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ORIGINAL PAPER

Beyond the "Ick Factor": Counseling Non-offending Persons with Pedophilia

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Abstract
Would you feel prepared if a client in your clinical practice shared that he was sexually attracted to children? Mental health professionals come in contact with these individuals primarily through the child welfare or criminal justice systems. But it is now increasingly evident that a population exists of non-offending minor-attracted persons (MAPs) who have never molested a child and have no intention of doing so. By becoming familiar with their unique treatment needs, clinicians can develop competence to provide effective, ethical, and compassionate services for this stigmatized and hard-to-reach population, with a dual focus on sexual abuse prevention and client well-being. This article will first describe what is known about pedophilia and minor-attraction. Next, the legal and ethical questions that therapists may ask in relation to this work will be explored. This paper will review obstacles to help-seeking identified by MAPs and discuss their treatment needs. Finally, recommendations will be offered for engaging MAPs in an emotionally safe and non-shaming therapeutic encounter. In this way, clinical social workers can contribute to advancing child sexual abuse prevention efforts.

Keywords Pedophilia · Minor-attracted persons · MAP · Stigma · prevention · Child sexual abuse · Minor-attraction

Introduction

What would you do if a client in your clinical practice shared that he was sexually attracted to children? Let's be honest: many therapists would feel some revulsion, anxiety about liability, and skepticism about whether the client could even be helped (Jahnke 2018; Lasher and Stinson 2017; Stiels-Glenn 2010). These reactions often lead social workers and other mental health professionals to choose not to work with such clients. However, therapy for people with pedophilia is a crucial element of a comprehensive sexual abuse prevention strategy. One in five Americans is sexually abused before age 18, and child sexual abuse (CSA) is considered a serious public health problem (Anda et al. 2010; Larkin et al. 2014; Letourneau et al. 2014). Moreover, it is estimated that up to 5% of adult men may have pedophilic interests or tendencies (Ahlers et al. 2011; Dombert et al. 2016; Seto 2018). A growing literature describes the unique mental health and psychosocial needs of non-offending people with pedophilia, who often refer to themselves as minor-attracted persons (MAPs) (Levenson and Grady 2018).

Without question, viewing people with pedophilia more holistically as clients with a variety of treatment needs would represent a significant paradigm shift. As with most paradigm shifts, the first step is a willingness to begin a public dialogue about topics that are uncomfortable or controversial. There is no criminal more reviled than child sex abusers, and perhaps no mental disorder more stigmatizing than pedophilia (Imhoff 2015; Jahnke 2018). Even so, a new perspective has begun to emerge. In a cutting-edge 2014 episode of *This American Life* on National Public Radio, journalist Luke Malone interviewed a young man called Adam who recounted his evolving comprehension that he was sexually attracted to children (Malone 2014). Adam's poignant story of self-awareness, his angst about sharing

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his concern with his mother, his discouraging experience in counseling, and his effort to seek support through online forums was told in a remarkably compassionate way that revealed the humanity behind a disorder often perceived as monstrous. Shortly after, an investigative journalism piece in the mainstream magazine *Psychology Today* also gave voice to the hidden lives of people suffering from pedophilia (Bleyer 2015).

By becoming more familiar with the treatment needs and services relevant to people with pedophilic interests, social workers can enhance their competence to provide effective, ethical, and compassionate counseling for this stigmatized and hard-to-reach population. Such an approach is a critical component of CSA prevention. The primary aims of this article are to summarize what is known about minor-attraction, address some of the ethical questions that may arise when working with MAPs, and to equip social workers with information and skills needed to work with this neglected population. In this unique way, clinical social workers can contribute to preventing sexual abuse of children before it occurs.

What Do We Know About Minor-Attraction and Pedophilia?

The 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association 2013) separated paraphilias from paraphilic disorders to acknowledge that attractions and behaviors are different phenomena and do not always co-occur. "The term *paraphilia* denotes any intense and persistent sexual interest" other than attraction to physically mature and consenting humans (p. 685). A *paraphilic disorder* requires distress or impairment, or harm or risk of harm to others. The DSM-5 goes on to say that "a paraphilia is a necessary but not sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not necessarily justify or require clinical intervention" (p. 686). Pedophilia is an attraction to prepubescent children (typically under age 13), but pedophilic disorder requires a pattern of recurrent fantasies, urges, or behaviors that persist over a period of at least 6 months and cause distress or interpersonal difficulty (American Psychiatric Association 2013). The sexual interest can be exclusive (attracted only to children) or not. Though debated in the literature and not listed as a DSM diagnosis, there is evidence and clinical consensus that some MAPs have a *hebephilic* sexual interest in pubescent young teens (e.g. usually age 13–15) (Seto 2017, 2018; Stephens et al. 2017). Others may be preferentially attracted to older teens, and this is called *ephebophilia*. In this paper we will avoid diagnostic labels and use the inclusive term MAP, but these distinctions are important to avoid misdiagnoses and to better understand treatment needs.

Importantly, not all individuals who molest children meet DSM criteria for pedophilic disorder, and not all people with pedophilia abuse children. In fact, there are MAPs who refer to themselves as "virtuous pedophiles" and do not act on their attractions because they appreciate why sexual abuse is harmful to youngsters (Bailey et al. 2016; Mitchell and Galupo 2018). Important differences have been found between non-offending MAPs and those convicted of crimes against children (Mitchell and Galupo 2018). Non-offending MAPs were more able to view CSA from the victim's perspective and to recognize its diverse and long-term direct and indirect negative impacts. They understood that engaging in sexual activity with a minor would be harmful and exploitative, and that taking advantage of a youngster's trust and vulnerability would have damaging and far-reaching effects (Cohen et al. 2018; Mitchell and Galupo 2018). Conversely, many individuals who committed sexual crimes against minors reported that they knew their behavior was illegal, but did not fully appreciate *why* abuse was so detrimental to children, or understand how severe the consequences would be to their victims and to themselves (Levenson et al. 2017; Mitchell and Galupo 2018).

Scholars continue to speculate about the etiology of pedophilia, pointing to a complex interaction of biological, social, and psychological factors that contribute to the development of sexual interests (Marshall 1997; Seto 2018). There is reason to believe that for some MAPs, pedophilia is a sexual orientation, biologically pre-determined and not likely to be altered (Cantor et al. 2016; Seto 2012, 2017). For others, early experiences can shape the development of their sexual template (Levenson et al. 2017). Most MAPs become aware of their atypical sexual interests during their teenage or young adult years (Bailey et al. 2016; Buckman et al. 2016). Many describe themselves as noticing that as they grew older, the age of the people they were attracted to did not increase.

Stigma as a Barrier to Help-Seeking

Researchers have found that the stigma of minor-attraction can lead to avoidance of help-seeking, increasing risk to abuse children (Blagden et al. 2017; Grady et al. 2018). Despite ambivalence about sharing their secret, some MAPs reported a willingness to seek therapy, but less than half found the experience to be helpful (Levenson et al. 2018). Non-offending MAPs, as well as those who abuse children, report common themes ranging from self-loathing to cognitive dissonance (Grady et al. 2018; Houtepen et al. 2016). Some describe enormous shame and despondence at the realization that they are suffering from an affliction which seems to have no satisfying resolution. Suicidal thinking is extremely common, with one-quarter to one-third of MAPs reporting at least one suicide attempt (B4UAct 2011b;

Blagden et al. 2017; Cohen et al. 2018; Levenson et al. 2018). Often, suicidal thoughts are fueled by feelings of shame, isolation, hopelessness, fear of rejection, and anxiety about the future. Other MAPs grapple with distorted thinking, attributing sexualized motives to minors while lamenting a society that misunderstands their love and affection. These findings suggest that both MAP wellbeing and prevention of child harm represent a dual focus for counseling with a clinical social worker.

According to minority stress theory, members of sexual minority groups are at increased risk for negative experiences and mental health problems due to being marginalized and discriminated against (Meyer 2003). Using a theory of "queer criminology," Walker and Panfil (2017) posited that people with non-normative sexual identities and interests, including MAPs, face stigma, negative stereotyping, and discrimination. To counter these experiences, affirmative cognitive-behavioral therapies have been developed for LGBTQ clients. These therapies focus on self-acceptance by promoting authenticity and embracing a new construct of personal identity (Austin and Craig 2015; Panchankis 2014). As noted, there is empirical support for the idea that minor-attraction is, for some individuals, a sexual orientation (Cantor et al. 2016; Lasher et al. 2017; Seto 2017). To be clear, we are in no way implying that sexual *activity* with minors is ever acceptable or appropriate. People do not choose their attractions but acting upon those interests is always a choice. Walker and Panfil (2017) argued that the social construction of pedophilia as only a criminal issue has neglected the health and wellbeing of MAPs. Several scholars have agreed that a more humanistic approach to counseling MAPs could provide an important avenue for CSA prevention (Jahnke 2018; Walker and Panfil 2017). Consistent with social work values, respecting the dignity and worth of all clients is a crucial component of client-centered engagement (Hepworth et al. 2016; Saleebey 2011).

Public perceptions about people with minor-attraction are nearly universally negative, and common responses include fear, anger, and revulsion. For instance, there is a pervasive belief that MAPs are disgusting, dangerous, sick, perverted, pathetic, and immoral (Jahnke et al. 2015; Richards 2018), and that MAPs are "better off dead" (Jahnke et al. 2015, p. 24) even if they have never molested a child. Richards (2018) found that believing that sexual attraction to children is innate increased both the perceived *dangerousness* and *blameworthiness* of the individual, regardless of whether one had engaged in sexually abusive acts. There is skepticism that pedophilia is a mental illness and minor-attraction is perceived as an immutable lifestyle *choice*: "hang them… they don't get better" (Richards 2018, p. 842). Unsurprisingly, these societal narratives are internalized by MAPs, infusing psychologically damaging beliefs into their own identity and deterring them from seeking help (Blagden et al. 2017).

Despite wanting help, many MAPs are reluctant to seek mental health services due to expectations that they will be treated disrespectfully or judgmentally, fears of unethical breaches of confidentiality, and apprehension that counselors do not have enough knowledge about minor-attraction to help them (B4UAct 2011a; Grady et al. 2018). As a result, most MAPs, if they receive mental health care, do not obtain it until many years after first recognizing their attractions, and only a minority report satisfaction with the services they received. Ironically, many do not receive any help at all until after a conviction for abusing a child.

Ethical and Legal Issues

Confidentiality and Mandatory Reporting

A concern about working with clients attracted to minors is the mandate to report child abuse (McPhail et al. 2018). The National Association of Social Workers (NASW) Code of Ethics emphasizes that client confidentiality is paramount, and all information should be protected except for a narrow set of compelling reasons (National Association of Social Workers 2018). The code reminds us that while social workers' primary responsibility is to promote client wellbeing, a duty to the larger society or a specific legal obligation must, at times, supersede the loyalty owed to clients. All the helping professions (e.g. NASW, American Psychological Association, American Counseling Association) require therapists to gain informed consent by telling clients of the conditions requiring exposure of confidential information—ideally, at the initiation of services and prior to a disclosure (Kenny et al. 2017; Parsons 2001).

The specifics of each state law are different, but in general social workers are required to report suspicion that a child under 18 has been abused by a parent, caretaker, or other adult (Kenny et al. 2017; Pietrantonio et al. 2013). Typically, we are required to report *behaviors*, not *thoughts*, unless a client articulates a credible future threat against an identifiable person, triggering a duty to warn. Thus, a logical interpretation of the NASW code suggests that when a client discloses attraction to children but gives no indication of having perpetrated abuse, the communication should remain privileged. Breaching confidentiality can be a serious ethical and legal violation, so social workers must carefully consider whether there is reasonable cause to suspect that a child could be harmed by a MAP, and weigh competing professional values using an intentional process of ethical decision-making (Lowenberg and Dolgoff 1992; Parsons 2001; Pietrantonio et al. 2013; Ward et al. 2009).

Statutes in California, Pennsylvania, and Delaware now require therapists to report viewing of child pornography. Mental health professionals in these states lobbied against the new mandate, citing concerns that MAPs would be discouraged from seeking help to prevent contact abuse, and that counselors would be placed in a position of breaching ethical commitments to client privacy (Clark-Flory 2016). Counselors are typically not required to report other crimes unless they meet the exceptions to confidentiality described above. Given the variation that exists across jurisdictions, clinical social workers need to be familiar with their local reporting laws.

Child abuse reporting mandates are designed to protect children from harm, and social workers must adhere to state laws. MAPs have described instances, however, where breaches of confidentiality have occurred even when the client disclosed only thoughts or feelings about children but not actions (B4UAct 2017; Buckman et al. 2016; Houtepen et al. 2016; Levenson et al. 2017; Piché et al. 2016). As a result, concerns about privacy can create a substantial obstacle to help-seeking prior to offending (Levenson et al. 2018; McPhail et al. 2018). Similar controversies have been deliberated in other contexts; for instance, substance-using women may avoid prenatal care due to fear of punitive consequences, creating a different set of risks for infant health (Stone 2015). Though mandatory reporting laws were passed to protect children, they can have a paradoxical effect if they deter people from seeking preventive therapies (Beier 2016; Jahnke 2018; Lasher et al. 2017; McPhail et al. 2018).

An alternative strategy exists in Germany, where mandated reporting is not required and fear of legal consequences is less of a barrier to help-seeking. A voluntary treatment program called the *Dunkelfeld Project* used public service advertisements to proactively reach adults and teens with sexual preferences for children. In response, hundreds of MAPs in Germany have participated in prevention programs, resulting in some observed decreases in offense-supportive attitudes and risk related behaviors, and some reported improvements in sexual self-regulation (Beier et al. 2009, 2016). This model depicts an example of a preventive approach to protecting children from sexual abuse.

Autonomy and Social Justice

Professional codes of ethics provide a foundation for decision-making and establish important fundamental values: autonomy, beneficence, non-maleficence, and social justice (American Psychological Association 2017; Glaser 2003; National Association of Social Workers 2018; Parsons 2001; Ward et al. 2009). Autonomy implies that clients have the right to self-determination in defining their own priorities and goals. Beneficence means promoting client well-being regardless of the helper's personal opinions or reactions to the material disclosed in therapy. Non-maleficence means doing no harm and requires that when obligations to a client conflict with protection of others, we engage in a thoughtful, transparent decision-making process that minimizes the damage to the client and to the therapeutic relationship. Social justice requires equal access to treatment, ensuring that services are not denied to marginalized populations due to prejudice, discrimination, or stigma. Social workers' ethical values are grounded in the essential component of trust, and we must take care not to undermine the sanctity of this foundation of our profession.

Obstacles to services for MAPs are formidable, and include stigmatizing assumptions made by helping professionals (Jahnke et al. 2015). In one study, 95% of psychotherapists surveyed said that they would refuse to work with pedophiles (Stiels-Glenn 2010). Many clinicians feel unprepared to work with MAPs due to a lack of knowledge, negative countertransference, assumptions that therapy will be ineffective, and concerns about liability (Jahnke and Hoyer 2013; Jahnke et al. 2015; Lasher et al. 2017; Stiels-Glenn 2010). These challenges can impede the non-judgmental client-centered objectivity needed to engage clients and establish a positive therapeutic alliance (Jahnke 2018).

Attitudes that discourage MAPs from seeking help represent a social injustice and do a disservice to CSA prevention efforts (Houtepen et al. 2016; Jahnke et al. 2013). Stigma and discrimination deprive MAPs from receiving services to relieve their distress, and in some cases this can increase their risk for harming youngsters (Jahnke 2018). When MAPs do seek help, some therapists emphasize social control rather than a compassionate style of client-centered assessment and treatment planning (B4UAct 2011a; Houtepen et al. 2016; Levenson et al. 2017). MAPs report that failure to receive proper help can exacerbate mental health symptoms and increase risk, and 4% said that they went on to commit a sexual crime (B4UAct 2011a).

Providing therapists with this information can humanize people with pedophilia and challenge stereotypes. First-person narratives can reduce stigmatizing and punitive attitudes, negative emotional responses, and social distancing reactions (Harper et al. 2016; Jahnke et al. 2015). When asked to describe what *was* helpful in counseling, MAPs identified the same conditions that we know to be true for other clients: active listening, assistance with coping strategies, a chance to discuss their own trauma history, and a non-judgmental counselor who offered hope (Blagden et al. 2016; Jahnke 2018; Levenson et al. 2018; Levenson et al. 2017). Clinical social workers must be prepared to listen with respect and compassion even when clients present material that may be disturbing or provoke negative feelings.

Delivering Ethical and Compassionate Clinical Services

Addressing the Therapeutic Needs and Goals of MAPs

Good social work always starts where the client is (Hepworth et al. 2016). MAPs report encountering clinicians who assumed that the dominant goal of their therapy should be to control or change sexual feelings; however, MAPs themselves have identified a range of other psychological needs that are important to them when seeking counseling (B4UAct 2011b; Blagden et al. 2017; Buckman et al. 2016; Grady et al. 2018; Levenson et al. 2018). These goals include a desire to improve self-esteem, decrease isolation, and deal with the socio-cultural stigma of minor-attraction. They want to understand their sexuality and have genuine and authentic relationships; they hope to feel less depressed and more content with their lives (B4UAct 2011a; Blagden et al. 2017; Houtepen et al. 2016; Levenson et al. 2018). Importantly, many said that their therapy goals were sometimes incompatible with the agenda of a mental health professional who made inaccurate assumptions that obstructed the therapeutic alliance (e.g. that the client had already or would inevitably engage in victimization). Some did identify sexual frustration as a goal for therapy, along with a desire to reduce attraction to children or increase attraction to adults, requiring a dual focus on CSA prevention and client well-being. Preventing abusive behavior is in the best interest of MAP clients, since most wish to avoid both harming children and suffering legal consequences.

Clinical social workers are trained to work with clients from diverse backgrounds with myriad psychosocial needs. The models with which social workers are already familiar can easily be adapted to meet the needs of this population. For example, cognitive-behavioral therapy (CBT) encourages individuals to adopt alternative ways of thinking about situations and problems, which in turn prompts changes in feelings and behaviors (Beck 1993; Thomlison and Thomlison 2017). Strategies that supplement CBT are also useful, such as trauma-informed models that integrate understanding of a client's developmental experiences, self-narrative, and relational patterns (Howe et al. 2018; Knight 2015; Mishna et al. 2013; Tosone 2013).

Some theoretical and clinical concepts can be borrowed from affirmative CBT models designed for work with sexual minority clients, which aim to help clinicians avoid judgmental or invalidating responses to sexual orientation or gender identity (Austin et al. 2017). Affirmative CBT helps clients reframe one's view of self from "disordered" and "pathological" toward a more accepting self-narrative, and to cope with a complex range of internal feelings and external messages that are stigmatizing and demoralizing (Austin and Craig 2015, p. 24). In working with MAPs, this method clearly condemns abuse of children while attempting to congruently re-align thoughts and feelings of self-acceptance. A trauma-informed affirmative CBT approach will explore internalization of stigma and separate the sexuality from their identity: "Having these attractions does not mean that I am a bad person."

Specific treatment goals will differ for each MAP client. Some may require help with safety planning and structuring boundaries if being around children feels like a risk factor for them. For instance, such plans might require the client to identify a support system who can chaperone contact with children. Some clients will need to correct distorted thinking about sexualization of minors, or to improve healthy social skills with age-appropriate peers. For others, priority will be placed on co-morbid conditions such as anxiety, depression, substance abuse, or hypersexuality, and feelings of despondence or loneliness. Creating a compassionate and non-shaming therapeutic alliance is especially important to help MAPs share openly about the impact of minor-attraction on his or her life. As with every social work intervention, the therapy process begins with a warm, respectful, empathic presence and a client-directed approach (Hepworth et al. 2016; Saleebey 2011).

Strategies for Engaging MAPs

(1) Accept and affirm the client's dignity and worth: *Welcome, I'm glad you decided to come talk with me. I hope to create a safe space for you to explore and understand your unique experience of sexual attraction*. Social workers can validate and examine feelings while not condoning sexual abuse of children. The worker's acceptance of the client does not imply endorsement of illegal or abusive contact.

(2) Use neutral language that reflects the client's preferred terminology: *Let's try to avoid labels and diagnoses. Some people refer to themselves as "minor-attracted." What term is most comfortable for you*? Asking clients to share how they view themselves and how they recognized the evolution of their sexuality will help make sense of their self-narrative and identity. Remember that sexuality is fluid, dynamic, and uniquely experienced.

(3) Clarify the clinician's role and the primary purpose of the therapeutic relationship (e.g., to support client self-determination in the quest for well-being). Because MAP clients pursue mental health services for a variety of reasons, the therapist should seek to understand the client's perspective: *Everyone who*

goes to talk to a therapist about minor-attraction has a different set of goals. Can you tell me three things you'd prioritize as the main reasons you came to therapy? What are the areas you want to work on?

(4) Be direct and don't shy away from tough content, while taking care not to make assumptions. Ask, don't tell: *Can you tell me more about how your minor-attraction affects your life on a daily basis? What are the things that concern you most about your sexual interests? What do you want me to understand about your experience and how it shapes how you feel about yourself*?

(5) Convey an understanding of the client's experience and normalize feelings: *It can be really isolating and lonely to have a secret you feel you can't share with anyone. I bet this isn't something you can talk to many people about, and you probably haven't met others who have shared similar things with you. But I can tell you that you are not the only one who has these feelings.*

(6) Offering psycho-education about pedophilia, minor-attraction, and the development of sexuality can provide accurate information and disconfirmation of flawed beliefs. Some MAPs believe, based on news media reports, that people with pedophilia are "monsters" who cannot be helped, and they want reassurance that hope is possible. *Having these attractions does not make you a bad person. I think you are here because you don't want to harm anyone, and you want to feel better about yourself. I can help you with that. You are brave for coming here. I know it wasn't easy.*

(7) Do not assume that MAPs have stronger or more uncontrollable sexual urges than other people. On the other hand, hypersexuality, impulsivity, emotional dysregulation, or sexualized methods for coping with stress can increase risk for abusive behavior. These should be areas for assessment and attention if needed: *Can you tell me about how you handle these attractions?* Helping clients devise healthy coping strategies can foster a sense of self-efficacy so they can live in a way that is congruent with their personal values.

(8) Some minor-attracted clients have a history of childhood or adult trauma, which can increase the risk for maladaptive thinking, relational issues, self-regulation challenges, or ineffective coping. Thus, a trauma-informed approach will be useful in conceptualizing client problems, strengths, and needs.

(9) Acknowledge the pain associated with the loss of one's sexual self. Clients with exclusive minor-attraction may find themselves in the unenviable position of having to give up the one potential source of sexual satisfaction that exists for them. They may feel destined to live a lonely life without intimate connection, marriage, or family. *It must at times feel lonely or scary or frustrating to give up this part of yourself. You might feel like you will never have the things that almost everyone wants.*

(10) Finally, it is important to offer hope. Clients can have a "normal" life despite their minor-attraction if they are helped to build meaningful relationships with other adults and pursue avenues for self-esteem. *I am optimistic that we can work together to help you build a satisfying and fulfilling life.*

In summary, it is important to remember that each individual will have unique needs and goals. Some of the most salient treatment goals that MAPs identify include: Self-acceptance (dealing with stigma, shame, identity confusion); Cognitive schema restructuring (changing self-narrative and the meaning that they've attached to their minor attraction); Alleviation of related symptoms (depression, anxiety, suicidality); Relationship and intimacy issues (sexual and non-sexual intimacy: secrecy can be very isolating); Future hopes, dreams, and goals (wanting to have what others have: a sense of belonging, self-actualization); Living an authentic life (figuring out how to surround oneself with safe and supportive others in order to have genuine and close relationships) (B4UAct 2011a; Levenson et al. 2018).

Additional Challenges and Points to Consider

Sometimes, a MAP will not acknowledge sexual attractions to children in the first visit or early in therapy. He or she may want to build trust with the therapist before taking the risk of revealing such a shameful secret. When the minor-attraction is disclosed unexpectedly, it may elicit a strong counter-transference reaction. This can potentially create an obstacle, making it difficult for the therapist to experience and convey empathy. Responding in a judgmental, hostile, or rejecting way, even unintentionally, will lead to a rupture in the therapeutic alliance (Binder and Strupp 1997; Teyber and Teyber 2017; Watson et al. 2015). Clinicians must be able to provide a safe space for clients who seek to avoid behaviors they know will be harmful to others; this requires us to employ our therapeutic skills even when clients elicit feelings of disdain or contempt (Hepworth et al. 2016; Saleebey 2011).

Of course, because sexual abuse is enormously harmful to children, it is necessary for MAPs to make a commitment to *not act* on their attraction to youngsters. We might ask ourselves what it might feel like to give up our own ability to satisfy our sexual needs with the one person or type of person to whom we feel most attracted. We cannot expect these clients to easily just stop being attracted to minors, and

we must be willing to hear their inner conflict, their subjective distress, and the pain associated with accepting that one may never feel the sexual enjoyment that is such an integral part of human intimacy.

Finally, good social work practice involves helping clients build their social networks and connections with others. Shame, secrecy, and stigma prevent MAPs from finding formal and informal supports to help them navigate the complexities of minor-attraction and maintain an emotionally healthy life. Talking with family or friends about their concerns is often not perceived as a viable option, and in order to minimize risk of rejection, many turn to anonymous online communities (Bailey et al. 2016; Grady et al. 2018; Houtepen et al. 2016). Clients should be cautioned about websites that reinforce, justify, and validate sexually abusive behavior, or those that share child pornography (Holt et al. 2010). However, anti-contact online resources and forums do exist for positive support, sharing, and exchange of information, with an aim to help MAPs resist abusing children and enhance emotional wellness. These resources include B4UAct, Virtuous Pedophiles, Stop it Now!, and Global Prevention Project:

- www.b4uact.org
- www.virped.org
- www.stopitnow.org
- http://theglobalpreventionproject.org/maps/

Clinicians should explore with MAPs which sites they may be visiting and discuss the culture and messages that these sites endorse.

Summary and Conclusions

Clinical social workers play an important role in sexual abuse prevention by engaging MAPs in compassionate, ethical, competent services. Therapy can improve their internal controls and self-regulation capacities as well as relieve emotional distress. Not all minor-attracted clients will meet criteria for pedophilic disorder, and those who do may not be exclusively attracted to children or at risk for abusing them. Social workers must be able to balance a dual set of priorities: MAP wellbeing and prevention of CSA.

An internalized belief that one's authentic self must remain hidden brings with it profound psychological consequences (Pachankis 2009). Rejecting the stigmatizing labels and stereotypes associated with pedophilia is consistent with the grand challenges of social work: we advocate for social justice through access to services for marginalized groups (Uehara et al. 2013; Willis 2017). Affirmative CBT allows for the safe exploration of one's sexuality and acceptance of self (Austin and Craig 2015; Pachankis 2009) while simultaneously reinforcing appropriate boundaries and self-regulation. This approach offers a new paradigm in the prevention of sexual abuse. Without caring and competent professionals willing to help them, "many individuals with pedophilic preferences remain standing at the edge of society, waiting for self-regulation to fail" (Houtepen et al. 2016, p. 63).

Guiding principles for mental health professionals who encounter minor-attracted people have been developed (B4UAct 2017), and these guidelines are consistent with the values of social work practice. It is important to understand that MAPs do not fit a "profile" of personality characteristics, and each has a unique set of strengths and needs. Nor should it be assumed that they abuse children, that they are prone to dishonesty or violence, or that their sexuality is more compulsive or uncontrollable than anyone else's. Social workers should avoid the use of pejorative and stigmatizing words like "deviant" or "perverted," focus on the whole person rather than a label, and separate the attraction from someone's identity (Willis 2017). As with all clients, social workers should take a collaborative approach to defining problems and identifying goals. Professionals should clarify their understanding of local mandatory reporting laws to allow for ethical decision-making. Informed consent procedures should ensure accurate and explicit conversations about the limits of confidentiality so that MAPs may engage in a therapeutic process that is transparent and allows for self-determination, beneficence, and non-maleficence (American Psychological Association 2017; B4UAct 2017; National Association of Social Workers 2018).

Finally, we hope to underscore that effective clinical services for MAPs are valuable not only as a means to prevent child abuse, but also to achieve social work's mission to honor human dignity and provide respectful, non-judgmental care to all who seek it. Our intent is not to minimize the importance of child protection, to ignore risk, to suggest evasion of mandatory reporting laws, or to excuse CSA. We believe that research can shed light on the inner experience of minor-attraction and inform empirically-supported, ethical, compassionate social work services. People do not choose their attractions, but they can choose whether or not to act on them. We hope that by opening this dialogue, we can help devise effective strategies that contribute to the prevention of child sexual abuse.

Compliance with Ethical Standards

Conflict of interest All authors declare that they have no conflict of interest.

Research Involving Human and Animal Participants This article does not contain any studies with human or animal participants performed by any of the authors.

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