Applying desistance principles to improve wellbeing and prevent child sexual abuse among minor-attracted persons

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Abstract

The prevention of sexual abuse among people with sexual attractions to minors is a field of study that is growing in both size and importance. While there is an increasing amount of research into this topic, particularly in relation to the stigmatisation of minor-attracted persons (MAPs) and the barriers to them seeking help, there is currently no theoretical framework within which to consider this prevention landscape. In this paper, we suggest that an extension of Göbbels, Ward, and Willis' (2012) integrative theory of desistance from sexual offending could fill this gap in the literature. We explore what the aims of 'prevention' initiatives could, or perhaps should, be, before exploring how an extension and adaptation of the desistance framework could provide a framework for working with MAPs in their journey for sound mental health and, ultimately, the prevention of sexual offending.

Key words: desistance; paedophilia; minor attraction; wellbeing; sexual abuse prevention

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Introduction

Individuals who have a sexual attraction to minors face vast amounts of social stigma (Jahnke et al., 2015a) and experience stress and mental ill health as a result of this (Jahnke et al., 2015b; Lievesley et al., 2020). These issues can have profound effects on MAPs' willingness and ability to seek support for their sexual interests (Grady et al., 2018; Levenson & Grady, 2019; Levenson et al., 2017), which reduces the potential reach and impact of schemes designed to prevent the incidence of child sexual abuse.

While the majority of research in this area focuses on the narrower category of paedophilia (e.g., Cantor & McPhail, 2016; Jahnke, 2018a; 2018b; Seto, 2012), our focus here is on 'minor attraction' in a broader sense. In our use of this term, we encompass a range of chronophilic attraction categories (Seto, 2017). As such, we refer to this population as 'minor-attracted persons' (MAPs) in line with recent work suggesting the chronophilic non-exclusivity of sexual attractions to children (Lievesley et al, 2020; Martijn et al., 2020; McPhail et al., 2018).

At present there are no formalised frameworks for understanding sexual crime prevention before offenses have occurred. Although several initiatives are running prevention services, these each use local protocols rather than having a consistent approach (Beier, 2019; Christofferson et al., 2020a; Hocken, 2018). Our aim here is therefore to set out a potential framework by demonstrating how concepts related to desistance from sexual offending (e.g., deciding to change, rehabilitation) can be applied to the front-end of any possible offense chain as practitioners and policy makers seek to prevent child sexual abuse. In doing so we do not discount the potential utility of informal support services (e.g., online forums and social media) that may equally lead to the achievement of important human goals (e.g., connectedness and relatedness to others; Ward et al., 2007). However, our focus here is on formal treatment provision within a prevention context. From the outset, we view minor attraction through a public health and wellbeing lens (see also Letourneau et al., 2014; Lievesley et al., 2020) for reasons that will become apparent. That is, we begin from the perspective that assisting MAPs in improving their wellbeing (a primary aim of treatment) leads to subsequent reductions in sexual offending (the secondary aim).

Levels of Sexual Abuse Prevention

Defining 'prevention'

'Prevention' is a broad label for several approaches to reducing the rate of (in this context, sexual) offending. Specifically, theorists discuss three distinct levels of prevention: primary, secondary, and tertiary (for a review, see Allardyce, 2018).

Primary prevention refers to the enaction of widespread societal initiatives to reduce the incidence of sexual abuse. These take the form of large-scale public health and psychoeducation campaigns, and may teach children about the importance of personal protection, or place advertisements about the damaging nature of child sexual exploitation material (CSEM) on search engine websites. In contrast to this, secondary prevention schemes are more focused and targeted at individuals who may present an elevated risk of engaging in sexual abuse. These initiatives will include the promotion of prevention schemes (see Christiansen & Martinez-Dettamanti, 2018) that offer support to those who self-identify as having a potentially problematic sexual interest (e.g., minor attraction, or interests in violent or coercive sexual interactions). In turn, tertiary prevention efforts are targeted at those individuals who have already committed acts of sexual abuse. This prevention activity is most typically provided in correctional settings (e.g., prisons or secure mental health facilities), with the aim being to reduce the likelihood of repeated offending.

The Need for Conceptual Consistency (not Conceptual Novelty)

Across a range of research areas in psychological science, we have a tendency to over-theorise and seek conceptual novelty when trying to explain human behaviour (Kruglanksi, 2001), with 'new' theories often having little practicability (Berkman & Wilson, 2020). Forensic psychologists also indulge this tendency (Ildeniz & Ó Ciardha, 2019). That is, many researchers are attempting to formulate new or novel theoretical paradigms for understanding criminal behaviour and its prevention. For example, we still do not have a single unified theory of sexual offending, but rather we take insights from a range of multi-factorial frameworks, such as the preconditions model (Finkelhor, 1984), either of two integrated theories (Marshall & Barbaree, 1990; Ward & Beech, 2006), the quadripartite model (Hall & Hirschmann, 1991), the pathways model (Ward & Siegert, 2002), and most recently the motivation-facilitation model (Seto, 2019). This multiplicity of theoretical

frameworks is perhaps more surprising when considering the amount of overlap between them, with a small number of core constructs being present across different theories (i.e., emotional dysregulation, deviant or excessive sexual arousal, offense-supportive cognitions, antisocial personality traits, and interpersonal skill deficits).

We take the view that to understand the primary and secondary prevention of sexual offending, it is not necessary to produce an entirely novel theoretical framework. Instead, adaptations can be made to existing models of desistance from crime to, in effect, shift the process of desistance back one step. That is, instead of seeing desistance as beginning once a sexual offense has taken place, we might conceptualise it as having its origin when an individual chooses to move away from a potential offending trajectory. Not only does this provide us with a basis for understanding the process of desistance from its earliest possible point, but it allows us to develop such an understanding within a common conceptual framework. This makes it easier to translate our thoughts into existing correctional and treatment practices, as the field already possesses the terminology and language with which we communicate the ideas that follow. With this in mind, we turn our attention to one such model that allows us to do this within the context of sexual offending.

The Integrative Theory of Desistance from Sexual Offending

The forensic literature on the prevention of offending has historically focused on tertiary prevention. In the area of desistance from sexual offending, the most comprehensive model is the *Integrated Theory of Desistance from Sexual Offending* (ITDSO; Göbbels et al., 2012). This framework is comprised of four distinct phases of desistance, with each informing and underpinning the next. The four phases are labelled 'decisive momentum', 'rehabilitation', re-entry', and 'normalcy'. In the following sections we provide an overview of these phases and how they are conceptualised in relation to the desistance processes of individuals convicted of sexual offenses.

Decisive momentum

The beginning of a successful desistance process is characterised by an individual making a decision to change. This may be due to some intrinsic motivation related to a desired change to their personal identity, or something more extrinsic, such as working towards a parole hearing, or wanting to maintain social capital such as an intimate relationship,

friendships, or education and employment prospects (Weaver & McNeill, 2015). This phase signifies a turning point in the individual's life, and a re-orientation towards a new non-offending identity. Göbbels et al. (2012) suggested that this process of decision making and re-orientation towards change is not quick. That is, there can be weeks, months, or even years of considering behaviour change, as also theorised by Prochaska and DiClemente's (1983) stages of change framework (for critical commentary and review of this model, see Bridle et al. 2005).

This initial stage of desistance is primarily related to readiness to change, with forensic professionals working with their service users to develop viable future identities and plans for obtaining and living these out. As such, individuals at this stage will typically benefit from attempts to develop insight into the problematic nature of their behaviour in order to help them to be more ready for formal treatments, either from friends and family in the community or from professionals within forensic settings (McMurran & Ward, 2004; Vancampfort et al., 2015), although engagement with these treatments may still be some way into the future. The aim here is to help service users to contemplate on their behaviour and acknowledge that this needs to change. Often at this point, "contemplators struggle to understand their problem, to see its causes, and to think about possible solutions" (DiClemente & Velasquez, 2002, p. 208) despite realising that they need to do something to modify their behaviour. This means that individuals at this stage of change should be encouraged to think about the possible reasons for change, and professionals may work on developing a sense of agency and ability with them in order to build confidence in their own abilities to achieve and sustain long-term behaviour change. According to Göbbels et al. (2012), the aim of this process of re-evaluating their lives is the development of a range of possible future identities. Once this is achieved, the individual is ready to engage in formal treatment programmes in pursuit of these action goals, moving on to the next phase of desistance.

Rehabilitation

Having made the decision to change, an individual with sexual convictions should then engage with treatment to allow them to work towards their possible positive future identity. While some high-profile reports have criticised treatment programmes for individuals with sexual convictions (e.g., Mews et al., 2017), major meta-analyses do support the effectiveness

of treatment for this population (Gannon et al., 2019; Lösel & Schmucker, 2005; Schmucker & Lösel, 2017). Typically, this means focusing on core criminogenic needs (i.e., those factors that are causally related to offending behaviour), to help individuals to learn about their specific triggers for offending, and to offer support in developing the skills to avoid such triggers or cope with them as they arise. At its core, this process involves a "reconstruction of the self" (Göbbels et al., 2012, p. 457) into their new (non-offending) identity. Such a development of a non-offending identity can be self-reinforcing over time, and promote long-term desistance from crime (Rocque et al., 2016).

While the principles of risk-need-responsivity (Andrews et al., 2011) are central to the rehabilitation stage, Göbbels et al. (2012) also stress the importance of positive psychological approaches, and the need for individuals with sexual convictions to not only address deficits, but also to achieve primary human goods. These are set out in the Good Lives Model of rehabilitation (Ward & Stewart, 2003), and relate to things such as living a healthy life, engaging in a range of hobbies, having close ties to the community and other people, findings purpose and meaning, and gaining control over your own behaviour and circumstances. Having these goals contributes to a commitment to change (Prochaska & DiClemente, 1983), which in turn fosters a sense of agentic, cognitive, and emotional investment in the desistance process on the part of the desisting individual (Farrell & Calverley, 2006; McNeill, 2006).

Re-entry and Normalcy

Once the individual with sexual convictions has completed their custodial sentence (or, in some cases, engaged in treatment programmes in the community), they begin the next phase of desistance, which is re-entry into the community. In the first two ITDSO phases the focus is placed on building up the necessary motivation to change behaviour, and then to acquire the skills to move forward in life with a new non-offending identity. Here, though, is where the individual is required to live in the community *as* that new identity. The addition of a 'Good Lives Plan' (Ward & Fortune, 2013; Willis & Ward, 2011) upon release is designed to assist in this process, identifying the various strengths of the individual being released, as well as areas where further treatment or additional social support might be needed.

While this phase does seem to indicate the end of treatment in a traditional sense, engagement with initiatives like Circles of Support and Accountability (CoSA) can help bridge the gap between incarceration and the community, while also helping the individual to build

up social capital in the form of emerging social relationships with trained volunteer helpers (Wilson et al., 2007). The importance of social capital and relationships is indicative of the role of the community at this phase of the desistance process. That is, social attitudes towards people with sexual convictions can play a pivotal role in the availability of accommodation and work, as well as dictating the general levels of acceptance experienced by people re-entering the community (Harper et al., 2017; Willis et al., 2010). According to Göbbels et al. (2012), the social environment must reinforce the new skills and identities that have been developed within more formal treatment programmes, allowing these to be practiced and embedded into a more 'normal' routine of living in the community. In the language of behaviour change theory, this is referred to as the maintenance stage (Prochaska & DiClemente, 1983), and represents a final move towards the long-term change of previously problematic patterns of behaviour.

Within the ITDSO, the length of time between 're-entry' and 'normalcy' is not specified. However, Hanson et al. (2018) reported a gradual reduction in re-offense risk over time among convicted individuals, such that risk dropped to the same level as those with no offending history after being offense-free for 10-15 years.

Applying the ITDSO to the Prevention Context

Having identified the Göbbels et al. (2012) ITDSO as a potential model for application in the prevention context, it is important to set out exactly where these applications lie. In the sections that follow, we consider each stage of the ITDSO and how it can encourage a desistance-like process before a sexual offense has taken place.

To be clear, we make a distinction between 'prevention', which we define as the successful prevention of offending before any sexual offense has taken place, and 'desistance', which we define as the reduction or stopping of sexual offending after an initial offense has been committed (the tertiary level of prevention). This distinction is important, not only for clarity in this paper but also because the term 'prevention' has connotations related to its temporal position in the offense chain among lay readers. By explicitly separating these terms in our framework, we can acknowledge the important work undertaken by professionals at the tertiary level while providing a clear and consistent vocabulary for those less versed in theories of prevention.

In our approach, decisions to seek support as a precursor to mental health treatment are akin to individuals who have offended making the conscious decision to engage in formal treatment programmes. This treatment can either be classified as successful (i.e., maintaining non-offending) or ineffective (i.e., leading to a sexual offense). Crucially this means that we allow for a link between the pre-offense (prevention) and post-offence (desistance) treatment contexts. We elaborate on these processes in subsequent sections.

Initial Momentum and the Decision to Seek Support

Previous research has found that many self-identified MAPs who are either seeking support for emotional symptoms associated with their sexual attractions (Levenson & Grady, 2019), or wish to access such support if they are not already doing so (Lievesley et al., 2020). The decision to seek support is an important one, and indicates a motivation to address levels of distress (an intrinsic motivation) or to reduce a possible risk of sexual offending (an extrinsic motivation). Recent surveys have found that motivations are predominantly intrinsic in nature (i.e., MAPs desire support for mental health issues, such as depression, anxiety, shame, loneliness, and self-esteem issues; B4U-ACT, 2011; Levenson & Grady, 2019; Shields et al., 2020) as they struggle with their MAP identity.

Although there is little research into why MAPs do seek support, a fear of revealing this aspect of their MAP identity is often cited as a barrier to help-seeking (Grady et al., 2018; Levenson & Grady, 2019), with its suppression being linked to negative mental health outcomes (Lievesley et al., 2020). In an analysis of posts from the *Virtuous Pedophiles* forum, Stevens and Wood (2019) reported how coping strategies for MAPs fell into four categories: 'managing risk', 'managing mood', 'managing preferences prosocially', and 'family, friends, and relationships'. Within these categories, references were made to MAPs trying to accept their attraction ('managing mood'), expressing their attractions in legal ways ('managing preferences prosocially'), and being able to live socially-connected lives ('family, friends, and relationships'). These are all related to the desire to not be defined *as* a MAP, but to integrate this aspect of the self into a broader self-identity, consistent with larger survey work suggesting a need for MAPs to improve their self-concept, deal with social stigma, and learn to live in society with their attractions (B4U-ACT, 2011). Given the apparent importance of managing mood in some MAPs' decision to seek professional support, we argue that

accepting one's attraction as a MAP may be a key distinguishing feature of the initial decision to engage in help-seeking.

It is here that we see the first similarity between our application of the ITDSO and the original model. Just as in the MAP context, the development of a prosocial and interpersonally connected self-identity is a key motivating factor in the decision for some people with convictions to engage in rehabilitation (Göbbels et al., 2012; Maruna, 2001), and as such the development of viable future identities (and working towards these) have become a mainstay of treatment approaches for those working with people with sexual convictions. This approach may thus form an important aspect of the treatment process within the prevention context. It may be particularly important to do this in relation to helping MAPs use known coping strategies, such as via managing emotions via healthy living and self-acceptance, facilitating the legal expression of sexuality, and forming close peer and family relationships (Stevens & Wood, 2019). Having identified these themes as being potentially important drivers of a decision to seek help, these then have implications for determining treatment goals in therapeutic contexts.

Formalised Treatment Efforts

Having decided to seek support, it is important that treatment is non-judgemental and responsive to MAPs' specific needs (B4U-ACT, 2011). This is similar to any other mental health or forensic treatment approach (Andrews et al., 2011) but is particularly important in light of the many social barriers to help-seeking among this population.

Setting appropriate treatment goals and philosophies

Among forensic professionals, the goal of a 'prevention' treatment service is simply to stop, slow, or reduce the intensity of offending behaviour (Allardyce, 2018). As such, many prevention services achieve this by working with individuals that have already offended, rather than before an offence has occurred. For example, in Germany's 'Dunkelfeld Project' up to 92% of participants report some form of child sexual offending (Konrad et al., 2017) and the 'Aurora Project' in the UK reports that up to 85% of participants either have a history of sexual offending, or are subject to a police investigation for this (Hocken et al., 2019). An explicit prevention focus in these contexts seems more aligned with a tertiary prevention

approach, rather than having the effect of reducing the incidence of first-time offending among MAPs with no criminal history.

Specifically looking at the Dunkelfeld Project, treatment takes the form of anonymous work based around the principles of cognitive-behavioural therapy, wherein service users are encouraged to work on their self-concept, to develop prosocial and adaptive coping skills, and to address offense-supportive sexual thinking (Beier, 2019). While multiple papers have suggested that the Dunkelfeld approach leads to reductions in sexual offense risk (Beier et al., 2009; 2015), these analyses have crucially omitted to examine the important time × group interaction. That is, while some reductions in indices of offending risk have been reported as a function of the treatment programme, these changes were not different to those observed in a control group receiving no support (Mokros & Banse, 2019).

Having a fixed (and explicit) 'prevention' focus might explain this lack of specific treatment effect (Lievesley et al., 2020). That is, if the focus of treatment is on the prevention of a particular behaviour, and the reduction of scores on indices of that behaviour, then other potential outcomes are not being considered. For example, in Beier et al. (2015) the outcomes measured included sexual self-control and offense-supportive cognitions. While these are clearly important factors to consider when trying to reduce the incidence of sexual abuse, they ignore outcomes related to mental health, self-acceptance, and shame. This is a particularly important point given that these issues are the primary targets of treatment that MAPs themselves self-identify (B4U-ACT, 2011; Levenson & Grady, 2019). These issues have also been demonstrated as problematic in this population (Jahnke et al., 2015b; Lievesley et al., 2020), as well as being identified as barriers to help-seeking behaviours more generally (Grady et al., 2018; Levenson & Grady, 2019; Levenson et al., 2017). For this reason, while the prevention of sexual abuse is likely to be high on forensic practitioners' list of treatment priorities, it may also be necessary to encourage non-forensic health professionals to engage with this population in a manner than begins to open up support services in non-forensic contexts.

Adopting a non-forensic focus requires health professionals to use broader skill sets and treatment philosophies Process-oriented models acknowledge that individuals experience distress in the context of broader social systems. In doing so, therapists engage with their clients as a part of such systems, with compassion for service users' social positioning being a fundamental part of the therapeutic relationship (Gilbert, 2014). This places an emphasis not

on treating surface-level symptoms, but on exploring and integrating deeper emotional states, such as shame and fear into a positive self-identity. These emotions have been reported to be particularly prevalent in MAP communities (e.g., Grady et al., 2018; Levenson & Grady, 2019; Lievesley et al., 2020), which has led some to advocate for them to become a treatment target in sexual crime prevention (Hocken, 2018; Lievesley et al., 2018). This approach is also consistent with emergent approaches to *prehabilitation* in sexual crime prevention services (Christofferson et al., 2020b). In this paradigm, clients with sexual attractions to children are not encouraged to address offence-supportive beliefs or engage in abuse prevention work as in other services (e.g., the Dunkelfeld Project). Instead, prehabilitation seeks to "understand and cater to the needs of minor-attracted members of the general population, rather than simply transposing justice-setting rehabilitation approaches into an earlier prevention context" (Christofferson et al., 2020a, n.d.). This involves using compassion-focused techniques to work through experiences of (self-)stigmatisation and coping with minor attraction in a more general sense to help MAPs live constructive lives *with* their attractions, rather than being dominated by them.

Professional training requirements

If primary care health professionals (e.g., general practitioners, health care assistants, psychotherapists, sexual health workers) are to play a role in the treatment of MAPs, there are likely to be many challenges to this. A small collection of studies has explored the potential predictors of not seeking treatment among MAPs, finding that concerns about the availability of knowledgeable and non-judgemental therapists is a major barrier to help-seeking (Grady et al., 2018; Levenson & Grady, 2019; Levenson et al., 2017). While these perceptions may read like paranoid expectations among a stigmatised population, there is some evidence to suggest they are accurate. For example, in a German sample of trained psychotherapists, upwards of 95% of participants suggested that they would be unwilling to work with this population in a therapeutic setting (Stiels-Glenn, 2010; see also Cantor, 2014). There were several reasons for this lack of willingness. Aside from generalised negative attitudes towards MAPs (see Jahnke et al. (2015c) for a discussion), these psychotherapists did not feel they had the requisite skills or experiences to adequately work with MAPs. This is unsurprising, as core medical (e.g., General Medical Council, 2016) and psychotherapeutic (Royal College of Psychiatrists, 2013/2017) training curricula do not typically contain any information about

minor attraction (with the only mention of sexuality in syllabi being related to the need to sensitively work with people from diverse backgrounds). As reported by Cohen et al. (2018), most therapeutic input with MAPs takes place with those who have previously committed sexual offenses. This potentially creates a further heuristic among professionals that minor attraction is synonymous with sexual offending, contributing to stigma and a decreased willingness to work with this population.

With a lack of specific training and limited experience in mind, it is perhaps reasonable to expect that a large proportion of medical and mental health professionals hold the same kinds of biases as some well-educated members of the public. These include the view that paedophilia (as is the common label for minor attraction within society) is synonymous with child sexual abuse (Feelgood & Hoyer, 2008; Harper & Hogue, 2017; Harrison et al., 2010), and that MAPs possess some degree of control or responsibility over their attraction patterns (Jahnke et al., 2015a). While the evidence about the lack of controllability and choice of sexual attractions towards children is clear (Cantor, 2015; Cantor et al., 2008; Seto, 2012), the persistence of erroneous beliefs about minor attraction may lead some professionals to formulate treatment targets related to the lowering of sexual attractions to children, and the increase of sexual attractions towards adults. This is despite a lack of credible evidence being available at present to suggest that predominant or exclusive sexual attractions towards children can be changed in this way (for a summary of this research area, see Cantor & Federoff, 2018), and the difference between these goals and the stated aims of MAPs themselves; B4U-ACT, 2011).

These issues point to a need for further specialist training for medical and psychotherapy providers, including introductions to what minor attraction is, how it operates non-synonymously with sexual abuse, the treatment targets of MAPs, and the potential dangers of tackling this issue through a strictly prevention-based lens. This training would seemingly need to incorporate some information about the boundaries of confidentiality in order to ensure that treatment providers know when they should and should not be making disclosures about their service users to safeguarding and law enforcement agencies. These reporting responsibilities could be clarified through a more unified and consistent approach to reporting legislation, as we now turn our attention to.

Required legislation

High quality stigma-reducing professional training needs to be supported by a legislative infrastructure that allows for the constructive treatment of MAPs without the need to place them under investigation for, or suspicion of, sexual offending. A fear of reporting is a barrier to help-seeking among non-offending MAPs living in the community (B4U-ACT, 2011; Grady et al., 2018; Levenson & Grady, 2019; Levenson et al., 2017). The difficulty in achieving legislative security this internationally is self-evident, with different countries having their own policies on mandatory reporting. For example, most US States have mandatory reporting practices, whereby licenced professionals working with children have a legal obligation to report a case to authorities is there is evidence of abuse, or they have reasonable grounds for suspecting that abuse is taking place. In the UK, there is no statutory or mandatory reporting legislation. Instead, responsibility for setting reporting requirements are set by independent regulatory bodies for each professional group (e.g., psychologists, social workers, healthcare professionals), meaning that failing to act can lead to disciplinary action, including the loss of professional accreditation. In contrast, German therapists have no statutory obligation to report anything, and instead have a duty of confidentiality to their clients.

Laws and guidelines such as those in the US and UK leave many cases open to professional judgement, with these being confounded with beliefs about minor attraction. For example, if a professional conflates minor attraction with child sexual abuse, it quickly becomes a *reasonable suspicion* that a MAP who seeks treatment could be a risk to children that s/he has regular contact with. This is even the case in the absence of any objective evidence of abuse, as some would (often incorrectly) infer than attraction is an indicator of imminent sexual offense risk. There is no easy solution to this issue. However, from a prevention perspective it is important to lower barriers to accessing support, such that as many MAPs can access services as feel they need to. It may therefore be wise to relax mandatory reporting laws to only encompass cases whereby there is concrete or self-disclosed evidence of maltreatment or abuse, and to ensure that this condition of reporting is clear and transparent to potential service users at the outset of treatment (Beggs Christofferson, 2019). Support for this recommendation, however, is required. For example, studies examining engagement with newly established prevention initiatives within areas with different degrees of reporting legislation might offer some insights as to whether

reporting requirements influence help-seeking behaviour, or if other non-legislative practices are more influential for engagement.

Normalcy

Consistent with the original ITDSO model (Göbbels et al., 2012), the ultimate aim for the end of treatment and professional support, for both MAPs and for individuals with sexual convictions, is for them to be able to live happily, healthily, and offense-free. Among MAPs, this process is less distinct than it is for individuals who have offended. For those who have been incarcerated, they have a buffer between formal treatment interventions and normalcy via the re-entry process. Among MAPs who do not engage in offending behaviour, it might be appropriate to view 'normalcy' as the phase of their life whereby they do not feel the need to suppress their sexual attractions, but instead can accept and integrate them as a part of their identity (Grady et al., 2018; Lievesley et al., 2018; Lievesley et al., 2020), and live productively with these attractions in a healthy and law-abiding way. This does not mean that support will not be needed. Among those exclusively attracted to children there will be experienced losses, such as a lack of authentic interpersonal relationships, and the inability to have a stable intimate or sexual partner. MAPs will still experience high levels of societal stigma.

The lack (or loss) of authentic friendships and family relationships is a common experience among MAPs (Elliott et al., 2018; Lievesley & Harper, 2019). Common themes of not being able to be open with friends and family about one's sexual orientation is tied up with fears and experiences of societal stigma. As such, support may be offered by professionals about how to best have conversations about minor attraction with trusted friends and loved ones. These conversations may happen privately or within the context of relationship or family therapy, but the aim may be to help to integrate knowledge of MAPs' sexual attractions into existing close bonds (rather than seeking to alter relationships to accommodate this new knowledge).

Support may be offered in the form of ways to effectively manage sexual arousal in a way that is both safe (for others) and satisfying (for the MAP). There is scant work on this route to normalcy and sexual satisfaction in MAPs at this point. Mundy and Cioe (2019) have reported that individuals with "criminal paraphilic interests" (p. 304), which encompass minor attraction, report lower levels of sexual satisfaction when they are not able to engage in some

form of paraphilia-related sexual behaviour. Given that sexual satisfaction has been identified as a primary human good (Ward & Marshall, 2004), it is possible to suggest that allowing some form of sexual expression may be effective for both increasing MAPs' mental wellbeing and potentially decreasing forensic risk. A precise route to achieving this is morally unclear. Safe sexual expression may come in the form of fantasy engagement, or more tangibly in the form of the use of inanimate aids, such as sex dolls or computerised sexual imagery. However, these options should be carefully considered before being enacted, and significantly more research is needed to identify which forms of sexual expression are effective, and for whom.

Social Context

While the sections above (making a decision to seek support, and engaging in treatment until reaching a point of normalcy) involve direct action on the part of MAPs and treatment providers, it is important to acknowledge the pivotal role of the social context within which these processes play out. Within the original ITDSO framework (Göbbels et al., 2012), the role of the social context was related to the need for a rehabilitation-reinforcing environment, within with people with sexual convictions can live out their reformed identities in productive ways. However, in the prevention context the role of the social context is not only related to reinforcing treatment but is also vital for providing the foundations for effective help-seeking behaviours.

At the core of addressing the social context of prevention is understanding and tackling social stigma about minor attraction. There is widespread social stigmatization directed towards MAPs (Harper et al., 2018; Jahnke & Hoyer, 2013; Jahnke et al., 2015a, 2015b, 2018a, 2018b). This stigma is not only observed within general public samples, but also among the media (Harper & Hogue, 2017), researchers who study 'paedophilia' using samples consisting only of individuals with sexual convictions (Feelgood & Hoyer, 2008), and health professionals (Jahnke et al., 2015c; Stiels-Glenn, 2010). This societal stigma can become internalized among MAPs (Jahnke et al., 2015b; Lievesley et al., 2020), in turn leading to barriers to help-seeking when support when it is desired (Grady et al., 2018). In other stigmatized groups (e.g., racial and gender minorities), stigma is also linked to reductions in self-regulatory capacities (e.g., Baumeister et al., 2007; Inzlicht et al., 2006). As such, addressing social and professional stigma towards MAPs should be considered a priority in any framework that seeks to increase prolonged engagement with mental health or preventative initiatives.

In addition to specifically trying to address such views, the (online) social community of MAPs is also a potential source of support for promoting prevention efforts. As noted by Holt et al. (2010), the online MAP community is vast. While this has drawn popular attention and critique, the benefits of social support systems are well-documented in relation to a range of mental health conditions in reducing social isolation and sharing helpful coping strategies (Wright, 2016). Not only this, but the online MAP community is well-connected, and has the potential to highlight 'safe' practitioners and sources of information. This approach to 'recommending' service providers may have subsequent effects for reducing some of the barriers to help-seeking, as fears about professional judgements or a lack of expertise can be alleviated by learning from the experiences of others. In this sense, the prosocial anti-contact aspects of the online MAP community has the potential to play a crucial role in promoting engagement with the prevention process, minimising the potential influence from antisocial pro-contact individuals.

Conclusion

In this paper we have explored how the sexual crime desistance framework proposed by Göbbels et al. (2012) might be applied to the pre-offense prevention context. In doing so, we hope to have distinguished between prevention and desistance, although the latter may be classified as tertiary prevention in some circles given its focus on reducing re-offending. We have advocated for this approach due to the tendency of psychological and behavioural scientists to over-theorise and to attempt to design novel frameworks to solve social issues (Kruglanski, 2001), when existing models (once adapted slightly) may serve the purpose in a more coherent way.

Our framework places a wellbeing focus at the heart of 'preventative' treatment for MAPs. While this is at-odds with evaluation studies of gold-standard prevention initiatives (e.g., the Dunkelfeld Project; Beier et al., 2009; 2015), the recent re-analysis of their data (Mokros & Banse, 2019) demonstrate a lack a treatment effect, potentially indicating the need for a change of focus. In accordance with theoretical insights into the motivations of individuals who sexual offend (e.g., Hall & Hirschmann, 1991; Ward & Beech, 2006; Ward & Siegert, 2002), a focus on mental health treatment, shame reduction, and psychosocial wellbeing has the potential to prevent offending from taking place without treatment services being explicitly labelled as 'prevention'. They would also be more in keeping with MAPs' own

self-identified treatment targets (B4U-ACT, 2011; Levenson & Grady, 2019). While we argue that we do not need to invent new theoretical frameworks for understanding the prevention process, future research might focus on how to best promote such an approach in light of widespread public and professional stigmatisation of minor attraction.

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