"I despise myself for thinking about them."
A Thematic Analysis of the Mental Health Implications and Employed Coping Mechanisms of Self-Reported Non-Offending Minor Attracted Persons.

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Abstract

‘Non-offending pedophiles’ or ‘minor attracted persons’ are individuals who suppress an attraction to children (Blanchard et al., 2009). Previous analyses of this population’s mental illness employed overt self-report methods, limited by social desirability (Aldaeo et al., 2010; Jahnke & Hoyer, 2013). Additionally, studies assessing the coping mechanisms employed to remain offence-free are underpowered (Cantor & McPhail, 2016); understanding of these would facilitate the rehabilitation of prior offenders. A thematic analysis of coping mechanisms and mental illness was conducted on 5,210 posts on the ‘Virtuous Pedophiles’ forum. Four themes emerged for coping mechanisms: Managing risk and attraction to children, Managing mood, Managing preferences prosocially and Friends, family and relationships, with 13 subthemes. Five themes emerged for mental ill-health, including: Addiction, Anxiety, Depression, Self-hatred/Self-harm/Suicide and Other. Self-hatred/Self-harm/Suicide accounted for almost a third of discussed mental ill-health. These results highlight the severity of mental ill-health amongst this population and the coping mechanisms employed to remain offence-free.

Keywords: Suppression, Pedophilia, Minor attracted person, Mental ill-health, Coping Mechanisms.

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'Suppression' is an emotion regulation strategy, which inhibits inappropriate or unwanted emotional responses to stimuli (Gross, 2002). Suppression is considered maladaptive, as it appears to reduce emotion-related behavior but not experience of the emotion (Gross, 1998), designated the 'Rebound Effect' (Wegner, 1994). In addition, use of suppression techniques has been associated with increased risk of several psychopathologies including depression and substance misuse (Aldaeo et al., 2010; Beevers & Meyers, 2004).

Despite its maladaptive qualities, suppression is used to lessen the magnitude of several psychological experiences including sexual desire, i.e. a state motivated towards the experience of sexual pleasure (Friese & Hofmann, 2014). For example, elective celibacy is often employed by members of certain religious groups who subsequently report increased preoccupation with unwanted sexual thoughts, as well as higher levels of anxiety and depression (Efrati, 2018). Subsequently, suppression of sexual desire is associated with higher rates of depression and substance misuse (Hayes et al., 1999).

Sexual desire is predominantly directed by sexual orientation (Sell, 2007), defined as the "… directions of … sexual thoughts [and] fantasies…." (Seto, 2012, p.3). The most widely accepted orientation relates to gender (Seto, 2012). Historically, heterosexuality was the only socially accepted sexual orientation and discrimination against homosexuals caused many to suppress their orientation to avoid facing stigma (Pachankis, 2007), which had significant implications for their mental health (Pennebaker, 1993). Those who identify as gay, lesbian or bisexual and suppress their orientation are three times more likely to be diagnosed with depression, five times more likely to suffer from anxiety, have increased rates of substance misuse and suicidal ideation (Beals, Peplau & Gable, 2009; Cochran, Sullivan & Mays, 2003). These findings are consistent with research which identifies suppression of sexual orientation has a cumulative negative impact on well-being (Pennebaker, 1990).

Suppression of sexual orientation is most likely when it conflicts with social norms (Pachankis, 2007). An example of this is pedophilia, i.e. "… a stable... sexual interest in prepubescent children…" (Seto, 2012 p.164). Etiological similarities between pedophilia and gender orientation have led to suggestions that pedophilia is a sexual orientation (Seto, 2012). For example, awareness typically occurs prior to or during puberty, romantic and sexual relationships are desired, and preferences are stable throughout lifespan for both orientations (Houtepen, Sijtsema & Bogaerts, 2016; Seto, 2008). At present, there is some academic contention regarding this definition, with suggestions that considering pedophilia akin to a sexual orientation implies an immutability, impacting treatment prospects and assessments of future risk (Fedoroff, 2017). Seto (2018) responded suggesting comparability between research indicating the malleability of gender and age orientation. Additionally, that "… teleiophilia (sexual attraction to mature adults, aged 18 – late 30s) (Seto, 2017) is relatively stable across time… other age variants, particularly in their non-exclusive forms have the potential to shift …" (Seto, 2017). This paper does not seek to comment on whether pedophilia is life-course persistent, however longitudinal research is essential before conclusions can be made.

'Pedophile' and 'Child Molester' are not synonymous terms (Seto, 2008). In addition to personality and neurocognitive disparities between these groups, 50-65% of child molestation occurs in the absence of pedophilic attractions, meanwhile, a number of pedophiles have never offended (Seto, Cantor & Blanchard, 2006). Subsequently, non-offending pedophiles continuously suppress their orientation as their desires conflict with their moral conscience of not harming children (Moen, 2015). This population of non-offenders prefer the term 'minor attracted person' (MAP), which lacks the stigma associated with the term 'Pedophile' (Cohen, Ndukwe, Yaseen & Galynker, 2018). Therefore, from this point this report will employ the term 'minor attracted person' (MAP) to describe individuals who are attracted to children. The suppression literature has significant implications for the wellbeing of MAPs, as suppression of their sexual preference may compromise their mental health, whilst not inhibiting their desires.

Research supports that mental illness is comorbid with minor attraction amongst sexual offenders (Seto, 2008). Raymond, Coleman, Ohlerking, Christianson and Minor (1999) found two-thirds of convicted minor attracted child molesters suffered a comorbid mood disorder, anxiety disorder and/or substance misuse. Despite a small sample size and underpowered analysis, these findings are consistent with others in this area. Including Leue, Borchard and Hoyer (2004) who replicated Raymond et al's. (1999) findings of anxiety, mood disorder and substance misuse, alongside high rates of depression. Several other studies examining convicted sexual offenders have replicated these findings (Blagden, Mann, Webster, Lee & Williams, 2017).

However, a limitation of this research is its overreliance on forensic samples (Seto, 2008), as participants are predominantly identified via their offending history and subsequently their mental ill-health may relate to their incarceration (Cantor & McPhail, 2016; Cohen, et al., 2018). Consequently, there is a limited literature relating to non-offending MAPs (Cohen et al., 2018). A preliminary study interviewed 15 non-offending MAPs, recruited via online support groups, and found 47% had previously suffered from mental illness (Houtepen, Sijtsema & Bogaerts, 2016). This study represents one of the initial investigations of a non-offending MAP population, however although at interview the sample were dedicated to not offending several participants had historical convictions, confounding the sample. Additionally, although samples of 11-15 are considered sufficient to reach the 'saturation point' in qualitative research (Crouch & McKenzie, 2006), this limited sample cannot provide a representative estimate of the mental health of the wider non-offending MAP community. A more substantial study compared 223 minor attracted child molesters to 342 non-offending MAPs, with one third of both groups reporting chronic suicidal ideation (Cohen et al., 2018). Together this research highlights the mental health implications of minor attraction are not limited to those individuals who have offended, as previously suggested (Seto, 2008). Rather, a population of individuals exist who, due to the illegality and immoral nature of acting on their sexual desires, suppress their preferences with apparent impacts on their mental health.

The implications of comorbid psychopathologies and minor attraction are not limited to the individual's wellbeing. Mental illness poses a risk factor for sexual offending, by reducing intelligent thought and ability to regulate behavior (Cantor, 2014; Cohen et al., 2018). In addition, there are a lack of resources for help-seeking MAPs. Many professionals lack the clinical expertise to work with this population and hold stigmatizing attitudes meaning they are unwilling to begin a therapeutic relationship (Jahnke, Philipp & Hoyer, 2015; Seto, 2012). This stigma is rooted in societal stereotyping of MAPs as dangerous, which persists for individuals who are committed to not offending (Jahnke, 2018), significantly limiting the availability of effective, unbiased therapy for this community (Beir et al., 2015; Jahnke, Schmidt, Geradt & Hoyer, 2015).

An understanding of the coping mechanisms used by MAPs to remain offence-free is vital to preventing the perpetration of child sexual abuse (Cantor & McPhail, 2016; Jones, Ó Ciardha & Elliot, 2016). At present, analyses of coping mechanisms is limited to underpowered studies. For example, six out of 15 participants reported use of online forums for MAPs, to be an effective coping mechanism (Houtepen et al., 2016). The benefits of social support were reinforced by Mitchell and Galupo's (2018) larger survey of 69 MAPs. These samples are likely limited by social desirability bias, as this population is extremely fearful of being 'outed' as a MAP (Jahnke & Hoyer, 2013). Use of this overt analysis likely means the final samples suffer from attrition, leading to a diminished understanding of MAPs coping mechanisms.

The limited literature and stigmatization of this population results in a group of individuals suffering from the significant mental health implications of suppressing an unwanted sexual orientation (Seto, 2017). Non-offending MAPs are placed at increased risk of offending by a society which lacks sufficient resources to help and instead ostracizes them, leaving them to suffer alone. This study aims to begin correcting this, by ascertaining the prevalence of mental ill-health and coping mechanisms utilized by this population.

This study reviewed posts on the MAP support forum 'Virtuous Pedophiles', which related to the mental health or coping mechanisms of non-offending MAPs. This forum has previously been

studied (e.g. Jones, Ó Ciardha & Elliot, 2016). However, previous studies selected a limited number of conversations ('threads') which seemed most likely to contain relevant information, potentially ignoring significant themes (Buschman, et al., 2010). Contrastingly, this study reviewed over 500 'threads' equating to 5, 210 individual posts. To our knowledge this study represents the most comprehensive attempt to gain first-hand accounts of the psychological experiences and coping mechanisms of non-offending MAPs.

Method

Sample

This study analyzed 5, 210 posts on the online forum 'Virtuous Pedophiles' (virped.org) via thematic analysis. The forum is a community of over 3000 MAPs, who self-report to be currently non-offending, those who have previously offended are permitted to join the community (virped.org FAQs, 2018).

Due to the anonymous nature of the forum it is not possible to associate themes to specific individuals, or collect information relating to participant demographics, including gender, age/gender of sexual preference, presence/absence of prior offending etc.

Following approval by the University of Kent's School of Psychology Ethics Committee in March 2018 (Ref: 201815218361084909), researchers contacted the forum moderator and requested permission to conduct research. The moderator provided informed consent; however, individual members of the forum were not asked for informed consent as the analysis adopted a covert naturalistic approach to limit the effect of social desirability bias.

Data Collection

The forum has 22 discussion topics ranging from 'Video games' to 'Keeping Kids and Ourselves Safe'. As it was impractical to review all topics, a pilot survey assessed which topics contained the highest prevalence of posts relating to mental illness and coping mechanisms, between 1st of February 2018 and 1st of March 2018. The two topics with the most relevant posts were chosen.

Subsequently, all posts on 'Life Experiences' (246 threads) and 'Requests for Support' (275 threads) between the 1st of February 2017 and 1st of February 2018, were reviewed for discussions of mental illness/coping mechanisms. 'Threads' are conversations initiated by members within a discussion topic which members may post on. The number of posts on a single thread ranged from one to 203, with an average of 10.

The researcher manually coded posts using the software package NVivo which allows the user to manage and code large datasets and identify themes (Bazeley & Jackson, 2013).

Analysis

This study employed thematic analysis, a process of deducing patterns and meaning from qualitative datasets (Braun, Clarke & Weate, 2016). An inductive approach was used, meaning the analysis was grounded in the data rather than guided by existing theory (Braun & Clarke, 2006), allowing a genuine representation of the sample's coping mechanisms and mental illnesses to be developed. A critical realist perspective was adopted, meaning the analysis assumed "… language as shaping the meaning of social and interpersonal worlds…having material limits and implications…" (Braun & Clarke, 2013, p. 105). This analysis followed that recommended by Braun and Clarke (2006; 2013) and previously employed for analysis with this population (Jones et al., 2016).

The first element of this process involves familiarization with the data. Followed by manual development of initial codes by the first researcher, which act as the 'building blocks' of the analysis (Braun & Clarke, 2016). The third phase is active construction by researchers of initial codes into themes, creating a logical narrative (Braun & Clarke, 2013). The researcher reviewed potential themes, as to whether they fit with the data and initial codes. Phase five used previously made notes to create theme names (Braun and Clarke, 2016). Finally, the data is collated into a final report to demonstrate how the findings link to the literature and research questions (Braun & Clarke, 2013).

Over 5,000 posts were reviewed by the first researcher, who identified quotes pertaining to mental illness or coping mechanisms. Interrater-reliability was assessed by randomly selecting 10% of the data, which the second researcher interpreted in relation to the identified themes. The second

researcher was unaware how many extracts related to the themes, as not all extracts represented a theme, and some were represented multiple times. Percentage agreement was 95% (K =. 92), indicating strong agreement (Hallgren, 2012).

In line with the British Psychological Society's Ethics Guidelines on Internet-Meditated Research (2017) no direct quotes will be used in this report. Quotes used have been paraphrased to preserve meaning, whilst maintaining participants' confidentiality. Additionally, information with the potential to identify members, e.g. usernames, will not be listed.

Results

Coping Mechanisms

Managing Risk and Attraction to Children

This theme relates to the day-to-day techniques employed to manage risk of offending, and accounts for 20% of the coping mechanisms identified.

Avoidance. Avoidance techniques accounted for 11% of coping mechanisms, including, avoiding contact with children: "…I stopped going to places I knew children would be." Additionally, individuals used software to prevent them accessing illicit materials: "…software on my computer stops me accessing certain content…" These avoidant strategies were common amongst forum users, however, are associated with increased levels of depression and anxiety (Feldner, Zvolensky, Eifert & Spira, 2003).

Abstinence. Approximately 5% of coping mechanisms related to abstinence: "pornography is a slippery slope … may lead [to] children being hurt …" and "When my fantasies start to involve children, I abstain from masturbation." The literature supports the efficacy of this technique as masturbation to child-stimuli appear to reinforce the association between children and sexual arousal, thereby increasing risk (Bagley, Wood & Young, 1994). However, research in this area is conflicting and inconclusive (Malamuth, 2018).

Monitoring behavior. Monitoring behavior accounted for 4% of coping mechanisms. Many individuals limited interactions to those which would be appropriate in front of the child's parents: "If you wouldn't do it in front of the parents… shouldn't do it when you're alone". Negative reinforcement in the form of physical pain, was also common: "…whenever I'm at work and I catch myself staring I ping my wrist with a rubber band." Suggesting MAPs employ active techniques to combat their attractions.

Managing Mood

Mental ill-health is a risk factor for offending (Cantor & McPhail, 2016), forum members acknowledge this trend "…this depression and poor psychological well-being will lead to higher rates of child sexual abuse". This theme relates to methods of managing low mood to remain offence-free, making up 20% of discussed coping mechanisms.

Healthy lifestyle and mindfulness. Healthy lifestyle and mindfulness represent 9% of coping mechanisms, e.g. "Mindfulness …allows me to appreciate attractive children and … not offend against them." This supports suggestions that mindfulness techniques may combat offence-supportive cognitions amongst sexual offender populations (Dafoe, 2011). Additionally, exercise and diet appeared to manage mood: "It is easy to forget how much of a difference exercise and nutrition make to your …psychological health."

Psychological/pharmaceutical intervention for low mood. Psychological and pharmaceutical intervention accounted for 8% coping mechanisms. Including: "Having a therapist to talk to has been one of the best things... without him I would have killed myself as a result of my severe depression and suicidal ideation…" while others discussed the efficacy of antidepressants.

Accepting attraction. In-line with recent approaches to treatment (O'Donnell, Minehan & Blake, 2015), accepting their attractions had significant effects on member's quality of life: "The goal is to accept your attraction and yourself… as long as I don't have sexual contact with a child, I won't feel bad." Suggesting, this poses an effective objective in treatment of sexual offenders, although it only composed 3% of coping mechanisms.

Managing Preferences Prosocially

The third theme accounted for 39% of coping mechanisms discussed and related to dealing with sexual interest in an offense-free manner.

Psychological and pharmaceutical intervention for pedophilia. Psychological and pharmaceutical intervention accounted for 27% of all coping mechanisms. In order to reduce their attraction to children many members used chemical castration: "I have used chemical castration drugs for 4 years… it's great." Additionally, the benefits of therapy were discussed: "…Therapy helps me to remain non-offending… I am a changed person to the one I was a few years ago…". Subsequently, it is apparent engagement with at risk MAPs serves to protect children from abuse.

Prosocial Sexual Expression. Legal methods of sexual expression allowed many to stay offence free whilst meeting their sexual needs, e.g. "…legal images of children help me….". Another technique was fantasies depicting children: "I use fantasies to prevent …offending." Whilst the effectiveness of these techniques is debated in the literature (Seto, Hanson & Babchishin, 2011), it accounts for 8% of forum users' coping mechanisms.

Distraction techniques. Distraction techniques composed 4% of discussions relating to coping mechanisms. Hobbies distracted from their attractions: "Occupy your thoughts… try drawing?... I use these techniques to keep myself in control", which has previously been found to lessen the pervasiveness of invasive thoughts (Najimi, Riemann & Wegner, 2009).

Friends, Family and Relationships

This theme relates to the support received from others and accounts for 21% of coping mechanisms.

Peer support. Disclosing attractions to peers comprised 15% of discussed coping mechanisms, including telling friends: "…it was a very positive experience. I found telling someone so beneficial." However, the most discussed form of support was the forum itself. Many members found support from like-minded individuals, knowing other MAPs maintain offence-free lifestyles as well as advice on situations extremely beneficial: "I haven't been on this forum long… it has helped so much. I feel less suicidal and… enjoy living more."

Religion. Only a minority of forums members were openly religious, subsequently this theme only accounts for 3% of coping mechanisms. However previous studies support a significant impact of Religion in decreasing mental distress and offence supportive beliefs (Cranney, 2017). Religious members view offending as sinful and drives their motivation to stay offence-free. Several found comfort from acceptance by members of their religious community: "The priest … told me God had given me a large burden to carry…. that I am a decent person…". This theme denotes the protective nature of religious belief for some, however, simultaneously highlights it as a risk factor for previously religious individuals who become disillusioned.

Family support. Although many described intense anxiety at the prospect of revealing their attractions, familial support accounted for 3% of coping strategies discussed: "I told my mum …telling her has changed my life…" Suggesting, overcoming societal stigma by connecting with family is protective for vulnerable MAPs.

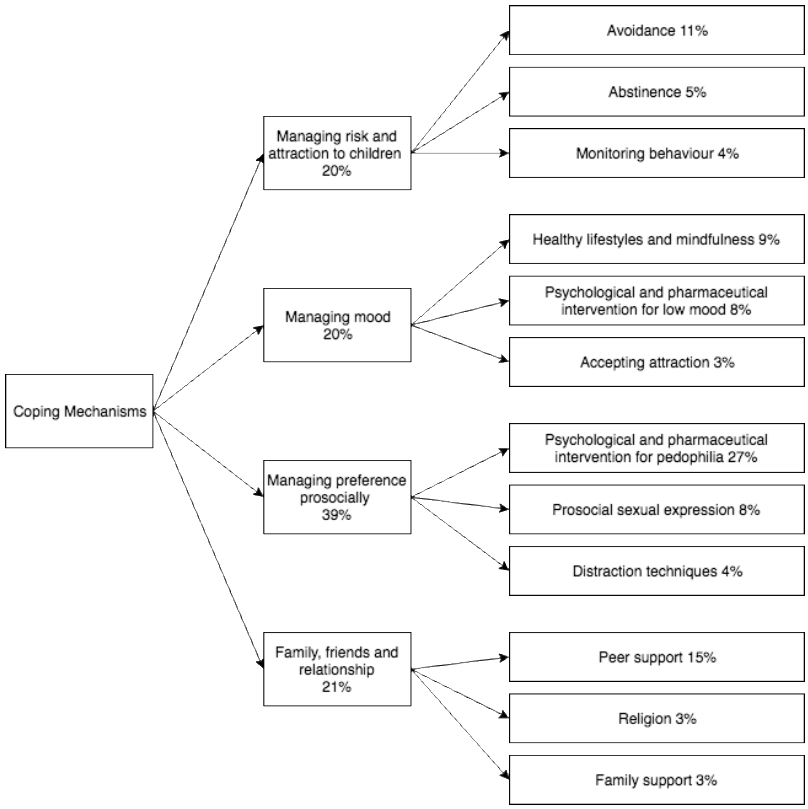

Figure 1. Flow Chart of Themes Relating to Coping Mechanisms

Mental Health

Mental ill-health was extremely prevalent, with high rates of addiction, anxiety, depression, self-harm/self-hatred/suicide as well as other more varied illnesses.

Addiction

Addiction accounted for 13% of discussed mental ill-health. Addictions ranged from gambling to pornography addictions, however, the majority discussed using substances to escape reality: "…There are days I cannot bear to be sober…. I … drink myself into a coma." Or as a form of self-harm: "…I was drinking so much…alongside tranquilizers and cannabis. I was trying to kill myself with substances..." The timespan and frequency of most substance abuse described, appeared indicative of a severe substance abuse disorder, according to the DSM-V (American Psychiatric Association, 2013).

Anxiety

Anxiety composed 18% of the mental ill-health in this population, predominantly stemming from insecurities relating to their attraction, specifically about being incapable of an intimate relationship with an age-appropriate partner: "I get so anxious… I might not… find a partner that loves me and I can satisfy." Additionally, members fear being 'outed', subsequent public persecution and even violence if their local community discovered their attractions. A public based survey suggests these fears are justified, as more than half of the sample supported non-offending MAPs being incarcerated and 28% believe they would be 'better dead' (Jahnke, Imhoff & Hoyer, 2015)

Depression

Predominately, feelings of depression were due to their attractions and societal stigmatization, as society fails to distinguish between a 'child molester' and a 'pedophile' (Cohen et al., 2016). These individuals feel disgust at their attractions: "I am stuck in a very deep depression due to the guilt of my attractions…" and "I became clinically depressed after discovering I was attracted to children". This theme of depression comprised 16% of mental ill-health but is strongly linked to the theme of

'Self-hatred/Self-harm/Suicide', although this pattern has previously been identified it is not yet clear how one influences another (Gilbert et al., 2013).

Self-Hatred/Self-Harm/Suicide

Comprising 30% of all references, 'Self-hatred/Self-harm/Suicide' is the largest theme relating to mental health. This included messages informing forum users of the suicide of other members, and references to previous suicide attempts. The main cause of self-hatred was their attractions: "I want to kill myself so badly… I have to mutilate myself as punishment for my attractions" and "I wish myself dead. I don't want to be attracted to children; I despise myself for fantasizing about them." It is impossible to ascertain a figure for the prevalence of suicide amongst this population through this form of analysis, however many members described previous attempts to take their lives and a genuine desire to die. For many, these thoughts plague them on a daily basis, suggesting they are at high risk of self-harm/suicide.

Other

'Other' represents mental illness which is not accounted for by the initial four themes and comprises 23%, including personality disorder, OCD, bulimia, etc. Although, this theme lacks the specificity of the previous four, the researchers felt it was important to provide an account of the varied experiences of mental ill-health in this population.

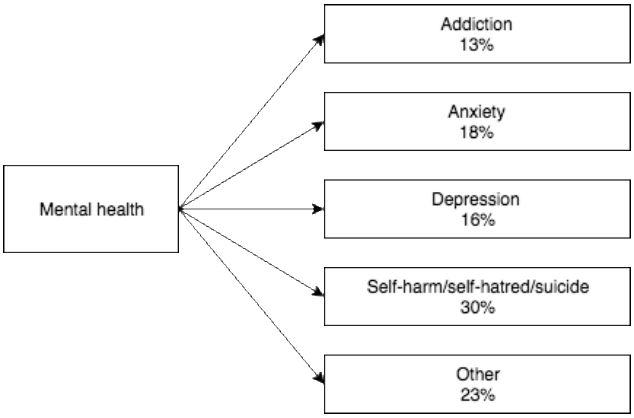

Figure 2. Flow Chart of Themes Relating to Mental Health

Discussion

A thematic analysis conducted on 5,210 posts on the 'Virtuous Pedophiles' forum produced four main themes for coping mechanisms: Managing risk and attraction to children, Managing mood, Managing preferences prosocially and Friends, family and relationships, with 13 subthemes. The analysis for mental health produced five themes: Addiction, Anxiety, Depression, Self-hatred/Self-harm/Suicide and Other.

The coping mechanisms identified are supported by earlier studies. Jones et al. (2016) conducted a thematic analysis on the 'Virtuous Pedophiles' forum, producing three themes and 11 subthemes similar to those identified in this study, including: Accepting and living with paedophilia, i.e. techniques for accepting their attraction, Staying Safe, e.g. maintaining contact rules, and When I get that feeling, i.e. legal sexual expression. Despite Jones et al.'s data set comprising only 6% of the current study, identification of equivalent coping mechanisms supports their presence and stability across time. Additionally, although their analysis did not examine mental health, their results referenced the 'devastating' psychological consequences of minor attraction (Jones et al., 2016, p. 6). Identification of psychological distress, coupled with the growth of the 'Virtuous Pedophiles' community (virped.org, 2018) suggests MAPs are increasingly turning to online communities, due to an absence of support in society.

Themes relating to mental health are supported by analysis of other online non-offending MAP communities. For example, B4U-ACT's (2011a) online survey found almost half of participants reported chronic suicidal ideation, 32% had planned suicide attempts and 13% had attempted suicide. These results appear to be consistent with 30% of references to mental health relating to self-

harm/self-hatred/suicide as identified in this study. Additionally, due to the nature of their study, B4U-ACT were able to identify suicide attempts and suicidal ideation were most prevalent aged 14 and 16, respectively (B4U-ACT, 2011a). Meanwhile, the average age of help-seeking behavior was 30 (B4U-ACT, 2011b). These figures indicate the population most at risk of mental illness, i.e. those aged 14-16, are least likely to seek help (B4U-ACT, 2011a).

As well as at the level of individual wellbeing, the significance of these findings should be considered in relation to child-protection. Research identifies those who experience mental ill-health are at increased risk of sexual offending (Cantor, 2014; Stillman & Baumeister, 2013). Therefore, alongside their minor attraction MAPs experiencing mental ill-health are at increased risk of self-harm and offending, unlikely to seek help (B4U-ACT, 2011a), while those who do are likely to find it inadequate (Cantor & McPhail, 2016; Jahnke, Phillipp & Hoyer, 2015).

This paper implicates suppression techniques as a cause of mental ill-health amongst non-offending MAPs. Research highlights the psychopathological consequences of suppression techniques, and the key factor differentiating between offending and non-offending MAPs is suppression of their desires (Cohen et al., 2018; Henry, Castellini, Moses & Scott, 2015). However, a growing body of literature implicates stigma as contributing to mental ill-health in MAPs (Hatzenbuehler, 2009; Pescosolido & Martin, 2015).

Meyer (2003) proposed 'Minority Stress Theory', suggesting stigmatized minorities expect and internalize stigmatizing attitudes, triggering stress which leads to mental ill-health (Liu & Mustanski, 2012). A significant cause of this psychological stress is public perception of MAPs as child molesters, frequently failing to differentiate between them in discourse, subsequently marginalizing this population (Seto, 2012; Ward & Syversen, 2009; Willis, 2018). In response, many professional bodies now advise referring to individuals by the labels they self-identify with (American Psychiatric Association, 2010, p. 72). However, the public remain pessimistic about the efficacy of treatment for prior offenders, hold punitive and stigmatizing attitudes towards MAPs (Levenson, Brannon, Fortney & Baker, 2007). The effect of this stigma is exacerbated by professionals with stigmatizing attitudes (Imhoff, 2015), decreasing the likelihood MAPs will seek support (Seto, 2008).

The stigma-related stress literature does implicate its role in mental ill-health amongst MAPs and is consistent with the results of this analysis as many MAPs had internalized views of themselves as 'monsters' (see Appendix B, 5C and 5A). However, the nature of this study was not to link suppression and mental health in a causal manner, rather to explore the experiences of a MA community committed to not offending. Subsequently, the analysis identified this population to be at high risk of mental ill-health as well as reviewed the main coping mechanisms employed.

To our knowledge this study represents the most comprehensive analysis of the mental health experiences and coping mechanisms employed by non-offending MAPs. Subsequently, this study can be considered a positive contribution to a growing literature, which addresses previous calls for naturalistic research assessing this population (Cantor & McPhail, 2016).

This study should be considered in light of several limitations. Firstly, to avoid attrition effects suffered in previous analyses we relied on self-reported experiences of mental illness, which cannot be considered equivalent to clinical diagnoses (Pyhälä et al., 2017) or confirmed by other methods such as peer/family ratings (American Psychiatric Association, 2013). However, the absence of researcher intervention may mediate the impact of this limitation, as members likely feel comfortable discussing their mental health and attractions on the forum and are unlikely to exaggerate or underplay their experiences. Although their experiences may not meet clinical thresholds, they are still relevant to this analysis (Jones, et al., 2016).

Thirdly, as it was impractical to review all 22 discussion topics, a pilot study found 'Life Experiences' and 'Requests for Support' had the highest prevalence of references to coping mechanisms and mental ill-health. The focus of the study was narrow in this sense and potentially neglected key themes from the remaining 20 discussion topics. This limitation is particularly relevant for discussion topics such as 'Keeping Kids and Ourselves Safe', whose title indicates discussions of coping mechanisms. However, the pilot identified this discussion topic comprised only 11% of total posts in the review period, while 'Requests for Support' and 'Life Experiences' accounted for 32% and 48% respectively, accounting for less discussion of relevant topics. It is suggested that future studies review all relevant discussion topics to ensure themes are accurate representations of the experiences of forum users.

Additionally, the nature of the study prevented demographics-based analysis, e.g. age and gender. This is limiting, as research suggests the expression and etiology of minor attraction differs between genders (Chivers, 2016; Seto, 2008), and the forum contains a mixture of individuals who identify as male, female and transsexual. We were unable to combat this by focusing solely on the experiences of males as very few individuals disclose their gender. A significant gender disparity in this population, 99% of the population are predicted to be male, reduces the impact of this limitation (Abel & Harlow, 2001; Seto, 2017).

Additionally, the forum permits members with a history of offending, on the condition they are currently non-offending (virped.org, FAQs). Due to the anonymous nature of the forum researchers were unable to mediate the impact of this by excluding those who have offended. The potential inclusion of offending MAPs may have impacted the themes identified as emerging research identifies disparities between these populations (Bailey et al., 2016). For example, offending MAPs report stronger attraction to children, possibly implicating differences in self-control between the populations (Cohen et al., 2018). It is recommended further research assesses these differences as they have implications for interventions and treatment.

Finally, extensive research with sexual offenders has noted the presence of 'implicit theories' (O'Ciardha, Gannon & Ward, 2016). Such cognitions rationalize abusive behaviors and are considered risk factors for future offences (Ward & Keenan, 1999). It is possible a selection of the coping mechanisms identified in this study may sit on a spectrum with implicit theories, such as 'children as sexual beings'. For instance, several forum members felt fantasies depicting children helped them stay offence free. Given the, admittedly conflicting, literature relating to reinforcement of sexual contact with children through use of indecent images of and fantasies depicting children, it is possible statements such as these represent rationalizations rather than effective coping mechanisms. Subsequently, the presence of these may be risk factors for members of this population. Additional research is recommended in order to assess the efficacy of this 'coping mechanism', as at present the literature lacks the ability to make this distinction.

Conclusion

Mental ill-health was found to be highly prevalent in this sample, supporting previous studies. These psychopathologies combined with a naivety and stigmatization by society and clinicians alike puts this population at increased risk of harming themselves and children. Additionally, this investigation identified four forms of coping mechanism. However, we are currently unable to identify the efficacy of these coping mechanisms and at present cannot know the degree to which these represent protective factors, future research should address this. It is hoped this report will contribute to a literature that continues to grow and has a positive effect on the quality of life of MAPs. An effective way to protect children from abuse is to protect MAPs from reaching crisis points which may result in offending. Engaging in sexual contact with a child in any sense is morally wrong and deserving of punishment. Being born with an unwanted sexual attraction is not.

Disclosure of Interest Authors have no conflicts to report.

Ethical Standards and Informed Consent All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation [institutional and national] and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was not obtained from all participants due to the nature of the study, however informed consent was obtained from the moderator of the forum.

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Appendix

Appendix A: Edited Quotes Relating to Coping Mechanisms.

Coping Mechanisms

1.) Managing risk and attraction to children
    a. Avoidance
        i. "…I stopped going to places I knew children would be started avoiding places where children might be…"
        ii. "Being lonely is worth protecting children, so I don't go out."
        iii. "I have software on my compute which stops me being able to access porn, so I don't feel as driven to view it."
    b. Abstinence
        i. "When my fantasies start to involves children, I abstain from masturbation."
        ii. "Viewing pornography is a slippery slope for me, and the fact that this may lead to children being hurt is very scary for me. So I no longer want to view porn."
    c. Monitoring behaviour
        i. "If you wouldn't do it in front of the kid's parents then you shouldn't do it when you're alone with them. For example, would you hug them like that is their mum was in the room?"
        ii. "I have a problem with staring, so whenever I am at work and I catch myself staring I ping my wrist with a rubber band."
2.) Managing mood
    a. Psychological/pharmaceutical intervention for low mood.
        i. "I take Celexa to deal with my anxiety."

ii. "Having a therapist to talk to have been one of the best things I have had over the last few years. Without him I would probably have killed myself as a result of my severe depression and suicidal ideation."

b. Healthy lifestyles and mindfulness
   i. "After I see a little girl I am attracted to but won't see again, I employ mindfulness so I can enjoy the moment then never think of it again."
   ii. "Who you find attractive does not define you, mindfulness has helped me so much. It allows me to appreciate attractive children and I will not offend against them."
   iii. "It is easy to forget how much of a difference exercise and nutrition make to your drive and psychological health. The best moments of my life have been when I am eating well and exercising frequently."

c. Accepting attraction
   i. "You don't have to love your sexuality. I don't like being attracted to children and if I could get rid of it I would. The goal is to accept your attraction and yourself. I think I am a nice person, I like myself. I wish I was attracted to adults but I don't dwell on it. I didn't choose to be a MAP, and I can't change it, but I don't feel bad about it, and as long as I don't have sexual contact with a child, I wont feel bad."

3.) Managing preferences prosaically
   a. Prosocial sexual expression
      i. "I use fantasies to prevent me from offending. I think God permits fantasy to help with self-control. I need fantasies to stay offence free."
      ii. "Some people, like me, find that non fantasising/masturbating to thoughts about children is dangerous because the sexual tension builds up which makes me frustrated and compromises my self-control. So I use masturbation to relieve this tension."
   b. Psychological and pharmaceutical intervention for paedophilia.
      i. "I use chemical castration drugs. You'll be okay without erections and the ability to ejaculate. Its okay, I have been doing it for 4 years and I think its great."
      ii. "I talk about my paedophilic disorder with my therapist. I saw her today and we discussed it amongst other things, like my education and anxieties. Its going really well."
      iii. "I have offended against children, which are all past the statute of limitations. Therapy helps me to remain non-offending. She helps me to find my own answers. I know I am a changed person to the one I was a few years ago."
   c. Distraction techniques.
      i. "Occupy your thoughts by reading, the more you read the smarter you will get and the better you are. You could try drawing? Use that to draw your emotions and experiences. I use these techniques to keep myself in control."

4.) Friends, Family and Relationships.
   a. Religion
      i. "The priest at my church told me God had given me a large burden to carry and that I am not limited by my desires. That I am a decent person. He told me that God is forgiving and sometimes its harder to forgive yourself….. I said I was too scared to tell him before because I thought he would hate me. He immediately held me and said he could never hate me."
   b. Family support
      i. "I told my mum and she wasn't surprised at all. I told her everything about my paedophilia. Previously she has not coped with life well so I didn't think I could rely on her. But she has changed so much and supported me when I needed her more than ever. Telling her has changed my life, I think reconnecting with my mum is exactly what I needed."

ii. “Whenever I need to talk to my grandfather about my paedophilia he will listen and try to understand. He is very understanding.”

c. Peer support
   i. “I have only told one person but it was a very positive experience. I found telling someone so beneficial.”
   ii. “I hope this group helps me, I think it already has.”

Appendix B: Edited Quotes Relating to Mental Illness.

Mental health

1.) Addiction
   a. “I have been addicted to alcohol and pornography before.”
   b. “I have battles with sex addiction, alcoholism and paranoia simultaneously.”
   c. “There are days when I cannot bear to be sober. I stopped smoking cannabis for a few weeks but then I relapsed, it’s not good for me to get high roughly four times a day and drink myself into a coma every few weeks.”
   d. “I was drinking so much (around 13 beers a day), alongside tranquilizers and cannabis. I was almost trying to kill myself with substances for 5 months last year.”

2.) Anxiety
   a. “I get so anxious that I can’t talk to people about being a MAP.”
   b. “My anxiety stems from insecurities about being a pedophile.”
   c. “I get so anxious that I might not be able to get with women or find a partner that loves me and I can satisfy. I wish I could feel secure in myself and know it will work out.”

3.) Depression
   a. “Without my therapist I would likely have killed myself to escape my depression.”
   b. “I am stuck in a very deep depression due to the guilt of my attractions, and worries that I’ll be alone forever (because I will have to tell potential partners about my convictions), I feel so helpless.”
   c. “Its very hard and lonely. I am very depressed and anxious. I can’t tell anyone and haven’t quite told my therapist, I hope the therapy helps.”

4.) Self-hatred/Self-harm/Suicide
   a. “I want to kill myself so badly, but it scares me failing again and being worse off. So I just have to mutilate myself as punishment for my attractions.”
   b. “I have just cut myself numerous times. I am starting to go numb and feeling is leaving me. I need to cut more, and I wish myself dead. I don’t want to be attracted to children, I despise myself for fantasizing about them.”
   c. “I deserve to die, I am a monster.”
   d. “I have persistent self-destructive thoughts, particularly when get fucked up. I think about stabbing myself in the neck and doing lots of dangerous drugs or beating on people that I hate.”
   e. “I used to hate myself for being a pedophile, because I was abused. I tried to kill myself because I was in such a bad place.”
   f. “Every day I think of killing myself, they intrude on my day and are often disturbing.”

g. “The idea of killing myself is tempting, I think about jumping off somewhere high. I don’t know how else to escape this mental august. I couldn’t tell anyone in my life that I am suicidal, the consequences of saying that and not doing it are too severe.”

5.) Other

a. “My OCD tells me I am a monster.”

b. “Last year I smoked cannabis to the point it gave me drug induced psychosis and I was in a mental unit for a week.”

c. “I can’t tell people why I am so sad. I tell people it’s my bipolar but I know the real reason is my pedophilia.”

d. “You have previously mentioned your personality disorder, that will influence how you interpret the world and other people’s behavior.”