions and actions. Applied to this study, the TPB offers a lens through which to understand how clinicians' attitudes, professional norms, and perceived control influence their willingness and ability to provide competent, compassionate care to MAP clients within a highly stigmatized context.

The findings of this study revealed that clinicians' experiences were shaped by a combination of linguistic, emotional, and institutional factors that collectively influenced their comfort, empathy, and willingness to engage with this population. Across all six themes, participants described a complex interplay between personal reactions, professional ethics, and societal narratives that sustain stigma and constrain open dialogue. The following discussion interprets these findings in relation to each research question, connecting them to existing research and theory on stigma, language, and therapeutic engagement.

### *Implications for Clinical Practice*

The results highlighted that clinicians benefit from clear, nonjudgmental language that distinguishes between attraction and behavior. Using terms such as MAPs may create psychological safety outcomes for both clients and providers The project's findings indicated that the sampled therapist believed that the term would help MAP clients overcome the shame that potentially stems from traditional clinical descriptions of minor attraction. The population's feedback also indicated that the term MAP would help therapists overcome their biases when treating clients impacted by this disorder. The collective themes thus described the term's potential role in facilitating disclosure and early intervention in clinical situations involving MAP clients. However, this study also underscores the need for clinicians to address their own biases and emotional responses through reflective practice and supervision. The findings related to Theme 3, Training, Experience, and Support specifically reflected the participants' beliefs that

ongoing forms of professional development would help them cope with the complex challenges associated with treating MAP clients. Building therapeutic trust requires sustained empathy, transparency, and an ability to navigate ethical complexity without reinforcing shame. The latter processes would be uniquely helpful for MAP clients as they overcome the internal shame they may feel associated with their attraction while receiving treatment that can improve their mental health. In practice, this means clinicians should receive structured support to manage internal discomfort while maintaining a client-centered stance that prioritizes safety, compassion, and accountability from peers and supervisors. Creating spaces where clinicians can openly discuss their reactions and uncertainties without judgment could reduce fear, build confidence, and ultimately improve access to competent care.

**Implications for Training and Professional Development**

Across participants, a consistent theme was the lack of formal education and preparation to work with this population. Graduate programs and continuing education curricula rarely address minor attraction or related ethical considerations, leaving clinicians to learn through experience or ad hoc supervision. This finding pointed to a clear need for more structured, bias-informed training. Educational programs for graduate students entering the profession should include modules on stigma reduction, risk assessment, empathy development, and mandatory reporting when working with those who are attracted to minors. Professional development programs geared toward practicing therapists could help the population understand and overcome bias related to MAP clients.

**Implications for Policy and Organizational Culture**

The study's findings also revealed that stigma operates at multiple systemic levels, including within institutions. Organizational norms and peer attitudes often reinforce avoidance

in serving or discussing this population, indirectly sustaining barriers to care. Policy makers and clinical leaders should therefore consider promoting institutional cultures that support ethical engagement with patients with attraction to minors rather than avoidance of providing services to this population. Clear guidance on confidentiality, reporting thresholds, and professional support networks may help reduce clinician anxiety and liability concerns. Additionally, reframing organizational dialogue to emphasize prevention, early intervention, and human dignity may counteract the pervasive fear that often surrounds this topic.

**Comparison of Results to the Literature Review**

Ultimately, participants portrayed stigma as a persistent barrier that shapes both client and clinician behavior, often determining whether treatment even begins. They described the process of countering this stigma as slow and deliberate, requiring ongoing advocacy, open discussion, and reflective practice within clinical settings. The use of MAPs helped to reduce the emotional and professional weight associated with the term "pedophile," in some cases enhancing therapeutic engagement through facilitating trust, empathy, and openness between clinician and client. Even though clinicians intellectually distinguished attraction from offending behavior, their emotional reactions were influenced by societal conditioning and pervasive moral panic surrounding pedophilia. These findings align closely with prior studies highlighting how clinicians' affective responses are shaped by deeply ingrained societal stigma (Levenson & Grady, 2019b; Lievesley et al., 2022). Similar to what Jahnke (2018) and Harper et al. (2021) observed, the word pedophile itself indeed evokes strong aversion and fear responses, which often inhibit clinicians' capacity for empathy at the outset of therapy. The present findings echoed those of Levenson and Grady (2019a), who noted that clinicians often experience internal conflict between professional ethics and social morality when working with MAP clients.

However, this study added nuance by situating these tensions within Ajzen's (1991) theoretical model, showing that such discomfort directly constrains behavioral intention, even when clinicians intellectually endorse compassion.

However, across accounts, the central message was clear: until stigma is actively addressed, individuals with minor attraction will continue to face obstacles to care, and clinicians will remain challenged in their efforts to provide effective, compassionate treatment. Despite these systemic and ethical challenges, participants emphasized that trust and alliance remain at the heart of effective treatment. Taken together, the perspectives that developed theme 6, reinforced the idea that trust is the cornerstone of effective therapeutic alliance. While language may serve as an entry point, signaling openness and respect, it is the clinician's empathy, transparency, and willingness to meet clients where they are that truly sustain engagement. As participants repeatedly emphasized, language can invite clients through the door, but compassion and consistency are what keep them in the room.

**Recommendations for Practice**

The findings of this study suggested several important implications for how clinicians, educators, and institutions can more effectively respond to the complex needs of individuals who experience minor attraction. While participants varied in their views on terminology, there was broad agreement that professional education, reflective supervision, and organizational culture play decisive roles in shaping whether treatment is approached with confidence and compassion or avoided altogether.

First, the results indicated a strong need to normalize education on minor attraction within clinical training. Many participants reported that their graduate programs offered little or no preparation for working with this population, leaving them uncertain and anxious when such

cases arose in practice. To address this gap, universities and professional training programs should integrate structured modules that address sexual diversity, stigma, and risk management into their curricula. Coursework should explicitly differentiate attraction from behavior and include case-based discussions, ethical reasoning exercises, and reflective activities that help future clinicians develop empathy without compromising accountability.

In addition to formal education, ongoing supervision and reflective practice were highlighted as essential supports. Because this work often evokes discomfort and moral tension, clinicians benefit from safe and structured spaces where they can explore their reactions and biases without fear of judgment. Supervisors and professional bodies should encourage regular consultation groups and ethics-based reflection sessions that allow for open dialogue around challenging cases. Such initiatives not only strengthen clinical judgment but also mitigate burnout and professional isolation, ensuring that care remains both ethical and sustainable.

Participants also emphasized the importance of clarifying reporting obligations and ethical boundaries. Many described significant anxiety surrounding mandatory reporting decisions and uncertainty about when attraction crosses into reportable risk. Organizations should provide accessible, scenario-based training that clearly distinguishes between thoughts, fantasies, and behaviors, alongside explicit guidance on legal and ethical thresholds. Transparent institutional policies, supported by supervision and consultation, can help clinicians navigate these dilemmas with greater confidence and consistency, reducing fear and promoting client trust.

Another recommendation involved the mindful use of person-first language in professional contexts. Although not all participants favored the term minor-attracted persons (MAPs), most agreed that person-centered terminology can reduce shame and defensiveness,

facilitating more productive dialogue in both therapy and collegial discussions. Professional associations and organizations should promote conversations about language that balance empathy with ethical clarity, helping clinicians find ways to communicate that humanize clients without obscuring risk or responsibility.

Beyond the individual clinician, these findings underscored the need for broader organizational and cultural change. Participants described workplace climates in which stigma and avoidance were common, sometimes reinforced by subtle cues or institutional policies that discouraged engagement. Clinical leaders and administrators should take active steps to challenge these attitudes by fostering open dialogue, providing staff training on stigma reduction, and modeling professional empathy from the top down. A visible commitment to compassion and competence can help shift professional norms toward inclusion rather than avoidance.

Finally, prevention-focused initiatives should be expanded to promote early engagement and reduce risk before harm occurs. Several clinicians suggested that language and public education could play vital roles in encouraging people to seek help earlier. Health agencies and professional organizations might develop outreach programs, public information campaigns, or confidential support lines aimed at reducing shame and normalizing early intervention. Such initiatives could make treatment more accessible and help prevent offending through proactive, stigma-sensitive care.

Taken together, these recommendations emphasized that progress in this field depends on an integrated approach involving education, supervision, policy, and advocacy. Clinicians must be equipped not only with technical knowledge but also with the emotional and ethical tools to manage discomfort and bias. Institutions, in turn, must provide the structures and support necessary to sustain such work responsibly. By fostering reflective, well-informed, and

empathetic practice, the mental health profession can play a critical role in reducing stigma, enhancing prevention, and promoting safety and dignity for both clients and communities.

**Recommendations for Future Research**

The findings of this study highlighted the need for continued research into the ways language, stigma, and professional culture shape clinical engagement with individuals who experience minor attraction. While this study provided insight into clinicians' experiences and perceptions, further inquiry is required to expand understanding across professional, organizational, and social contexts. Future studies should seek to include a broader range of participants across disciplines, such as social workers, psychiatric nurses, and forensic specialists, to capture more diverse professional perspectives. In the present study, participants' perspectives captured a single point in time. Future studies could use a larger sample from a larger geographic area to enhance depth and contextual relevance of the findings, thereby increasing transferability of results to broader populations of mental health clinicians. A larger geographical sample would also lessen the influence of regional, cultural, or organizational factors. Examining how comfort levels and stigma differ between settings such as community mental health, correctional, and private practice environments would provide a richer understanding of the factors that support or hinder engagement. Including participants from different cultural or national backgrounds would also help explore how linguistic and moral frameworks influence perceptions of minor attraction globally.

Equally important is the inclusion of client perspectives. This study focused primarily on clinicians; however, research incorporating the voices of individuals who identify as minor-attracted persons could illuminate how terminology, therapist attitudes, and disclosure experiences influence their willingness to seek and remain in treatment. Mixed-methods or

longitudinal designs could help evaluate whether the use of person-first language affects therapeutic alliance, perceived safety, and treatment outcomes over time. Given that participants consistently identified inadequate preparation as a barrier, future research should also investigate the effects of targeted educational interventions. Studies evaluating graduate training modules, continuing education workshops, or supervision models designed to reduce stigma and improve ethical decision-making would offer valuable guidance for curriculum development. Longitudinal studies could further assess how such training impacts clinician attitudes, confidence, and competence in working with this population.

At an organizational level, more research is needed to examine how workplace policies, reporting procedures, and risk-averse cultures influence clinician behavior and treatment access. Ethnographic or case study approaches could explore how stigma operates within institutions, shaping communication and clinical decision-making. Policy-oriented research may also clarify how legal mandates and professional regulations affect clinicians' sense of safety and responsibility when working with minor-attracted clients.

Finally, future research should continue to interrogate the broader societal implications of language reform. While some clinicians in this study viewed the term minor-attracted persons (MAPs) as a constructive step toward reducing stigma, others expressed concern that it might be perceived as minimizing harm. Empirical studies examining how different terminologies are interpreted by the public, media, and policymakers could help determine whether person-first language fosters trust or inadvertently fuels skepticism toward mental health professionals. Overall, future research should aim to deepen understanding of how language, education, and systemic structures intersect to influence stigma, access to care, and the quality of therapeutic relationships. By extending inquiry beyond individual clinicians to include clients, institutions,

and communities, researchers can contribute to a more comprehensive, evidence-based framework for addressing one of the most stigmatized and ethically complex areas of mental health practice.

**Study Summary**

The purpose of this qualitative descriptive study was to explore whether the renaming of the term "pedophile" to "minor-attracted person (MAP)" could alleviate the stigma-related barriers and challenges faced by mental health clinicians in treating this population. The study was guided by the theory of planned behavior (Ajzen, 1991), which posits that individual behavior is shaped by attitudes, subjective norms, and perceived behavioral control. These constructs provided a useful framework for understanding how stigma and language influence clinicians' willingness and ability to engage ethically and effectively with clients who experience minor attraction.

To address this research problem, data were collected through in-depth, semi-structured interviews with 16 licensed mental health professionals from diverse clinical settings. A qualitative descriptive approach was selected to capture the complexity and sensitivity of clinicians' lived experiences. Data were analyzed thematically, resulting in six overarching themes that reflected the interrelated personal, professional, and systemic dimensions of stigma and language in practice: Language as Gateway, Clinician Discomfort, Training, Experience, and Support, Mandatory Reporting Tensions, Stigma Blocking Care, and Trust and Alliance.

Findings revealed that stigma operates across individual, social, and institutional levels shaping not only how clinicians perceive their clients but also how they perceive their own professional identity. Participants described powerful emotional and moral reactions to the label "pedophile," which often elicited discomfort, apprehension, or self-censorship. These reactions

were reinforced by workplace cultures and social norms that discouraged open dialogue or active engagement with this population. Such findings highlighted how stigma undermines all three determinants of behavior described in the theory of planned behavior: it contributes to negative or conflicted attitudes, perpetuates unsupportive social norms, and erodes clinicians' perceived control in navigating treatment ethically and safely.

At the same time, the findings demonstrated that language could serve as a point of intervention. The term MAPs were consistently described as a more neutral, person-centered label that separates attraction from behavior, thereby allowing clinicians to approach clients with greater empathy and composure. Many participants observed that clients appeared less guarded and more open to therapeutic engagement when the term MAPs were used, suggesting that linguistic reframing can foster early disclosure and trust. The shift in terminology also helped some clinicians regulate their own emotional responses, creating a more grounded therapeutic space. Nevertheless, participants cautioned that language reform alone cannot dismantle deeply rooted stigma or replace the need for training, institutional support, and societal education.

The implications of these findings were both theoretical and practical. Theoretically, the study extended the application of the Theory of planned behavior by illustrating how stigma-related barriers affect clinicians' professional decision-making across all three behavioral determinants. Practically, the findings underscored the importance of comprehensive, bias-informed training and supportive institutional structures to equip clinicians for this complex work. Educational programs should explicitly address the difference between attraction and behavior, the ethics of mandatory reporting, and strategies for managing professional discomfort. Moreover, open dialogue within supervision and professional organizations can help normalize discussion of minor attraction, reducing isolation and fear among practitioners.

Based on these findings, several recommendations were made. Clinicians should receive structured education and supervision opportunities that foster stigma awareness, ethical confidence, and emotional resilience. Professional bodies and training programs should incorporate specialized modules on minor attractions to close the current educational gap. Institutions should adopt clear policies and risk management protocols that balance client safety with therapeutic openness, reducing clinician anxiety about liability. Finally, future research should explore public attitudes toward language change, longitudinal outcomes of MAP-inclusive practices, and the development of stigma-reduction interventions at both clinical and community levels.

In conclusion, this study contributed to a growing body of literature emphasizing that stigma remains one of the most formidable barriers to effective treatment for individuals who experience minor attraction. The findings affirmed that while language can open doors to empathy and understanding, sustained progress depends on systemic change through education, institutional support, and reflective professional practice. By integrating linguistic sensitivity with evidence-based training and organizational reform, the mental health field can move toward a more compassionate, prevention-oriented approach that upholds both ethical responsibility and human dignity.

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# Appendix A: Site Authorization Approval

SEXUAL OFFENDERS ASSESSMENT BOARD
1101 SOUTH FRONT STREET, SUITE 5700
HARRISBURG, PA 17104-2533

MEGHAN M. DADE
EXECUTIVE DIRECTOR

TELEPHONE – (717) 787-5430
FAX – (717) 705-2618

July 24, 2025

National University Institutional Review Board
IRB@nu.edu

Dear IRB Review Committee,

I am writing on behalf of the Pennsylvania Sexual Offenders Assessment Board (SOAB). We have been contacted by Janet Campbell, a doctoral student at National University, for permission to contact SOAB approved treatment providers as part of her research study titled *Clinician Experiences Treating Minor-Attracted Persons: A Qualitative Descriptive Study*.

We understand the purpose of this study is to explore the experiences of licensed mental health professionals who provide services to individuals identified as pedophiles or minor-attracted persons, with a particular focus on stigma related barriers and terminology use. We acknowledge that the study involves the minimal risk to participants and that participation is voluntary.

We grant permission for Janet Campbell to recruit potential participants by using our list of approved sex offender treatment providers that is listed on our public website.

If you require any further information, please feel free to contact me directly by phone at (717) 787-5430 or mdade@pa.gov.

Sincerely,

Meghan M. Dade

Meghan M. Dade

# Appendix B: IRB Approval

**9388 Lightwave Ave.**
**San Diego, CA 92123**
**irb@nu.edu**

**Notice of Exemption**
August 21, 2025

**To:** Janet Campbell

**Project Title:** Renaming Pedophilia to Minor-Attracted Persons to Minimize Stigma-related Barriers and Challenges Mental Health Professionals Face with Treating this Population
**NU IRB Number:** IRB-FY25-26-27
**Modification Determination:** Exempt from further review 45 CFR 46.101

**Status: Active - Research activities may begin as of August 21, 2025**

Dear Janet Campbell:

The study referenced above has been reviewed by the National University IRB. The IRB has determined the proposed modification to your research is exempt from further review under 45 CFR 46.101, which means you will not need to renew your study and may begin your study effective immediately. However, if you find the need to change your study in any way, you will need to submit a modification to the IRB prior to implementing the changes. This will allow the IRB to determine whether or not the study still meets exemption criteria.

Please review your Post Approval Responsibilities here: Approved Documents Guidelines

For any questions regarding your protocol, please reach out to the IRB at irb@nu.edu.

Sincerely,

Dr. Joseph Marron, IRB Chair

Dr. Brianne Mongeon, Director, HRPP & IRB

Jenessa Eberhardt, Associate Director, HRPP & IRB

## Appendix C: Recruitment Email Invitation

**Subject:** Invitation to Participate in a Research Study on Clinician Experiences Treating Minor-Attracted Persons

Dear [Prospective Participant],

My name is Janet Campbell, and I am conducting a research study as part of my doctoral dissertation at National University. I am writing because you have been identified as a mental health professional with experience in the treatment of individuals with pedophilic disorder. I would like to invite you to participate in a confidential study exploring the experiences of licensed mental health professionals who provide care to individuals identified as minor-attracted persons (MAPs). The purpose of this study is to examine whether terminology changes, such as the use of "minor-attracted persons" instead of "pedophilia," influence stigma-related barriers in clinical treatment settings.

**Participation in the study involves:**

- Completing a brief screening survey to confirm eligibility,
- Signing an informed consent form,
- Participating in a semi-structured interview via Zoom, lasting approximately 60 minutes,
- Optionally reviewing the transcript of your interview for accuracy.

**Eligibility criteria include:**

- Being 18 years of age or older,
- Holding an active clinical license (e.g., LPC, LCSW, Licensed Psychologist, Psychiatrist),
- Having a minimum of two years of independent mental health practice experience,
- Currently or previously providing services to individuals identified as MAPs,
- Willingness to participate in an audio-recorded interview.

Participation is entirely voluntary. Your responses will be kept confidential, and identifying information will not be linked to your interview data. There are no direct benefits to participation; however, your insights may contribute to improving mental health practices for this population.

If you are interested in participating, please complete the brief eligibility screening survey available at the following link: https://forms.gle/TrsKRUNVRWagENER9.

If you meet eligibility criteria, I will email you an informed consent (that can be signed using DocuSign) and schedule an interview for a time convenient for you.

Please feel free to contact me directly at J.Campbell1991@o365.ncu.edu if you have any questions or would like additional information about the study.

Thank you for considering this invitation.

Sincerely,
Janet Campbell
National University
J.Campbell1991@o365.ncu.edu
(814)657-6295

## Appendix D: Participant Eligibility Screening Questions

**Instructions:**
Before participating in the study, please answer the following eligibility questions. Please respond "Yes" or "No" to each item.

1. Are you 18 years of age or older?
    - ○ Yes
    - ○ No
2. Do you currently hold an active clinical license (e.g., LPC, LCSW, Licensed Psychologist, Psychiatrist)?
    - ○ Yes
    - ○ No
3. Do you have at least two years of independent clinical practice experience (post-licensure) providing mental health services?
    - ○ Yes
    - ○ No
4. Do you currently provide, or have you previously provided care to individuals identified as minor-attracted persons (MAPs)?
    - ○ Yes
    - ○ No
5. Are you willing to participate in an audio-recorded Zoom interview lasting approximately 60 minutes?
    - ○ Yes
    - ○ No

**Screening Criteria:**

- Participants must answer "Yes" to **all** five questions to qualify for the study.

## Appendix E: Informed Consent Form

**Title of the Study:**
Clinician Experiences Treating Minor-Attracted Persons: A Qualitative Descriptive Study

**Principal Investigator:**
Janet Campbell
National University
J.Campbell1991@o365.ncu.edu
(814) 657-6295

### *Purpose of the Study*

You are invited to participate in a research study examining the experiences of licensed mental health professionals who provide care to individuals identified as minor-attracted persons (MAPs). The purpose of this study is to explore whether terminology renaming, such as the use of "minor-attracted persons" instead of "pedophilia," influences stigma-related barriers to treatment.

### *Procedures*

If you agree to participate, you will:

- Complete a brief demographic survey prior to the interview.
- Participate in a semi-structured Zoom interview lasting approximately 60 minutes.
- Optionally review the transcript of your interview to ensure its accuracy.

The interview will be audio-recorded using Zoom's recording function. Only audio will be collected; no video or identifying information will be recorded in the transcript.

### *Voluntary Participation*

Participation in this study is completely voluntary. You may decline to answer any question or withdraw from the study at any time without any penalty or loss of benefits to which you are otherwise entitled. If you choose to withdraw, your data will not be used in the study analysis.

### *Confidentiality*

Every effort will be made to maintain your confidentiality. You will be assigned a participant code (e.g., P1, P2) and your name will not be associated with your responses. Audio recordings and transcripts will be stored securely on a password-protected, encrypted USB drive. Signed consent forms will be stored separately from all interview data to further protect your identity. All data will be retained securely for three years after publication and then permanently destroyed.

***Risks and Benefits***

**Risks:**
There are minimal risks associated with participation. You may experience slight emotional discomfort when discussing experiences related to clinical stigma or patient populations.

**Benefits:**
While there are no direct personal benefits to participating, your insights may contribute to better understanding stigma in clinical practice and help inform mental health treatment approaches for underserved populations.

***Compensation***

There is no monetary compensation for participating in this study.

***Questions***

If you have any questions about the study, please contact:
Janet Campbell at J.Campbell1991@o365.ncu.edu or (814) 657-6295.

If you have questions about your rights as a research participant or wish to report a research-related injury, you may contact National University IRB office at irb@nu.edu.

***Statement of Consent***

I have read the above information and have had an opportunity to ask questions. I voluntarily agree to participate in this study.

Participant Name (Printed): _____

Participant Signature: _____

Date: _____

Researcher Signature: _____

Date: _____

## Appendix F: Eligibility Confirmation Email

**Subject:** Eligibility Confirmation and Next Steps for Research Participation

Dear [Participant Name],

Thank you for completing the eligibility screening survey for the research study, *Clinician Experiences Treating Minor-Attracted Persons.* Based on your responses, you meet the criteria to participate.

The next step is to schedule your individual semi-structured interview, which will be conducted via Zoom and will last approximately 60 minutes. During the interview, we will discuss your professional experiences related to providing care to individuals identified as minor-attracted persons. Your participation and responses will remain confidential.

Please review and sign the informed consent found at (insert DocuSign link) if you have not already done so. Once the consent form is returned, we can proceed with scheduling your interview.

Please reply to this email with a few dates and times that would be convenient for you over the next two weeks. I will do my best to accommodate your availability.

If you have any questions about the study, your participation, or the consent process, please do not hesitate to contact me at J.Campbell1991@o365.ncu.edu or (814) 657-6295.

Thank you again for your willingness to contribute to this important research.

Sincerely,
Janet Campbell
National University
J.Campbell1991@o365.ncu.edu
(814) 657-6295

## Appendix G: Semi-Structured Interview Guide

**Title of Study:**
Renaming Pedophilia to Minor-Attracted Persons to Minimize Stigma-Related Barriers and Challenges Mental Health Professionals Face with Treating this Population

**Purpose of the Interview:**
The purpose of this interview is to explore mental health professionals' experiences with stigma-related barriers and challenges in treating individuals diagnosed with pedophilia and their perspectives on whether renaming pedophilia as minor-attracted persons (MAPs) could reduce those barriers.

***Instructions for Interviewer:***

- Begin with informed consent and a reminder of confidentiality.
- Allow participants to elaborate freely; use follow-up or probing questions as needed.
- Maintain a supportive, non-judgmental tone throughout the interview.

***Section 1: Background Information***

1. Can you tell me about your professional background and experience working with individuals diagnosed with pedophilia or MAPs?
2. How many years have you worked in mental health?
3. How would you describe your level of training or expertise in working with this population?

***Section 2: Barriers and Challenges***

4. What have been the primary challenges you have faced when working with individuals who are sexually attracted to minors?
5. Can you describe any stigma-related barriers that have impacted your ability or willingness to treat these clients?
6. How do societal attitudes or professional peer opinions influence your clinical work with this population?
7. Have you ever encountered ethical or legal dilemmas when working with these clients? Please elaborate.

***Section 3: Perspectives on Terminology and Renaming***

8. Are you familiar with the term "minor-attracted persons" (MAPs)?
9. What are your thoughts about using the term MAPs instead of "pedophile" in clinical practice?
10. In your opinion, does the use of the term MAPs reduce, increase, or have no impact on the stigma associated with working with this population?

11. Has the use of either term (pedophile or MAP) affected your therapeutic alliance or the willingness of clients to seek treatment?

***Section 4: Impact on Treatment and Professional Practice***

12. How do you think renaming pedophilia to MAPs might influence treatment approaches or outcomes?
13. Have you noticed any change in your own comfort level, or that of your colleagues, based on the language used to describe this population?
14. What recommendations would you offer for addressing stigma-related barriers in clinical settings?

***Section 5: Closing***

15. Is there anything else you would like to share about your experiences, perspectives, or suggestions related to the treatment of individuals who identify as MAPs or are diagnosed with pedophilic disorder?

## Appendix H: Mental Health Referral Resources

Dear Participant,

If, at any time during or after your participation in this research study, you experience emotional discomfort, distress, or the need to speak with a mental health professional, you are encouraged to seek support. Below is a list of mental health referral resources available to you. These services are independent of the study and are provided for your well-being.

**Substance Abuse and Mental Health Services Administration (SAMHSA) Helpline**
Phone: 1-800-662-HELP (4357)
Website: https://www.samhsa.gov
Services: 24/7 national helpline offering free, confidential referrals to local mental health professionals and treatment centers.

**Open Path Psychotherapy Collective**
Website: https://www.openpathcollective.org
Services: A nonprofit network that connects individuals with affordable, in-person or online psychotherapy sessions provided by licensed clinicians across the U.S.

**Psychology Today – Find a Therapist Directory**
Website: https://www.psychologytoday.com/us/therapists
Services: A searchable directory of licensed therapists nationwide, allowing participants to find local mental health professionals by location, specialty, insurance, and more.

Sincerely,
Janet Campbell
National University
J.Campbell1991@o365.ncu.edu
(814) 657-6295

## Appendix I: Member Checking Verification Form

Dear Participant,

Thank you again for your valuable contribution to this study exploring mental health professionals' perspectives on renaming 'pedophilia' to 'minor-attracted persons' (MAPs) to reduce stigma-related barriers and challenges in treatment.

As part of this study's commitment to research integrity and ethical qualitative practice, we are conducting a member checking process. This allows you to review a summary of your interview responses to ensure accuracy and to confirm that your views have been represented correctly.

Please review the summary below and respond to the prompts that follow.

**Participant Interview Summary**

[Insert summary of participant's responses here — approximately 1–2 paragraphs.]

**Verification Questions**

1. Does the summary above accurately reflect your thoughts, experiences, and perspectives?

☐ Yes ☐ No (please explain below)

2. Are there any points you feel were misinterpreted or need clarification?

3. Would you like to add or emphasize anything that you feel was missing?

4. Do you consent to the use of this summary as part of the study findings?

☐ Yes ☐ No (please explain below)

Please return this form via email to the researcher within 7 days. You may also schedule a brief follow-up conversation if you prefer to give your feedback verbally.

Researcher Contact:
Janet Campbell
Email: J.Campbell1991@o365.ncu.edu

Thank you again for your time and contribution to this important research.