TREATING PAEDOPHILIC DISORDER AND PAEDOPHILIC IDEATION: CURRENT INTERVENTIONS AMONG PSYCHOLOGISTS IN SOUTH AFRICA

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submitted in part fulfilment of the requirements
for the degree of

MASTER OF ARTS IN CLINICAL PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

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MAY 2023

Declaration

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Title of mini-dissertation

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Abstract

The study was motivated by the need to understand paedophilic disorder and paedophilic ideation as these are highly stigmatised, directly impacting treatment. It is ethical and pragmatic to support those suffering from paedophilic disorder and paedophilic ideation and to offer treatment free from stigma. The study was located in the theoretical framework of social constructionism utilising a qualitative approach. Data were collected through semi-structured interviews with six South African psychologists who treat these individuals. Thematic analysis was used to analyse emerging themes. The main findings were that stigma at various levels severely impacts the management and treatment of paedophilia disorder and ideation. There is a lack of training around paedophilia and no standardise psychometric assessments for a South African population to test paedophilic disorder and paedophilic ideation, resulting in psychologists using and adapting international therapeutic approaches. In the private setting, long-term therapy is viewed as effective in preventing reoffending, initially focusing on gaining a holistic understanding and the evolution of clients' attraction to children. In a correctional services context, cognitive behavioural therapy is indicated to be effective, given the contextual lack of resources. Female paedophiles remain largely invisible and are treated differently from their male counterparts when they are diagnosed with paedophilia. This is linked to the social construction of women as mothers and nurturers. Further, systemic change is needed to overcome the severe stigma cast over professionals who treat people with paedophilic tendencies and reduce the stigma toward individuals who are attracted to minors seeking therapeutic assistance.

Keywords: interventions, paedophilic disorder, paedophilic ideation, psychotherapy, social constructionism, stigma, thematic analysis

Opsomming

Hierdie studie was gemotiveer deur die nood om pedofiele versteuring en pedofiele ideasie te verstaan omdat dit hoogs gestigmatiseer is en behandeling direk afekteer. Dit is eties en pragmaties om diegene wie onder 'n pedofiele versteuring en pedofiele ideasie lei, te ondersteun sowel as behandeling aan te bied wat vry is van stigma. Hierdie studie was gefokus in die teoretiese raamwerk van sosiale konstruksionisme met die gebruik van 'n kwalitatiewe benadering. Data was versamel deur semi-gekonstrukteerde onderhoude te voer met ses Suid Afrikaanse sielkundiges wie hierdie individuele behandel. Tematiese analise was gebruik om opkomende temas te ontleed. Die hoof bevindinge was dat stigma op verskeie vlakke die hantering en behandeling van pedofiele versteuring en ideasie grootliks beinvloed. Daar is 'n gebrek in die opleiding rondom pedofilie en daar is geen standaard psigometriese assesserings vir 'n Suid Afrikaanse populasie om te toets vir pedofiele versteuring en pedofiele ideasie nie, wat beteken dat sielkundiges aanpas en gebruik maak van internasionale terapeutiese benaderinge. In die private instelling word lang termyn terapie beskou as effektief in die voorkoming van heroortreding, wat oorspronklik gefokus is om 'n hollistiese begrip te kry en die evolusie van kliente se aantrekings tot kinders beter te verstaan. In die regstellings dienste konteks, word kognitiewe gedragsterapie aangedui as effektief – gegewens die kontekstuele gebrek aan hulpbronne. Vroulike pedofiele bly grootliks onsigbaar en word verskillend behandel van hulle manlike eweknieë wanneer hulle wel gediagnoseer word met pedofilie. Hierdie is gekoppel aan die sosiale konstruksie van vrouens as moeders en koesterers. Verder, sistemiese verandering is nodig om die ernstige stigma wat oor die professionele wie individuele met pedofiliese neigings te behandel, te oorkom, en om die stigma te verminder teenoor individu wie aangetrokke is tot minerjariges en wat terapeutiese hulp wil benader.

Sleutelwoorde: ingrypings, pedofiele versteuring, pedofiele ideasie, psigoterapie, sosiale konstruksionisme, stigma, tematiese analise

Iqoqa

Lolu cwaningo lugqugquzelwe isidingo sokuqonda kabanzi ngesifiso nemidlinzo yenkanuko yocansi ebhekiswe ebantwaneni njengoba lokhu kuvezwe njengento enokucwaswa okukhulu futhi okungaba nomthelela ongemuhle kwezokulashwa. Kubalulekile kakhulu ukuseka nokungacwasi labo abanelesi sifo kanye nale midlinzo. Ulwazi luqoqwe ngokwenza inhlolokhono kodokotela abayisithupha abahlola ingqondo baseNingizimu Afrika, bahlole abantu abanesifiso nemidlinzo yenkanuko yocansi ebhekiswe ebantwaneni. Isihlaziyo sokuqoqa ulwazi i-thematic analysis sisetshenziswe ukudibanisa izigaba. Imiphumela iveze ukuthi ukucwaswa ezigabeni ezihlukene kube nomthelela ongemuhle ekulawuleni nokwelashwa kwesifo nemidlinzo yenkanuko yocansi ebhekiswe ebantwaneni. Kunokuntuleka kwezoqeqeshwa mayelana nesifo senkanuko yocansi ebhekiswe ebantwaneni futhi alukho uhlelo olugunyaziwe lokuhlolwa ngokwengqondo kubahlali baseNingizimu Afrika ukubheka lesi isifo nemidlinzo, okuholela ekutheni odokotela abahlola ingqondo bagcine besebenzisa baphinde benze okuhlobene nezindlela ezisetshenziswa emazweni aphesheya. Ezindaweni zangasese, ukuhlinzekwa ngokululekwa ngokwengqondo okuthatha isikhathi eside kuvezwa njengokuyikho okufanele ukugwema isigameko ukuthi singanzeki ngokuphindelela, ekuqaleni ebesigxile kakhulu kukho ukuqonda nokwazi izizathu eziholela ekutheni kungani abanalengcizi behehwa izingane ezincane. Okuqhukethwe kwezokuqondiswa izigwegwe, ukululekwa ngokwengqondo kuvezwe njengokusemqoka, nakuba kunokuntuleka kwezinsiza. Isibalo sabesifazane abanezinkanuko zocansi ezibhekiswe ebantwaneni asivezwa ngokucacile futhi baphathwa ngokuhlukile kunabelisa abakhungethwe ilesi sifo. Lokhu kuhambisana ngendlela abesimame ababukwa ngayo emphakathini njengoba bethathwa njengomama kanye nabafukameli. Okunye, kudingeka ushintsho ukubhekana nokucwasa okunzulu okuvela kubasebenzi abangabelaphi ngokusemthathweni kulolu hlobo labantu kanye nokunciphisa ukucwasa kulabo abahehwa izingane ezincane ngoba bandinga usizo lokulashwa ngokwengqondo.

Amagama asemqoka: imingenelelo, isifo senkanuko yocansi ebhekiswe ebantwaneni, imidlinzo yenkanuko yocansi ebhekiswe ebantwaneni, ukulwasha ngokwenqondo, isimo senhlalo yomphakathi, ukucwasa, isihlaziyo se-themathikhi.

Acknowledgements

While I firmly believe it is never too late to follow a dream, I can wholeheartedly say that I was not alone in this endeavour. Instead, I was privileged to have been guided and supported along each step. I would therefore like to express my sincere gratitude to the following people, whose continuous and valued support carried me through the ups and downs of my training as a clinical psychologist and this research study.

To my supervisors, Prof Juan Nel and Prof Martin Terre Blanche. Your guidance, support and acknowledgement gave me the confidence to navigate this research endeavour and add to my repertoire of skills as I grappled with each element of this study. I thank you both and appreciate the vital role each of you played in seeing this research study come to fruition.

To Stephanie Terre Blanche, apart from the knowledge you imparted as a lecturer and mentor, thank you for contributing to my growth as a clinical psychologist and a human being. Thank you for your endless patience, unwavering support and congruent guidance, which helped me navigate toward finding meaning in not only understanding but also overcoming my struggles as I found my path toward individuation. I am proud to call you not only a colleague but also a true friend.

To Vanessa-Lynn Neophytou, thank you for your endless support and for standing by me, encouraging me, and sharing important spaces with me as we grappled with the ins and outs of what it means to be a researcher, but further to provide meaningful research within the constructs of society.

To the participants in this study and the researchers who contributed to the rich literature, I thank you for sharing the sacred spaces of your personal experiences and for allowing this research to unfold through your narratives, professionalism, research and expertise.

Thank you to my family and friends who continuously gave me the space, encouragement, and courage to be proudly me. You shared in my triumphs when times were good, and you were there to carry me through the tougher periods of growth. Not only have you provided key life structures for me through this journey, but as a continuous and pertinent scaffold for my voyage through life.

To my mother, Kim, I thank you for all the sacrifices you have made to help me realise my dreams. Your love and unconditional support have shown me the true meaning of being a parent and role model. I am forever grateful for the valuable

lessons of responsibility, perseverance, and strength you have taught me. I am truly blessed and incredibly proud to be your son.

Lastly, to my amazing son, Corbin, you have been a beam of joy, happiness and love that is indescribable. It is an honour to be your father, and I promise always to strive to be your best parent and to hold space for you to walk through life with your head high. I am truly proud of you each and every day. Keep that beautiful smile on your face, my boy. Always walk through life with pride and autonomy in who you truly are, as I know you will make the world a better place.

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Chapter One
Introduction

1.1 Background and Context

The focus of this study is to examine current interventions used by psychologists in South Africa when treating individuals with paedophilic disorder and paedophilic ideation.

Paedophilia[1] disorder and paedophilic ideation are highly stigmatised with onerous consequences on treatment, inspiring the need for this study. The idea of "person-centred care" is gaining traction because those providing mental health care have been identified as stigmatising those in their care (Stuart, 2017). In person-centred care, there is an ethical imperative to support those suffering from paedophilic disorder, and it is pragmatic regarding prevention (Seto, 2012). Furthermore, the treatment should be client-centred and free from stigma. This study explores what is meant by the term paedophilia within the context of it being a mental health disorder. Child sexual abuse has been framed by the media, medical literature and legislation that terms such as "molester", "paedophile", and "child abuser" are used interchangeably, contributing to the dehumanisation of paedophilia. The result is a belief that individuals with paedophilic disorder or ideation do not deserve treatment and are untreatable. This dehumanisation also contributes to individuals who suffer from this condition to self-stigmatise and not seeking treatment for fear of being misunderstood by professionals.

There is a lack of local and international research on effective management and treatment strategies for individuals with paedophilic disorder, paedophilic ideation, or sexual interest in children. In addition, the available research is conflicting with little to offer in effective treatment techniques. This gap in the research showed that a study in South Africa would be beneficial to understand current therapeutic interventions used by psychologists who treat paedophilic disorder or paedophilic ideation and then determine which approach(s) have or have not been effective.

1.2 Research Question and Objectives

The central research question that guides this study is to examine and understand the therapeutic practices engaged in by psychologists in South Africa who

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[1]Note the spelling of paedophilia as per South African usage unless quoting directly from a source which uses the American spelling "pedophilia".

treat clients who have paedophilic disorder and paedophilic ideation. This is achieved through the following objectives:

- Establish how psychologists in South Africa conceptualise paedophilic disorder, paedophilic ideation, and its management and treatment.
- Identify which interventions psychologists in South Africa use when dealing with paedophilic disorder and paedophilic ideation.
- Establish the key challenges experienced by psychologists in South Africa who have dealt with paedophilic disorder and paedophilic ideation.
- Identify how psychologists in South Africa draw on existing treatment protocols or fail to draw on such protocols in their interaction with individuals (their clients) with paedophilic disorder and paedophilic ideation.

1.3 Rationale for the Research

The sexual abuse of children is a human rights issue and one of great interest to science (Bowman, 2010; Richter et al., 2008). South Africa has one of the highest rates of reported child sexual abuse globally (Petersen et al., 2005). In addition, studies have found overwhelming correlations between experiences of child sexual abuse and significant physical and mental health problems (Selengia et al., 2020). The sexual abuse of children and adolescents is widespread (Ajayi et al., 2021; Artz et al., 2018). Meinck et al. (2017) conducted the first study evaluating self-reported child abuse through a large, community-based sample in South Africa. They found high rates of physical, emotional and sexual abuse.

The central research question stemmed from the rationale that providing treatment to individuals who suffer from paedophilic disorder and/or paedophilic ideation is practical because it can go to prevention. Prevention through treatment is ethical. It is also ethical because treatment can alleviate individuals with paedophilic disorder or paedophilic ideation who find their conditions cause them suffering. In addition, the stigma associated with this specific mental health disorder sees individuals with paedophilic disorder and paedophilic ideation stigmatised by mental health providers. In addition, incarceration is used as a means or attempt to rectify pathology, which desperately needs mental health intervention. The systemic stigma prevalent in society results in many individuals remaining untreated. This leads to recidivism. Thus, research needs to be done to understand current therapeutic intervention strategies. This research could go towards refining the current treatment

interventions and/or therapeutic guidelines to assist psychologists who treat individuals with paedophilic disorder and paedophilic ideation.

1.4 Problem Statement

Child sexual abuse is a large problem in South Africa for various reasons. For the most part, South Africa relies heavily on a judicial system to address problems associated with people with paedophilic disorder and ideation. It is a problem faced by the world, and in most societies, individuals with paedophilic tendencies are addressed through punishment for unlawful acts, barring a few exceptions of countries that do not legislate the aforementioned.

There is a scarcity of research in South Africa on paedophilia. The actual treatment of paedophilic disorder from a psychotherapeutic standpoint is not well researched, especially in a South African society which is rich with diverse cultures. There is a significant lack of training in this relevant specialised area of our population and minimal guidance within the South African population as opposed to other countries that are establishing organisations to assist these individuals who suffer from self-harming comorbidities. Furthermore, these international organisations assist society as a whole by treating individuals with paedophilia, thereby lowering the rates of initial violating behaviour and recidivism, but also providing training and additional research worldwide.

1.5 Significance of the Study

Given the lack of research into the treatment of paedophilic disorder and paedophilic ideation, specifically in a South African context, this study will add to the limited body of knowledge which currently exists. Further, this study will highlight how society has stigmatised and stereotyped this population of individuals with paedophilic disorder and paedophilic ideation and further delve into the various elements of associated stigmas held by psychologists and mental health professionals who encounter these individuals. This will highlight a need for systemic change and a reduction of stigmas associated with paedophilia at various levels.

1.6 Theoretical Approach

In this study, social constructionism is used and understood as a meta-theoretical framework, as detailed in the literature review chapter. Social constructionism examines the nature of reality as being constructed through a dialectical process between an individual’s subjective reality and the objective reality of phenomena. It emphasises everyday interactions between people whose shared

meaning is cultural and historically contextual. Social constructionism focuses on how knowledge is constructed, and the social practices people engage in are the focus of enquiry (Andrews, 2012). Social constructionism underpins this study theoretically and methodologically. It allows the researcher the view that diseases and illnesses (physical and mental) can and do exist as an independent reality. However, the naming of disease/illness and what constitutes it, for instance, in the DMS-5-TR, are socially constructed. This is significant as this is what allows for diagnosis and treatment. This directly affects this study's aim regarding how the participants, South African psychologists, understand paedophilic disorder and paedophilic ideation and treat individuals with these conditions.

1.7 Methods

This study used a qualitative study design carried out by conducting semi-structured interviews with registered psychologists in South Africa who treat individuals with paedophilic disorder or paedophilic ideation. This study adopted an interpretivist paradigm, which informed the foundation of the mini-dissertation's qualitative method (Ponterotto, 2005). Semi-structured interviews were used to gather the data as these allowed for the detailed information and experiences of the psychologists who treat paedophilic disorder to be gathered and explored in real-time to obtain rich data. Thematic analysis was used to analyse the data as it allows for the data to be analysed through systematically identifying, organising, and providing insight into the thematic patterns which arose from the data collected (Braun & Clarke, 2012).

1.8 Chapter Outline

Chapter One presents the study's research question, aim, objectives, and background context. Chapter Two explains the term paedophilia when understanding paedophilic disorder. This understanding is punctuated by the context of paedophilic disorder as a mental health disorder in the DSM-5-TR (American Psychiatric Association, 2022). Laws relevant to paedophilia and child sexual abuse are explored, and other modalities of how paedophilia is viewed. Therefore, the aetiology of paedophilic disorder, current research revolving around management and treatments, and the relevant associated stigmatisation and societal underpinnings are also investigated to offer a holistic body of knowledge regarding paedophilic disorder and paedophilic ideation in relation to this study. Social constructionism as a theoretical

framework is used in this study epistemologically to understand reality/ies due to its emphasis on relational processes.

Chapter Three presents an understanding of the research methodology, which is qualitative and how this informed the data collection through the use of semi-structured interviews. The data analysis in the form of thematic analysis is presented, and relevant ethics involved in carrying out the research study regarding confidentiality, credibility and trustworthiness are explained.

Chapter Four presents the findings and a discussion, drawing on the relevant literature and theoretical framework of social constructionism. The findings are organised into the themes which emerged from the data, punctuated with the participants' quotes to illustrate their experiences. Five main themes are presented with corresponding subthemes to understand the outcomes regarding treating paedophilic disorder and paedophilic ideation by psychologists in South Africa.

Chapter Five presents the research's conclusions, strengths and limitations and proposals for potential further research.

Chapter Two
Literature Review

2.1 Introduction

This chapter will outline an understanding of what is meant by the terms paedophilia and paedophilic ideation in relation to paedophilic disorder within the context of it being a mental health disorder. The chapter will cover an understanding of the term paedophilia as per the DSM-5-TR (American Psychiatric Association, 2022). Comorbidities will be discussed because paedophilia often does not occur in isolation, given how it affects the individuals concerned. A brief overview of the causes of paedophilic disorder and paedophilic ideation follows this discussion. The law associated with the disorder in South Africa is briefly considered, followed by a more in-depth discussion of stigmatisation. Next, the therapeutic approaches and theoretical models used by psychologists and the New Zealand and Canadian models that psychologists in South Africa draw on will be discussed. Finally, the theoretical approach of social constructionism will be explained.

Not all sexual offenders have paedophilic disorder, and not all individuals with paedophilic disorder are sexual offenders. However, the literature often conflates these terms. Jonker and Du Preez (2012) stated that the dominant and universal characteristic of sexual offenders is their rarely expressed willingness to seek treatment or behavioural intervention. This notion points toward a potential lack of internal locus of motivation or insight, which affects the necessary changes in offenders' lives. However, cognitive distortions may also prohibit the perception of sexual violation, such as fear of repercussions (Papakyriakou, 2017). Thus, should individuals undergo treatment, it is most often due to the external motivation enforced by the criminal justice system, which then mandates treatment. Mandatory treatment is problematic in South Africa because it is still unclear who is qualified to provide it (Papakyriakou, 2017). Moreover, in the White Paper on Corrections (Mills, 2019), rehabilitation is the focus of the Department of Correctional Services (DCS) as opposed to only incarceration. This focus is on rehabilitation with aftercare and community involvement as an "Integrated Justice System" where the state and community work together. The Correctional Services Act No. 111 of 1998, amended in 2015, and the White Paper on Corrections have placed an enormous burden on the

DCS as rehabilitation is framed as a right, not a luxury (Omar, 2011). However, the necessary resources to provide rehabilitation do not correspond with the intent.

Regarding female paedophilia, there is a dearth of research. Notably, with the exception of a study by Kramer and Bowman (2011) and Kramer (2010; 2014) discussed in this chapter, research on female paedophilia is wanting. This follows the international trend of a lack of research on female paedophilia (Chow & Choy, 2002). Taking this into account, Lievesley and Lapworth (2022) conducted a study using the term "women living with a sexual interest in minors". However, their study was based on six women who self-identified as such. Thus, their findings are not generalisable.

2.2 Paedophilia

Jahnke (2015) highlighted the contention surrounding the definition of paedophilia in that scholars and professionals seem to disagree on a definition. Particularly problematic is that "paedophile" and "child abuser" are used interchangeably. This conflation impacts the understanding of paedophilic disorder and paedophilic ideation, which is a reductionist perspective of a complex disorder (Harrison et al., 2010). The media often misconstrue this simplistic understanding of paedophilic disorder and paedophilic ideation. The language used to depict these individuals is somewhat unique in that research explains that no other crime or criminal is marginalised and dehumanised in the same manner as those with paedophilia (Imhoff, 2014; Jahnke & Hoyer, 2015). This dehumanisation leads to the indoctrination of the public and professionals toward the belief that individuals with paedophilic disorder will offend and that there is no therapeutic aid with regard to treatment, but further, that these individuals do not deserve treatment. This notion extends to academic and professional contexts whereby professionals are reluctant to assist individuals with paedophilic disorder and paedophilic ideation or reluctant to show a willingness to understand further the diagnosis affecting this population. This has led to discrimination in terms of understanding the disorder and research thereof and adequately and concisely defining paedophilic disorder (Jahnke & Hoyer, 2015).

One of the first attempts to classify paedophilia was conducted by Cohen et al. (1969) to find a classification more valuable than the medicolegal one. This resulted in categories of "fixated, regressed, and aggressive groups" (Cohen et al., 1969, p. 251). Knight and Prentky (1990) went on to further investigate rapists and child molesters, disregarding the aforementioned "fixated" and "regressed" categories, but instead, they extended this by dividing individuals into eight categories. After this

comprehensive study, Ward and Hudson (1998, p. 260) proposed "the self-regulation model as an alternative to relapse prevention". This process became significant regarding the categorisation and treatment of individuals suffering from paedophilic disorder. Their research shows 13 finite distinctions between offenders and situates these individuals into pathways, for instance, "avoidant-passive pathway" and "avoidant-active pathway" (Ward & Hudson, 1998, p. 261). Further distinctions were made based on "clinical descriptions, demographic clusters, psychometric profiles, and theory-driven typologies" (Bickley & Beech, 2001, pp. 55-62). Although this research is seemingly productive towards a definition and understanding of paedophilic disorder, it has limitations due to methodological constraints and pitfalls.

In contrast to paedophilic disorder, Cantor and McPhail (2016) described individuals with paedophilic ideation as being non-offending paedophiles in that they have sexual interests towards children; however, they have never acted on (nor do they have the desire to act on) these urges physically. Furthermore, individuals with paedophilic ideation have not engaged in exploitative material such as pornography. Therefore, individuals can have paedophilic ideation and still not meet the criteria of paedophilic disorder. Verridt (2019) explained that the difference between paedophilic disorder and paedophilic ideation caused conflicting ideas among researchers and professionals regarding the DSM-5 diagnostic criteria. Verrijdt (2019) suggested that a way to deal with this would be distinguishing between child sexual offenders who suffered from paedophilic disorder and those who did not.

Given the scope of this study, I decided to punctuate from the DSM-5-TR's (American Psychiatric Association, 2022) definition and diagnosis primarily. Paedophilia is classified as a psychiatric disorder and therefore requires psychiatric treatment. Internationally, an approach to treatment combines psychotherapeutic treatment (Bjelajac et al., 2020). Therefore, this section will look at definitions of paedophilia, paedophilic disorder and paedophilic ideation, starting with DSM-5-TR (American Psychiatric Association, 2022). According to Silverman et al. (2015), the American Psychiatric Association practice guidelines were implemented in 2011 to evaluate adults' psychiatric conditions. This is done by clearly defining and rating the processes of establishing evidence and strengths of systematic reviews within the scientific literature on mental disorders. The process of establishing these guidelines is said to be consistent and cooperative with the input and recommendations of authoritative boards, experts, and establishments in an attempt to research and review

guidelines. After final approval by a board of trustees, these guidelines are solidified in full-text guidelines and dispersed.

2.3 Paedophilic Disorder

In this study, the focus is understanding paedophilic disorder as a paraphilia in accordance with the DSM-5-TR. To be a paraphilic disorder, it must be “currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others” (American Psychiatric Association 2022, p. 781).

Within psychopathology and punctuating from a position of mental disorders, paedophilia as a perversion was first recognised in 1968 as a mental disorder in the DSM-II; however, it has seen changes to its criteria over the years (Bowman, 2010). The DSM-5 introduced a distinction between paedophilia and paedophilic disorder (Münch et al., 2020). Today, the DSM-5-TR (America Psychiatric Association, 2022) is a starting block in understanding the disorder (see Table 2.1 for the full diagnostic criteria).

Table 2.1

DSM-5-TR Pedophilic Disorder

Diagnostic Criteria F65.4	
A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a pre-pubescent child or children (generally age 13 years or younger).	*Specify whether:* **Exclusive type** (attracted only to children) **Nonexclusive type**
B. The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.	*Specify if*: **Sexually attracted to males** **Sexually attracted to females** **Sexually attracted to both**
C. The individual is at least age 16 years and at least 5 years older than the child or children in Criterion A.	*Specify if:* **Limited to incest**

Note: From the American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev. pp. 772-793).

According to the DSM-5-TR (American Psychiatric Association, 2022, p. 1485-6), for paedophilic disorder to be diagnosed, it must occur "over a period of at least 6 months" and involves "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a pre-pubescent child or children …". Bartol and Bartol (2017, p. 398) pointed out that the terms fantasies and sexual urges in this definition "are not criminal unless there is an accompanying action (behavior) that is against the law". Regarding criterion A, first, the DSM-5-TR (American Psychiatric Association, 2022, p. 1486) states the "age guideline of 13 or younger is approximate," as when puberty begins varies individually and culturally. Second, this intense sexual interest in children is the same as having an increased or even equal attraction to children as one would have to mature adults.The intense sexual interest in criterion A is the same as it was in the DSM-5.

It should be noted that the DSM -5 TR (being a scientific and medical diagnostic tool) does make mention of a definition of pre-pubescent children, being those children 13 years and younger. Hebephilia "refers to a sexual preference in pubescent children (Tanner stages 2 or 3)" ages 11 to 14 (Stephens & Seto, 2015, p. 29). The age ranges for hebephilia (and paedophilia) are approximate because individuals vary when they reach puberty (Stephens & Seto, 2015). Many persons, the majority being men, sexually prefer pubertal, not pre-pubertal children. Decades of research reveal that more heterosexual than homosexual paedophiles have sexually offended against children (Freund et al., 1984; Freund & Watson, 1992; Manning et al., 2007; Rahman & Wilson, 2003). Some individuals have no paedophilic interest in children but have committed sexual offences against them (Tenbergen et al., 2015). There are paedophilic men who have fantasies about children but do not act on them and those whose fantasies do not satisfy them and are at risk of committing an offence (Tenbergen et al., 2015).

When looking at paedophilic disorder as a paraphilia, Barker (2018, p. 70) states "that they are simply a reflection of our current social mores rather than any kind of objective scientific list of pathological sexual practices". She also notes that the DSM defines what is normal or functional sex. Barker (2018) points out problems with the meaning of "abnormal" and "normal/natural". Barker (2018) suggests paraphilias could be differentiated between socially transgressive ones and coercive ones (Barker, 2018, 85).

Münch et al. (2020) stated that the diagnosis of part of paedophilic disorder in the DSM-5 should be reformulated to be consistent with a medical model of a mental disorder, meaning it should only be applicable to individuals who are distressed or impaired by it so that they can get treatment within the health system. Their point holds true for the revised edition. They stated it should not be possible to make the diagnosis solely based on behaviour harmful to others and suggested adding a category "pedophilia with mental abnormality" for forensic purposes (Münch et al., 2020). This has implications for treatment possibilities discussed further in this chapter.

It can further be argued that care must be taken to distinguish between child abuse and paedophilia as these terms are often conflated, especially when taking into account the criteria set by the DSM-5-TR in that reference is made to individuals with sexual urges and behaviours towards children. However, the criteria do not state how this relates to child sexual abuse when considering individuals who do not fit the criteria for paedophilic disorder. Aina-Pelemo (2021) explained that there are various categories of paedophiles within an understanding of paedophilic disorder, for example, the category of "seductive or fixated" paedophiles, seemingly groom children through building relationships with them as well as using reinforcements such as buying these children toys and gifts to build their confidence in the relationship. On the other end of the spectrum, a "sadistic" category of paedophiles, sometimes referred to as "mysopeds", not only use elaborate means to build their relationships with children, but the intended end goal leads to mutilation of the child and, in some case murder. Taylor (2013, as cited in Adetutu, 2019, p. 136) outlines the most well-known types of paedophilic categories: 1) "The Fixed immature paedophile is uncomfortable in adult relationships but loves children" and believes that children are better able to understand them and believes "they have done nothing wrong" 2) "The Regressed Paedophiles … may have been in adult relationships, but their masculinity or femininity has been threatened, so they enter into relationships with children." They have the potential to be rehabilitated. 3) "The Exploitative Paedophile … seeks sexual acts with children and deems them as sexual objects". They are hard to rehabilitate. 4) "Aggressive and/or Sadistic Paedophile" actively pursues children for sexual and sadistic pleasure, is linked to possible antisocial behaviours, and is also hard to rehabilitate. 5) A hebephile is a category of paedophile attracted to pubescent (as opposed to pre-pubertal) children. These children are usually between 14 and 16 years old).

Fred (2014) highlighted that the previous DSM-5 criteria overlooked that not all people with paedophilic disorder have intense distress, specifically those who suffer from paedophilic disorder who can control their urges. So there would be less distress and intensity. However, given that the intensity of the response elicited is on a continuum, this would leave a gap in diagnosis and treatment, causing some misconceptions. The current DSM-5 TR (American Psychiatric Association, 2022) has included distress as part of the diagnostic criteria and, in so doing, indicates marked distress in relation to sexual fantasies and sexual urges as being sufficient to diagnose paedophilic disorder, in conjunction with meeting other criteria.

There is a lack of global and local research on females with paedophilic interests. It is this area that is now considered.

2.3.1 Females with Paedophilic Interests

Paedophiles are, in the main, male and heterosexual, as previously stated, with the rarer occurrence of female paedophiles. Still, because this area is overlooked, it is difficult to gauge its extent. More problematic is that this area is under-researched because the idea of the female paedophile is “so antithetical to her gendering that the female sexual offender attracted to children is not possible in the present” (Kramer & Bowman, 2011, p. 12). It is “the last taboo” (Koonin, 1995, p. 31). The social construction of women through their gender as a mother is nurturing, sexually dependent and passive. Collins-McKinnel (2013) also stated that the social construction of women contributes to the underreporting of female sexual abuse. Sexual violence perpetrated by females is often minimised and not understood well (Stemple et al., 2016). This is because of gender stereotypes viewing women as “nurturing, submissive helpmates to men” (Stemple et al., 2016, p. 2).

Female paedophiles are not an homogenous group. Although the literature is scarce on female paedophiles, Vandiver and Kercher (2004, as cited in Bartol & Bartol, 2017) developed a typology of female sex offenders. This is useful for mental health practitioners. The typology was developed from research on 471 registered adult female sexual offenders in Texas, USA. They identified six types: “1. Heterosexual nurturers 2. Noncriminal homosexual offenders 3. Female sexual predators 4. Young adult child exploiters 5. Homosexual criminals 6. Aggressive homosexual offenders” (Bartol & Bartol, 2017, p. 417). Heterosexual nurturers were in teacher/mentor roles. They failed to see that their relationship with the child was harmful. The teacher “lover/heterosexual nurturer typology describes female sexual offenders who sexually

abuse adolescent boys in the context of an acquaintance or position-of-trust relationship" (Simons, 2015, p. 2). Noncriminal homosexual offenders had similar traits to the first typology, with a sexual preference for females. The third typology, female sexual predators, selected male and female children (Bartol & Bartol, 2017, 417). Their sexual offending behaviour might be part of their broader criminal behaviour. The fourth typology, young adult child exploiters, often committed sexual assault against young male and female children. The fifth typology, aggressive homosexual offenders, had a detailed long history of antisocial behaviour and targeted young female children, with an average age of 11 (Bartol & Bartol, 2017, p. 417). It was noted by Bartol and Bartol (2017) that other researchers found that the gender of the victims was not as consistent as laid out in the typologies.

When looking at research on women paedophiles in South Africa, Papakyriakou (2017) mentioned that a review of the literature yielded minimal studies showing the prevalence of female paedophiles. Kramer and Bowman (2011, p. 5) conducted research involving four experts "in the field of child sexual abuse in South Africa". The study revealed resistance to the idea of female paedophilia, given the social construction of women. Kramer's (2014) doctoral thesis involving child sexual abuse victims by females was groundbreaking because it shifted the focus from males, particularly given the social construction of gender examined in the 2011 study conducted with Bowman. One of the findings in her thesis was that the female participants took no responsibility for their actions despite being incarcerated (Kramer, 2014).

A national school study of a sample of 269,705 learners by Andersson and Ho-Foster (2008) in South Africa found that roughly 9% of males between 11 and 19 years old reported being sexually abused in the past 12 months. Furthermore, 41% of the respondents said they were abused by females, compared to 32% who reported that males had committed sexual acts against them. However, this study is on sexual abuse and not on paedophilia in females, so one cannot make claims based on this that female paedophilia is increasing in South Africa. A meta-analysis by Cortoni et al. (2017), which involved 17 samples from 12 international countries, discovered that females perpetrated a minor portion of sexual offences reported to legal authorities. Again, this is the broad area of sexual offences and not paedophilia. However, they noted, "victimization surveys indicated prevalence rates of female sexual offenders that were six times higher than official data" (Cortoni et al., 2017, p. 145). Therefore,

concerning prevalence, the reports made to the police are underestimated and underreported. This suggests a predisposition to downplay the seriousness of sex crimes carried out by females (Bader et al., 2010). According to McLeod et al. (2015), sexual offences by females are underreported, poorly understood, and not recognised by mental health professionals. Whilst this might be true, care must be exercised that females committing sexual offences are not categorised as paedophiles. Further research is needed within this population.

According to Levenson et al. (2015), female sex offenders were three times more likely to have experienced sexual abuse. In a review of female sex offenders, Tsopelas et al. (2011) found high rates of physical, emotional and sexual abuse incidences in their lives. Within this population, most females had further experienced maltreatment as a child and often revealed having a delinquent intimate partner (Wijkman et al., 2010). It was noted by Hislop (2013, para 8), “laws protecting individuals from sex crimes have not historically considered female offenders”. The focus is typically on men. Furthermore, studies on female sexual offenders explore the effects of it as being different from male sexual offenders, going as far as to say it causes less harm to the child (Kramer & Bowman, 2011). It is difficult to gauge the extent of female paedophilia as the studies above have examined females harming children and female sexual offenders but not specifically females with paedophilic tendencies.

The lack of research on female paedophilia results in society and mental health professionals holding misconceptions about what it is and how it should be addressed. Not understanding female paedophilia can perpetuate a “culture of denial”. Denying the issue prevents both female paedophiles and females with paedophilic tendencies from seeking help. It also hampers mental health professionals from responding appropriately to victims.

Having defined paedophilia and considered the DSM-5-TR definition, comorbidities are examined as individuals with paedophilic disorder and paedophilic ideation tend to experience other disorders.

2.3.2 Comorbidities

Paedophilia does not necessarily occur in isolation (Tenbergen et al., 2015). Comorbidity is a term used to describe two or more disorders or conditions occurring in the same person during the same period (National Institute of Drug Abuse, 2011). A link between paedophilia and comorbid disorders has been identified, with many

reporting a history of depression, anxiety, or substance abuse (Fagan et al., 2002; Garcia & Thibaut, 2011). This is substantiated by Cassiani-Miranda et al. (2019) and Hall and Hall (2009), who stated that paedophiles also experienced other psychiatric disorders such as affective illness, anxiety disorder, personality disorder and addictive disorders. The DSM-5-TR (American Psychiatric Association, 2022) indicates various comorbidities with paedophilic disorder, primarily for males who have been convicted of sexual offences. These comorbidities include "substance use disorders; depressive, bipolar, and anxiety disorders; antisocial personality disorder …" (American Psychiatric Association, 2022, p. 1492). Prior to this, Cohen and Galynker (2002) looked at impulse control and antisocial personality disorder. They stated that more research is needed on links to abuse in childhood and frontal and temporal lobe conditions that could cause paedophilia. Gerwinn et al. (2015) found that harmful childhood experiences were prevalent in individuals with paedophilic disorder.

A dated study cited – as current ones are scarce – was conducted by Raymond et al. (1999) on the prevalence of comorbidities and paedophilia in a group of paedophile sexual offenders. They found that most participants in their study presented with comorbidities of mood disorders (depression, anxiety, social phobia) and substance abuse (alcohol, cannabis, cocaine). These findings could be useful for treatment protocols. Adiele et al. (2011), wanting to understand the mental health needs of incarcerated paedophiles, conducted a study finding that prevalent comorbidities were alcohol abuse, mood disorders and generalised anxiety disorders. The comorbidities cited indicate that individuals with paedophilic disorder and paedophilic ideation are not a homogenous group. This may offer insight into management and treatment goals from a psychotherapeutic perspective. However, in addition to defining paedophilic disorder and paedophilic ideation, the causes of it are provided as this enhances understanding and speaks to how best to manage and treat the disorder and ideation.

2.4 Aetiology of Paedophilia

Before understanding the management and treatment of paedophilia as a disorder and ideation, different perspectives on the causes of paedophilia are provided, from neurological to social factors.

2.4.1 Neurological Causes

According to Jahnke (2015, p. 22), "relatively little is known about the neurobiology of pedophilia compared to other disorders". Biological factors have been

associated with paedophilia, such as changes in brain structure and function (Mohnke et al., 2014). The links to any neurobiological basis for paedophilic disorder are debatable.

2.4.1.1 Anatomy of the Brain

According to Cantor et al. (2008), evidence that points to a neurodevelopmental basis for paedophilia (and hebephilia) is not conclusive. Cantor et al. (2008) conducted a study using magnetic resonance imaging (MRI) to identify which brain regions differentiate paedophilic from non-paedophilic men and found no significant differences. However, research by Fonteille et al. (2012) found that brain lesions (often in frontal or temporal regions) resulted in a change in sexual behaviour, including the late appearance in adults of a sexual attraction to pre-pubescent children. Mohnke et al. (2014) reviewed the growing literature on changes in the brain structure of paedophilic men. They did find case studies that showed abnormalities in the brain in the frontal and temporal lobes that may be associated with impaired impulse inhibition. However, they pointed out that because the findings are so varied and there were methodological issues with some of the studies, more research is necessary to unravel the neurobiological mechanisms of paedophilic preference.

Gerwinn et al. (2015, p. 246) pointed out that four studies used MRI to “test for differences in brain structure between paedophilic (i.e. sexually attracted to pre-pubescent children) and teleiophilic (i.e. sexually attracted to adults) men” with conflicting results. They then re-examined this issue with a sample of 24 paedophilic and 32 teleiophilic men and did not find any significant grey or white matter differences. In terms of brain function, a study using neuroimaging techniques investigated the mechanisms of sexual attraction to children with a sample of 25 male outpatients with paedophilic disorder and a control group of 24 males, but the findings were contradictory and could not be replicated (Cazala et al., 2019). In addition, Schiffer et al. (2017) stated that six structural MRI studies had been published on the anatomical features of grey matter in paedophilia with inconclusive results. Given these unsatisfying results, they designed a study to distinguish between structural brain irregularities associated with paedophilia from those related to sexual offending in paedophiles (Schiffer et al. 2017). They believed their study to be the first to differentiate brain structural anomalies in paedophiles with and without a history of offending. The study substantiates the idea that child sexual offending in paedophilia

rather than paedophilia alone is associated with changes in the grey matter, predominantly in the right temporal pole (Schiffer et al., 2017).

Further, it has been claimed that neuroimaging studies have shown that paedophilia is associated with reduced grey and white matter in brain regions involved in sexual areas that regulate impulse inhibition and reward (Scarpazza et al., 2021). However, there is considerable variation in the results of studies on neuroimaging, and the results remain inconclusive. Thus, Scarpazza et al. (2021) set out to determine how brain alterations may be related to distinct psychopathological features in paedophilia. They found that atypical brain activity is related to paedophilia in cases where the disorder develops through individual life circumstances but not related to idiopathic paedophilia (when the cause is unknown). Based on the aforementioned, studies that show differences in the brain structure and function of paedophiles are inconclusive. This is because there seem to be limitations in neuroimaging techniques concerning small sample sizes, methodological problems, and wide sampling variances regarding sole populations. Limitations also arise due to the focus on sexual offenders, individuals who self-identify as paedophiles, and individuals with histories of sexual offences against children.

2.4.2 Social Factors

Nunes et al. (2013) and Yunus et al. (2018) stated that children who are sexually abused might develop paedophilic disorder. This is often referred to as the cycle of abuse theory. It is contested as a dangerous ideology that prevents those who have been abused from disclosing, fearing the stigma that they will be viewed as potentially harmful to children. Therefore, care must be taken to distinguish between child abuse and paedophilia when reviewing research regarding the cycle of abuse theory. For example, Kütük et al. (2017) stated that previous studies indicated that about one-third of children subjected to abuse might become abusers in the future. Similarly, Lambie and Miller (2015) stated that there is evidence to show that the prevalence of childhood sexual abuse is higher among sexual offenders than non-sexual offenders.

However, the introduction of polygraphs in the 1980s, instead of relying on self-report measures, revealed that sex offenders had inflated their claims of being abused as children (Hindman & Peters, 2001). Leach et al. (2016) found no link between childhood sexual abuse and sexual offending. Conversely, Pham et al.’s (2022) study, which considered the hypothesis that childhood sexual victimisation might lead to the

development of paedophilic interest and, in turn, lead to sexual offending against children, found that those who had experienced sexual abuse/violence before the age of 12 or 13 were more inclined to paedophilic disorder. Moreover, Pham et al. (2022) stated that their findings corresponded to those of other researchers, such as Nunes et al. (2013) and Seto (2018). However, despite their study being limited and based on self-report as opposed to official documentation, their results and research from others did suggest that child sexual abuse/violence may be linked to greater sexual interest in children (Pham et al., 2022). Thus, according to Pham et al. (2022), recent research is inclining towards the latter view. However, overall, it seems mistaken to suspect a definitive correlation as findings have been inconclusive. Studies retained small sample sizes and often included methodological limitations.

The cycle of abuse theory considers that individuals who have been sexually abused as children might develop paedophilic interests. Therefore, an element of sexual abuse to be considered is grooming, a process that occurs within a child's social environment over a long period of time.

2.4.2.1 Paedophilia and Grooming

Sexual grooming is not well understood, with the problem in the definitions of this phenomenon. According to Gillespie (2002, p. 411), grooming is "the process by which a child is befriended by a would-be abuser in an attempt to gain the child's confidence and trust, enabling them to get the child to acquiesce to abusive activity". It is important to understand how grooming facilitates sexual offences against children regarding managing potential offenders' motivation before the offence occurs. To this end, one distinguishes between self-grooming, grooming the environment and significant others, and grooming the child (Craven et al., 2006). Self-grooming is the process of justifying or denying the offending behaviour and plays a part in moving from motivation to targeting to sexually abusing the child (van Dam, 2001). Grooming the environment starts with finding a vulnerable child (van Dam, 2001), and grooming the significant others is the integration process with family members or teachers. Grooming the child involves physical and psychological elements, slowly sexualising the relationship, telling the child different narratives, e.g. to keep their interactions a secret, or it is their fault and so on, all dependent on the individual child and situation. Lawson (2003) substantiated this, stating grooming was a process of isolating children from their family and friends and slowly sexualising the relationship, justifying to themselves that it is based on love and common interests. This allowed them to deny

the power inequality between the adults and the children they targeted. “Power and control is one of the tools” used by adults grooming children (Randhawa & Jacobs, 2013, p. 21). In addition, it must be noted that this process occurs over a long period. Randhawa and Jacobs (2013) stated that “committed paedophiles” build relationships with families to access a child or even two or three children in the same family over the years.

Craven et al. (2006, p. 297) proposed a definition of grooming that shows its complexity: “A process by which a person prepares a child, significant adults and the environment for the abuse of this child. Specific goals include gaining access to the child, gaining the child’s compliance, and maintaining the child’s secrecy to avoid disclosure”.

This process strengthens the offender’s abusive pattern, as it may be used to justify or deny their actions. Hall and Hall (2009, p. 526) pointed out that paedophiles minimise their actions by saying they had “educational value”, that the child “derived pleasure”, or “was provocative and encouraged the acts in some way”. Further justification is that they are teaching children about their perceived “facts of life” or “love” (Wings of Love, 2023, para 8).

Distinguishing between sexually motivated grooming behaviours and “normal” child-adult interaction is difficult when most people do not know what grooming strategies are used by individuals who sexually abuse children (Winters & Jeglic, 2017). These authors point to one study exploring people’s ability to recognise sexual grooming behaviours in which participants were most likely only to recognise behaviour as unsuitable if it involved physical touching and isolation (Winters & Jeglic, 2017). Their study also found that people cannot identify sexual grooming behaviour, both blatant (gaining access to the child, desensitising the child to touch) and hidden (choosing a vulnerable child and gaining their trust).

The next part of the literature review discusses the law in South Africa regarding paedophilia as this pertains to the protection of children and issues of reporting in psychotherapy when dealing with individuals with paedophilic interests.

2.5 Paedophilia and the Law in South Africa

In 1994, South Africa established a “legal framework that defines a wide spectrum of abuse and obliges the government to establish a child protection system that provides services to manage abuse and maltreatment” (Jamieson et al., 2017, p. 8). This legal framework is briefly explained by Jamieson et al. (2017, p. 8); first, the

Children's Amendment Act 41 of 2007 (see part 2) provides "for social services to children" and establishes a surveillance system – the National Child Protection Register (NCPR), second, "the Criminal Law (Sexual Offences and Related Matters) Amendment Act" 1632 Of 2007 "deals with sexual offences against children", and third, "The National Instruction on Sexual Offences17 guides South African Police Service (SAPS) officials on services available to victims".

Sexual Offences and Related Matters Amendment (SORMA) Act 32 of 2007, with Sections 15 and 16 relevant to paedophilia, became effective on 16 December 2007. A unique characteristic of SORMA was how it elaborated on sexual offences against children. Sexual penetration of a child is statutory rape. In addition, SORMA detailed sexual penetration, including by objects in any part of the body, even if the child consented (Carstens & Stevens, 2016). In terms of Section 16, a person who commits an act of sexual violation with a child is, despite the child's consent, guilty of the offence of having committed an act of consensual sexual violation with a child. In light of the grooming discussed in the previous section, note that Section 18 of SORMA, Act 32 of 2007, provides for the criminalisation of the sexual grooming of children (Carstens & Stevens, 2016).

If convicted, offenders are placed on a register called the National Register for Sexual Offenders (NRSO), which was established in 2007. It is a register of names of people found guilty of sexual offences against children and mentally disabled people (Republic of South Africa, 2022). Only specific people may apply for information, such as those applying to foster care or who work with children (Department of Justice and Constitutional Development, 2022) and aims to increase social controls over "sexual deviants" (Mollema, 2015).

Section 54 of the SORMA requires "'[a] person' who knows or who has a 'reasonable belief or suspicion' of any form of sexual abuse against a child or mentally challenged individual to report it to a police official" (Hendricks, 2014, p. 4). More detail on who must report is contained in Section 110 of the Children's Amendment Act 41 of 2007 (amended in 2021), including medical practitioners and psychologists (Republic of South Africa, 2020; Republic of South Africa, 2007a). In addition, the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 makes it mandatory that all citizens report sexual abuse of children to the police. This is clear in Chapter 7 under General Provisions: "A person who has knowledge that a sexual offence has been committed against a child must report such knowledge

immediately to a police official" (Republic of South Africa, 2007b, p. 40). Failure to do so is a criminal offence. If a child tells an adult of sexual abuse, such as a teacher, they may seek Childline's assistance and report it to the police (Bhana et al., 2010).

In South African criminal law, paedophilia is acknowledged as a form of sexual deviance that presents unnatural sexual behaviour and is therefore criminalised (Carstens & Stevens, 2016; Le Roux & Mureriwa, 2004). Although paedophilia is criminalised, one needs to understand what criminal capacity means to know how it is applied. To be found guilty of breaking the law in South Africa, a person must have criminal responsibility and the mental ability to know their action is wrong. Section 78 of the Criminal Procedure Act deals directly with the criminal capacity of the accused. Suppose a claim is made of a lack of criminal responsibility. In that case, the court refers the individual to a psychiatrist or a panel of psychiatrists and a clinical psychologist for evaluation, as dealt with in Section 77(1) and 78(1) of the Criminal Procedure Act. The accused is usually admitted to a state psychiatric hospital for observation for 30 days (Swanepoel, 2015). It is important to emphasise that the court, not the psychiatrists, makes the final decision (Snyman, 2002).

The DCS has national guidelines for the treatment of sexual offenders, but this does not specify individuals with paedophilic disorder. All individuals with paedophilic disorder convicted of a sexual offence are categorised in a correctional setting as sexual offenders. The DCS guidelines are noted because they pertain to rehabilitation and parole conditions. The South African Correctional Services Act No. 111 of 1998, amended in 2015, stated that the DCS must provide rehabilitation programmes and activities (Republic of South Africa, 2015a). Part of this is attending the Sexual Offender Treatment Programme (SOTP), which is necessary to qualify for parole (Republic of South Africa, 2016). Attendance of the SOTP is part of the broad rehabilitation agenda of the DCS. Several correctional centres have a programme called Preparatory Sexual Offences, which aims to address "sexual offending behaviour through the acquisition of the relevant knowledge and skills" (United Nations Office on Drugs and Crime [UNODC], 2022, p. 8). The DCS is committed to providing psychological services to offenders in line with the new goals established in the White Paper on Corrections aligned "to developing and sustaining a correction-focused correctional system" (Republic of South Africa, 2015b, p. 4) with a focus on rehabilitation and reintegration of a productive member into the community. Participation in the various programmes is stated as being voluntary. However, those

who do not attend will not qualify for parole. It must also be noted that these rehabilitation programmes have not been a success due to overcrowding, a lack of resources, and a lack of psychologists, and the programmes are not geared towards specific sexual offences or sexual interests (Murhula & Singh, 2019). The DCS pointed out that the number of psychologists it employs cannot see to the mental health of its inmate population (Mills, 2019). Thus, there is a gap between what the law sets out and what is taking place in correctional settings. It is hypothesised that paedophilia should be considered a sexual orientation, having examined the law. This hypothesis is discussed because the consideration of paedophilia as a sexual orientation shifts paedophilia from its classification as a psychiatric disorder. It would shift to becoming the core of one's identity pertaining to sexual orientation and thereby having associations with human and constitutional rights. In essence, this would have legal and ethical implications pertaining to consent and the acceptance of sexual violation of minors.The notion of paedophilia as a sexual orientation is contentious, particularly as in South Africa, sexual orientation has rights forbidding discrimination based on sex, gender or sexual orientation.

2.6 Paedophilia and Sexual Orientation

Some scholars, as will be discussed, have suggested that paedophilia as a sexual orientation will not only change the way paedophilia is viewed, reducing stigma, but has implications for prevention and treatment. This is debatable and contentious and would require a significant theoretical shift for clinicians. To regard paedophilia as a sexual orientation is contentious because the term holds a certain weight concerning recognition and rights accorded by the state. These rights have legal and policy implications in society.

As noted, the argument put forward to view paedophilia as a sexual orientation only has limited scholarship support. Seto (2012) stated that determining if paedophilia in men is a sexual orientation regarding age has implications for research and treatment. He also stated that paedophilia in women seemed rare, and when it occurred, it manifested differently (Seto, 2012). He argued that sexual orientation is characterised by the age of onset before the beginning of puberty and by stability over time and that paedophilia is similar in these respects (Seto, 2012). He stated that the time of the age of onset means that treatment to decrease sexual attraction to children does not work. Seto et al. (2017) further explained that in the same way that homosexuality can be defined as a sexual orientation for gender, paedophilia could be

defined as a sexual orientation for age. This is disingenuous, as one cannot equate the categories of age and gender. Baker (2021) stated that viewing paedophilia as a sexual orientation was positive and overcame political and social concerns, but her article is a review of Seto's argument and does not put forward any new evidence.

The argument to support paedophilia being a sexual orientation rests on it as unchangeable. However, this is problematic. Tozdan and Briken (2017) stated that to argue that paedophilia is unchangeable is scientifically premature, and second, it means it is less open to change. Furthermore, one needs to consider the message of acceptance stemming from paedophilia as a sexual orientation. If society and the individual accept their paedophilic attraction as a sexual orientation, then one could ponder on what basis they would seek treatment.

Grundmann et al. (2016) stated that measures of the changeability and stability of paedophilia supported the idea of paedophilia as an "element" of sexual orientation. But they provided little evidence to back this up. Fedoroff (2020, p. 11) examined paedophilia as a sexual orientation where sexual orientation is defined as "attraction to members of the same sex, both sexes or the other sex". The authors in favour of paedophilia as a sexual orientation acknowledged hormones, genes, environment and non-social influences to determine orientation, stating that "behavior, attraction, identity and arousal … tend to go together," but "not always" (Fedoroff, 2020, p. 11). The authors stated that this broad definition of sexual orientation supports the idea that paedophilia can be viewed as a sexual orientation. However, Fedoroff (2020) pointed out the problems with this idea, as paedophilia is defined based on an individual's sexual attraction to children, and sexual orientation is defined on gender attraction. It is problematic to conflate the two attractions as it does not account for the pathology of attraction to children, which is sexual, as the individual is sexually aroused by children. Fedoroff (2020) stated paedophilia should not be classified as a sexual orientation as paedophilic interest can change over time. Although some believe that emotional attraction ("strong feelings of affection …or love") toward children is different from physical attraction to them, the two constructs are generally thought to be key elements of paedophilia (Fedoroff, 2020). Research has consistently found that emotional congruence with children and paedophilic sexual interest are strongly correlated (Fedoroff, 2020).

Mundy's (2022) study examined self-identified pedohebephilic attractions to assess whether the sample characteristics followed Seto's (2012) conceptual outline

of paedophilia as an orientation to sexual maturity, finding overlapping patterns with relation to the age of onset, expressions of both sexual and romantic attractions, and stability of such attraction over time. Despite resistance to this understanding of paedophilia, Mundy's (2022) findings indicated that orientation to sexual maturity reflects the developmental path of gender sexual orientation, as outlined in Seto's seminal paper.

There are implications of looking at it as a sexual orientation for treatment/prevention. Some therapists argued that viewing paedophilia as a sexual orientation, that "acceptance" (Lampalzer et al., 2021) of paedophilic interest assists in the prevention of sexual offending against children and assists in dealing with individuals with a sexual interest in children in a responsible way. The therapist's attitude towards paedophilia and their acceptance of individuals sexually attracted to minors are crucial to an effective therapeutic process. Studies have been conducted on the relationship between therapists' attitudes to the immutability of individuals with an attraction to minors and their ability to change that attraction. It has been found that if the therapist believes the attraction can be changed, so does the individual. However, studies have not shown conclusive correlations. It has also been debated if therapists should tell individuals that their attraction is immutable (or not) or if this can only be addressed in therapy as part of the process (Lampalzer et al., 2021).

An important area to examine concerning paedophilic disorder and ideation is stigma, as this ranges from broad social stigma, such as in the media, to self-stigma in the individual and the stigma associated with mental health care workers who treat individuals with paedophilic attractions.

2.7 Stigmatisation

Society has constructed ideologies and taboos around the general concept of paedophilia. These ideologies and taboos affect those with paedophilic disorder and paedophilic ideation and the healthcare workers and programmes which treat these individuals. In both instances, there are negative associations to either being a paedophile or to those working with paedophiles.

2.7.1 Stigmatisation of Paedophilic Disorder

The issue of stigmatising paedophiles by society is addressed, as stigmatisation prevents individuals who suffer from paedophilic disorder or paedophilic ideation from seeking treatment. While all psychiatric disorders are important to treat, paedophilic disorder and paedophilic ideation are perceived negatively by society,

often leaving individuals in a position of fearing treatment, let alone disclosing their feelings, due to societal stigma (Hanson, 2018). If individuals do not seek help, it negatively impacts their mental health, increasing their risk of suicidal thoughts. Paedophiles may self-stigmatise with negative consequences on their well-being as they fear their identity being discovered.

Stigmatisation against paedophiles emerges from the common misconception that paedophilic disorder or paedophilic ideation is the same as child abuse or sexual offending against children, as dealt with earlier in this chapter. Harper et al. (2022) argued that paedophiles are seen as predatory child sexual offenders. In the study by Jahnke et al. (2015) conducted in Germany, many survey respondents agreed that those with paedophilic interests should be “dead”. Furthermore, 39% of the German participants felt that a paedophile should be imprisoned regardless of whether they had committed a criminal act by acting on their impulses or not. This study also found that stigmatisation hinders paedophiles from getting emotional support. It also found that lack of support has a ripple effect in that paedophiles are more likely to act on impulses and abuse a child due to guilt and internalised stigma, among other factors (Jahnke et al., 2015).

Media coverage of paedophilia is often informed by extreme cases of child sexual abuse, reinforcing the stigmatising belief that individuals with paedophilia are “predatory child sexual offenders” and that “every child sexual offender has paedophilic interests” (Stelzmann et al., 2020). According to Hatzenbuehler (2009), the media play a vital role in stigmatising paedophilia through their incorrect use of terminology toward child sexual abusers and child sexual offenders. The media’s use of inflammatory and dehumanising words when reporting on those convicted of sexual crimes (e.g. “beast”, “monster”, and “fiend”) (Harper et al., 2022) coupled with conflating all sexual offenders as paedophiles are part of the stigmatisation. As the media plays a role in influencing people’s attitudes, it could play a role in educating people if it is reported more accurately on paedophilic disorder. To destigmatise paedophilia and benefit the prevention of child sexual abuse, Stelzmann et al. (2020) developed a fact box for journalists based on health experts’ knowledge. Based on an extensive literature review, Jahnke and Hoyer (2015) and Jahnke et al. (2015) argued that research around stigma research has blind spots regarding paedophilia. They further stated that findings indicate paedophilia to be amongst the most stigmatised characteristics of human behaviour.

Furthermore, individuals convicted of sexual offences, which would include paedophiles, are subject to stigmatisation "perceived as monsters – neither respected, tolerated, nor accepted in society" (Ricciardelli & Mackenzie, 2013, p. 354). These authors stated that a hierarchy exists among offenders in correctional settings, with rapists slightly above paedophiles. Sexual offenders are often isolated from the general population for protection from harassment and violence. Trammell and Chenault (2009) studied inmates' reasons for assaulting men who had sexually harmed children. They found that inmates justified it as preventative, raised their status in prisons, and distanced themselves from these offenders and their behaviours.

2.7.2 Self-Stigma

Self-stigma occurs when individuals with paedophilic disorder or paedophilic ideation internalise social stigma. Self-stigma is the internalisation of negative social attitudes and stereotypes (Lievesley et al., 2020). Self-stigma impacts an individual's well-being negatively and harms their self-esteem. According to Lievesley et al. (2020), self-stigma also causes people with paedophilic disorder or paedophilic ideation to isolate themselves, which is a risk factor in sexual offending.

In addition, self-stigma impacts whether individuals with paedophilic disorder or paedophilic ideation will look for treatment, fearing the responses of the therapists and the likelihood of being rejected or further stigmatised in a context that should be supportive and therapeutic. However, the fear is that they will be further judged negatively and receive inadequate treatment or understanding of their disorder. Many individuals with paedophilic sexual interests may be unwilling to access treatment because of doubts over whether the professionals offering these services will be non-judgemental and offer a safe therapeutic space for them to receive treatment (B4U-ACT, 2011; B4U-ACT, 2022; Cracknell, 2021; Levenson & Grady, 2019; Piché et al., 2018). Individuals who have used mental health services have been reported to be more distressed. Lawrence and Willis (2021, p. 10) reported that the participants emphasised being "judged, rejected, or ignored, resulting in hopelessness, shame, and feeling unworthy of treatment". Schmidt and Niehaus (2022) provide an overview of the stigmatisation of mental health care providers of paedophiles they defined as minor-attracted persons. Their study was conducted on the stigma held by psychotherapists working voluntarily in an outpatient setting in Switzerland. Schmidt and Niehaus (2022) found high rates of stigma, punitive attitudes and a lack of knowledge in the field. In addition, the findings showed that although therapists

believed in the efficacy of treatment, they revealed an unwillingness to treat individuals who had harmed children, with more willingness to treat those who had not harmed children.

2.7.3 Stigma Experienced by Psychologists

This section discusses the stigma and consequences on psychologists and professionals who engage with individuals with paedophilic disorder and ideation. It also raises some possible coping mechanisms to cope with harmful effects. However, most of the research examined the stigma of working with sexual offenders who may or may not have paedophilic tendencies.

Some therapists may decline such clients in order to prevent judgement from others in the mental health field. Some insight into psychologists' experiences is given in several studies on working with sexual offenders in general and not with paedophilia specifically (see Bach & Demuth, 2018; Kadambi & Truscott, 2003). For example, Scheela's (2001, p. 757) study suggested that sex offender therapists who expressed ideas against leading, negative attitudes, or "advocated for offender treatment and the capacity to change … were seen as the enemy, too; people adopted a 'kill the messenger' mentality". Roche and Stephens (2022) examined the willingness to treat individuals with a sexual interest in children, focusing on stigma and the therapist's competency. They found that the more competent the psychotherapist, the less stigma they held against individuals with a sexual interest in children. Roche and Stephens (2022) found that mental health professionals who stigmatised individuals with a sexual interest in children had a higher probability of reporting them if they expressed this interest in therapy.

According to Bach and Demuth (2018), some therapists who choose to engage with sexual offenders might be hesitant to talk about their work, fearing adverse reactions from friends and colleagues. Elias and Haj-Yahia (2016, p. 2) stated that these therapists might feel "loneliness" in their work, making them feel they have to say sorry to colleagues, friends and family for their work choices. Elias and Jay-Yahia (2016) conducted a study on therapists working with sexual offenders and the impact it had on their lives. They found this work harmed their intimate relationships, including parenting, as they had anxiety about their children's safety.

Several coping mechanisms were identified, with support from one's peers being significant. Having backup from colleagues helped sex offender therapists cope (Clarke & Roger, 2002; Ennis & Horne, 2003). In addition to peer support and

supervision plus debriefing, self-reflection and self-care are important aspects for psychologists and all professionals engaging with individuals who sexually offend (Evans et al., 2019). This lends insight into what is needed for psychologists who manage and treat clients with paedophilic disorder and ideation. Another coping mechanism identified in a study by Elias and Haj-Yahia (2016) was gaining knowledge of their work area. Finally, it was highly beneficial to engage in personal therapy (Kadambi & Truscott, 2003).

Therapists are hesitant to work with individuals with paedophilic disorder and paedophilic ideation, and it is not just through lack of knowledge or their personal attitudes concerning these types of clients but the negative attitudes from the larger society, their community of friends and family who might think they sanctioned paedophilic behaviour. However, Scheela (2001) found positive aspects in this line of work, such as the challenges the work presented, knowing the community was being helped and seeing their clients' growth. These positive aspects were substantiated by Bach and Demuth (2018), who found that many therapists who worked with this client population experienced satisfaction with their work and in helping society.

Having discussed the stigmatisation of individuals with paedophilic disorder and paedophilic ideation, the stigma they experience and that experienced by mental health professionals, such as psychologists engaged in management and treatment, the following section presents the theoretical framework drawn on in the study.

2.8 Therapeutic Approaches and Theoretical Models for Treatment of Paedophilic Disorder and Paedophilic Ideation

Several theoretical approaches and models that psychologists use are briefly considered as these assist in predicting, evaluating, and improving therapy outcomes.

The evidence-based approach is defined by the American Psychological Association, 2008, para 1) as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences". It is beyond the scope of this mini-dissertation to address all interventions that fall within the approach. However, two evidence-based approaches will be briefly presented: cognitive behavioural therapy (CBT) and solution-focused brief therapy (SFBT).

Cognitive behavioural therapy (CBT) is a structured approach that explores the links between thoughts, emotions and behaviour. It involves efforts to change thinking and behavioural patterns emphasising helping individuals learn to be their own therapists (American Psychological Association, 2017). This approach is based on the

cognitive model that distorted and dysfunctional thinking is a common symptom of all psychological problems, and these distorted thoughts influence a person's moods and behaviours (Moster et al., 2008). A person's thoughts, attitudes, and beliefs determine their emotional experience and behaviour. Therefore, if someone wants to change how they behave or experience and expresses emotion, they must study and change their thoughts and beliefs (Moster et al., 2008). A highly collaborative relationship is established in therapy to help clients define their problems and gain skills to manage them (Wright, 2006). This approach aims to lessen "distress by helping patients to develop more adaptive cognitions and behaviours" (Fenn & Byrne, 2013, p. 579.)

Solution-focused brief therapy (SFBT) is a short-term, goal-focused evidence-based therapeutic approach. The premise of this approach is that understanding the problem does not always lead to a solution, and the focus is on solution-building. The approach is that the client is the expert on their life and the psychologist the expert on asking questions to guide the client; thus, realistic goals are set that are "specific, actionable, and measurable" and "make the solution image clearer" (Takagi et al., 2022, p. 2). This approach is a general one to help clients achieve their goals. It is not a specific therapy for a specific disorder. It was developed to construct a quick intervention and provide simple solutions, which is an advantage to disadvantaged populations (Beyebach et al., 2021).

The biopsychosocial model is seen as a guiding psychological framework that considers an individual's various systemic contexts in therapy. Namely, the impact of their biology is their physiology, psychological ideologies, and cognitive makeup, as well as their relationships and interpersonal system. This approach sees an integration into these various elements of an individual to gain a holistic understanding of them (Suls & Rothman, 2004). The focus is on the whole person, changing their behaviour and beliefs, developing coping strategies, and teaching the client to take responsibility for their actions. In this model, the client is responsible for their illness and health (Taukeni, 2019). Furthermore, the challenging behaviour is seen as a symptom of other conditions. This shifts the focus from the behaviour to the conditions that produce the behavioural symptom (Griffiths & Gardner, 2002).

Psychoanalytic theory draws on the theories of psychodynamics with a focus on the internal drives of a client and the unconscious structures that affect their behaviours. Frosh (2012) points out that there are many ways of doing psychoanalysis and many theories within it, but there is agreement on exploring the workings of the

unconscious. In therapy, the focus is on the client's unconscious, and the client-therapist relationship is key. The talk sessions include dream analysis as one element of various techniques drawn on to understand, conceptualise, and treat an individual in therapy. The goal is to assist the client in finding patterns in their thoughts and emotions to gain insight into who they are. It draws on the well-known work of Sigmund Freud (Frosh, 2012).

Positive psychology looks to assisting individuals in a therapeutic context, which finds its roots in understanding how different psychiatric disorders impact the optimal functioning of an individual but also how this impacts various groups and institutions. Positive psychology aims to understand what is "right with people" (Gable & Haidt, 2005, p. 105), their strengths and virtues because a better understanding of a person's strengths and environment can be a defence against illness or stress. Positive psychology moves beyond suffering and how to ease it to happiness in three areas: pleasure, engagement and meaning (Duckworth et al., 2005).

Eclectic approaches draw from a range of techniques to address the individual's distinctive needs, allowing an individualised, flexible approach where the individual may feel more involved in the therapeutic process. Behan (2022) states that there are more than 400 different psychotherapy models, each with a discrete conceptualisation and treatment of mental illnesses. Furthermore, no single model has emerged as the best. More and more psychologists prefer not to identify themselves entirely within a single approach, instead defining themselves as eclectic (Zarbo et al., 2021). An advantage of this approach is that it allows the therapist to maintain an open mind, reflecting on all the information the client presents, encouraging a holistic view of the client (Larsen, 1999). It is noted by Behan (2022) that most psychotherapists began from a more traditional orientation before evolving into eclecticism.

2.9 Therapists Working with Paedophilia

A study by Stiels-Glenn (2010) conducted in Germany among psychotherapists found that 95% were disinclined to treat paedophiles because they held negative attitudes and hostile feelings and attitudes towards them. Some psychologists have negative attitudes toward people with paedophilic tendencies, usually producing feelings of revulsion, concerns about if they could be helped, and worries about liability regarding reporting, as it is mandatory by law to report harm or suspicions of harm toward children (Stelzmann et al., 2020). Attitudes held by therapists could also be explained by their lack of knowledge or experience with individuals who suffer from

paedophilic disorder. Research demonstrated that many healthcare practitioners lacked knowledge of paedophilic disorder and paedophilic ideation (Levenson & Grady, 2019; Serigstad, 2016).

The study by Serigstad (2016) on nine health providers in Central Norway examined the providers' emotions, thoughts, and actions towards people with paedophilia. They reported that healthcare providers had limited experience with individuals with paedophilia and lacked expertise in this regard. Further, the healthcare workers were surprised by the estimated prevalence of paedophilia. A few healthcare providers experienced the treatment of individuals with paedophilia as unproblematic. However, other healthcare providers experienced talking about paedophilia as eliciting negative feelings. Results suggested that treating individuals with paedophilic problematic areas included communication, the patient-healthcare provider relationship, and the responsibility of assessing dangerous behaviours. Most participants in the study felt unsure about the aetiology of paedophilia, and their ideologies differed as to what treatments could be offered to people with paedophilia in the healthcare system. The findings of this study suggest that healthcare professionals require more training regarding communication around areas of patient-healthprovider relationships concerning paedophilia. There is a lack of consensus among experts and mental health providers regarding the aetiology and definition of paedophilia. While healthcare providers expressed willingness to accept individuals with paedophilia for treatment, they lacked consensus on the possible achievements within a therapeutic setting (Serigstad, 2016).

Part of treatment and education around this is the ethics of informed consent. When initiating therapy for individuals who become their clients, psychologists have an ethical duty to obtain informed consent from them. Part of this informed consent is confidentiality, and a critical understanding is that only identifiable acts are to be reported, not ideation. This leaves a grey area for clinicians who treat paedophilic disorder and paedophilic ideation and who worry they may be breaking the law and the guidelines of their profession (Levenson & Grady, 2019). The therapist must explain the limits of confidentiality as there is an obligation to protect the individual (their client) and others in society if a threat of harm to themselves or others arises; for example, the therapist is legally obliged to report suspected child abuse (Hendricks, 2014; Saleh & Malin, 2013). This must be made clear in the verbal and written informed consent process at the onset of therapy. "Confidentiality is a respected part of

psychology's code of ethics" (American Psychological Association, 2019, para 1). However, confidentiality does not mean health professionals can ignore their legal obligations regarding reporting any suspicions of child abuse. In South Africa, the patient's right to confidentiality is protected through the National Health Act 61 of 2003 (Republic of South Africa, 2003). This is consistent with the right to privacy in the South African Constitution [Act No. 108 of 1996] (Republic of South Africa, 1996).

An element of ethical practice is a mandatory and legal obligation for therapists to report any illegal sexual activity concerning children (Hendricks, 2014; Hunter, 2006; Republic of South Africa, 2007b). Given the nature of a psychotherapeutic relationship that encourages trust and rapport, this creates an ethical dilemma for mental health professionals by creating a conflictual position whereby the very person (therapist) who is attempting to offer therapy may have to overrule the patient's right to privacy due to being bound by legal and ethical responsibilities to the public. Notably, mental healthcare workers treating sexual offenders must be well informed regarding their constraints around confidentiality and privacy within the professional environment. However, they need to make these distinctions clear from the onset of the therapeutic relationship using a contract and waiver of confidentiality. This agreement should explicitly state the limits to confidentiality, which is explained to all participants of a therapeutic relationship and includes a signed agreement between the patient and psychologist (Papakyriakou, 2017).

Given these concerns, it is plausible that there may be apprehension on behalf of a psychologist in managing and treating an individual with paedophilic ideation. A primary ethical obligation by a psychologist is the notion of non-maleficence, which refers to the idea of doing no harm toward an individual. This notion relates to not holding a prejudice when treating an individual in therapy (Levenson et al., 2019). The imposing feelings and concerns (of social stigma) on paedophiles within the therapeutic setting are concerning if they are responsible for the lack of treatment for a group who desperately needs psychological intervention. Understandably, this is why Seto (2012) stated that offering the required support to those suffering from paedophilic disorder and paedophilic ideation is both a moral and practical issue.

Before discussing treatment and intervention strategies, the idea of the support required for therapists working with paedophiles is explored. Effective support is crucial, mainly because there is a significant shortage of psychologists within the public sector (Psychological Society of South Africa, 2017).

A lack of psychologists within the public sector translates into a small pool of psychologists managing and treating paedophilia. Thus, it is necessary to recognise the stress psychologists experience working with individuals with paedophilic disorder and paedophilic ideation. Bach and Demuth (2018) reviewed the literature on the experiences of therapists working directly with child sexual offenders and/or individuals with paedophilia, revealing that they suffer from traumatic stress, compassion fatigue, vicarious traumatisation and burnout. Clarke and Rogers (2007) stated that the content of the work engaged in therapy with this population leads to high rates of psychological damage. Therapists in this line of work must, therefore, receive peer support and supervision.

2.10 Treatment and Intervention Strategies

The effectiveness of types of treatment and intervention plans available for paedophilic disorder and paedophilic ideation have contradictory findings. However, it is important to note that a number of studies have focused on sexual offenders, rendering it complex to discern the suitability of treatment for paedophilic disorder and paedophilic ideation. This is substantiated by Cohen et al. (2020), who stated that most research focuses on individuals whose past behaviour has been identified through the legal system. This means that individuals attracted to children but who have not acted upon their urges or desires are severely under-researched and poorly understood in the broader literature and subsequent therapeutic intervention plans, which has dire consequences for providing appropriate treatment.

Treatment or intervention strategies fall into two broad categories: 1) medical interventions-surgery and pharmacotherapy, physical and chemical castration and the use of selective serotonin re-uptake inhibitors (SSRIs), and 2) psychotherapy tailored to the individual or group/family setting.

2.10.1 Medical Interventions

Surgical interventions refer to the removal of the hypothalamus in the brain or the removal of the testes in males. They are dealt with briefly as they have fallen out of favour, especially given that male individuals could still partake in sexual intercourse (Hughes, 2007). The practice of removing the person’s hypothalamus, in whole or part, was practised until the 1970s as a common treatment for sexual offenders in several European countries (Thibaut et al., 2020). It was invasive and had no positive results. Surgical castration refers to the removal of the testes to lower sex drive and is invasive and also ineffective (Lumen Abnormal Psychology, 2022).

2.10.2 Pharmacotherapy

The DSM-5-TR (American Psychiatric Association, 2022) does not specify treatment options for paedophilic disorder and paedophilic ideation. The discussion to follow reveals that the efficacy of pharmacotherapy is inconclusive. Pharmacotherapy refers to chemical castration using chemical anti-libidinal medications to reduce sex hormones to lower sexual desires so that people cannot have sex (Habermeyer et al., 2011). Chemical castration or antiandrogen therapy (ADT) has been used since the eighties to treat paedophilic people to reduce their sex drive and recidivism. However, the success of this treatment is uncertain (Jordan et al., 2014). Antiandrogen therapy (ADT) to reduce levels of androgens can be done surgically or chemically. However, those who had undergone these procedures could sexually offend by other means (Hughes, 2007). Boons et al. (2021), in their study of 12 male adults diagnosed with paedophilic disorder, stated it showed promising results but noted side effects of bone loss, weight gain, and breast formation.

Given the lack of conclusive findings on the success of ADT as a treatment for paedophilic disorder, Jordan et al. (2014) undertook a single case study on the usefulness of an eye-tracking method and a functional magnetic resonance imaging (fMRI)-design regarding the assessment of ADT in paedophiles, which they viewed as significant. A study by Amelung et al. (2012, p. 176) had positive results for “help-seeking” paedophiles using ADT “in a clinical context” but stressed “the importance of careful education and monitoring”. It found a decrease in aberrant sexual behaviours and an increase in empathy for potential victims. This demonstrates continued support for ADT use, although there is inconclusive evidence that people with paedophilic disorder have higher testosterone. Individuals, specifically males with higher testosterone levels, elicit behaviours conducive to higher sexual drive and difficulties with impulse control. The literature, therefore, indicates that even though individuals with paedophilic disorder have been found to have higher levels of testosterone, these results are inconclusive and cannot necessarily attribute higher levels of testosterone to the conflation of paedophilic behaviour being attributed to an increased impulse control or higher sex drive.

Wong and Gravel (2018) conducted a meta-analysis of the relationship between sexual offenders and high levels of testosterone across 20 electronic databases and found no difference in levels of sexual offenders and non-offenders. Despite this, legislation in Indonesia, the United States of America (USA), Argentina,

Australia, New Zealand, Estonia, Israel, and many European countries, including the United Kingdom (UK), do provide for the use of chemical castration (Ratkoceri, 2017). For instance, several states in the USA allow for sexual offenders to be injected with Depo Provera (a hormone-suppressing contraceptive injection), which lowers testosterone levels and allows mandatory injections for repeat offenders ("Chemical and Surgical Castration", 2019). It is argued by Ratkoceri (2017) that chemical castration is a humane and necessary treatment. However, this is open to contestation and needs to be examined from an ethical position. It could be argued that this approach is more of a band-aid approach, used to inhibit the overt symptomology of a mental disorder as opposed to the internal psychic structures and/or cognitive distortions responsible, which could elicit further trauma and mental health issues for the individual(s) concerned.

The usefulness of pharmacological interventions, such as chemical castration, is to reduce the sex drive in people and to help manage paedophilic urges. If implemented, it should be with therapy such as CBT. In the UK, for instance, chemical castration is offered to sex offenders on a voluntary basis. However, the idea of "voluntary" needs to be examined more closely. There might be direct or subtle pressure from lawyers, employers, or family members. Curtis (2021) reported that 100 sexual offenders at a prison in the UK underwent voluntary chemical castration, with the Minister of Justice saying there was evidence it was effective. However, Curtis (2021) questioned this evidence and asked if these crimes were about sex drive or violence. These are pertinent questions to raise, given the inconclusive findings on chemical castration.

Chemical castration as a treatment has complications; it is costly to administer, has to be administered regularly to the person, and has side effects. Gooren (2011) states that the side effects include osteoporosis, cardiovascular disease, and mood disorders. Gooren's (2011) paper was a meta-analysis that provided an ethical framework for guiding the androgen deprivation treatment of sexual offenders and managing side effects. The ethics considered voluntary participation with informed consent. Treatment can be 3 to 5 years or lifelong, with additional side effects to the ones previously mentioned, such as depression, hot flashes, infertility, and anaemia (Lee & Cho, 2013). Another difficulty with chemical castration is compliance with the medical regime. It is also not effective once the treatment is stopped.

The research on the efficacy of chemical castration reveals that it only reduces recidivism if offered within a psychotherapeutic context (Kutcher, 2010). In addition, it must be voluntary (Kutcher, 2010) or with the person's consent (Douglas et al., 2013). Clinical evidence for the efficacy of chemical castration is inconclusive (Caplan, 2020; Kuther, 2010). Regarding chemical castration, according to White et al. (2009, as cited in Kuther, 2010, p. 211) " … there is no trial-derived data to support or refute their use". Paedophilia also concerns the person's attitudes towards children, which speaks to the internal symptomology and psychic structures versus the removal of physiological limbic responses. Paedophilic disorder is not a sexual fixation but more a feeling of compulsion based on an individual's aetiology.

Other methods believed to be effective in treating paedophilic disorder and paedophilic ideation include the use of SSRI antidepressants (Gupta, 2020). Gerardin and Thibaut (2004) claim SSRIs are effective because they reduce comorbid depressive symptoms, allowing people to manage their behaviour better. However, they have side effects of reduced sex drive (libido) and sexual performance. The goal of using SSRIs is to allow the person to manage themselves better. This is further substantiated by Adi et al. (2002), who stated that one of the main justifications for believing SSRIs might be effective in treating sexual offenders is the similarity between sex offences and obsessive-compulsive disorder (OCD). Specifically, Zoloft, Cipramil, Prozac and Faverin are mentioned as being effective. These drugs have the effect of lowering sex drives and being less harmful than chemical castration. However, Langdren et al. (2022) noted that reducing sex drive does not necessarily translate into reducing sexual interest or activities for individuals with paedophilic disorder. On a positive note, SSRIs also have fewer side effects than ADT, and the individual can conduct an appropriate intimate sexual relationship while taking it (Langdren et al., 2022). A consideration with SSRIs is the individual's ability to comply with the medical regime, as medication needs to be taken regularly to be effective. However, taking SSRIs does not result in an internal psychic change. Plus, compliance with medicinal schedules is important for them to be effective, and SSRIs are taken for many years. This might influence whether individuals are willing to take them. Furthermore, the negative side effects may also stop individuals from taking the medication. These effects include but are not limited to "nausea, vomiting, dyspepsia, abdominal pain, diarrhoea … anxiety, headache, insomnia, tremors" (Adi et al., 2002, p. 9).

A large study conducted in the UK in 2002 that examined current, published and unpublished trials on the use of SSRIs in the treatment of sexual offenders found that initial data suggested the potential value of SSRIs in the treatment of sexual offenders (Adi et al. 2002). However, this study focused on all sexual offenders and did not distinguish individuals with paedophilic disorder or paedophilic ideation. According to Beech and Harkins (2012), it cannot be established if SSRIs are an effective treatment for paedophilia because the studies to date are not of high quality. Hall and Hall (2009) stated that SSRIs might be helpful when used with monitoring, psychotherapy, and hormonal treatment. They also felt treatment would not be successful unless the paedophile wanted to be treated. It is noted that using SSRIs is more effective if combined with therapy (Thibaut et al., 2020). The World Federation of Societies of Biological Psychiatry drew up guidelines for clinicians who treated adult males with paraphilia (within which paedophilia falls), which said that combining medical treatment with therapy was more effective than medical treatment on its own (Thibaut et al., 2020).

Hall and Hall (2009) noted that studies showed that after a year, individuals in combined treatment of SSRIs and psychotherapy indicated sexual attraction to children. However, the self-reported frequency of urges to act had decreased, signifying that the core attraction to children cannot alter behaviour. Porter (2022) stated that pharmacotherapy focusing on reducing the sex drive through medication such as oestrogen and SSRIs is not a successful treatment.

2.10.3 Psychotherapy

Paedophilia is classified as a psychiatric disorder and requires psychiatric management treatment. Internationally, an approach to management and treatment draws on psychotherapeutic treatment (Banović et al., 2020). Given the aforementioned, there are different psychotherapeutic treatments for individuals presenting with paedophilic disorder and paedophilic ideation. For example, aversion therapy, which falls under behavioural therapy, posits that an individual's undesirable sexual urges are linked with something disagreeable, such as a bad smell, to make an association (Marshall, 2006). The appropriate sexual urge is matched with something pleasant to strengthen the required association (Marshall, 2006). This means that this approach exposes the individual to an erotic stimulus while simultaneously exposing them to a negative stimulus to create a negative association between the two. The negative stimuli can be the administering of electrical shocks,

olfactive stimuli such as ammonia salts, covert sensitisation and shame induction. Aversion therapy has not been successful. A literature review by the Minnesota Department of Health (2022) revealed harmful side effects, such as depression, anxiety and suicide. Other therapeutic intervention includes masturbation and verbalisation, in which verbalisation of sexual fantasies is linked to masturbation to satisfy an individual's sexual desire and aid them in behaviour control. There is little evidence to suggest this works (Hughes, 2007). There is an argument that fantasies are private even if they are deviant. Thus, deviant fantasies must be managed and not blocked, teaching the individual to be accountable for how they deal with their fantasies, i.e. to not act on them (Vanhoeck et al., 2011). These authors raised the idea of reappraisal rather than suppression and discussed a technique called "urge surfing" (Vanhoeck et al., 2011, p. 10). Here, the client learns to create emotional distance instead of fighting it, which causes distress.

Naude (2005) found that specific categories of paedophiles, such as fixed immature, understood their close relationships with children as a need for emotional fulfilment. A Berlin hospital at 31 centres throughout Germany oversaw weekly two-hour therapy sessions with chemical castration as an option for treatment, with 7000 people voluntarily expressing interest in it and 251 people completing the whole programme ("German Hospital Uses Therapy", 2016). Scientists from France, Switzerland, the USA and India paid attention to the programme ("German Hospital Uses Therapy", 2016). However, the positive outcomes were not statistically significant (Beier et al., 2014).

Individual, group, and family therapy are worthwhile treatment modalities for paedophilic disorder and paedophilic ideation. However, group therapy is the preferred treatment of "best practice" (Hubbard, 2014). In contrast, Wilcox et al. (2014) expressed a need for individualised therapeutic interventions for paedophilic disorder and paedophilic ideation. However, it should be noted that the positive effects of group therapy are undisputed by the authors. Similarly, Jonker and Du Preez (2012) stated that a combination of group therapy and individualised therapeutic intervention processes are necessary when specifically working with incarcerated sexual offenders (Papakyriakou, 2017).

2.10.3.1 Intra-Psychological and Cognitive Factors

It can be argued that treatment must consider the internal psychic structures. This is because the cognitive distortions held by individuals with paedophilic disorder

and paedophilic ideation form integral and pertinent formulations of how an individual perceives themselves and others and how they experience and behaviourally react to their environment. Grady et al. (2016) and Lee et al. (2002) pointed to specific developmental factors present in the narrative of those with paedophilic disorder and paedophilic ideation, such as early sexualisation of the individual, childhood trauma (emotional, physical, and sexual), behavioural issues, and problematic familial relationships. Sullivan and Sheehan (2016) found that individuals with paedophilic disorder and paedophilic ideation who experienced sexual abuse as a child rationalised their beliefs as normal and even pleasurable. This ideology of the individual led them to develop a sexual attraction to and fascination with children. Ward and Hudson (1998) also considered the cognitive distortions of sexual offenders regarding the offender's views on the individuals they harm. As stated previously, Naude (2005) noted that some individuals with paedophilic disorder and paedophilic ideation were aware that intimate relationships with children were for emotional fulfilment. Thus, Blake and Gannon (2008) suggested that these cognitive distortions affect how individuals who harm children interpret the behaviour of children. Moreover, Blake and Gannon's (2008) research, which was conducted on the cognitive distortions, social perception, and empathy skills of sexual offenders, found that offenders might not be able to read an individual's emotions accurately and that other individuals might have desires that differ from theirs, as well as maladaptive attitudes. Therefore, understanding cognitive distortions in paedophilia could assist therapists in helping individuals with paedophilic disorder and paedophilic ideation to develop and maintain a positive self-image and address how they perceive the harm caused to children through their fantasies, urges, or actions.

Further, according to Sigre-Leirós et al. (2015), individuals who sexually harm children have a great sense of worthlessness, view children as sexual objects who can agree to and instigate sexual desires and acts, as well as have a sense of entitlement in which the individual sees themselves as being deserving of sex. These individuals also perceive the world as hazardous, are unable to control their sex drive, and believe that no harm is caused to children through their actions (Sigre-Leirós et al., 2015). The authors further stated that sexual offences against children and paedophilia are viewed as the same, and research is needed to understand the difference as not all sex offenders with child victims present paedophilic interests, and this understanding affects treatment programmes. Therefore, it is pertinent that

therapists understand cognitive distortions, perception problems, and lack of empathy for the victim held by individuals with paedophilic disorder and paedophilic ideation, as well as how these are linked and the differences between individuals who sexually offend and do not in order to develop appropriate treatment programmes. In turn, treatment should focus on exploring and challenging the cognitive distortions of individuals with paedophilic disorder and paedophilic ideation as they seem to hold some common factors, but the content of which may be unique to each individual- especially in terms of their family upbringing and life experiences (Ciardha & Gannon, 2011; Levenson, 2014; Sullivan & Sheehan, 2016). Thus, Levenson and Socia (2016) and Sullivan and Sheehan (2016) explained that a better understanding of the individual trauma suffered, such as emotional neglect and child abuse by the individual with paedophilic disorder and paedophilic ideation, would make therapy programmes more effective and enable the therapists to be more attuned toward positive outcomes.

2.10.3.2 Empathy in Paedophilia

In addition to understanding cognitive development, empathy is also an important concept to consider concerning the effective development of treatment and intervention for paedophilic disorder and paedophilic ideation. Blake and Gannon (2008) stated that there is a lack of knowledge of what empathy means and described it as the ability to understand and share another person's emotional state. They further stated that this understanding is vital because it is widely thought that a lack of empathy leads to antisocial behaviour (Blake & Gannon, 2008). Therefore, individuals who lack empathy for children are more likely to harm them. Ward and Durrant (2013) noted that treatment programmes for sexual offenders include an empathy training element but pointed out that evidence of their lack of empathy was inconclusive, as well as the efficacy of the programmes. They suggested that rather than focusing on empathy, which is either present or absent, one should focus on actions as described by Kitcher’s concept of psychological altruism, “evident when an individual adjusts his/her actions to take into account the interests and desires of other people” (Ward & Durrant, 2013, p.68).

Schuler et al.’s (2019, p. 454) study on empathy sought to address the failure of studies to distinguish between what they labelled “pedophilic and nonpedophilic sexual offenders” and “cognitive and affective empathy”. Their findings indicated that men with paedophilia who had not offended showed high affective empathy to children suggesting they were more open to the therapy process. After the offence has

occurred, empathy rates are lower. This could impact therapeutic intervention as the individual's cognitive relations regarding their behaviour lead to them eliciting less empathy towards children. Although, it can be argued that guilt and shame also play an important factor, along with the fact that post-offending is then a crime.

However, the findings on empathy proved to be divided in that some studies have shown a reduction in empathy by those with paedophilic interests (Elliott et al., 2009; Gery et al., 2009), while others have not. Regardless of the diverse findings of these studies, Schuler et al. (2019) maintained that empathy should be upheld as an effective predictor of recidivism regarding individuals with paedophilic interests. They maintained that empathy is a vital factor within therapeutic treatment protocols and should also form a functional basis of instruments used for forensic testing when assessing the risk of individuals with paedophilic ideation (Schuler et al., 2019). Cohen et al. (2020) further stated that there is a dire need for treatment protocols that are client-centred and free from stigma. However, given the suicide risk and the stigma associated with paedophilic disorder and paedophilic ideation, these individuals are less likely to get the much-needed therapy. However, although the broader literature revealed inconclusive findings, there seems to be some evidence for positive treatment outcomes for people with paedophilic disorder and paedophilic ideation. This leads to the conclusion that people with paedophilic disorder and paedophilic ideation, who are willing to change their behaviour and engage in therapy that suits their individual needs may benefit from a combination of therapeutic interventions. As each individual will experience their own associations and experiences differently, treatment needs to be somewhat flexible in an attempt to rehabilitate individuals according to their individuality concerning their psychopathology.

2.11 Prevention and Rehabilitation Programmes

Prevention programmes look to assess and diagnose disorders to address them therapeutically within the context of paedophilic disorder. According to Marshall et al. (2009), the general idea behind behavioural intervention programmes is to treat paedophilic disorder by providing men (primarily) with the means to inhibit and/or control their sexual desires for children. Flora and Keohane (2013) and Pflugradt and Cortoni (2015) stated that female child sexual offenders (this includes females who have sexually abused/harmed children) have a range of clinical features such as cognitive distortions, sexual problems, relational issues, and problems with social functioning. These individuals "do not turn to their internal locus of control to elicit

change within their lives" (Papakyriakou, 2017, p. 74); instead, as perpetrators, they are seemingly at the mercy of their external world. It can, therefore, be argued that prevention models need to address the presentation of males and females as perpetrators of child sexual abuse and in relation to paedophilic disorder and paedophilic ideation. In addition, a gender-informed approach is needed, not one that is gender-neutral. According to McPhail and Olver (2020), when assessed using phallometric testing as an assessment tool, behavioural treatments show reasonable results in treating paedophilic interests, whereas pharmacological treatments show more equivocal results. Bouchard et al. (2019) conducted a study looking at the genital responses of women who have paraphilic interests. The findings showed that women who have paraphilic interests and who previously engaged in sexual acts toward others showed virtually no genital response when using these responses as an assessment measure in clinical and forensic contexts (Bouchard et al., 2019). In view of the aforementioned, it becomes imperative to investigate various treatment protocols because if one modality or a combination of modalities proves to be effective in treating paedophilic disorder, it will assist in offering guidance for treatment.

The National Sexual Violence Resources Centre [NSVRC], (2011) stated that a primary prevention approach is necessary. This approach addresses the conditions that allow the abuse to take place. The NSVRC (2011) provides a risk reduction approach guide for parents to access, as many do not talk to their children about abuse. However, the responsibility to stop child abuse must not be placed on children. Hence community involvement is necessary. A multisectoral approach in South Africa, including school authorities, parents, community figures, and social workers, shows that much can be done to prevent child sexual abuse (Mabetshe et al., 2022). Multisectoral includes primary, secondary and tertiary prevention, with primary focusing on the whole community, secondary more on children at risk and tertiary aimed at preventing abuse in families where it has happened (James, 2000).

In South Africa, serious problems were found with interventions around child sexual abuse, particularly when it came to sexual offenders. A presentation to the Portfolio Committee on Justice and Constitutional Development asked, "If sexual offences are a priority, why is there no coherent policy?" (Vetten, 2013, para 2). There were problems with existing policies and a lack of funds. Policy problems were evident, and the capability of psychosocial services, training, and being ready for court and specialised courts (Vetten, 2013). While it is noted that there are good intentions when

providing rehabilitation to inmates in correctional contexts, it is alarming to see the relation to poor outcomes. Gahler (2017) conducted a study on the lack of rehabilitation occurring in correctional centres, noting that the South African criminal justice system is effectively ignoring rehabilitation efforts. This means that inmates with paedophilic disorder who are incarcerated for sexual offences cannot easily access rehabilitation programmes.

Bjelajac et al. (2020) carried out a study in Serbia using an anonymous survey, establishing an Internet profile “underagegirl13bg” and chatroom, and using statistical data from the Ministry of Interior and Ministry of Justice. The study aimed to assess the number of perpetrators of child sexual offences. The prevalence of paedophilia was shown in the general population, being 2.13%, and the majority were individuals between the ages of 30 and 50. The findings of this study pointed toward general prevention measures, including educating parents concerning child protection when using the Internet and further managing the content to which children have access (Bjelajac et al.,2020). Additionally, it was recommended that school involvement is pertinent given the contextual capabilities of schools to educate children about potential harm when using the Internet, for instance, to teach security workshops. The study pointed toward special attention being placed on victims of paedophilia through psychotherapeutic interventions as well as multidisciplinary approaches aimed at reducing trauma and further mental distress as well as the physical development of children. A basic preventative measure would involve implementing programmes aimed at preventing paedophilia. This programme would help and inspire individuals suffering from paedophilic disorder to accept it and take on voluntary activities to help them. These activities could help these individuals avoid paedophilic contact with children and child pornography. The aim of this programme is to reduce sexual offences by paedophiles. The study explained that one such prevention measure necessitates a public register of paedophiles, which would be available to the general public. The study further pointed to lawmakers and experts regulating and maintaining accurate records of convicted paedophiles (Bjelajac et al., 2020).

Countries that have managed to implement programmes for paedophilia prevention are Canada, the USA, New Zealand and Germany. The success of programmes within these countries helped to spread the concept of these programmes to other countries (the UK, Netherlands, etc.). These programmes are

dedicated to assisting individuals with paedophilic disorder and paedophilic ideation to receive psychotherapeutic help.

Canada's programmes are based on the risk, need, and responsivity model and the good lives model, focusing on "intimacy/relationship skills, emotional regulation, and social skills" (Ellerby et al., 2010, p. 3). Initially, relapse prevention was the core of their programme, but after criticisms, this changed. Ellerby et al. (2010) stated that the literature revealed the importance of using evidence-based risk assessments for sexual offenders (which includes individuals with paedophilic disorder who have offended). Programmes in Canada include these assessments and have psychophysiological instruments at their disposal. In the USA, programmes to treat individuals who commit sexual abuse (they do not state if they are paedophilic) use evidence-based change models (McGrath et al., 2009). These programmes also use dynamic risk assessments, with the "Stable 2007 and the Acute 2007" being the most common (McGrath et al., 2009, p. ix). According to Hanson et al.(2007, para 1), these risk assessment instruments are "designed to assist with the community supervision of individuals who have committed sexual offences". Stable 2007 "is a measure of risk-relevant propensities for adult males convicted of a sexual offense" (Brankley et al., 2019, p. 34). In New Zealand, programmes typically begin with a risk assessment of individuals who committed a sexual offence. The "expected standards of practice Glazebrook" set the guidelines (McCartan & Laws, 2018, para 5). Formal risk assessments take place within an evidence-based risk model (same as Canada) using Stable 2007 and Structured Professional Judgement (SPJ), where psychologists draw on their skills and knowledge by offering clinical judgement. More information on the treatment approaches of these programmes will be provided in the following section, 2.11, on prevention and rehabilitation programmes.

In Germany, the "Behandlungsprogramm für Sexualstraftäter" (BPS), a treatment programme for sexual offenders, was established at the end of the nineties (Rehder, 2014). This is known as the "Treatment Program for Sexual Offenders" (Rehder, 2014. p. 1). This programme considered that sexual offenders had little access to treatment; treatment might only take place if mandated, e.g. for parole, and participants' fear of talking about their thoughts/fantasies in therapy. The BPS is structured into two parts. It is long as it is over 90 sessions to account for the two parts. Part one, which is non-offence specific includes the introductory and warming up phase, the treatment sessions and learning to talk about sexuality sessions (Rehder,

2014). Part two is offence-specific and uses CBT and relapse prevention (Rehder, 2014).

In addition, in Germany, there are programmes devoted to preventing reoffending. Beier et al. (2009) described the Berlin Prevention Project Dunkelfeld (PPD) in Germany, which has shown success. The initiative aims to help individuals by creating a confidential and safe environment for those with paedophilic ideation. The initiative is focused on individuals who fear they may sexually abuse children, primarily those who seek help without being mandated to do so. According to Beier et al. (2009), the project takes place over 1 to 2 years and involves a 2-hour psychotherapeutic session every week. During these therapy sessions, the individual is taught to develop strategies to stop themselves from acting on their tendencies and using child pornography. The programme further aids the individual in developing empathy towards potential victims. Such empathy is an unusual step which could go a long way toward dissuading these individuals from hurting potential victims. During the project's therapeutic process, individuals can remain unidentified, even with their therapist(s), and at the end of the programme, they can ask for follow-ups if need be (Verrijdt, 2019).

Another organisation that has been set up in the UK is B4U-ACT. This organisation is set up and run by self-identified paedophiles who established the organisation to assist other individuals with paedophilic disorder or paedophilic ideation who want to live without breaking any laws, as well as to assist practitoners in the mental health community (Cohen et al., 2020). The approach of B4U-ACT is to accept the individual's paedophilic preferences "as stable and unlikely to change"; help individuals to "learn how to live with their sexual feelings in a healthy way"; help individuals develop "self-acceptance via positive and realistic self-concepts, without resorting to cognitions that rationalize and normalize adult–child sexual activity"; and to help individuals "learn to cope adaptively with the intense societal stigma" (Cohen et al., 2020, p. 20). Following a similar premise to the aforementioned programmes, Cantor and McPhil (2016) explained that similar treatment projects in the UK show great promise toward the assistance and rehabilitation of paedophilic ideation, such as "Help Wanted". Help Wanted was primarily established to offer effective treatment of paedophilia and assist non-offending paedophiles in remaining free from committing an offence by prescribing measures similar to the aforementioned projects.

2.12 Success of Treatment, Intervention and Prevention Programmes

Drapeau et al. (2004) found that individuals with paedophilic disorder and paedophilic ideation retained attitudes toward voluntary treatment where they felt safe enough to allow themselves to express their feelings and experiences. In contrast, in other settings or instances, they could not. Moreover, the treatment allowed them to gain access to information they previously were unaware of, which assisted in their self-understanding and understanding of their victims (Drapeau et al., 2004). As discussed previously, 31 centres across Germany oversaw weekly 2-hour therapy sessions with chemical castration as an option for treatment ("German Hospital Uses Therapy", 2016).

Notably, Porter (2022) highlighted that paedophilic disorder and paedophilic ideation do not respond to psychotherapy based on the failure of many methods in therapy, such as the relapse-prevention model and CBT. The relapse-prevention model concerns helping the individual identify high-risk situations where they might feel or act on inappropriate sexual urges and then teach them how to avoid those situations (Marshall, 2006; Marshall et al., 2006). However, studies have shown that long-term outcomes in terms of recidivism are worse for offenders who receive relapse-prevention therapy (Harvard University, 2010). The risk/needs responsivity model and the good lives model are two models used in therapy. According to Ward et al. (2007), the risk/needs responsivity model assesses the subject regarding the risk the person with paedophilic disorder and paedophilic ideation poses and then personalising treatment to enable the most effective outcome. The good lives model focuses on prevention. It builds on personal strengths and respect for the individual to help patients self-actualise, reducing their desire to harm others (Ward et al., 2007). This model looks at the individual's personal agency. Thus, their context must be considered. For example, in a correctional setting, individuals lack autonomy, which must be accounted for. In New Zealand, this model is used in the correctional setting to teach individuals that they can change (McCartan & Laws, 2018). The rehabilitation element includes community-based sentencing involving the police service and various agency programmes. McCartan and Laws (2018) noted that New Zealand has the advantage of being resourced with multiple agencies working together with one police force and one corrections department. For instance, the Kia Marama sex offender treatment programme provides group-based treatment. However, in this programme, all members are categorised as sexual offenders, which does not mean

they have paedophilic disorder or ideation. Zeccola et al. (2021) examined if the good lives model affected recidivism, finding it did not. But their focus was on all convicted offenders, not on sexual offenders and not on individuals with paedophilic interests.

The relapse-prevention model is a CBT approach. It is focused on reducing harm and teaching the sexual offender to control their sexual impulses towards children using a risk assessment approach (Wheeler et al., 2005). According to Melemis (2015), this model is based on the idea that several factors will cause a sexual offender to reoffend and look at high-risk situations, mainly that relapse is a process that happens slowly. Marques et al. (2005) found that CBT treatment was effective for members of a California sex offender group if they met all the programme’s targets. According to Harvard University (2010), as these treatments do not work long-term, incarceration and post-release monitoring and supervision are the most viable methods in this instance. Studer and Alwyin (2006) stated typical CBT-based relapse-prevention treatment for paedophilia has negligible results after reviewing the typical CBT-based relapse-prevention treatment for paedophilia. They suggested that parts of CBT are helpful but inadequate in isolation and must be utilised with other treatment modalities.

However, Hanson et al. (2002) found positive results regarding treatment and intervention in the community and institutional settings for sexual offenders. Lösel and Schmucker (2019) stated that most reviews had lower recidivism in the groups who received treatment versus those who did not. Their studies incorporated both chemical castration and CBT psychotherapy as a more integrative approach. Further, the authors stated that even though the treatment showed positive results for sexual offenders, the reviewed studies all varied in the sample size, type and settings of treatment, and all studies were conducted in the USA. Nonetheless, a large study conducted from 2000 to 2012 of sexual offenders in UK prisons looking at therapy and recidivism rates caused doubt that inmates could be rehabilitated through therapy (Gannon et al., 2019). According to Przybylski (2015), although Hanson et al.’s (2002) study was criticised for being small, it was repeated by two other meta-analyses by MacKenzie (2006) and Hanson and colleagues (2009). MacKenzie’s analysis found that “treated” sexual offenders had a significantly lower rate of recidivism than “untreated” sexual offenders. Moreover, Hanson et al. (2009) noted a combination of treatments that were positive: cognitive behavioural/relapse-prevention treatment, behavioural treatment, and hormonal medication. Przybylski (2015) further stated that

Hanson and his colleagues (2009) also found that treatment for paedophilic disorder and paedophilic ideation was effective.

Allen et al. (2020) examined how psychotherapy could impact sexual fantasies. From the 10 studies they reviewed, they tentatively concluded that using CBT, group or individual therapy to address the sexual fantasies of sexual offenders had the best results. The study results were limited, indicating that further research needs to investigate the multifaceted nature of sexual fantasies and their application to paedophilic tendencies, as well as treatment protocols for treating these individuals and overcoming recidivism among this population. Sexual fantasies are a normal part of human exploration and existence; however, little is known about the psychological interventions in treating these fantasies when they become pathological in society (Allen et al., 2020). There is little research on understanding sexual fantasies regarding treatment for sexual offending (Gee et al., 2004). Their research provided a first step in developing a comprehensive framework of sexual fantasies of offenders. They put forward that sexual fantasies are diverse but could signal offenders to put coping strategies in place.

It is pertinent to note that there is a lack of research in terms of different treatment modalities as well as a lack of research around treatment for paedophilic disorder and paedophilic ideation (McPhail & Olver, 2020). Furthermore, the study by McPhail and Olver (2020) indicated that treatments do not increase sexual interest in adults and that individuals who have committed sexual offences indicated an unwillingness to manage their sexual arousal toward children. The deduction here would be that treatment should focus on pre-offending individuals. While their study was carried out on treatments regarding pedohebephilic arousal, McPhail and Olver (2020) offer insight into treatments that could be further investigated when applied to paedophilic disorder. In addition, McKillop (2019) suggested three ways to address sexual acts toward children and therefore assist in the prevention of thereof: 1) preventing these incidents from occurring, 2) assisting those individuals who pose risk factors with regard to committing sexual acts towards children as well as working with victims of child sexual abuse and 3) focusing on ways in which individuals are encouraged to disclose their paedophilic ideation timeously to ensure better prognosis with regards to therapeutic intervention and assist in reducing reoffending. This framework would not only target potential offenders but would also be geared toward assisting victims and ecological systems associated with the individuals, including

family, peers, neighbours etc. The main goal of this approach is to prevent child sexual acts from occurring; however, in the event of this prevention failing, children need to be taught to find their voice through psycho-educative means, as well as individuals with paedophilic disorder and paedophilic ideation being able to receive therapeutic assistance and ultimately prevent further offending or prevent offending from happening in the first place (McKillop, 2019). The discussion turns to the theoretical framework utilised in the study, having successfully reviewed the literature.

2.13 Theoretical Approach – Social Constructionism

In this study, social constructionism is viewed as a meta-theoretical framework. This means it is a "'theory about theories' of life and the world around us" (Carruthers, 2007, p. 69). According to Hosking and McNamee (2006), social constructionism is a way of engaging with the world with a focus on relational practices and the social realities which these practices create, maintain and transform.

Social constructionism originated as an attempt to come to terms with the nature of reality and adopts an anti-realist, relativist stance (Andrews, 2012). Social constructionism can and does act as a necessary form of social criticism (Gergen, 1985). It places great emphasis on everyday interactions between people and how they use language to construct their reality and share meaning. Hence, there is an unspoken agreement on language in order to have a shared meaning. Social constructionism focuses on how knowledge is constructed "within relationships expressed through language" (Carruthers, 2007, p. 72).

Thus, social constructionism underpins this study theoretically and methodologically, allowing for the examination of the psychologists' (in this study) understanding of paedophilic disorder and paedophilic ideation. Social constructionism offers insight into how treatments may be impacted by how society has constructed the language, understanding and ideologies of paedophilia as a socially constructed label, that is, as an umbrella term for those who sexually abuse children. However, it becomes important to understand how this construction then impacts the availability and the types of treatment being offered currently in South Africa to those who have an attraction to minors. Social constructionism allows for the notion that diseases and illnesses (physical and mental health) can and do exist as an independent reality. However, part of what is being investigated is what constitutes the disease/illness as a mental health disorder, for instance, in the DSM-5-TR, because these are socially constructed and lead to diagnosis and treatment. This has a direct

bearing on this study's aim regarding how the participants, psychologists in South Africa, understand paedophilic disorder and paedophilic ideation and treat individuals with this disorder. This study does not claim that a disease or illness "has no independent existence beyond language" (Andrews, 2012, p. 42). Social constructionism, as will be discussed, as a theoretical framework, can lead to a change in thinking as various realities are considered. For instance, through the participant's own words, the notion of viewing clients with paedophilia with empathy and humanity allows for some shift in perspective of a highly stigmatised population.

Social constructionism emphasises the idea that society is actively produced by individuals. Individuals together create and sustain all social phenomena through social practices, and the processes through which this occurs are externalisation, objectivation and internalisation. These processes show how the world can be socially constructed by the individual's social practices but at the same time experienced by them as if the nature of their world is pre-given and fixed (Burr, 1995). Knowledge, in part, is a product of human thought rather than grounded in external reality (Burr, 1995). Individuals encounter phenomena in a social world, the objective reality, and they hold their own subjective reality. When the two "meet" in a dialectic relationship, a way of thinking about the phenomena encountered through a discourse continuously under construction emerges. Individuals are socialised into identities and roles that are continually under construction through interactions with others.

Social constructionism has many influences, yet there are areas of broad agreement. These are 1) social processes are primary, 2) critical of the construction of social reality and knowledge, 3) social realities are understood through discourses of knowledge and power, 4) there is space for multiple realities, and 5) identity is socially constructed.

The world individuals experience and their identity is a product of social processes. Within this focus on social processes, social constructionism has a relational focus which means focusing on activities between individuals and the meanings they share (Geldenhuys, 2015).

Social constructionism is a "lens through which to challenge the accepted status quo and the current views of society and therapy" (Carruthers, 2007, p. 69). It accepts that there is an objective reality, but it is concerned with how knowledge is constructed and understood. It has, therefore, an epistemological focus (Andrews, 2012). This means that "it is not interested in the literalness of things or so-called 'facts', but in the

meanings attributed to them, with the focus on the processes through which people arrive at their understandings of themselves and their worlds" (Gergen & Gergen, 2003, as cited in Geldenhuys, 2015, p. 4).

Knowledge is socially constructed, "representing different realities, all knowledge is regarded as perspectivistic" (Geldenhuys, 2015, p. 4). Knowledge can be viewed as offering "a subjective frame of reference" (Geldenhuys, 2015, p. 4). Scientific communities and scholarly disciplines (in this study, psychiatry and psychology are relevant) develop knowledge and rules often as means to gain social control (Gergen, 1985). This draws on Foucault's understanding of knowledge and power. Power is derived from the techniques and procedures which are sanctioned by the scientific communities and disciplines. For example, psychiatry and psychology disciplines sanction the use of the DSM-5-TR for diagnosis, and along with the bodies (such as the Health Professions Council of South Africa [HPCSA]), sanction one to implement certain therapeutic techniques or placement in psychiatric facilities whereupon a range of other techniques are sanctioned for the management of a diagnosed condition.

Knowledge as a form of scholarship is not "out there". Because it is expressed in and through a relationship, it is a relational activity; individuals construct knowledge together in a process (Geldenhuys, 2015). Furthermore, individuals gain knowledge about the world in which they live through their relatedness with or experience of the world. Knowledge is an active interaction, thus constantly open to change as people have agency. An example is the very study being undertaken which examines the current knowledge about paedophilia by looking at the literature and through interviews with the participants. Because in making knowledge, individuals are sorting out meaning between themselves in the interaction, making it, contesting it, and changing it.

Thus knowledge is contextual or participative (Anderson, 2007; Hosking & Morley, 2004). "It is developed by and within a community of people who, through its development, not only develop new knowledge but also set the rules for it" (Geldenhuys, 2015, p. 5). For instance, those who developed the DSM categories; those who contest it.

Social constructionism takes a particular stance on the construction and transformation of social realities. Social constructionism draws on Foucault regarding knowledge and power to theorise how people construct their social realities

(Geldenhuys, 2015). For Foucault, it is through discourses (as in knowledge) that people are made (Pitsoe & Letseka, 2013). Discourse, knowledge and power are intertwined. Foucault was clear that those in power decide what can be said and thought and “who can speak, when, and with what authority”(Pitsoe & Letseka, 2013, p. 24). A discourse offers “the framework for what is right and wrong” (Geldenhuys, 2015, p. 5). Understanding the cultural and historical context in which discourses are located is needed. This is because knowledge changes. Because what was considered “knowledge and truth at one time in history is often not regarded as knowledge and truth at another time” (Geldenhuys, 2015, p. 5). Foucault stressed how medical discourse constructs knowledge about the body. The medical discourse can influence people’s behaviours, shape their identities, and legitimate medical interventions (Conrad & Barker, 2010; Foucault, 1972). Individuals’ identities are shaped because they are actively located in the particular discourse, e.g. paedophilia within the DSM-5-TR, which influences their subjective being and social interaction. The position in a discourse provides individuals with knowledge of self, known as subjectivity. When thinking of subjective knowledge of self and interaction with others, consider the notion of self-stigma. Individuals with paedophilic disorder or paedophilic ideation might self-stigmatise, preventing them from seeking treatment. Researchers have examined the construction and impact of a number of stigmatised illnesses, including mental illness, epilepsy, cancer, Human Immunodeficiency Virus (HIV)/AIDS, and sexually transmitted infections (STIs). They identified how some illnesses become stigmatised, the impact of stigma, how individuals and groups manage stigma, and how illness stigma can change over time (Conrad & Barker, 2010). The lesson from all the research is that it is not the illness that makes it stigmatising but how society responds to it or the type of individuals who suffer from it (Conrad & Barker, 2010). The consequences “of diagnostic labels cannot be abstracted from the context in which they are understood by the person who is labelled” (van Zyl, 2009, p. 43). Thus, this study's literature review showed how the social response to paedophilia is generally negative and imbued with stigma.

Social constructionism becomes a psychological approach that starts from the problematising premise (in Foucault’s sense) of “making alien something that seems very obvious, very coherent” (Parker, 1999, p. 86). Problematising is understanding how and why something has acquired the status of unquestionable evidence. Problematising is relevant to this study because what is being problematised is the

current understanding of paedophilic disorder and paedophilic ideation, which directly affects the treatment thereof because the medical position has the status of being unquestionable. The problematising occurs through the participants who describe their current understandings (treatment) thereof interpreted against the current literature.

According to Geldenhuys (2015, p. 6), “social constructionism allows for the possibility of bringing together multiple realities as different but equal”, allowing for change. Therapists can work with clients to discuss nondominant stories with the potential for change. When “problematic” realities can be “deconstructed”, new realities can be “reconstructed/co-constructed” by the therapist and client to produce new meaning (van Niekerk, 2005). This will influence how they act and relate to others (Geldenhuys, 2015).

Within the perspective of social constructionism, identity construction is an active engagement with socialisation into an individual’s culture through language in interaction with others. Branaman (2001) explained how the important people in one’s life view and reassure one are vital to how one perceives oneself. Individuals know themselves and others through interaction, culture and language, which has shared meaning. Language plays a major role in social constructionism as a vehicle through which people construct, make sense of and change their world (Anderson, 2012; Gergen & Gergen, 2003). Individuals use language to make sense of the world they inhabit (Geldenhuys, 2015). It can facilitate making a current reality when people talk and offer the possibility of creating future worlds (Anderson & Gehart, 2007). In this sense, language opens up the possibility of transformation. It provides the opportunity for collaboratively transforming current realities into new future realities (Geldenhuys, 2015). The transformative power of language is emphasised in social constructionism (Gergen, 1985).

An individual’s identity regarding gender, sexuality, race, and ethnicity is socially constructed. The starting point for most (but not all) feminist theory is the conceptual distinction between gender and sex. Feminists claim that gender is a social construction, meaning our ideas about gender (i.e. norms and standards concerning femininity and masculinity) are not predetermined by biological sex differences. Therefore, our ideas about gender and social practices can be changed (Conrad & Barker, 2010). Heterosexuality is invisible because it is the norm. It is seen as “natural”, and what is different is deviant or unnatural. Therefore, heteronormativity is the notion that heterosexual attraction and relationships are the norm (Barker, 2014). Paedophilia

is stigmatised not only because sexual acts between adults and children are immoral and a criminal offence but also because it breaks gender and heteronormative constructs. It challenges the notion of societal views of adult-children relationships, leading to debates about consent regarding the threshold of developmental and mental ages. For instance, the ages of consent regarding marriage and sexual activity differ globally, but for the most part, society frowns upon sexual relationships between children or minors and adults.

It breaks social stereotypes of the gender, sexuality and masculinity of "real" men and women as nurturers. Men are socially constructed dichotomously to women. They are viewed as independent, strong, protectors and heads of families, and sexually aggressive; plus, men and boys are under a lot of social pressure to endorse gendered societal prescriptions (Courtenay, 2000). Women are constructed to complement men as wives, mothers, and nurturers and to be sexually passive. Having discussed social constructionism, a conclusion to this chapter is presented.

2.14 Conclusion

This chapter presented the literature review, which examined the relevant literature regarding the research question. Current understandings of paedophilia as a psychiatric disorder were examined, and comorbidities because paedophilia does not only occur in isolation. The controversial idea of it as a sexual orientation was considered briefly, but the lack of scholarship in this area reveals it has little merit. The aetiology of paedophilia was presented from clinical presentations, neurological causes and social factors. The main issue of stigma was discussed because this impacts treatment regarding social stigma from society and professionals offering treatment. The stigma experienced by professionals offering treatment and self-stigma experienced by individuals with paedophilic interest was also discussed, as this might prevent individuals from seeking treatment. Various therapeutic approaches and theoretical models for psychologists working with individuals with paedophilic interests were considered. The theory of social constructionism was discussed with a focus on relational processes and meaning as individuals construct their identity socially through culture and language, which provides shared meaning.

Internationally, research has focused on paedophilia within the judicial system and the related risks; however, current research is beginning to lean toward paedophiles who have never engaged sexually with children (Cohen et al., 2020). With

this lack of available research both locally and internationally, there is currently little hope for effective treatment for individuals suffering from this disorder (Moulden et al., 2009). This is compounded by conflicting studies and varying approaches to adequately working with paedophilic disorder and paedophilic ideation in a psychotherapeutic setting, with very few techniques offering effective treatment (Gopalan & Arvind, 2018). Therefore, there is a need to develop and implement therapeutic approaches, therapeutic treatment interventions and techniques that psychologists could use. This gap in research shows that a qualitative study would be beneficial to understand what current therapeutic interventions are being used by psychologists who treat paedophilic disorder or paedophilic ideation and then determine which approach(es) have or have not been effective.

Chapter three is presented next, offering a description of the qualitative research design and the study’s methods of data collection and analysis to address this study's aims and objectives.

Chapter Three
Methods

This chapter describes the methodology, research design and methods used to achieve the research aim of this study. The chapter begins with the research question, aim and objectives to show how qualitative methodology, the research design and methods have been appropriately selected. The chapter will then detail the methodologically relevant choices that were made in this study. Ethical considerations, rigour, credibility, trustworthiness and validity will also be explained.

3.1 Research Question

The central research question is, "how do clinical and counselling psychologists in South Africa currently treat clients with paedophilic disorder or paedophilic disorder ideation?" This is achieved through the objectives below.

3.2 Objectives

Based on the research question stated above, the following objectives were identified for this study:

- Establish how psychologists in South Africa who participated in the current study conceptualise paedophilic disorder, paedophilic ideation and its treatment.
- Identify which interventions psychologists in South Africa who participated in the current study use when dealing with paedophilic disorder and paedophilic ideation.
- Establish the key challenges experienced by psychologists in South Africa who participated in the current study who have dealt with paedophilic disorder and paedophilic ideation.
- Identify how psychologists in South Africa who participated in the current study draw on existing treatment protocols or fail to draw on such protocols in their interaction with clients with paedophilic disorder and paedophilic ideation.

3.3 Research Design

Qualitative research is not predisposed to "fixed" meanings but instead makes interpretations about meaning (Murphy et al.,1998). In addition, within social constructionism, findings are not presented in objectivist terms. Instead, researchers rely on their plausibility (Andrews, 2012). In this study, within the interpretivist

paradigm, the epistemological perspective is social constructionism. This is because the focus is on how knowledge of social reality is constructed and the shared meaning of this social reality. Social constructionism in psychology as an inquiry is an interactional and participatory process between those involved (researchers and participants) in constructing new ways of knowledge (Losantos et al., 2016).

A qualitative approach emphasises the perspective of the involved participants whereby the researcher focuses on understandings as well as the meanings attributed by the participants and the views they hold about the problem under study. Social constructionism can generate honest debate and lead to change. According to Berger and Luckmann (1991), human activity causes change. Although reality is socially defined by individuals and groups, those with the most power decide on the dominant reality. However, individuals and groups will always contest the dominant social reality as societal power shifts and new realities emerge. This study was located within the interpretivist paradigm, used a qualitative methodology and collected data through semi-structured interviews with registered psychologists who treat paedophilic disorder or paedophilic ideation in South Africa.

Babbie and Mouton (2008) and Creswell (2007) explain that within a qualitative approach, the researcher is seen to be a vital component and main instrument. In this study, the researcher is a student clinical psychologist interested in paedophilic disorder and paedophilic ideation. However, as a 36-year-old white male of middle socioeconomic class and a single parent, I had certain blind spots, which I addressed through the process of supervision, whereby I submitted my work for critique. This process also allowed me to be self-reflexive.

I collected data by examining documents and interviewing participants. The qualitative nature of this study allowed the research data to be collected in the participants' familiar working environment, which allowed for the interpretation of their experience of the research problem (Creswell, 2007). I engaged with each participant in a dyadic interaction, which is vital in capturing and describing their experience in treating individuals with paedophilic disorder or paedophilic ideation (Ponterotto, 2005). According to Creswell (2007), interviewing, as a research method, allows for the detailed gathering of information and experiences of the psychologists who treat paedophilic disorder. A qualitative approach allowed for an open platform to understand the therapeutic techniques and, more broadly, the interventions used to treat paedophilic disorder or ideation.

3.4 Research Purpose

The research purpose of this study is exploratory research, demarcated as research to examine a problem that is not evidently defined. Exploratory research is done to gain improved understanding of existing research problems but will not deliver definite results.

3.5 Type of Research

The type of research for the current study will be basic research and not applied. It is basic research not just because basic research doe not yield immediate results when it is finished, but also because the primary aim of basic research is to comprehend the understanding of a phenomena.

3.6 Sampling

The study used purposive sampling (non-probability sampling), a technique widely used in qualitative research to identify and select information-rich cases for the most effective use of limited resources (Patton, 2002). This involves identifying and selecting individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest (Creswell & Plano Clark, 2011). In addition to knowledge and experience, Bernard (2002) noted the importance of availability, willingness to participate, and the ability to communicate experiences and opinions in an articulate, expressive, and reflective manner.

3.6.1 Sample Selection

The sample size for this study relied on participants who were experienced (see sampling criteria specified below) in the given area that this study focused on, given that not all psychologists treat individuals (their clients) with paedophilic disorder or paedophilic ideation. A recruitment advert (see Appendix B) was placed online on my personal WhatsApp status, personal Facebook and platforms/groups specifically for South African psychologists that only psychologists can join but networking throughout South Africa, and on my LinkedIn, which is a professional online community. I emailed the advert to several institutions, reaching out to psychologists and the Psychological Society of South Africa (PsySSA) lecturers at the University of South Africa (UNISA) and personal networks of professionals built up over the years and asked them to pass it on to psychologists in South Africa. The advert summarised the need for this study and the interview procedures.

3.6.1.1 Sampling Criteria

Table 3.1

Sampling Criteria of Participants

Inclusion Criteria	Exclusion Criteria
Registered with the HPCSA as a clinical or counselling psychologist in South Africa.	Individuals not registered with the HPCSA as a clinical or counselling psychologist in South Africa.
Have treated individuals with paedophilic disorder or paedophilic ideation in psychotherapeutic sessions in accordance with their scope of practice, even where this was not the main presenting complaint.	Have not carried out a therapeutic process for paedophilic disorder or paedophilic ideation in therapeutic sessions.

Sampling criteria entailed that participants were clinical and counselling psychologists registered with the HPCSA and included clinical psychologists registered with the HPCSA but completing their community service year. According to the HPCSA, Act No 58 (1974), clinical and counselling are specialised categories of psychologists who, corresponding to their scope of practice governed by the HPCSA, are allowed to offer psychotherapeutic treatment of mental health disorders of adults ranging from mild to complex in severity (clinical psychologists) as well as mental health disorders ranging from mild to moderate in severity (counselling psychologists). Other categories of psychology professionals registered with the HPCSA are limited in terms of their scope of practice. Therefore, their abilities to provide specialist psychotherapeutic interventions are limited, and these professionals (such as educational psychologists and registered counsellors) do not fit the criteria for this mini-dissertation.

Nine participants responded to the recruitment advert. However, only six of these nine, who have previously treated individuals (whether successfully or unsuccessfully) with paedophilic disorder or paedophilic ideation, were included in the study. Three potential participants did not wish to participate inthe study. One declined due to their professional indemnity insurance provider's advice. In South Africa, the law is strict on adults and children not engaging in sexual relationships. However, this then leaves grey areas for not only the individual with paedophilia but a treating therapist as well. It is the duty of a therapist to report any sexual abuse of a child, and

it is one of the areas in which confidentiality can be broken. The core of any psychotherapeutic ethic relies on the ethics of beneficence and non-maleficence, which creates a grey area and possible concern for an insurance provider. Of utmost importance linked to risk and ethics is that of confidentiality. I postulate that the service provider protects not only the psychologist under their cover but, by default, the patient population. Even though this study was deemed low risk in terms of ethics, the professional indemnity insurance provider highlighted one of the perceived reasons that professionals do not always wish to engage in psychotherapy with individuals with paedophilia, as it is too high risk for these individuals from an ethical and legal standpoint.

Another potential participant declined due to time constraints and unavailability to participate, and a third stopped responding to correspondence without reason. After several months of receiving no further responses to my recruitment advert and other methods of sourcing participants, I decided to conduct the study with the six participants I had found. Time was of the essence to conduct the research and meet the university's deadlines. Thus, saturation, that is, the repetition of information from interviews, did not feature in this study.

3.7 Data Collection

According to Smith et al. (2009), a qualitative approach allows for natural and purposeful dialogue to occur during interviews. This idea stems from the fact that participants can speak freely and reflectively as they construct their ideas and experiences. Interviewing, as a data collection method, is vital in order to understand the therapeutic interventions currently being used by psychologists in South Africa who treat clients with paedophilic disorder or paedophilic ideation. Kelly (2006) explains that meanings are co-constructed during an interview through the product created by the two individuals, the interviewer and interviewee, but also as they are products of larger social systems.

3.7.1 Semi-Structured Interviews

Interviews are conversations to gain insights into a person's subjective experiences, opinions and motivations – as opposed to facts or behaviours (Busetto et al., 2020). Semi-structured interviews are characterised by open-ended questions and the use of an interview guide (or topic guide/list) in which the broad areas of interest, sometimes including sub-questions, are defined (Busetto et al., 2020). The primary research question of the study may well serve as the first interview question.

However, between 5 and 10 more specific questions are usually developed to explore different aspects of the research issue (Dicocco-Bloom & Crabtree, 2006).

In order to collect the necessary data, participants were interviewed in a semi-structured manner, either in person or using an online platform where the sessions and recordings were encrypted. The online platform used was Zoom. This online communication platform with audio and video capability allows participants to meet virtually in real-time and record their interactions. Zoom was preferable as this allowed me to conduct interviews in various provinces, mitigating the need for costly and time-consuming travel. Zoom is advantageous because it saves costs in reducing or eliminating travel time and finding a suitable venue to conduct interviews (Archibald et al., 2019). It is also a simple and user-friendly platform. One of the disadvantages of Zoom is that an unstable Internet connection can affect the interview's quality and impact rapport. This occurs when researchers and participants do not have high-speed connectivity. However, this was not the case for the researcher or participants in this study. Although online interviews were recorded, I also took notes where necessary. Interviews were conducted in English, given that this is my mother tongue and participants were fluent in English (participants' demographics are provided further on). Each interview lasted approximately an hour and a half, given that the participants were working professionals. Of the six interviews that took place, two were in person; one was at the participant's residence, and the other was at a correctional services institution where the participant was employed. The details about time constraints were agreed to before the interview. Participants were asked to sign a consent form (see Appendix C) and were free to exit the interview at any point, for whatever reason, without explanation.

Each participant was asked a series of open-and close-ended questions (see Appendix F). This was to create a flow to the interview process and obtain relevant information to the research, such as the participants' therapeutic approaches and theoretical models used when treating paedophilic disorder and paedophilic ideation, probing around stigma, whether individuals were mandated to psychotherapy or self-referred etc. The semi-structured manner of the interview allowed for questions to be asked based on the literature review as well as questions in line with the objectives of the study (see Appendix F). Further questions were asked as relevant themes presented themselves, which followed in an unstructured manner.

A transcriber who agreed to and signed the non-disclosure agreement (see Appendix E) was used in order to convert the voice recordings into readable material analysis. Ethics regarding the use of a transcriber is discussed in further detail below. The purpose of the non-disclosure agreement (Appendix E) is to ensure ethics are maintained and, more specifically, to ensure confidentiality, which is discussed in detail within this chapter. Interviews were transcribed verbatim. Since the focus was mainly on the content of what participants said, the transcriptions, for the most part, did not attempt to capture paralinguistic details such as inflections and pauses.

3.8 Reflexivity

Reflexivity is being sensitive to the relationship between the researcher and the researched, including how participants were found, how contact was upheld, and the demographic details and experience of myself involved in data collection and analysis. These details are pertinent because, in qualitative research, the researcher is part of the research process. Thus, their age, gender and race, for instance, may impact the research both positively and negatively (Busetto et al., 2020).

I am aware of my own political body and context in that I am a 36-year-old, white South African single gay father, currently in the capacity of student clinical psychologist. As a student clinical psychologist, I do not have as much real-life exposure to treating paedophilic disorder and paedophilic ideation. However, I have worked extensively as a registered counsellor for 10 years, having worked for the SAPS and being co-founder of a trauma unit specifically catering to the counselling needs of the community in Durban North, KwaZulu-Natal. I have worked in various clinical settings during my master's training over 2 years. Further, I have embedded myself in literature and relevant teachings around this research topic. As a gay male, I am fortunate to live in a diverse country such as South Africa, where laws surrounding my sexuality are more “normalised/approved of” compared to other countries where homosexuality is a crime. I mention this to allude to the idea that South Africa is a country which, due to our previous struggles, has a democratic constitution which allows for individuality and more acceptance for those deemed different by society. That is not to say that stigma is absent, but I feel South Africa is embedded in a constitution allowing for less stigmatisation of individuals. On this note, however, I have personally been incorrectly stigmatised as being perceived by others as a paedophile, given their misconceptions surrounding homosexuality. This ignorance became one of the reasons I chose to investigate further into the understanding of

paedophilia. It formed one of the bases for wanting to understand the disorder, how those affected are not understood by society and how they receive the necessary support for their mental health. In terms of my own reflexivity, I am part of a research support group with various members around the world who conduct research on paedophilia and attraction to minors. I discovered the research group when looking into the literature, and I reached out to B4U-ACT, who established the research network in March 2011. The group was compiled to connect researchers worldwide related to the mental health of people attracted to minors. The aims of the research group are to help researchers network and support one another. Furthermore, the research group offers online events, allowing researchers and other interested parties to present ongoing research and stay informed of developments in the field. I use this forum and my personal psychotherapeutic context to work through my ideas and the impact of the research conducted. Lastly, I keep a personal journal of my thoughts, ideas, associations, and relevant emotions in such a way as to create a reflexive self-narrative which in itself is therapeutic.

3.9 Pilot Interviews

Qualitative research is cyclical, and this strengthens it as the researcher goes back and forth between data collection and analysis, revising and improving the approach where necessary. One way of doing this is to conduct pilot interviews. This allows the researcher to assess how the interview went regarding format, time and site; for instance, were the questions easy to comprehend, and were they all managed within the time limit? The researcher can amend where appropriate after conducting a pilot study. In this study, I conducted a pilot study by interviewing a participant in the field of clinical psychology. Thereafter, I amended the interview schedule to clarify some questions and ensured that they met the stipulated 60 to 90-minute interview time frame. The pilot study formed part of the data analysis.

3.10 Participants’ Demographics

Bearing in mind the ethical need to protect participants’ identities, only those demographics pertinent to the study, as discussed in the findings, are provided. For ease of reference, these are presented in tabular form. The qualifications of the participants are relevant as the study aims to understand how psychologists in South Africa who participated in this study currently therapeutically treat clients with paedophilic disorder and paedophilic ideation. Thus, establishing expertise in the field is essential, which is augmented with participants’ experience regarding the length of

practice, particularly with clients with paedophilic disorder and paedophilic ideation. The categories of age, race and gender are relevant regarding how participants' identities are socially constructed concerning their clients.

The sample of participants comprised three males and three females with ages varying from mid-twenties to mid-seventies, as depicted in Table 3.2. Four participants were white, one was black, and one was Indian. This represents an over-representation of white participants relative to South African demographics but roughly corresponds to the demographics of registered psychologists in South Africa, most of whom are white. All participants have the qualifications necessary to therapeutically treat clients with paedophilic disorder and paedophilic ideation with varying ranges of experiences. Table 3.2 shows where the participants obtained their degrees, all to the master's level. Five of the six participants were registered as clinical psychologists. One participant was registered as a counselling psychologist. Years of being in professional practice and years of experience with paedophilia varied among participants, with 1 participant having 40 years of experience as a psychologist, with corresponding experience with paedophilia being 30 years. Another participant had 30 years of experience as a psychologist, with 10 of those years relating to paedophilia. Only 1 participant had an equal number of years of experience as a psychologist treating paedophilia, which was 8 years. A single participant had 10 years of experience as a psychologist, with 5 years contributing to their experience with treating paedophilia. A further participant had 17 years of experience as a registered psychologist, with 16 of these years having been involved with and having experience in treating paedophilia. The last participant has been qualified for 11 years, with 10 of those years corresponding to treatment experience with paedophilia. Two participants work in private practice. However, one of these in private practice works with clients who are, at times, referred to them by the state for psychological intervention. Three participants work in the correctional service setting, and one participant works in both the correctional services setting and private practice setting. Therefore, the majority of participants from the sample provided psychological intervention within the correctional services setting.

Table 3.2

Participants' Demographics

	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Participant 6
Qualifications	MA Clinical Psychology, University of KwaZulu-Natal (UKZN)	MA Clinical Psychology, The University of South Africa (UNISA)	MA Clinical Psychology, University of the Free State (UFS)	MA Clinical Psychology, Nelson Mandela University (NMMU)	MA Clinical Psychology, UKZN	MA Counselling Psychology, UKZN
Age	50–60	60–70	20–30	30–40	30-40	30–40
Gender	Male	Male	Female	Male	Female	Female
Race	White	White	White	White	Black	Indian
Practicing Years	40	30	8	10	17	11
Experience[a]	30	10	8	5	16	10
Practice Location	Private	Private and Correctional Services	Correctional Services	Private Practice	Correctional Services	Correctional Services

Note: [a]Treating clients with paedophilic disorder/ideation

3.10 Data Analysis

Polit and Beck (2010) suggest that qualitative data analysis is an active process of purposely reading and re-reading the data and looking for significance and deeper understanding. In this study, thematic analysis was used, which is discussed next.

3.10.1 Thematic Analysis

Thematic analysis, according to Braun and Clarke (2012), is a unique and valuable qualitative method that has become a qualitative approach used globally. Thematic analysis is a form of pattern recognition within the data, with emerging themes becoming the categories for analysis (Fereday & Muir-Cochrane, 2006). The process involves a careful review of the data. Thematic analysis is broken down into phases because the different phases of data analysis in qualitative research are a bridge between a more abstract theory with practical reality. Insight will be gained with thematic analysis through systematically identifying, organising, and providing an understanding of the thematic patterns that will arise from the data collected.

Inductive and Deductive Approach

Both inductive and deductive approaches were used for this study. Inductive versus deductive has to do with the source of the data and what is done with the data. Inductive uses the data to try and discover new concepts/categories/themes; deductive uses existing concepts/categories/themes to organise and interpret the data. Qualitative thematic analysis is at the inductive end of the spectrum. However, all research involves an interplay between inductive and deductive elements. In the case of this study, there are existing categories that come from the literature (especially from existing practice guidelines and policies) that helped in structuring the interview schedule and will also be present in the analysis of the data. In this regard, this study is deductive. At the same time, I examined concepts/categories/themes that arose “organically” from the interviews to offer new ways of making sense of what unfolded; therefore, the mini-dissertation is also inductive. An inductive approach is mostly experiential in that it “gives voice” to the experiences of participants, and this will be obtained through one-on-one interviews with psychologists who treat clients with paedophilic disorder or paedophilic ideation. An inductive approach relies on a bottom-up style, which is led by the content of the data from the interviews, meaning that codes and themes will emerge from the content of the interviews (data). On the opposite side, a deductive approach is a top-down method where the researcher relies on concepts and ideas brought into the research and then interpreted the data in terms

of these external concepts and ideas. The codes and themes mapped by the researcher under this approach do not always connect to the semantic content of the data. Braun and Clarke (2012) provided a six-phase approach to thematic analysis; the different phases are now discussed.

Six-Phase Approach to Thematic Analysis

The first phase is familiarising oneself with the data. This “involves *immersing* yourself in the data” (Braun & Clarke, 2012, p. 9), which I did. I read and re-read the data obtained from the transcriptions of the interviews whilst making notes. This is a form of pattern recognition where the emerging themes become the categories for analysis (Fereday & Muir-Cochrane, 2006). I familiarised myself with the interview data analytically and critically instead of just reading on the surface.

The second phase is the generating of *initial* codes. The systematic analysis of the data obtained from the interviews was coded within this phase with one or more short descriptors of the content of a sentence or paragraph (Fossey et al., 2002). Coding is the process of linking the raw data to the concepts and theories one uses in the study (Busetto et al., 2020). Codes identify and label potentially relevant data. These codes provided labels of codes taken from the interview data, allowing for a summary of the descriptive codes and the content of the data obtained from the interviews with psychologists. Coding further allowed for the interpretation of the data content, which is more in-depth than the surface meaning. Whilst generating initial codes, I formed a shorthand, which I relied on when making sense of the data. Again, during this coding phase, I thoroughly re-read all the data obtained from the interviews (checking codes). This phase was concluded only once all data had been entirely coded and all relevant codes had been collated.

The third phase is searching for themes. The codes previously obtained were converted into themes under this phase. Themes relate to important points directly related to this study’s objectives. Further, themes establish a level of patterns that give a response and develop meaning within the data set in that themes emerge from the data. In this manner, themes are actively processed, and meaning is attributed to them as they are constructed. During this phase, I reviewed the coded data and identified areas of similarity and any overlaps between codes. Codes were, therefore clustered if they shared the same features in order to reflect on as well as describe meaningful patterns in the data. A component of this phase is the exploration of the relationships

between emerging themes and beginning to understand how these themes relate to each other, which themes are distinctive, and themes that work together as a whole.

The fourth phase is reviewing the potential themes. I reviewed emerging themes against the compiled extracts of data in order to identify if the theme was workable in relation to the data collected. After themes became distinct, I reviewed the entire process. This entailed re-reading all data to determine if themes were meaningful and if they captured the data set as a whole (Braun & Clarke, 2012).

The fifth phase is defining and naming themes. When themes were defined and named, specific themes became clearly stated as to what is unique about each theme and how each theme can be summed up. These themes were singular in focus and did not overlap; however, they built on each other and directly addressed the research question: "How do clinical and counselling psychologists in South Africa currently treat clients with paedophilic disorder or paedophilic disorder ideation?" This phase was analytical and crucial as it separated itself from the final phase. It did so in that I selected extracts to analyse during this phase, and a story of each theme was set. These extracts formed the structure for the analysis and became the narrative that informed readers of my interpretation of the data and the meanings assigned. The data was interpreted and linked to the current study's objectives as well as the field of psychological practices when clinical and counselling psychologists treat paedophilic disorder or paedophilic ideation. Conclusions were drawn across the entire analysis, and interconnections were made between themes which provided information about the data set. Finally, each theme was given a name.

Phase six is the production of the chapter on findings within the mini-dissertation. The writing and analysis were interwoven and comprised of all informal writing, including note-taking, memos as well as the formal writing of the mini-dissertation. This mini-dissertation gives a concise story about the data based on my analysis, as well as addresses the research question and the objectives of this study.

3.11 Rigour, Credibility, Confidentiality, Trustworthiness and Validity

3.11.1 Rigour

Fossey et al. (2002) pointed out that qualitative research should be assessed against criteria more consistent with its philosophical position. The process of rigour begins in establishing the purpose of the study and locating it epistemologically, that is, within knowledge about reality.

3.11.2 Credibility

In the qualitative research process, it is important to represent participants' perspectives; the data must be collected authentically, and coherence is ensured between the findings and the social context from which they emanated. It is also important to consider who the researcher and researched are, i.e. the power relations between them. In addition, one must be transparent in data collection, analysis and how the findings are reported.

Furthermore, credibility can be enhanced in the way the findings are presented. Fereday and Muir-Cochrane (2006) stated that the researcher must show how they interpreted the data with directed quotations. The participants' ideas and knowledge of the subject, in their own words, strengthen the credibility of the research (Patton, 2002).

Member checking is part of enhancing credibility. This asks the participants to read their transcripts to see if they accurately capture their ideas. Member checking, also called participant validation, refers to the practice of checking back with study participants to see if the research is in line with their views (Birt et al., 2016). Interviewees can be provided with (summaries of) their transcripts and asked whether they believe this to be a complete representation of their views or whether they would like to clarify or elaborate on their responses. Birt et al. (2016) pointed out that this step allows the researcher to claim that the transcripts are accurate and can be trusted, but member checking does not mean one can claim the analysis is trustworthy. The researcher knows knowledge is intersubjective and that there are many interpretations of one phenomenon, as the literature review on the topic has shown. Thus, I confirmed some of the data with the research participants through the member-checking process.

3.11.3 Trustworthiness

Good qualitative research is iterative in nature; it is cyclical, going back and forth, and it is transparent. Researchers are aware of their bias as they acknowledge subjectivity; rather than denying their ideas and experiences, they acknowledge it in note-taking by keeping a research journal. To strive for transparency, I documented all decisions made at various stages of the research process. According to Shenton (2004, p. 71), "the study should be reported in detail". The researcher must follow guidelines of good practice to ensure the trustworthiness of a qualitative study as this applies to reliability and validity, which will be discussed below:

First, the researcher should specify their values, theoretical framework and any preconceptions they may have. Next, they must explain how the social and cultural context relates to the given perspective in which the given problem was viewed within the study. They must describe their awareness of their own internal processes during the research process, as this helps shape their observations and interpretations of data (Noble & Smith, 2015). Finally, the researcher must establish trust and rapport with the participants and immerse themselves in the material. Then, they will move between the text, in this case, the interview transcripts, and interpretation, making links (Noble & Smith, 2015).

Validity comprises reflexive and catalytic. Reflexive validity refers to how the theory and the researcher's thinking evolved or shifted, given the study's findings. In contrast, catalytic validity refers to how sufficiently the researcher empowered the study participants. In this study, my thinking changed due to the participants' input and the literature review conducted.

I adhered to the guidelines above of good practice during this study to ensure the rigour, credibility and trustworthiness of the research.

3.12 Ethical Considerations

Ethical approval was obtained before data collection commenced to conform to the HPCSA requirements and to protect participants from any harm or misconduct (see Appendix A). According to Rubin and Rubin (2012), participants who participate in a research study must be protected, understandably so.

3.12.1 Autonomy, Confidentiality and Respect

Autonomy, confidentiality and respect for participants were upheld throughout the study. These ethical principles refer to the rights of the participants' agency throughout the research process. This is ensured by their understanding that their involvement in the study is voluntary, that they can withdraw at any time without giving any explanation, that they are fully aware of the nature and purpose of the study and that their identity or any identifying information will be kept confidential as well as all information they share with the researcher (Wassenaar, 2006). In order to ensure the protection of participants' confidentiality, numeric numbers were allocated to each participant. Participants were asked to use pseudonyms for clients to ensure their confidentiality, should it come up during the data collection. In addition, transcribers were asked to sign a non-disclosure agreement protecting participants and all data (see Appendix E). All data that was voice recorded on the Zoom platform, as well as

any notes that were taken, were securely kept in my personal safe, ensuring the security of all data. All data that was transcribed was kept on a laptop computer in a secure folder. The laptop computer has a security code for access. As an extension of their autonomy, each participant in this study was supplied with a consent to participate form (see Appendix C) as well as an information sheet (see Appendix D). The participation form, in conjunction with the information sheet, explained the purpose of this study and described the right of participants to withdraw from the research study at any time. Participant involvement is voluntary and in the sole interest of the research. The participants received information explaining the purpose of this study, the role of interviewees, the benefits of participating and the contact details of supervisors were given should participants require contact with the supervisors of this study. Each participant was allowed to ask questions before and after the interview, and it was explained to the participants that there were no anticipated risks to any participant in this research study.

3.12.2 Beneficence

Beneficence is defined by Orb et al. (2001, p. 95) as "doing good for others and preventing harm". I ensured that every attempt was made to provide support and respect to participants to maintain this code. I also created a balance during the interviews whereby participants obtained information whilst speaking to their strengths as psychologists who treat a specialised portion of society and reduce the stigma attached to their work within the mental health profession.

3.12.3 Non-Maleficence

Non-maleficence is an ethical principle in research and a requirement. It means one must reduce "any threat of harm (physical, psychological, social, economic, legal, and dignitary harm) to the participants" (Yin, 2011, p. 46). I maintained adherence to this ethical principle by ensuring participants' protection from any emotional or relational harm due to the carrying out of the research study. However, given that participants recounted their process of offering psychotherapy to individuals with paedophilic disorder and ideation, it was observed that some emotional or relational harm might occur. If so, the participants, as professionals in the field, would have a better capacity to deal with that. Participants were put at ease regarding their privacy. In addition to this, I was cognisant in taking care to avoid framing participants' experiences in a way that could be perceived as stigmatising or negative.

3.13 Conclusion

This chapter discussed the research methodology used in this research study and how these methods were carried out through the research process that unfolded. In addition, I gave reasoning as to why I chose a qualitative approach to the study. The process behind sample selection was discussed and explained, followed by my explanation regarding the chosen method used for data collection and data analysis. After this, an explanation regarding the reliability and validity of the study was given. Lastly, ethical considerations were explained in accordance with their application to the study.

Chapter Four
Findings and Discussion

4.1 Introduction

The primary goal of this research was to investigate how psychologists in South Africa currently therapeutically treat clients with paedophilic disorder and paedophilic ideation. This chapter provides the participants' narratives organised into themes. It will present a discussion of how the themes were derived through coding. This chapter will look at the data analysed by presenting the main themes and subthemes which were identified.

Interviews took place through semi-structured interviews in person or using the Zoom online platform. An interview guide of semi-structured questions was used to facilitate the interviews. Six participants were interviewed and formed part of the data collection. Before presenting themes, the participants' experience and expertise are provided.

4.2 The Participants

Table 3.2 in the methods chapter presented the participants' demographics with discussion. These were three males and three females ranging in age from mid-twenties to mid-seventies. Five participants were registered clinical psychologists, and the sixth was registered as a counselling psychologist. They were all qualified to therapeutically treat clients with paedophilic disorder and paedophilic ideation. All except one participant (in their twenties) had vast experience practising as psychologists and, furthermore, with clients with paedophilia, which comes through in their narratives. Two participants were based in private practice, with one also taking on clients referred by the state. Four of the participants were located in a correctional setting, with one of these also taking on private clients.

4.3 Themes

Themes were derived from collating the relevant codes and organising them into the themes and subthemes that emerged. The themes and subthemes are presented in tabular form (see Table 4.1) for ease of reference with a brief explanation. The discussion and interpretation of these themes and subthemes, drawing on the participants' words and the literature, are presented after the table.

Table 4.1

Themes and Subthemes

Themes	Subthemes
Theme one**:** Paedophilic disorder and paedophilic ideation	• Comorbidities • Types of paedophiles • Grooming • Sexual orientation
Theme two: Psychotherapeutic interventions	• Individual and group therapy • Participants' skills
Theme three: Therapeutic approaches and theoretical models	• Training • International guidelines, organisations and models
Theme four: The law	• Correctional services • Mandated therapy
Theme five: Stigma	• Stigma toward individuals with paedophilic disorder and paedophilic ideation • Stigma toward the professionals who treat individuals with paedophilic disorder and paedophilic ideation

4.3.1 Paedophilic Disorder and Paedophilic Ideation

This was chosen as a central theme as it emerged in every interview and encompassed subthemes that give an understanding of the individuals with paedophilic disorder or paedophilic ideation. Within this main theme, which examined not only the disorder itself and paedophilic ideation, subthemes were found. The first examined the emergence of comorbidities, the second various types of paedophiles encountered by participants, and how this impacted their approach to therapy. The

third subtheme addressed the prominence of grooming behaviour associated with the disorder by individuals toward others, and lastly, the idea of paedophilia as a sexual orientation.

4.3.2 Psychotherapeutic Interventions

The theme of psychotherapeutic interventions involved examining the various psychotherapeutic treatments, interventions, modalities and intervention strategies used by psychologists when treating individuals for paedophilic disorder and paedophilic ideation. The emergence of the subtheme, group therapy, in relation to the treatment of paedophilic disorder and paedophilic ideation, offered a range of responses as each participant spoke about their use of assessment tools and the related accessibility of these assessment tools in South Africa. Within this subtheme, there was a clear emergence of specific traits and skills relating to the participants as psychologists who treat clients with paedophilic disorder and paedophilic ideation.

4.3.3 Therapeutic Approaches and Theoretical Models

This was a main theme which emerged in the interviews with all the participants. All the participants relayed information about their specific theoretical/therapeutic approaches to individuals with paedophilic disorder and paedophilic ideation. Each participant spoke to the subtheme of training and offered insight into their specific training relating to their abilities in treating individuals with paedophilic disorder and paedophilic ideation, as well as the gaps in their training. The subtheme of international guidelines and organisations was identified, given that the participants' focus on training specific to treatment stemmed from international training. This was further extended to the subtheme of international models as participants drew on these in the therapeutic setting.

4.3.4 The Law

This theme emerged unexpectedly as many participants worked in correctional services, which impacted the treatment and overall understanding of paedophilic disorder and paedophilic ideation, specifically within this context. This led to the subtheme of correctional services to allow for an understanding of paedophilic disorder and paedophilic ideation and how it is treated and managed within this context. In turn, this led to the subtheme of mandated therapy, given that it related directly to how individuals were treated in psychotherapy and a holistic understanding of how this impacted treatment.

4.3.5 Stigma

This was the final main theme which emerged. It encompassed two subthemes, that is, stigma toward the individuals with paedophilic disorder and paedophilic ideation and stigma toward the professionals who treat these individuals. This theme and subthemes included a discussion on the broader stigmatisation of paedophilia by society.

4.4 Discussion of Themes

What follows is a discussion of the participants' narratives organised into themes and subthemes, drawing on the literature regarding the study's research question to understand how psychologists in South Africa from the current sample currently therapeutically treat clients with paedophilic ideation and paedophilic disorder. The discussion will provide the participants' own words under each theme and subtheme. The participants' words are provided verbatim in line with the qualitative approach used in this study, emphasising the participants' perspectives of the issues being studied.

4.4.1 Theme One: Paedophilic Disorder and Paedophilic Ideation

Within this theme, participants spoke of their understanding of paedophilic disorder and paedophilic ideation in the context of their experience and the issue of female paedophilia. The discussion later examines accompanying comorbidities and whether this was a mental disorder or a sexual orientation.

> "I haven't looked at the latest DSM-5 or what they said about paedophilia or paedophilic disorder … Depends on whether it's purely therapeutic or whether it's understanding the legal context of why the person committed whatever they did, but invariably I try to understand, how and why did this come about … is it that because of the preoccupation with, usually it's sexual images of children and pairing that with sexual self-satisfaction they develop that kind of, association and then identification." [P1]

> "Um, a lot of them are practising paedophiles, but they are ego-dystonic in other words, they are not happy with it but that's where their erotic attraction lies … who went to therapy … purposefully avoided exposing himself to minors … that prognosis tends to be better." [P1]

> "This nanny would expose herself to him from a very young age and let him play with her vagina and breasts, so he became quite intrigued by that; now, he

is not a paedophile, but he’s developed sexual behaviours in his adult life that has affected his ability to sustain relationships.” P1]

Participant 1’s extracts above reveal that paedophilic disorder is an identification that occurs, and the goal for understanding their sexual associations and paraphilia is to understand where it originated from and how it evolved over time. In terms of prognosis, participant 1 alluded to the idea that when there is insight on the client's behalf, and they maintain restraint of not acting on sexual urges but understand and admit to having a sexual attraction to children, then the prognosis of treating these individuals increases successfully. Participant 1 stated that his understanding of the disorder is on a continuum. In some cases, the individual may not have complete insight into their sexual attraction to those younger than themselves and may not be considered paedophilic. However, significant gaps in age between them and their younger adult partners affect the individual's ability to maintain relationships. A key element is the developmental understanding that this fixation stems from when the individual was younger and sexually abused themselves, whereby a confusing emotional state was at play being the idea of finding pleasure and playfulness associated with their sexual abuse and developing into a key element to their sexual preferences and sexual underpinnings.

“The victim pool is generally very close to the age when they were abused … eventually when they grow up ... they remain in that mode; they want sex with children.” [P2]

“He was abused as a child … he was rejected by his parents … and he married, I think 48, and he married a girl of 18 … there was this whole thing of inappropriate age difference, the whole, primal thing … Pattern of being rejected as children, a very dominant aggressive mother.” [P2]

“So if they were molested at the age of 7, they generally seem to be offending at that same age.” [P4].

Participant 2 agreed with participants 1 and 4 in associating prior abuse as a child with their sexual development and sexual attraction later in life. Nunes et al. (2013) and Yunus et al. (2018) stated that children who are sexually abused might develop paedophilic disorder, often referred to as the cycle of abuse theory. However, there is conflicting research on this. For instance, a study by Leach et al. (2016) found no link. Participant 2 added that rejection by primary caregivers further impacted this deviation in sexual development. Participant 2 offered further insight into the makeup

and understanding that not only did primary caregivers play a role, but usually one of the primary caregivers would be an aggressive female role and also that the rates of incest or their initial abuser being known to them as a child was significantly high. Further stating that the attraction the individuals with paedophilic tendencies have now seems to mirror their own sexual abuse as children, in that their attraction to a specific age group mirrors the age when they were sexually abused. Participant 2 offered further understanding in that it alludes to a type of indoctrination of children who become instilled with a sexual experience as a child or adolescent and then go on to want to act on urges created through their experiences of sex and sexuality through their sexual abuse.

> "So I wouldn't necessarily see a difference between ideation and actual disorder. For me, it would be the same thing. You are still being dominated by an intrusive thought." [P4]
>
> "With children, there is no mystery … children generally are sexually innocent. So, if you're attracted to a child, what you seem to be bypassing is an element of mystery that you would always have to negotiate in an adult relationship. Our sexual unconscious is formed by our parents' sexual unconscious." [P4]
>
> "So if you looking at incest cases, that child is going to grow up and cross that boundary from being a child to adolescent teenager, and does that attraction remain? And they saying yes, for incest cases, yes." [P4]

Participant 4 indicated a lack of literature on the topic of paedophilic disorder and paedophilic disorder ideation, leading to unknowns within the therapeutic field. In offering an understanding of what comprises paedophilic disorder or ideation in individuals, participant 4 initially narrated that in adult relationships, there would be a sense of mystery and intrigue, which would seemingly be traumatic to the individual to handle these situations in relation to their past abuse. Therefore, they are almost innately drawn to children as a coping mechanism to bypass the trauma of mystery in adult relationships. Furthermore, participant 4 narrated an inseparable connection between a primary caregiver's sexual unconscious and intrapsychic material being linked to the child's sexual unconscious material in that there is almost a passing down or transmission of these experiences from a caregiver to a child.

> "It was love, affection, regard, discipline … the child was getting something from the sexual encounter even if it was acceptance they would describe a kind of relationship … you'd hear fathers who raped their kids they would say … they

> felt this emotional connection this level of intimacy with their child victims, and they believe that it was beneficial to the child, whether it was for educational purposes whether it was meeting a need in the child, whether they misinterpreted the child's general cues as being sexually provocative of some sort." [P6]

Participant 6's narrative was on how paedophiles saw their relationship with children as being of value to children in that it was seen as a mutually beneficial relationship similar to that of an adult-adult relationship. Hall and Hall (2009, p. 523) substantiated that paedophiles say their actions have "educational value", that the child derived pleasure from the acts or attention, or that the child was provocative and encouraged the acts in some way". Regarding "educational value" the actions are justified by stating they are teaching the child about the "facts of life" or "love" (Wings for Truth, 2023, para 8). Participant 6 reinforced what previous participants had said about the seeming innocence of the individual attracted to minors in the way they understand the relationship. This often leads to misinterpretations of what is perceived as sexual advances by the child toward individuals attracted to minors.

4.4.1.1 Subtheme: Comorbidities

Under the theme of paedophilic disorder and paedophilic ideation, various subthemes emerged related to understanding the disorder and/or the understanding of paedophilic ideation. Central to this was the first subtheme relating to comorbidities experienced by those individuals who have been treated by various psychologists for paedophilic disorder and paedophilic ideation.

Men with paedophile disorder have a long history of other psychiatric disorders, a high prevalence of mood or anxiety disorders, personality disorders and substance abuse, rendering treatment complex (Cassiani-Miranda et al., 2019). In this study, the only participant who did not allude to comorbidities was participant 4. However, all other participants indicated comorbid mental health issues associated with paedophilic disorder and paedophilic ideation. The most prominent of these comorbidities are antisocial personality traits.

> "Well, when you have somebody with paedophilic ideation, and it's ego-dystonic, they don't want to have that, then they'll be a co-existing anxiety-depression, often issues of self-loathing … the other pathologies that exist, obviously you know, you going to get people with more your, how can I put it, you have to use the old term, your antisocial personality traits, whereby um,

they don't have a very good ability to have empathy … the impulse control is such that they will be very, very ego-centric in trying to satisfy what they are looking for." [P1]

Participant 1 had primary concerns relating specifically to individuals' attracted to minors lack of empathy or insight regarding the realistic nature of adult-child relationships being harmful to children, given that it is sexual abuse. Schuler et al. (2019) conducted their first study, which aimed to disentangle cognitive and affective empathy regarding the emotional states of children and adults by differentiating between the effects of paedophilia and child sexual abuse concerning an individual's ability to empathise. Their study drew on a complex explorative approach looking at empathy from two perspectives: cognitive empathy and emotional empathy. The authors concluded that non-offending paedophiles show greater empathy towards children, and should intervention occur during this time, the chances of offending become lowered (Schuler et al., 2019). However, after the offence has occurred, empathy rates are lower, which could impact therapeutic intervention as the individual's cognitive relations regarding their behaviour lead to them having less empathy towards children.

"There's clear psychopathy or antisocial personality disorder that is caused by drug abuse. So um, nowadays, it's difficult to find a clear-cut paedophile." [P2]

However, participant 2 associated antisocial personality traits with substance use. He elaborated that substance abuse was a coping mechanism. He viewed the development of antisocial personality traits and lack of empathy would develop prior to the onset of paedophilic disorder and paedophilic ideation induced by the abused substance rather than the paedophilic disorder. Raymond et al. (1999) also found high rates of substance abuse disorders. Adiele et al.'s (2011) study found high rates of alcohol abuse.

However, if we look at the response by participant 6, there are comorbidities of conduct disorder and oppositional defiance disorder, which are typically prerequisites for the later diagnosis of antisocial personality disorder after the age of 18.

"You know from conduct disorders, oppositional defiance disorders, antisocial personality disorders … certainly is quite a high prevalence rate of mental illnesses amongst child sexual offenders that I clinically believe as well underpins a lot of the criminal actions." [P6]

Both participants 2 and 6 work in correctional services, which is significant regarding their views on comorbidities. As participant 6 points out, there are often overlooked mental health issues within these settings. Therefore, I hypothesised that little to no intervention for conduct disorders could lead to substance use and impact the development of antisocial personality traits or personality.

> "But one of the things that is often comorbid is anxiety, um, so they are very anxious, and I think mostly sometimes it might be because they feel or they know that what they are doing is wrong and they, there's continually this fear of being caught out or people finding out. Um, so definitely anxiety and then with anxiety, a lot of them also have sexualised coping behaviour … Big clusters being, either narcissistic or borderline personality … trauma-related responses, even worse self-esteem." [P3]

Participant 3 alluded to the anxiety experienced by individuals with paedophilic disorder and paedophilic ideation. Participant 3 also indicated an emphasis leaning more toward narcissistic traits and personality as well as borderline traits and personality. Individuals with paedophilic traits have been associated with comorbid disorders, but research differs on the type and prevalence. Adiele et al.'s (2011) study on the mental health of incarcerated inmates who met the DSM-5 criteria of paedophilia found that the most common Axis I disorders were alcohol abuse and generalised mood disorders, while the most common Axis II was Cluster C personality disorder with avoidant personality disorder and dependent personality disorder the most prevalent. Cassiani-Miranda et al. (2019) found a link between paedophilic disorder and alcohol and drugs. A much older study by Raymond et al. (1999) found that mood and anxiety disorders were most common and that personality disorders, such as antisocial, were offered to explain paedophilic behaviour, even though not much literature supports the latter idea.

This leads one to question if the associated personality traits are coincidental with paedophilic disorder, as it is mainly seen in correctional settings along with substance use, which is a known trigger for the development of psychotic disorders and some personality disorders. In other cases, substance use disorders become a comorbidity of personality structure. For example, unlike the private sector, an individual would be ego-dystonic and actively seek help, assuming empathy and not wanting to act on impulses that harm others.

4.4.1.2 Types of Paedophiles

Participants 2 and 3 also discussed types of paedophiles that could be encountered under the diagnosis of paedophilic disorder and paedophilic ideation. However, this would be specific to a correctional setting. Within the private therapeutic context, the paedophilic individual seemed to stick to a constant, as mentioned under the main theme above. Participant 2 spoke to encounters within the correctional setting in relation to individuals with paedophilic disorder.

> "Some of them are soft-hearted … they have good jobs, they do well … timid type of people, they grew up timid, they haven't been strong, they haven't got strong ego, they haven't got good ego strength … never grow up as adults." [P2]

> "We have our sadistic paedophiles, and I mean those are just the same as our sadistic rapists. But we have for them it's not about loving the children, for them, it's about inflicting pain and harm … It's baby rape … that even goes beyond paedophilic, I've seen a few of them … rape babies, but there's been this whole thing that they believe that they will not get AIDS." [P3]

Participants 2 and 3 described a range of typologies on a continuum of presentation of paedophilic disorder from soft-hearted individuals to sadistic paedophiles. According to Adetutu (2019), experts classify two major paedophilic types: seductive/fixated and sadistic. Participant 3 described sadistic paedophiles as being the same as sadistic rapists. Neither of the participants understood this category of sexual interest as purely paedophilic. Instead, it was linked more to sadistic rape. Participant 2 linked the rapes in some instances to false beliefs regarding HIV and that intercourse with a baby would cure individuals of the virus, which was therefore not linked to paedophilic ideation. According to Epstein and Jewkes (2009), studies in South Africa and Namibia reveal that the idea of baby rape curing AIDS is seldom a motive in the rape of children or child abuse.

Participant 3 expanded further into baby rapists being associated with a more sadistic type of sexual interest in which the individual wants to inflict pain and harm and derive sexual pleasure and gratification from the sadism and power differentials involved. Explaining further that therapy in these instances cannot look to an approach in the same manner as typical paedophilic presentations (as explained in the DSM-5-TR) by looking into their interest and developing empathy by relating it to hurting others, as this leads to reinforcing their sadistic fantasies and has a counterproductive

effect. Paedophiles have generally been categorised as fixated-regressed, exploitative and aggressive. Taylor (2013, as cited in Adetutu, 2019) highlighted the most well-known types of paedophilic categories as a fixed immature paedophile, regressed paedophile, exploitative paedophile, aggressive and/or sadistic paedophile, and hebephile. Regarding types of paedophiles, participants also discussed female paedophilia, with most saying they had not encountered this phenomenon.

> "I've worked in the female prison for about two years, and I never encountered any of that." [P2]

> "I'm not sure that there is really fewer female perpetrators. What I do think is that there's a lot less being reported, and I think a lot of it has to do with society … if it's a 13-year-old boy and there's an adult female, you know making sexual advances and sexually harassing them or fondling them or then even if it goes to penetrative sex, you know the response, for that individual, for that little boy, it is a horrible experience, they don't enjoy it, it's not fun, it hurt. You know they feel violated, but society's response to that is, you know, all the friends are like 'oh you the man, older woman, you so lucky, you know, what was it like?'" [P3]

Participant 2 clearly expressed that they had never encountered female paedophilia. Participant 2 was the oldest participant with decades of experience, yet had never encountered female paedophilia. This led me to hypothesise that perhaps he believed that paedophilia is only associated with males. Interestingly research tends toward this claim. Hislop (2013) stated that laws had not considered female sexual offenders. This hypothesis remained untested as the limited time of the interview meant focusing on his actual experience with paedophilic individuals and therapeutic interventions.

> "There's a lack of literature on female paedophiles ... society has said, is it paedophilia if it's a woman? And secondly to that is … if a woman offends against, let's say, a teenage child, it almost seems as great, well done to you, but if it's done the opposite way, then it becomes a bit of a crime, and society calls it a taboo." [P4]

Participant 4 expressed that there was a gap in research on female paedophilia. This was substantiated by Kramer (2010; 2014), who stated that limited research was conducted on female paedophilia in South Africa.

> "I think women do offend. Maybe it's not as reported as when it's male; that's offending, and also, when we talk of rape, we talk of rape as a society as a male

that is committing it against a woman. When we talk of sexual crimes, it's a man that must commit it against women. I don't think it's a matter of women don't offend … society doesn't have enough knowledge to classify whatever the woman is doing as it falls under rape." [P5]

"There's a very, very strong denialism around female child sexual offending, and the reason for that is because it's very difficult to hold that conflicting notion of a woman, a mother and nurturer to a perpetrator and perpetrating the very same child that you're responsible for nurturing …. proving it is even more difficult because of course of the level of penetration that happens in female .... also, the females are usually the primary caregivers, which means that there is very limited avenues for reporting the crime by the child." [P6]

Participants 5 and 6 did not use the term female paedophilia but referred to female offending or child sex offending. Participant 6 spoke about society's denialism, which cannot fathom that women ascribed to the role of mother as a nurturer could engage in harmful behaviour such as displaying sexual interest in children. According to Bexson (2011, as cited in Papakyriakou, 2017, p. 31), "female-perpetrated child sexual abuse is the ultimate betrayal". In South Africa, there is scant information on the prevalence of female paedophiles. Furthermore, female paedophiles are viewed differently from males, as in being less harmful to children; many male victims say they initiated or consented and view the sexual encounter as positive (Papakyriakou, 2017). Through a patriarchal lens, if a younger male has sexual encounters with an older female, this is considered an accomplishment.

However, if there is sexual interaction between an older male and a younger female, it is then a crime and frowned upon. Here, participant 4 spoke about a significantly pertinent point, and some of these thoughts were shared by participant 6, who agreed that there is a denialism by society around female sexual abusers and paedophiles who are seen by society as nurturers and caregivers to children. Participant 6 further stated that from a correctional services perspective, it becomes difficult to prove the guilt of sexual activity given the anatomy of a female versus a male. However, on a psychological level, there is a power differential where children see their mothers as nurturers and caregivers, and this psychological connection provides safety. Even though their mother or female role model may be harming them, the child protects this relationship out of survival, even to their detriment. Furthermore, even if children disclose, their voices are lost as no one might believe them, given how

society constructs females. Papakyriakou (2017) cited the two studies by Kramer (2010; 2014) mentioned above, pointing out that in South Africa, no other studies show the prevalence of female paedophiles.

4.4.1.3 Grooming

> "As children who were groomed … only when they reach a certain stage of maturity do they, in hindsight, realise what was happening because often the sensations are pleasurable, the rewards are there for continued behaviour … There's a very complex relationship between a person doing the grooming and the child, and when you deal with the older child whose been exposed to that, there's a time where there's a cognitive shift where they say, intuitively I knew that this was wrong." [P1]

> "They would be a very typical grooming process, it feels like a relationship, it looks like a relationship … it is perceived and construed as a transactional, mutually beneficial relationship, very seldom would you hear paedophile say, 'you know I violated the will of the child'." [P6]

Participant 1 and participant 6 had a substantial overlap in expressing that there is a typical grooming process. However, participant 1 spoke more about how the idea of grooming originates, indicating it is a process involved in developing trust and a relationship with the minor. Participant 6 mentioned the transactional relationships associated with the grooming process and the initial feelings of it being mutually beneficial. Participant 6 further stated how there is a lack of insight in that the adult paedophile does not seem to understand that grooming the undeveloped child is taking advantage of their autonomy and consent as they are not developmentally mature enough to elicit these. Before the age of 14 or 15, a child is cognitively immature and cannot fully understand the implications of their behaviour or the decisions they make (Naude, 2005). An element of Craven's (2006, p. 297) definition of grooming stated it was a "process by which a person prepares a child". This preparation in grooming is part of the paedophile's way of internally and externally justifying their actions based on shared love and interests in minors (Lawson, 2003). However, adults who think children are giving consent are imposing their own ideas of consent from an adult perspective. They also deny the power imbalance between adults and children, which alludes to a lack of insight.

4.4.1.4 Sexual Orientation

The unexpected subtheme of whether to consider paedophilia as a sexual orientation or not emerged.

Participant 1 raised the notion of organisations in the UK and USA in the eighties that tried to push for paedophilia to be recognised as a sexual orientation. Participant 1 was clear they disagreed with this position.

> "There were certain, and this was quite a long time ago, this was kind of the mid-80s; there were, uh, how can I put it, organisations or groups in the UK and America that believed that um, paedophilia was an orientation and it shouldn't be stigmatised. I would not identify with it being an orientation. I believe that people like certain paraphilias… either have a preference for children or are exclusively attracted to children and not to the adult form." [P1]

Participant 1 did not regard paedophilia as a sexual orientation. Participant 3 said that paedophilia was a sexual attraction referring to true paedophiles. However, sexual attraction is not equal to sexual orientation or sexual behaviour. Whom one is attracted to forms part of one's sexual orientation; it does not define it. Sexual orientation "refers to the predominant focus of sexual attraction," and numerous research has dealt with "measures of sexual attraction, sexual identity, or sexual behavior" (Cooke, 2019, p. 2).

> "I know it was a thing in the media when, um, in the DSM 5, the initial before they revised the text, they say its um, it's a sexual orientation … I don't think we can change whom they are attracted to …. we can change how you go about your attraction because obviously, a kid can't consent, so that would never be a relationship that would be sanctioned but this is offending behaviour… teach you behavioural things and skills not to act on the ideation …. true paedophiles … it's a sexual attraction for them." [P3]

> "In the most psychoanalytic sense of the word, it's sexuality; it's not paedophilia. We're dealing with sexuality." [P4]

Participant 3 viewed sexual attraction as an inability to change whom one is attracted to. However, this should not exclude the reality that sexually interacting with a child is a criminal offence and would have legal implications. Participant 3 only applied the notion of paedophilia as a sexual attraction to what they termed a "true paedophile", i.e. those who fit the DSM 5 criteria and not other subtypes such as sadistic paedophiles with sadistic behaviour and thought patterns. Participant 4 stated

that they understood paedophilia as a sexuality within the context of psychoanalytic theory; this had occurred within a broader discussion of Laplanche and the unconscious transmission of messages. Participant 6 understood paedophilia as a sexual orientation.

> "In most contexts, this is a sexual orientation, a sexual preference for the child victim … there is a core to sexual orientation, and that's established during adolescence when … the identity starts developing … I think we are missing the mark as treatment providers but also as society by believing that this can be treated, that this can be changed … I think the reluctance to call it a sexual orientation … I think the fear and the concern then is … because it's a sexual orientation would then also be protected. We need to understand that awareness and understanding knowledge is not linearly related to condoning or accepting and not criminally convicting their behaviour … raising awareness of it to inform treatment, to inform management and to inform prevention programmes. The prognosis for change is quite poor because of how we are defining change and that is to completely eradicate sexual fantasies of children, but if we were to reconceptualise what change looks like and look at it from the perspective of how do we then help individuals understand that this is my preference, that, that preference is criminal, it's wrong, it's unacceptable, it violates the rights of another being and then being able to engage in more pro-social behaviour. I think we would address the, you know, the issue of paedophilia a lot better." [P6]

Participant 6 believed paedophilia to be linked to a preferential sexual attraction toward the child form versus the adult form. This participant showed apparent hesitation and appeared uncomfortable when explaining her reasoning behind paedophilic disorder and paedophilic ideation being a sexual orientation. Participant 6 clarified her hesitancy in disclosing their professional opinion explaining it was related to how society constructs sexuality. Participant 6 stated there would be ramifications for allowing paedophilia to be seen as a sexual orientation, one being creating turmoil, specifically in South Africa, where one's sexual orientation is protected by law. This would lead to the erroneous belief that sexual interactions between adults and children would be protected. This leads to a catch-22 situation because, as participant 6 explained, paedophilic disorder cannot be adequately treated through

psychotherapeutic intervention until it is understood as a sexual orientation, which will then inform treatment and other interventions.

Considering paedophilia as a sexual orientation is debatable and contentious. Participant 6 stated that it not only changes the way paedophilia is viewed but also has implications for prevention and treatment. It is not clear why viewing paedophilia this way would allow the therapist to have more acceptance or empathy or would change how clients' issues, for example, cognitive distortions, fantasy management, and skill acquisition, would be dealt with in therapy.

4.4.2 Theme Two: Psychotherapeutic Interventions

This central theme of psychotherapeutic interventions forms the crux of this research. The research question examines how psychologists in South Africa currently manage and treat clients with paedophilic ideation and paedophilic disorder. A central aim of this study is to describe current therapeutic practices that psychologists engage in regarding current treatment protocols, therapeutic interventions, approaches and techniques that are implemented when treating individuals who have been implicated in sexual activities with minors or who have expressed having a sexual attraction to minors forming a paedophilic ideation or paedophilic disorder.

> "The research shows us that it's very difficult to treat and to really change … very long-term therapy and you build a trusting relationship with these guys over years and years … might deny or they might admit, but then there's a break in therapy … after a year or two they'll come back … they had time to process … quite a number of people who initially denied the crime … subsequently confessed to the crime and then you can actually work." [P3]
>
> "Any punitive form of therapy … causing anxiety, we are causing stress, we are causing a lot of negative emotions, and if they have sexualised coping behaviour, that means that they are going to cope with those negative emotions through sexualised emotions … escalating the behaviour." [P3]

Within their therapeutic protocol, participant 3 described that they consider long-term therapy most beneficial as there needs to be constant engagement as well as time for the individual to process the content and process that unfold in therapy before they can work with the psychologist with the relevant insight required. Drapeau et al. (2004) found that individuals with paedophilic disorder and paedophilic ideation retained attitudes toward voluntary treatment where they felt safe enough to express their feelings and experiences. In contrast, in other settings or instances, they could

not. Moreover, the treatment allowed them to gain access to information they previously were unaware of, which assisted in their self-understanding and understanding of their victims (Drapeau et al., 2004). In this vein, participant 3 refrains from any punitive approaches and techniques, as this causes further anxiety and negative emotions and often leads to sexualised behaviour escalating, given its correlation as a coping mechanism to negative emotions. Studer and Alwyin (2006) stated, after reviewing the typical CBT-based relapse-prevention treatment for paedophilia, that it has sub-optimal results. They suggested that parts of CBT are helpful to use but are not adequate in isolation and would need to be utilised in conjunction with other treatment modalities.

The management and treatment of paedophilic disorder and paedophilic ideation within the correctional services setting were discussed in detail by participant 6.

> "In more controlled centres where contraband is minimal, you would find that the paedophilic ideation does reduce significantly … temporary alleviation might be associated with a prison context but long-term rehabilitation. Unfortunately, that's quite a pessimistic outlook … most effective would be … chemical castration paired with ongoing psychotherapy for the rest of their lives … the prognosis is so poor, and psychotherapy has such a minimal impact because there isn't a designed programme for paedophiles." [P6]

Participant 6 spoke from a seemingly disheartened stance in that they mentioned there need to be significant changes at various systemic, institutional, and legal levels for significant therapeutic intervention to occur. This would lean into changing the taboo of paedophilia at a societal level and changing the way paedophilic disorder is understood from a psychiatric and psychological level in order to implement relevant therapeutic interventions and establish grounded prevention programmes. While this may seem a large undertaking, psychologists' prime responsibility is to help those in need, to do no harm and prevent harm. The only way to do this is perhaps to start provoking changes, as every small step is still a step forward. However, participant 6 explained that from a systemic perspective of the correctional services system, the only time a prisoner may get assistance is when they are in prison.

The participants' narratives regarding sexual offenders and reoffending point to what unfolds once sexual offenders are released from correctional services in South Africa.

"He was in his fourth sentence of sexual abuse of children … I have never seen him again; he went under the radar, and haven't seen him again for therapy." [P2]

"If you've offended against a child … reoffending is much higher … we have this immense gap about what do we actually need to do in terms of rehabilitation because, ultimately, these guys must go out at one point, so what happens in that gap and we need a lot of research there." [P3]

"I think it becomes much easier if, if that is part of the research, where you track them over time. So there's a possibility that they, they reoffend, but we don't get to know." [P5]

"Psychologists are based in the prison … once an offender leaves prison, the possibility of them getting ongoing treatment psychologically and psychiatrically is minimal". [P6]

The lack of rehabilitation in correctional centres leads to high rates of reoffending. Given the stigma against sexual offenders (which includes paedophiles), many will not attend or speak freely in programmes on offer for fear of being targeted by other inmates. Furthermore, overcrowding and lack of resources mean that individuals with paedophilic disorder cannot access help in correctional centres. There are also no programmes in place to follow up with them once they are paroled. Correctional settings in South Africa do not have the resources to engage in rehabilitation programmes despite their best intentions. As Harvard University (2010) pointed out, monitoring and supervision are vital to prevent reoffending after a prisoner's release.

Participants narrated the insight individuals needed into their disorder and the need for empathy development to enhance treatment. In this regard, an individual who lacks insight would struggle within a psychotherapeutic session and require even longer therapeutic engagement until the sense of conscious or unconscious denial is dealt with. However, a crucial point to therapy is empathy because if individuals can understand they are causing harm to minors, this would impact their behaviour and actions toward minors. A lack of empathy is typical of individuals with antisocial personalities, often seen in more sadistic attractions. However, across the spectrum of paedophilic sexual interest, a key element is a combination of creating insight into how their attractions potentially affect the minors and others and extending on having empathy for harming others both physically and psychologically.

> "But you can also get somebody … on condition, to remain in the relationship or whatever insists that that person comes to therapy … coming in but coerced by somebody else … whether, in fact, they had the same insight … I also try and psycho-educate the development of healthy child-sexuality and how their lack of impulse control or fixation can be damaging to a child to try and see whether there's an empathy." [P1]
>
> "It's an empathy thing … teach him control." [P2]
>
> "True paedophiles … I get that you love children, but you are actually hurting them, and we work through, you know, raising awareness of how you are hurting them physically, emotionally, socially, what is the long-term impact for these kids, and just kind of point out how they were hurting them and they normally develop empathy for them … don't think that we can ever really change the ideation part … Insight is required." [P3]
>
> "Can't implant empathy … you can develop empathy if you go back to what you are not supposed to remember …. the only way you will develop empathy is when you can empathise with what happened to you, and that's what a lot of paedophiles dissociate, is their child part because it was their child part that was traumatised." [P4]

Further regarding treatment, participant 1 explained that a key component of therapeutic intervention is the notion of insight needed for treatment. However, this might not happen if they did not come to therapy on their own accord. Further, focus within a psychotherapeutic context pertained to focusing on empathy development through psychoeducation and the development of healthier sexuality, as well as working on these individuals' impulse control, which can lead to harming minors if not corrected. Participants 1, 2, 3 and 4 all spoke about empathy as a core focus of therapeutic intervention, which would link to the earlier theme of comorbidity and how a lack of empathy was prominent. Participant 3 explained how they hoped to develop empathy by pointing out that the paedophile's actions were hurting the child. This is a challenging area. As Schuler et al. (2019) explained, paedophiles have emotional congruence with children; they relate to children better than adults, which might be seen as empathy. However, this does not translate to stopping the harmful behaviour, as adults harming children "show compromised abilities to infer and represent the perspective of child victims of sexual abuse" (Schuler et al., 2019, p. 455).

Chemical castration was a treatment option discussed by the participants, with most of them stating it would not work.

> "The problem is between the ears and not between the legs … castrating … if the person is receiving therapy and they're not acting out sexually because they can't, and because they are under house arrest and it lasts a period of four years, and they're being receptive and cooperative with therapy, I think it's likely to have some beneficial effects." [P1]
>
> "Chemical castration is just as effective as long as you take the medication, um, and if somebody's is not volun-voluntarily taking that, you know, you can't force them, we might have the case in forcing them while they are incarcerated … But once they've served their sentence, you know, the Constitution doesn't allow for us to chemically castrate them … the rape isn't, isn't a function, it's not about sex it's about power ... it has no effect on your ideations. It has no effect on your fantasies." [P3]
>
> "They certainly not going to be rehabilitated through a clinical process of castration … So if we going to inhibit you from getting an erection, let's say it's a man, you still have hands, and you still have other objects." [P4]
>
> "The paedophile will find other means of sexually offending the child … it's more about gratification, so he will find other means of satisfying himself besides using his private organs." [P5]
>
> "So, in my opinion, the most effective would be pharmacotherapy, so that's your chemical castration paired with ongoing psychotherapy for the rest of the lives because, um, the prognosis is so poor." [P6]

Participant 1 explained that they had experience in working with an individual under very particular circumstances relating to treatment and believed that castration would only be effective if combined with house arrest, regular individual therapy, group therapeutic process, and also taking responsibility for the harm they have caused to their victims. However, the core understanding of participant 1 is that castration is not an answer as the cause and underpinnings of paedophilia are not physiological but psychological. Participant 5 agreed with participant 1 in that they stated that if physiological responses (for men) in getting an erection were eradicated, there would be other means of committing the sexual activity, as it is a psychological disorder. Furthermore, chemical castration was invasive and had no positive results (Lumen

Abnormal Psychology, 2022). Plus, the literature reviewed on chemical castration in Chapter 2 concluded that its efficacy is inconclusive and recidivism rates are high.

Managing treatment regarding the use of assessments before treatment began was raised by participants. Participants talked about different types of assessments they used and the lack of an appropriate assessment for paedophilic disorder specific to a South African population. The idea of prevention was also raised by one participant.

> "I know a very prominent colleague uses the Rorschach quite a lot, you know, to what extent, you gotta be able to, to, use that, maybe the therapeutic context might be, have you heard of the South African Sexual Functioning and Adaption test (SAFT)?… it's quite defunct now … it used the heteronormative model as the healthy model and looked at similar to a Thematic Apperception Test (T.A.T) … But it's no longer, it's used, but it's no longer a recognised test on the HPCSA, uh, kind of list of tests, and there are a couple, I can look at what else I've used in the past, but they are based on norms that are so difficult to apply in South Africa, and also, and I say this with absolute kind of respect, of the reality of the situation, but I'm dealing with the certain clientele generally um, that function economically, and intellectually and all the rest, and socially at the certain level… I've kind of compiled from a lot of risk assessment tools just to identify those who have maybe higher risk of offending, which includes those with offences against children. So, it's not a formal screening tool … I don't have a specific screening tool for paedophilia." [P1]

> "When he is admitting when he's taking responsibility for his condition. If you don't have that commitment from a guy properly, then it's not so easy.... there's no psychometric assessment …not even a specific risk tool that one can apply … Hanson psychological meaning factors for sexual disorders. There's no psychometric assessment … not even a specific risk tool that one can apply. Hanson psychological meaning factors for sexual disorders. Research; who goes for sexual, who goes for the paedophilic girl and who goes for the paedophilic male. … there's difference between the incest guys and the non-incest guys, and I think there needs to be a lot of research done." [P2]

> "Talking about assessment, which they do anyway, they do it in the correctional facilities. And then you, well, what do you do with this assessment now that you know that he's got ideation? Does the treatment stop there? Um, and what we

seeing is if you're dealing with fantasy, you have to understand what's being repeated, um, you not gonna challenge thoughts here, you're staying at the manifest content there. What is driving you is a foreign body, something there that has taken on a life of its own that is speaking through the symptom, that you can't assess and you can't treat it if you don't re-enact it in the treatment, and that's where transference comes, transference comes in, but we will get there." [P4]

"We don't have psychometric assessments … the Millon Clinical Multiaxial Inventory (MCMI) is pretty clear on a diagnosis … we don't have that for paedophilia, that I'm aware of that's norm for the South African population. I don't think it's; it's understood within context of it being a mental illness. I think it's more condemning than anything else … denial is quite a common defence mechanism that's used by child sexual offenders. Again, not admitting to it, um, helps them feel a bit safer. It's less threatening to their self-identity. It preserves, and it maintains the sense of innate goodness within themselves … To understand that awareness and understanding knowledge does not is not linearly related to condoning or accepting and not criminally convicting their behaviour … raising awareness of it to inform treatment, to inform management and to inform prevention programmes." P6]

Participants noted that they lacked assessments or screening tools to aid them in diagnosis and treatment. Participant 1 mentioned the SAFT, a test that the HPCSA no longer recognises. This participant also mentioned the Rorschach test. However, very few psychologists are trained in its use, plus it is a projective and subjective assessment versus an objective assessment. Participant 3 compiled their own risk assessment tools to at least identify possible higher risks of offending. Participant 4 did not rely much on actual assessments and stated no assessments are available, especially within the South African context. Within a correctional service setting, participant 5 relied on the MCMI to pick up antisocial traits but concurred that there are no assessments available in South Africa for paedophilic disorder and paedophilic ideation. Participant 6 agreed with this statement, stating they were unaware of assessments in South Africa used to assess paedophilic disorder or ideation. Once released, their chances of receiving psychiatric and psychological support in South Africa are meagre. Therefore, participant 6, with a fairly pessimistic feeling about the situation, stated that the best option would be chemical castration and lifelong therapy

as there are no programmes designed to assist individuals with paedophilic disorder and paedophilic ideation adequately.

4.4.2.1 Individual Versus Group Therapy

> "I think the combination is ideal …whole lot of people that will be coming together, not presenting with the same form of sexual expression or you know, but being able to talk about it in a way that they wouldn't be able to talk about it in many other settings and I think the individual therapy, as far as benefitting, the benefit of individual therapy is very dependent on the competency and receptiveness of the therapist." [P1]

Participant 1 explained that group therapy should be more homogeneous and combined with individual therapy as individuals with paedophilic disorder may not fully disclose in a group therapy setting as they would in individual therapy. That being said, participant 1 stated that, like group therapy, individual therapy relies on the therapists' skills, abilities and openness.

Some participants opted for group therapy, particularly in a correctional setting.

> "Currently, I'm only doing individual … Ideally, I would want to render group therapy … it's important for us to, kind of keep the sexually offenders' group as homogenous as possible." [P3]

> "I would advocate for group therapy but not the kind that's based on modelling, or testimony because you can't implant empathy. The group should be strictly a closed group, using psychoanalytic as a framework and should extend over a long period of time, not short groups". [P4]

> "Mmm, I think certainly group programme has its place, and there's this lot of limitations to it, and I say this because I was, I was heavily criticised for starting a group for paedophiles. The reason why I started the groups with paedophiles is because I had so many paedophiles in the individual therapy and that I felt that we plateaued … one of the critiques for paedophile support groups and the same with … your Alcoholics Anonymous (AA) and your Narcotics Anonymous (NA) groups, for example, is that they feed off each other's fantasies … so I think it has to be very carefully managed. So group therapy certainly has its place. I remember quite distinctly … I felt very sad … there was a male in his seventies, um, he says, 'so there's more like me?'" [P6]

Within the correctional services setting, participant 3 explained that individual treatment is predominantly offered by them. However, it is voluntary and not always

followed through by sexual offenders who are all placed into this category and not more specifically defined. Ideally, participant 3 would prefer adding homogeneous group therapy over and above individual therapy. Group programme attendance is linked to gaining parole, which will be addressed in more detail in theme four. Furthermore, these are usually only informative and not therapeutically based. Participant 4 felt strongly that the core of therapy should be individual therapy but advocated for adding group therapy. However, participant 4 stated that there would be criteria for the group therapeutic process. It would be that it is kept as a closed group over a long period of time with a psychoanalytic model being used. Participant 5 concurred with participant 3 and explained that the only group intervention is that of a sexual offenders' programme, which is educative in nature, but that the sole means of therapy is individual therapy. Participant 6 did not favour AA groups or models, stating that these create a context in which members feed off each other's fantasies.

However, the success of group therapy was questioned within a correctional setting, given how they are designed, allowing all sexual offenders as members with no differentiation.

> "There's a programme that we call Sexual Offenders Program, SOP in short. All the offenders that have committed rape, whether being classified as paedophiles or just rape in general, we just group them as it's just rape." [P5]

In terms of individual and group therapy, participants drew on their experiences and also what they wished to see implemented, given that they were often using their own judgements when approaching treatments in therapy. Participant 6 explained their experience with group therapy programmes, which usually followed modules similar to AA 12-step programmes, which included complete abstinence for 2 years. However, the concept was realised to introduce more adaptive and healthier sexual activity later in the therapeutic process. In essence, it was pushing the reset button. Participant 6 advocated for group therapy but stated it needed to be monitored so that group members did not feed off each other's fantasies. This participant saw the value in group support. This participant also described a now-defunct sexual predator's group (not a paedophile group), designed on the AA-twelve step model.

> "There was at one stage. It doesn't exist anymore … it wasn't, a paedophile group, it was a sexual perpetrators group … similar model to the AA-twelve step … had to stop for a significant period … those models are still being used ... combination is ideal." [P1]

However, participants 1 and 2 preferred individual therapy, with participant 2 going as far as to state that group therapy did not work.

"Not presenting with the same form of sexual expression … but being able; to talk about it in a way that they wouldn't be able to talk about it in many other settings, and I think the individual therapy, as far as benefitting." [P1]

"No, I don't think group works … I've been pleading for in South Africa. I said, 'Please, let's have a treatment group' … individual works." [P2]

Participant 2 advocated strongly for individual therapy over group therapy, adding that group therapy could assist. However, group therapy could be beneficial only once the individual is embedded in an individual therapeutic process. The literature reviewed revealed that individual and group therapy were worthwhile treatment interventions for paedophilic disorder and paedophilic ideation. Papakyriakou (2017) pointed out that a combination of group therapy and individual therapy was particularly necessary when working with incarcerated sexual offenders. Hubbard (2014) supported group therapy for sex offenders, including individuals who had sexually harmed children, as no distinction is made between types of sexual offences.

4.4.2.2 Participants' Skills

Participants were asked what specific skills are needed, besides training, to work with paedophilic disorder. Participants spoke about their character traits and alluded to being comfortable with who they are as a therapist and as a person.

"Curiosity is one, and I think being quite comfortable about who I am and where I stand." [P1]

"Most females can't see these individuals … you must be comfortable in yourself and strong." [P2]

"Comfortable in who you are." [P3]

"Accept yourself first; work on yourself so you can be curious but also comfortable in who you are." [P4]

The literature reviewed did not directly cover the participants' observations regarding self-confidence. However, Flora and Keohane (2013) stated that therapists working with sexual offenders must be comfortable with human sexuality. This is significant given the therapeutic content and process. Participant 2 agreed with the other participants, however, adding that they felt it was an area most suited to males, as, in his experience, females "shy away" from working with this population within

society. This notion was supported by Jonker and Du Preez (2012), whose study disclosed 80% of female social workers experienced discomfort regarding sexual issues during therapy sessions for male sexual offenders in South African correctional services. While there is a discrepancy in the aforementioned study regarding the scope of practice for a social worker and that of a psychologist, it raises an important consideration.

> "As a mother, obviously there will be that countertransference … goes back to me reminding myself this is the setting that I have chosen … I have to focus on treating them. Unless it's really, really affecting me, then obviously I would ask another colleague to assist … also remember we are also trying to protect the, the community." [P5]

> "Support you and peer supervision became very useful. I see myself as somebody who knows so little, and there's just so much the more you know. That's the conundrum of knowledge base. Hey, the more you learn, the more you realise how little you know … within correctional services; I would be called upon to, to assist with difficult cases … every case is so different then you feel yourself being quite out of your depths with it." [P6]

Participant 5 stated that she had made peace with countertransference by reminding herself that she chose this line of work, which came across almost as a vice or a mantra when cases with paedophilic disorder and paedophilic ideation became difficult. This indicated a possible blind spot when working with these individuals by concretising her role as a means of her own defense mechanism to her possible blind spot and thereby distancing herself toward this population's pathology.

Further, participant 5 stated that they relied on debriefing with a colleague within the same field. Participant 6, with 10 years of experience, spoke about feeling out of depth with complex cases as the more one learnt, the more one realised the knowledge that was still needed. Nevertheless, there was a need for peer support or some form of supervision, especially given the ratio of the therapist to inmates and the helplessness of questioning their training. Bach and Demuth's (2018) study revealed the challenges these therapists face, such as secondary traumatic stress and burnout, but also pointed out that many therapists found satisfaction in their work. In addition to collegial support, self-care must be practised; activities to promote well-being and engage in self-reflection, supervision, and debriefing (Evans et al., 2019).

4.4.3 Theme Three: Therapeutic Approaches and Theoretical Models

This theme considers the therapeutic approaches and theoretical models the participants use for understanding and treating individuals with paedophilic disorder and paedophilic ideation. It also appraises the subthemes, training and international guidelines, organisations and models.

> "I'm eclectic … she has these thoughts that are distressing … aspects of real OCD that present themselves." [P1]

> "So I work from a positive psychology framework, and I use solution-focused therapy a lot, and then, I'm very eclectic. I work from a positive psychology, but I do. Obviously, you do incorporate some CBT techniques … So I would probably base kind of a hybrid between the good lives model. So, the good lives model is something that you can apply in group settings or individual settings. So it would be a hybrid between the good lives model and then solutions in terms of addressing the deficits. CBT can be effective … CBT it's very difficult to access those cognitions because the perpetrators are so ashamed … because of the stigma attached to it … difficult to access that cognitive content … look at skills deficits actually because they either can't talk to their peers, or they can't build appropriate relations. And then you can intervene, in well, probably any modality that you like." [P3]

Participants 1 and 3 ascribed to being eclectic. Zarbo et al. (2021) pointed out that there is more agreement that no single approach is effective for all clients and their problems. An eclectic approach is multi-modal, adapting to the individual client's specific needs. Participant 1 said that individuals with paedophilic disorder and paedophilic ideation presented with OCD. Participant 3 mentioned CBT as a theoretical framework but explained that it was problematic. This is because shame and social judgement emanate from social and self-stigma within this specific population of individuals with paedophilic disorder and paedophilic ideation. Self-stigma is addressed in the discussion in theme five. However, social judgement from society becomes a significant barrier to a CBT approach as it is challenging to access cognitive content. In these situations, participant 3 relied more on incorporating social skills development and how to build relationships but within other modalities. Many individuals who have sexually harmed children are in denial. Participant 3 drew on solution-focused brief therapy incorporating positive psychology principles to help

clients come up with solutions rather than focus on their problems. Participant 3 would generally subscribe to a positive psychology framework by seeing their clients in therapy as people and not their pathology label, focusing on clients as individuals and getting to know who they are beyond their paedophilia. Positive psychology is a framework which attempts to develop social skills and build relationships, which was seen as more practical for a correctional services population but not for non-offenders.

Other participants found CBT to be useful.

> “Initially, if the offender is in denial, even in CBT, there’s nothing much that I can do up until the breakthrough. Then, when they come back, then we start the process. I do see improvement, some shift in their cognitions … because you might have five, six sessions with this particular offender denying.” [P5]

> “I am a CBT-trained therapist, and I felt that I failed dismally using a disclosure-based programme such as CBT because that's quite confrontational. It's quite direct and for a group that is so, so highly stigmatised … so we would work on symptomatic skills, such as social skills training, intimacy deficit, sexual awareness, healthy sexual relationships, communications skills, fantasy management but the actual treatment of paedophilia, has been quite a challenge … addressing cognitive restructuring faulty belief systems and those treatments are really symptomatic treatments … you are telling somebody who is sitting with an erection, a full-on erection to control his thoughts right now … there's quite a mind-body struggle and tug of war that goes on there, and unfortunately, the body generally wins. You would find that quite clearly in the ideation and the cognitive process of paedophiles that they would articulate, ‘I debated with myself, I knew it was wrong’. The moral … a sense of helplessness, powerlessness and lack of volition when it comes to an overpowering libido hyper-sexuality, for example … the prognosis has been quite poor.” [P6]

Two participants had different ideas about the value of CBT. Participant 5 would apply CBT as a framework, given that therapy in the correctional setting was inconsistent and short-term. For CBT to be effective, the individual’s cognitive distortions need to be reduced, and for this to occur, the individual needs to talk about their behaviour. An example of a cognitive distortion would be denying or minimising their actions. According to Schneider and Wright (2004, p. 3), “denial may be best

understood as the acceptance of explanations that reduce accountability and are reinforced by distorted beliefs and self-deceptive thinking processes”.

Participant 6, also located in corrections, stated that she had identified as a CBT-trained therapist but disagreed with using CBT as a framework in this context. Cognitive-based therapy (CBT) is a confrontational and direct approach that negatively impacts this population of clients who are already highly stigmatised. Therefore, the prognosis of using CBT is poor. Participant 6 said the difficulty lies in addressing the cognitive process when, for, e.g. “telling somebody who is sitting with an erection, a full-on erection, to control his thoughts right now”. In addition, the sense of helplessness, powerlessness and lack of volition renders CBT ineffective. Cognitive-based therapy (CBT) was used as a theoretical framework to address cognitive structures and behaviour. However, its efficacy is mostly associated with a correctional service setting, given that it is a short-term approach and that therapeutic intervention needs to be quick within these contexts. However, the prognosis for CBT is said to be minimal for this population.

Therapeutic approaches and theoretical models form the crux of how psychologists formulate, treat and manage their clients in therapy. These approaches and models assist in predicting, evaluating, and improving therapy outcomes. Thus, this is pertinent to understanding participants’ approaches and what evidence-based theories informed their approach to therapeutic intervention. The literature indicated that typical CBT-based relapse-prevention treatment for paedophilia has poor results and needs to be used with other treatment modalities (Studer & Alwyin, 2006). Participant 6’s ideas around CBT are similar to those of Porter (2022), who emphasised that paedophilic disorder and paedophilic ideation does not respond to psychotherapy based on the failure of many methods in therapy, such as the relapse-prevention model and CBT. Participant 6 focused on skills associated with the symptomatic presentation of each client in therapy with paedophilic disorder and paedophilic ideation, such as social skills training, sexual awareness, healthy sexual relationships, communication skills and fantasy management.

Participant 2 did not subscribe to a specific theoretical modality but incorporated a psychodynamic and CBT approach and primarily used an offender’s cycle.

> “You have to go into an offence cycle, and from there on, you start uncovering the sort of thinking, and from then on, you bring the dynamic factors in, where does it come from, when did you start experiencing these feelings and so on,

and it differs from person to person … We start with offence cycles, and you work, but you must work hard at building relationships, and it takes time for some of them man, to, to, to get them to trust and to get them to feel safe in your, with you." [P2]

Participant 4 only used a psychoanalytic approach.

"Laplanche says this, we all have messages that we struggle to translate, but I think what differentiates us from paedophiles is … you are constricted by something that is dominating you, that is the disorder, not the action or not the type of action, whether we talking about a masochist or a paedophile. The behaviour is not the disorder. It's the fact that you are dominated by a structure, by an unconscious structure, that determines that you can only relate sexually in this way. That, for me, is, um, differentiating the behaviour from the structure. Wouldn't necessarily see a difference between ideation and actual disorder. For me, it would be the same thing, you are still being dominated by an intrusive thought … They are dominated by something, by a, if you, if you want to call it a perversity, and we all have perversions. I mean, Freud said that sexuality is, our sexuality is made up of a polymorphous perversity. We all have the tendency to be perverse. Perversion is not on the firing line here." [P4]

Participant 4 worked solely from a psychoanalytic framework from a Freudian perspective, and a significant source of understanding was derived from the works of Laplanche. Based on participant 4's narrative, it seemed that a psychoanalytic theoretical framework is the only modality with a clear understanding of sexuality. It occurs over a long-term therapeutic process in which one draws on the individual's past and its impact on the present. The aim of therapy is to enable the client to develop insight regarding their attraction to children and empathy towards them. This means focusing on impulse control.

Some of the participants focused on fantasy, albeit working within different therapeutic approaches and theoretical models.

"I think the major, major thing of all them it's fantasy. He was overthinking of sexual fantasy, busy with sex all the time in his head …. But then you must work with fantasy, okay, what is the fantasy, how do we break the fantasy" [P2]

"So if you just go in and say tell me about your fantasy with children, you know it's very difficult, because the motivation behind that is not understood very clearly. But with the good lives model, I won't say I go into a lot of depth into

the fantasy, so obviously you don't want to, you don't want to colour their fantasies in more than what it already is. You kind of just want to get the gist of the fantasy … an idea of what the fantasies are, but you don't want to know the step-by-step of the fantasies. You just kind of want to get themes." [P3]

"My treatment approach will be aimed at; well, listen, you are suffering, your fantasies, um, might be impairing … because we talking about a perverse structure here. You know that's what I want patients to realise how constrained he is by his fantasies. I wouldn't base an intervention on whether they will act on it or not but whether they suffer in some way from having these fantasies, from having these thoughts." [P4]

Participant 3 and 4 both worked with fantasy. Participant 2, within the offence cycle, stated one had to work with the client's fantasy and participant 4, within a psychoanalytic approach, also examined fantasy. Participant 3, working within the good lives model did not work with fantasy in detail. Participants 2 and 4 spoke about working with their client's paedophilic fantasy to understand the basics of the fantasy but warned about monitoring this process not to expand the fantasy. The literature confirms the views of participant 4 in that psychoanalytic theory focuses on the internal drives of a client (their unconscious structures), which affect behaviours and the construction of sexual drives—using talk therapy to understand and treat individuals in the therapeutic context. The aim is to find patterns in a client's thoughts and emotions to gain insight into who they are (Frosh, 2012). Fantasies may be managed if the individual in question finds them adverse; this process cannot be imposed on them. Vanhoeck et al. (2011) stated that fantasies cannot be controlled but can be managed, and a client can learn what to do when a fantasy occurs. As Vanhoeck et al. (2011) stated, suppressing the fantasy once it has "popped up" is not a good strategy; instead, learning what to do when this happens and what choices to make should be the focus in therapy.

Training was identified as a subtheme within theme three on therapeutic approaches and theoretical models.

4.4.3.1 Training

"Masters was not sufficient … research the topics … after masters, expanding one's knowledge on sexual health, sexual diversity … opening up ones' mind to the paraphilia's and what do you do … supervision, is, really important." [P1]

"In South Africa, there's a total lack of knowledge about these things … New Zealand for 6 months, where I worked in the corrections department, that's where I picked up these things … Hanson has redefined the whole thing into psychological meaningful factors offence cycle …no there is no specific training, you must train yourself". [P2]

"Master's training is lacking … no training for dealing with offender behaviour and repetitive behaviour … we kind of do peer training … Canadian organisation that deals with especially sexual offender reputation … basically applying them to the sex offender treatment model than to the paedophilic disorder and those of paedophilia … I do think all of us need more training. I do think we need more research-based programmes … I think that something in South Africa that we really lack is research and things in terms of offender treatment, we are using a lot of overseas models, and well, everybody's just doing their own thing." [P3]

"There is no training you learn from your own studying further, internationally, not South African-based." [P4]

"When it comes to specific crimes like rape, the system never prepared us for that at all." [P5]

"We're not trained in paedophilia … browsed over in a 15-minute lecture on paraphilias … in my master's training, so um, treatment, I think is, is quite a difficult one … within the correction system, there are no training programmes for treating child sexual offenders. Rely on your own research because there is very little training on it. There is a complete underrepresentation and inadequacy of the service when it comes to mental healthcare. Insufficient training because there's not enough professional practices as well because you lecture on something you have competence in, so who is the expert? So expertise is certainly lacking, and therefore, you know we are stuck in the vicious cycle, and because there is incompetence there is a lack of training capacity for paedophilia." [P6]

When discussing their masters' training, every participant agreed that there was insufficient training to understand paedophilic disorder and paedophilic ideation for treatment purposes. Psychology in South Africa has been criticised for not being relevant to the local context (Long & Foster, 2013) and for the level of training, practice and function for being inappropriate to the needs of the majority of South Africans.

Pillay et al. (2013) argued that aspects of clinical psychology training in South Africa are problematic but are generally of a high standard. They do note that mental health resources and training are skewed and argue for a re-examination of the provision of clinical psychological services and training of clinical psychologists. Padmanabhanunni et al. (2022) stated that academic curricula in psychology in universities are Eurocentric, which does not always apply to the South African population. However, this is a blanket statement that does not account for changes in curricula at some universities. For instance, Joosub (2021) reveals decolonisation change in a particular psychology module at the University of Johannesburg.

Every participant relied on self-study, specifically international training. Participant 1 explained that they additionally did training around expanding their knowledge on sexual health and sexual diversity, specific to paraphilias. Participant 2 stated that they experienced a complete lack of training in South Africa which led them to gain experience and training in New Zealand in a correctional setting for 6 months. This training focused on an offender's cycle and integrating it into meaningful psychological factors, based on an approach by Hanson. Participant 3 stated that they relied on overseas models and that South Africa needed more research-based programmes. They also alluded to peer training, but given the lack of training in South Africa, they relied on training through a Canadian organisation, focusing on sexual offender reputation training. Participant 3 combined this training from the Canadian organisation with the standard sex offender treatment model to create a self-formulated model for paedophilic disorder and paedophilic ideation. This participant commented that "everybody's just doing their own thing". Participant 4 agreed with all other participants that psychologists rely on international studies due to the severe lack of training available in South Africa. Participant 6 concurred with a lack of training, especially at a master's level, even though other paraphilias were covered.

Within the corrections setting, participant 6 agreed with participants 2, 3 and 5 in that there is no training offered in this context, further expanding that there is a general inadequacy of services provided to the mental healthcare professions. Participant 6 raised a significant point in stating that given the lack of professionals in South Africa who work in the area of paedophilic disorder and paedophilic ideation, it is not surprising that there are no competent professionals to lecture and train in this

field. Participant 6 stated that the best option, given the circumstances, is to rely on peers for support.

The participants' narratives are indicative of how larger societal stigmas have infiltrated the training of healthcare professionals toward paedophilic disorder and paedophilic ideation, creating a helpless situation for this population. This creates a paradox of how society will be able to protect children from the very individuals that they stigmatise if the taboo is so significant that those who wish to help individuals with paedophilic disorder and paedophilic ideation cannot even be trained to do so.

4.4.3.2 International Guidelines, Organisations and Models

> "I mean I got into corrections. I was in New Zealand. I was working in corrections in way back 1983/84 … and there, it's a major eye opener and despite, despite that exposure, coming back it took me time to really understand what I was doing." [P2]
>
> "I've attended some training by a Canadian organisation, they have a model of sexual offender treatment called the good live's model … a positive psychology slant, but it helps you to identify which are the areas that need to be addressed … it has these 10 life goals that they say all of us wants to reach these life goals, but some of us just go about it in maladaptive ways, and that's how they see sexually offending behaviour … the same goes with paedophilic guys, it's very similar and for a lot of guys. One basic model that we work with … called the risk-need-responsivity (RNR) model, so risk-need-responsivity … identify criminogenic needs and then those who have the highest motivation because that's your best chance for success." [P3]
>
> "Psychoanalysis is the only theory or is the only model that has come up with a theory about sexuality …. how to think about them and how to treat them." [P4]
>
> "The kinds of programmes that we use predominantly are rehabilitation programmes and not psychological intervention … not developed within the South African context … I've personally adopted a couple of programmes from Canadian prisons as well as prisons in New Zealand …. there's a programme called the Sexual-Abuse Treatment Offender Program (Stop) that's a sexual treatment of offenders … a pre-test you have the intervention, and you have the post-test … those interventions were predominantly CBT-based … When we try to conceptualise the aetiology of paedophilia we, we really grasp that straws to be honest. I think the biopsychosocial, uh, there's many derivatives

of that, but I think looking at it holistically is quite important and attributing it just to, you know, the cycle of abuse, attributing it just to neurotransmitters, particular hormones, attributing it just to, you know, adversity or identity confusion … tries to understand paedophilia holistically and not just as a perversion.” [P6]

Participant 2 uses the models from the correctional settings in New Zealand. This is the RNR model, which focuses on risk, and the good lives model, which focuses on prevention. In therapy, there is also a focus on reducing harm to others. However, New Zealand has the resources to utilise these programmes and to work closely with police and outreach programmes in the community.

Participant 3 relies specifically on a Canadian-based model called the good lives model. This model is grounded in positive psychology and assists the psychologist in identifying significant areas of importance when treating a client with paedophilic disorder or paedophilic disorder ideation. The good lives model builds on personal strengths and respect for the individual to help patients self-actualise, reducing their desire to harm others (Ward et al., 2007). Critiques of the relapse-prevention model argue that its strengths are based on approaches such as the good lives model and are seen as being idealistic and basic. Therefore, the goal of promoting positives is described as being impossible for individuals who are deemed unsafe and who reside in harsh contexts (Ward et al., 2007). However, according to Harvard University (2010), as these treatments do not work long-term, incarceration and post-release monitoring and supervision are the most feasible routes in this instance. Participant 4 solely uses a psychoanalytic approach, explaining that psychanalysis is the only model that has come up with a theory on sexuality in terms of how psychologists think about paedophilic disorder and paedophilic ideation as a sexuality and further extending into how to then treat these individuals, due to the time restrictions in a correctional setting. Participant 5 solely practised within a CBT approach and did not rely on other models of treatment. Participant 6 spoke about programmes adapted from Canada and New Zealand, which were rehabilitation, not intervention programmes, one of which is the Stop Program. This programme looks at the sexual treatment of offenders in general but is not relevant to paedophilic disorder. However, participant 6 described the biopsychosocial model as one that attempts to view paedophilic disorder and paedophilic ideation holistically, not just as a perversion. Participant 6 was not in favour of AA groups or models, stating that these create a

context in which members then feed off each other's fantasies. The biopsychosocial model is seen as a guiding psychological framework that considers various systemic contexts of an individual in therapy: body, mind, thoughts and relationships to gain a holistic understanding of them (Rothman, 2004).

Participants' responses give a negative impression of the state of training in South Africa as well as of the treatment of individuals with paedophilic disorder and paedophilic ideation. Given the circumstances, this leaves the impression that psychologists are operating in the dark and hoping for the best. Within the private sector and specifically within the positive and psychoanalytical approaches, there is a sense of humanising the individuals in therapy and specific to the psychoanalytic approach, exploring deeper internal structures of the individual's psyche and addressing their own sexuality and perversions with the ripple effect of empathy creation, trauma reduction and a more profound sense of self-understanding. There are varying approaches to adequately working with paedophilic disorder and paedophilic ideation in a psychotherapeutic setting, with very few techniques offering effective treatment (Gopalan & Arvind, 2018). Therefore, there is a need for the development and implementation of treatment therapeutic interventions and techniques that could be used by psychologists (Nobrega, 2016).

4.4.4 Theme Four: The Law

This theme examined how the law provided for reporting sexual offences and the grey area that sometimes arose in the therapeutic context. It addressed sexual offenders within correctional settings where a lack of distinctions are made regarding paedophiles versus other sexual offenders. The theme addressed mandatory programmes and therapy, which was said to be voluntary but was linked to parole, bringing the voluntary nature into possible disrepute.

> "Contravening the HPCSA or whatever legislation there is, but sometimes the reporting does more harm in the actual act. I had a person once who picked up a child from a school and drove her around, he had fantasies that she would allow him to play her and vice versa, and when she started crying, he was really surprised and took her back to the school and presented at my rooms directly after and basically I said to him that's fine, I'll continue working with you but if this case gets reported to the police station as the, as child abduction I can't, you know, I've got to say that uh, you have been a danger to the child. That's my responsibility." [P1]

"He was only 15 years old when he started, but today it's now, 7 or 8 years later, he was caught out doing that because he tried, and the little brother and he started to talk about it, and then luckily the parents felt that they didn't want to take him to the police or report the case. I should have reported the case now, but I felt, um, it's been in the family, the family sent him now, and we are working on it." [P2]

Participant 1 explained a scenario whereby psychologists are often led into a grey area of reporting a client who then never receives treatment. Instead, the trauma of the legal system ensues. This then leads the therapist, in this case, to cautiously contravene the HPCSA and legislation. Participant 2 agreed in this regard with participant 1 in that so long as there is an awareness by the psychologist who sets specific boundaries, then therapy can continue.

Sometimes cases, especially concerning paedophilic disorder and paedophilic ideation, are grey areas of the law. According to the law and HPCSA regulations, therapists must report sexual activity concerning children and adults (Hendricks, 2014; Hunter, 2006; Republic of South Africa, 2020). It is ethical practice to inform one's client that one is legally required to report suspected sexual abuse of children, which must be part of the informed verbal and written consent process (Salin & Malin, 2013).

4.4.4.1 Correctional Services

All sexual offenders in correctional services are labelled as such, with no differences between individuals who commit offences against adults or children or those with paedophilic disorder. Individuals who commit offences against children would try to hide this information even more than those labelled sexual offenders. Given social stigmas, which will be examined in more detail in theme five, the individual with paedophilic disorder or paedophilic ideation becomes further victimised and traumatised in this context. They are viewed as outcasts from other offenders and shunned or bullied in worse forms than in broader society.

"The sex, sexual offenders often get quite victimised in a prison … I think … incarceration protects society and does not do much for the perpetrator." [P1]

"Paedophile is not your typical criminal. Most of them don't have any other offences … so it could make sense, but if you then create a treatment, a specialised treatment within a psychiatric facility for paedophilic people with paedophilic interests … you could have them come in from an outpatient basis

but through that same unit, specialised treatment unit with specialised psychologists." [P2]

"Once the person is in our system, we can't refer the person to the outside hospital … it would help, but I, I think it's more the red flag within government … it would involve a lot of logistics." [P5]

"So, it's sexual offender programmes in general. So you're sitting there with an adult rapist, which could have been opportunistic, and they're not necessarily, um, sexually-orientated toward, uh, children, for example … it might not be psychologically motivated like it is for a paedophile, and they all sitting in the same programme … it's quite like, you know, almost like a one size fits all, there are no tailored programmes for child sexual offenders in South Africa." [P6]

Participant 1 stated that the experience he has gained in private practice and dealing with legal/forensic cases led to his opinion that no rehabilitation takes place in correctional contexts. Participant 2 referred to "true paedophilia". These individuals do not have other offences against them, rendering the question of whether they should receive psychiatric/psychological intervention instead of only incarceration. Participant 5 explained that once they are incarcerated, they cannot be referred to a hospital for psychological treatment, even though it would be beneficial. Finally, participant 6 described how the programme in the correctional centre would not work well because it comprises all sexual offenders. Murhula and Singh (2019, p. 27) substantiated this, stating that the programmes apply a "one size fits all" approach.

"There's no space in psychiatric hospitals … We're about 80 psychologists nationally, and there's about 160 000 prisoners." [P3]

"Under-resourced … at the moment, the population is about 820, but when I came in, the population varied between 1100 to 1200. I'm talking about medium and not other centres, meaning that all the offenders here are my responsibility, one psychologist at the moment versus 820." [P5]

"I was dealing predominantly with, um, psych patients. So that placement would be on the maximum centre where I was 1 to 1500 offenders … If you get to do therapy with one client, you know, twice a month, you're very fortunate, and so that intensity, the consistency what therapy as well is really lacking with correctional services." [P6]

Following the need to attend programmes while incarcerated is the issue of resources. Paedophilia might be classified as a mental disorder, but there are not

enough spaces in psychiatric hospitals, and thus most individuals are sent to correctional centres. The lack of spaces in psychiatric hospitals is part of a broader problem in South Africa's mental healthcare system, which is experiencing severe constraints. Docrat et al. (2019) found that in the 2016/17 financial year, 5% of the state budget was allocated to mental health care. Participant 3 stated that at a national level in South Africa, there are an estimated 80 psychologists to 160 000 inmates. Tollman (2021) gave the example of a psychologist placed at Bizzah Makhate Correctional Centre in Kroonstad who has to rotate across 14 correctional centres, thus impacting their ability to attend to emergency cases and have ongoing sessions or follow-up sessions. Participant 5 also spoke of the lack of psychologists available in correctional centres. Even though therapy is needed to get parole, participant 6 explained there is very little, if any, therapeutic intervention, given the overwhelming number of offenders, with a ratio at times of one psychologist to 1500 offenders. This results in no therapy but only assessments of offenders for parole. This is substantiated by Murhula and Singh (2019), who stated that there was a severe shortage of psychologists in correctional centres. The DCS has admitted that it is unlikely that the number of psychologists they employ can see to offenders' mental health care needs (Mills, 2019). According to participant 6, the best-case scenario is that therapy may occur twice a month, resulting in a lack of therapeutic intensity and consistency. Therefore, there is little room or possibility for therapeutic intervention and change, even with the stipulation of therapy needed for parole. It is just not possible.

Thus, individuals with paedophilic disorder are incarcerated for punitive and not rehabilitative purposes. The paradox of parole requiring therapy punishes individuals with paedophilic disorder, as treatment is unavailable. Correctional centre settings may also mask actual transformation, as participant 4 explained, given that there is little to no exposure of victims in this context and prison alone is insufficient to "cure" paedophilic disorder.

Several participants pointed out that the correctional centre context is not conducive to treating mental health illness in general. The issues are structural, as in a considerable lack of resources. First, the ratio of the therapist to client, as in the correctional services centre where participant 3 works, she estimated 1 psychologist (herself) to 820 inmates, increasing at times to a ratio of 1 to 1200 inmates. Second, follow-up services once inmates are paroled do not exist. There is no treatment

offered, no programmes of support once individuals are released, and the system to track their progress or behaviour, for instance, if they reoffend, needs more resources to be effective.

Participant 6 raised the idea of reintegration of sexual offenders. Successful reintegration into the home and community is crucial for an individual to lead a successful life and also speaks to reoffending.

> "Once they reintegrate into society, we have a whole different issue. The sexual offenders register is quite inactive in South Africa." [P6]

Participant 6 explained that the sexual offender's list, the NCPR in South Africa, is reportedly inactive. Further, there are meant to be disclosure-based programmes and child sex offender programmes to assist these individuals post-release. However, these do not exist, which also links to a lack of resources. This links back to the idea that individuals with paedophilic disorder and paedophilic ideation face punitive measures for their behaviour. Still, no attempt is made to treat or support them despite the severe stigma they face in correctional settings and once released. The victimisation and trauma experienced upon attempting to reintegrate into their community have been likened to torture.

4.4.4.2 Mandated Therapy

Participants spoke of mandated, court-ordered therapy that sexual offenders, in which individuals with paedophilic disorder would fall, have to attend.

> "Court-ordered therapy is not terribly successful, um and successful in as far as sustaining the desired, uh, kind of outcome … especially if it's part of the prison sentence or something like that, but in dealing with the long-term changes, it's usually not very successful." [P1]

> "Ja, well, they are not mandated, they have a choice in prison, um, but we, we tell them clearly that 'look, if you don't want to participate, then we cannot give you parole, um, because you are at risk' … Can't get parole unless they attend therapy … They had less than 5-year sentences, and so you cannot do long therapy with them." [P2]

> "The court can mandate someone to go to therapy so as part of their sentence the court would say they have to attend, or they have to see a psychologist … So, if an offender, if they don't want to engage with a psychologist they don't have to, but obviously a report is written saying that they don't wish to use to make use of the services." [P3]

"All sexual offenders … if they don't attend, they can't go to parole … so they have to attend it, its mandatory … can't get parole if don't do." [P4]

"To get parole consideration, you must attend that particular programme." [P5]

"In addition to that, I was placed at the centres to do the assessment of offenders for parole consideration." [P6]

Within a correctional service setting, psychotherapeutic intervention is technically voluntary. However, individuals are mandated to attend treatment programmes if they wish to qualify for parole. Further, individuals will not be considered for parole if they have not attended psychotherapy, raising the question of whether it is a true psychotherapeutic process or a means to obtain parole. Participant 1 raised the concern that although therapy was mandatory, e.g. a short sentence of 5 years, it would be ineffective as long-term changes would be minimal given the lack of therapeutic intervention. Rehabilitation is for offenders who have sentences longer than 2 years and would only attend sessions every 2 months. An offender with a 4 to 5 year sentence would then only receive 2 to 3 years of therapy every 2 months. This is very little therapeutic intervention. Participants 2 and 3 explained that when therapy is mandated, individuals attend with the malingering causality of wanting to get parole, not because they intend to be part of a therapeutic process and address their paedophilic disorder and paedophilic ideation. However, even if individuals with paedophilic disorder and paedophilic ideation wished to get long-term treatment, this is not possible within the context of correctional services. Only offenders with a sentence longer than 2 years qualify for rehabilitation, and, given the lack of resources and the hierarchy of social constructions, these individuals are at the bottom of the rung in terms of receiving treatment.

4.4.5 Theme Five: Stigma

Stigma was a dominant theme, emanating from the way paedophilia is viewed by the broader society, psychologists and mental health professionals in general. The stigma from society is reflected in the correctional centre setting, where all sexual offenders are stigmatised by the general population, including individuals who have harmed children. Further, alluding to the stigma psychologists practicing with these individuals experience to how individuals with paedophilic disorder and ideation self-stigmatise.

"Society regards paedophilia as a taboo, and it is therefore heavily stigmatised.

"There is so much stigma that they don't want to admit these thoughts and things, so they don't want to go for help because they are afraid of the stigma." [P3].

"At some point, paedophilia became a taboo in society, but whether that's the origin of or not doesn't matter currently because it's still a taboo, and you not gonna shift that cultural perception." [P4]

"It's a perversion, but that takes away the loadedness of the word paedophilia when we can think about it as a perversion per se, and then obviously society came in and said, well, it's worse that you're attracted to children." [P4]

Participant 3 explained how individuals were afraid of being stigmatised, which led to the denial of their thoughts and feelings but also prohibited them from reaching out for help. In theme one, under discussion of treatment participant 1 said they used CBT as an approach because of the stigma from society that made individuals with paedophilic disorder feel ashamed and judged. Participant 4 referred to paedophilia as a taboo. Literature alludes to this taboo whereby the media often misconstrue paedophilic disorder and paedophilic ideation, using language to depict these individuals in a manner which marginalises and dehumanises them (Imhoff, 2014; Jahnke et al., 2015).

The stigma held by society spills over to mental health professionals who work in the management and treatment of paedophilia, among other mental health disorders.

"Not a lot of people that are willing to treat paedophilic disorder or paedophilic ideation." [P1]

"Obviously, there would be stigma, but again, I don't think in a setting that we are in, we are being given a choice to say, I'm not gonna work with this person, even us, depending on the, the nature of the crime, child sexual offender but how was the entire thing committed. Even with us initially, sometimes we become a bit judgemental, but at the end of the day, I'm here; I have to see this person. Me as a therapist, I might be having stigma towards these child sexual offenders, but again, the environment is forcing me to kind of work with them." [P5]

"But it's also for reputation management. There's a great deal of stigma associated with being a child sexual offender. The word paedophile is not used very loosely in a corrections. You start questioning whether prisons are actually

just dumping ground for mentally ill patients … an even huger problem when these offenders are reintegrated into society because number one, societies has such poor awareness of paedophiles and how to manage paedophiles and how to then manage the context around them.” [P6]

Participant 1 and 6 shared that many psychologists were unwilling to work with clients with paedophilia. This was substantiated by Scheela’s (2001) study, which found that therapists who spoke against predominant, negative societal attitudes towards this population were viewed negatively. Participant 5 alluded to this stigma and revealed a sense of only working with paedophilic clients as it is part of their job description. But, therapy cannot be successful if the relationship is forced. Both the therapist and client must want to engage in the therapeutic process. Participant 6 extended this, stating that offenders who hold the title of paedophile experience a great deal of stigma, and for this reason, the label “paedophile” is not used loosely within the corrections setting. Further explaining that when these individuals are released into society, the stigma is exacerbated, and treatment and societal understanding become prohibitive factors due to the societal stigma. The literature states that the public and mental health professionals believe that individuals with paedophilic disorder will offend and that there is no therapeutic aid concerning treatment. Further, these individuals do not deserve treatment (Jahnke, 2015).

4.4.5.1 Stigma Toward the Individuals with Paedophilic Disorder and Paedophilic Ideation

“I don’t want to have nothing to do with a guy like that. Especially the females … you still have to help them. You say, ‘hey, you have to go in there’. You cannot avoid that part of therapy. So ja, I think it’s the whole thing, it’s the stigma, it’s the stigma of that specific type of offence and ja, the moralistic view of that, this is the thing … but I was trained … in my masters, and they will hammer that in, ‘don’t be moralistic’. You have to throw out your moral stuff a bit when you doing therapy because people, you can get funny people, and they come into therapy, and you sit and think, but you know, I cannot work with this guy because he’s so much different than me; he’s got different values and morals.” [P2]

“So ja, it takes me back now to my personal experience when I was doing my interviews … Now I was asked what kind of population I wouldn’t work with. I

immediately said …I wouldn't work for someone who has raped, especially raped a kid, because I would think, what if that is my kid." [P5]

"A paedophile certainly will not feature on a treatment list … due to the added stigma and marginalisation, which is rather sad because we are reintegrating them back into society, and the problem prevails. So, we're not treating those at all." [P6]

When looking at the impact of stigma toward clients with paedophilic disorder and paedophilic ideation, participant 2 explained that particularly female psychologists might not want to treat individuals who had harmed children but went back to their training where they were taught not to be moralistic. Participant 5 explained that when first interviewed for employment, they were clear they would not work with anyone who had raped a child as they could only think of their own child. However, this changed as participant 5 has 16 years of experience with individuals with paedophilic disorder and paedophilic ideation. Participant 5 explained that they had personal stigmas toward these clients and that it was purely a case of having no option, given the working context of a correctional setting. A study by Stiels-Glenn (2010) conducted in Germany among psychotherapists found that 95% were reluctant to treat paedophiles because they held negative attitudes and hostile feelings towards them. Some psychologists have negative attitudes toward people with paedophilic tendencies, usually producing feelings of revulsion, concerns about whether they could be helped and worries about liability (Stelzmann et al., 2020). This is not to suggest that stigma does not occur in other therapy settings, as psychologists might hold negative attitudes about other identity categories regarding race, sexuality, ethnicity and so on.

Within the correctional setting, stigma is also an issue which is reflective of broader societal stigmas.

"You get treated in an unfair manner by other offenders when it comes to raping kids. It becomes even worse. You sort of get bullied." [P5]

"Within the corrections setting as well amongst inmates, that's quite a hierarchy … that's placed amongst criminals themselves, and child sexual offenders really fall right at the bottom of that hierarchy in terms of stigma and condemnation … having to protect of these child sexual offenders against other offenders because they're also more vulnerable to sexual victimisation in the corrections setting … You've got to advocate for them to be placed in isolation

cells for example by themselves … it certainly is difficult, coming up against a system.” [P6]

Participants 5 and 6 described how individuals with paedophilic disorder and paedophilic ideation are treated in a correction setting. They are bullied by other inmates, and there is a hierarchy within this setting, with offences against children viewed as the worst offence. The existence of a hierarchy was confirmed by Ricciardelli and Mackenzie (2013, p. 359), who further stated that sexual offenders were considered ‘‘less than human” and targeted for theft, victimisation and harassment. This harassment often became violent, as confirmed by Trammell and Chenault’s (2009) study on inmates who assaulted offenders who had sexually harmed children. This leads to sexual offenders denying their attraction towards minors as a protective mechanism in the setting. Participant 6 agreed that a hierarchy existed within the corrections setting and that they advocated for them to be placed in isolation for their own protection. However, this was challenging to negotiate and begs the question of fairness or further imposed punishment.

Furthermore, often the family of the offenders do not visit sexual offenders if they are aware of their offence, leading to further victimisation from inmates.

“A visit is very important to offenders if you don’t get visited again. You get bullied, it’s like you are just nothing, you are worthless, you are useless, your family doesn’t want you, they get teased on that as well.” [P5]

Inmates who do not receive visitors from family experience bullying by other inmates. To ensure they receive visitors, sexual offenders, particularly those who have harmed children, deny the offence. Someone who has sexually violated a child is said to have committed the most heinous crime within correctional settings, even below murders. Harper et al. (2021) argued that paedophiles are considered predatory child sexual offenders. In the study by Jahnke et al. (2015) conducted in Germany, when surveyed, many agreed with the statement that those with paedophilic interests should be "dead”. Furthermore, 39% of the German participants felt that a paedophile should be imprisoned regardless of whether they had committed a criminal act by acting on their impulses or not. This study also found that not only does this stigmatisation hinder them from getting emotional support, but also that since they suffer from a lack of support, it is likely to have a ripple effect in that they are more likely to act on impulses and abuse a child, as a result of guilt and internalised stigma.

"Someone who has child victims … might not be as open to speak up freely … because … even within the prison there's different stigma." [P3]

"Um, so particularly in a correctional setting or in any other setting, I think the denial is quite commonly, uh, expressed by offenders, and that's because of the stigma." [P6]

Participant 3 alluded to the idea that these individuals are reluctant to open up in therapy within a correctional setting due to stigma. Participant 6 also spoke of the stigma in the correctional services context, alluding to its consequences, which linked back to the theme of treatment. Individuals with paedophilic disorder and ideation do not feature on the radar for therapy, as the correctional system holds a strong stigma toward this population. Given the victimisation they face in this context, they are often placed in isolation for their own protection. Being in isolation will have consequences, such as being unable to attend programmes in the correctional centre. Therefore, being denied adequate therapeutic intervention. This can impact their chances of reoffending as purely punishing these individuals through a judicial system is not treatment of a mental health disorder. Thus, society's welfare is not considered. This begs the question of how society is meant to assist these individuals if they cannot access help while incarcerated.

4.5.1.2 Stigma Toward the Professionals Who Treat Individuals with Paedophilic Disorder and Paedophilic Ideation

Professionals in this field experience stigma, which may impact their well-being negatively.

"I said, look, I can't come to this …conference they were like, 'Oh, there he goes again with his interest in sex.' You know, and then, I've also had, because of having been married and being married to a man, people kind of almost thinking that participant is very loose with what he expects, uh sexually … almost like, he's too permissive and that kind of thing … those kind of comments have come up … if they know you running a kind of group of paedophiles, how can you be in their presence." [P1]

"Other mental health care workers saying how can you help that population; they don't deserve to be helped. Yes, you hear that a lot, you hear that a lot when maybe you are in conferences. Or you meet people that you trained with. Now they are interested; where do you work?" [P5]

Participant 1 mentioned that his sexuality formed part of the stigma as it was perceived that because of his sexuality, he was too open-minded and permissive for the clients he treated with paedophilia. The implication is that this participant's sexuality, not being heterosexual, affects his value system, supporting the prevalence of heteronormativity. He also experienced dismay from colleagues who could not conceive why he would work with this population, revealing their stigma towards these individuals who suffer from paedophilic disorder and ideation. If colleagues in the mental health profession express this dismay, it reveals the unwillingness of many to treat this population as referred to previously.

Participant 5 also spoke of negative sentiments received from colleagues in that they believed that individuals with paedophilic disorder do not deserve to be helped. For example, a study by Scheela (2001) suggested that sex offender therapists who spoke against dominant, negative societal attitudes towards this population were viewed as the "enemy" for being willing to treat this population. As a result, some therapists may feel awkward telling people they work with these clients (Bach & Delmuth, 2018).

> "Working with the stigma, I've had to rephrase group titles … I wouldn't be able to put up adverts, advertising a paedophile support group which is what I would clinically call it, so I would put up a poster calling it a child sexual offender group … you've got to be very cautious and mindful of how you phrase things to colleagues within correctional services without a psychology background …as the paedophile's therapist … I became known as the paedo lady [laughs] … colleagues, psychologists who felt they didn't have the stomach or the empathy for paedophiles, I would be called in to assess particular, especially profile paedophiles … You know, telling people that you work with paedophiles, you enjoy working with paedophiles, you have a level of empathy for them, what they've been through, what they've endured, what they still fighting at the moment … but certainly, society also feels like you're wasting your time working with these, these people ... you're questioned for your own, your own morality and your own values of 'why would you do this?' It's almost as if you are treating them; you condone the behaviour." [P6]

The stigma experienced by participant 6 from her peers is evident in her narrative and backed up in the literature. Roche and Stephens' (2022) study revealed that the more knowledge and competence a mental health practitioner had with people

who expressed sexual interest in children, the more willing they were to offer treatment. Participant 6 was viewed by her peers as an expert, often called in to do assessments, albeit labelling her as the “paedo lady”, revealing their stigma. Participant 6 experienced being stigmatised as a psychologist who treats and assesses individuals with paedophilic disorder and paedophilic ideation, as a professional, but also because she is a mother.

> “Being a mother also been questioned multiple times, ‘why do you work with them? Don’t you don’t feel anything for your kids? What if that was your child?’ Precisely why I work with them because that could be my child … and I hope that I would have made a difference in a context such as that … I do have a very watered-down version of that stigma, a lot of judgement for wasting my time, my resources and a lot of questioning of my own ethics and values system for wanting to work with this particular group.” [P6]

Participant 6 is judged for working with paedophiles because she is a mother. This speaks to the social construction of women as mothers who are viewed as caring for children, thus not someone who would want to help a paedophile who harms children. Interestingly, participant 6 explained that part of her pull toward helping these individuals is because she is a mother and wishes to protect her children. If individuals with paedophilic disorder are not humanised by society and treated for their disorder, how will it ever stop?

4.5 Conclusion

This chapter presented the findings and discussion thereof. Under each theme and subtheme, the excerpts from the participants’ transcripts were presented. I then analysed these by referring back to the literature.

In theme one, paedophilic disorder and paedophilic ideation, participants narrated how they understood paedophilic disorder and paedophilic ideation based on their own experiences. Some participants said there was little literature on paedophilic disorder and paedophilic ideation. All the participants discussed comorbidities except for one (participant 4), mainly referring to antisocial personality traits. Within this, they also raised empathy, which individuals with paedophilic disorder lacked and that it was necessary to develop insight for treatment to be effective. Participants talked about different types of paedophiles, such as sadistic paedophiles, and the prevalence of females with paedophilic disorder with one participant, despite many decades of experience stating they had never encountered this.

Theme two, psychotherapeutic interventions, examined how psychologists in South Africa in this study currently manage and treat individuals with paedophilic ideation and paedophilic disorder. Long-term therapy was seen as the most effective. Empathy and development of insight, working with fantasies were all important components of psychotherapy raised by participants. Participants stated there was no appropriate assessment for paedophilic disorder in South Africa. Participants discussed their preferences for individual or group therapy or a combination of both. It was stated that group therapy would only be useful in a correctional setting if more homogenous, as currently, groups comprise all sexual offenders. Participants also discussed skills needed, with most talking more about the need for support.

Theme three examined the therapeutic approaches and theoretical models used by participants for understanding and treating individuals with paedophilic disorder and paedophilic ideation. The participants ranged from being eclectic to using the CBT approach to only using a psychoanalytic approach. One participant within a psychodynamic and CBT approach used the offender's cycle. This was linked to the training they had received in New Zealand. The participants stated that there was a lack of training on how to manage and treat paedophilic disorder and were critical of their master's training in this area. All the participants had to self-study and draw on international training.

Theme four examined the law in South Africa and how it was linked to reporting of sexual offences. It examined confidentiality between psychologists and their clients and that psychologists had to report all harm or threats of harm to children. Participants also discussed that therapy in a correctional setting is linked to gaining parole. This condition attached to therapy led to questioning the individual's commitment to treatment as it was not voluntary.

The final theme on stigma examined broad social stigma and the stigma experienced by mental health professionals who work with individuals with paedophilic disorder or ideation. Stigma in society is evident in correctional settings where individuals who have harmed children and sexual offenders, including paedophiles, are victimised and sometimes placed in isolation for their safety. Mental health professionals who manage and treat individuals with paedophilic disorder or paedophilic ideation experience stigma, making them cautious about revealing their work focus to friends and family.

Chapter five will present the conclusion, strengths and limitations of the study and recommendations for future research.

Chapter Five
Conclusions and Recommendations

5.1 Introduction

The main aim of this study was to examine and understand how psychologists in South Africa in this study currently manage and treat clients with paedophilic disorder and paedophilic ideation. The study was situated within the interpretivist paradigm and used a qualitative methodology. Data was collected through semi-structured interviews with registered psychologists who treat paedophilic disorder or ideation in South Africa. The epistemological perspective of the study was social constructionism, as the focus was on how individuals understand and know their social reality through interactional processes, thus making knowledge. Thus knowledge of social reality is constructed through human relationships in a particular social context. That context is historical and cultural because meanings shift according to the context.

This chapter presents the conclusions I drew, with the caveat that qualitative research resists the tendency to fix meanings but instead draws inferences about meaning (Murphy et al., 1998). Finally, the themes are presented with conclusions drawn and recommendations for future research.

5.2 Main Findings in Relation to the Research Question and Objectives

Five main themes emanated from the data collected with corresponding subthemes. The main findings of each will be discussed in relation to the research questions and objectives as detailed above.

5.2.1 Theme One: Paedophilic Disorder and Paedophilic Ideation with Subthemes Comorbidities, Types of Paedophiles, Grooming and Sexual Orientation

Regarding the main finding on the subtheme comorbidities, those found in a private therapeutic setting are dependant personality disorder, mood disorders and anxiety especially. The link is more ego-dystonic, alluding to the individual not wanting to have a sexual attraction to minors but being affected by these in the form of urges, fantasies etc. In a correctional setting, borderline personality disorder and narcissistic personality disorder are more prevalent, usually with a substance-related disorder. However, there are cases of conduct disorders and oppositional defiance disorders found in this setting, which are precursors for antisocial personality disorder, but these often get overlooked and untreated, given the lack of resources in these settings.

In this regard, the individual with paedophilic disorder or paedophilic ideation is, interestingly, often found to be a family member or an individual who is close to the family, such as a neighbour or friend of the family. This trauma associated with the individuals' own past childhood abuse (linked to the development of personality disorders) leads to the hypothesis that they develop a personality structure as a defence to their abuse. This creates pathological personality disorders, which become comorbid with their paedophilic interests. For this reason, therapeutic intervention should be lifelong, not only due to the possible personality structure but also due to the deep-rooted trauma associated with paedophilic disorder, which means that reoffending is likely to occur if it is terminated.

The main finding on the subtheme of grooming shows there is a typical grooming process involved with individuals with paedophilic disorder and ideation, which mirrors their own grooming. This grooming process is confusing to a minor as there is a dichotomy of pain versus pleasure that they cannot understand, given their lack of cognitive maturity. For this reason, these minors experience the sexual advances and sexual abuse as being pleasurable, and only in retrospect later on in life do they realise the understanding of this dichotomy. Initially, seeing the sexual exchange as mutually beneficial and part of a relational exchange, but as minors mature, they realise this is not the case. In reality, it was a violation of their autonomy and consent, often linked to a grooming process which builds a trusting relationship between the adult with paedophilic intentions and a minor.

Within theme one, a finding emerged concerning female paedophilia, which substantiated the lack of research in this area in South Africa. Female paedophilia remains largely invisible in South Africa, and when it is acknowledged, it is understood differently than male paedophilia. For example, often, they are viewed as being forced to work with male paedophiles. Female paedophilia is viewed differently from males, as less harmful to children (Papakyriakou, 2017). Further, female paedophilic sexual violations are often harder to prove in court.

The finding for the subtheme on understanding paedophilic disorder and paedophilic ideation as a sexual orientation emerged given the semi-structured approach to the interviews despite no set questions in this area. It was claimed that comprehension of an individual's sexual orientation would yield a better understanding of their pathology concerning paedophilic disorder. This is because if the paedophilic disorder were not just considered a paraphilia but a sexual orientation, it would lead

to a better understanding of the individuals' intrapsychic makeup and psychological formulation associated with paedophilic disorder. However, how this would inform therapeutic techniques remains unclear as more knowledge on paedophilic disorder and paedophilic ideation and an empathic approach by the psychologist toward the individual being treated is needed. Viewing paedophilic disorder is controversial and problematic given the associated legal, ethical, moral and societal implications when considering paedophilic disorder as possibly linked to sexual orientation. This is because, in South Africa, sexual orientations are given rights and protections under the Constitution. Although the same rights and protections are not proposed for paedophilia, as sexual acts between adults and children are a criminal offence and require consent as well as further moral and ethical implications, it would be difficult and illegal to persuade society to change its current stigmatising perception of paedophilia. Society's reasonable fears are that if paedophilia is not classified as a mental health disorder (if it changes to sexual orientation), it paves the way for rights and protections and the decriminalisation of sexual acts between adults and children. Instead, consideration should perhaps be directed toward a professional understanding whereby therapeutic formulation regarding the possible link to a psychotherapeutic treatment process concerning the individuals' sexual orientation is one consideration that could possibly affect the individual's psychological makeup concerning paedophilic disorder.

5.2.2 Theme Two: Psychotherapeutic Interventions with Subthemes Group Therapy and Participants' Skills

Psychotherapeutic interventions yielded rich information relevant to this study in that participants offered key information pertaining to treatment. Namely, to treat individuals with paedophilic disorder and paedophilic ideation, the therapeutic aim is for the individual who is attracted to minors to be aided to develop insight into their attraction and further establish empathy within therapy to navigate toward changing their behaviour toward minors. For this to be successful, impulse control would be a central focus of the therapeutic process. Working with psychological fantasies became a main element of this theme in that participants spoke to working with the patient's paedophilic fantasy in such a manner as to understand the basics of the fantasy. However, the participants warned about not allowing too much focus on fantasies because it could lead to the expansion of the fantasy, having a counterproductive effect. However, one therapeutic stance contradicted this and spoke about delving as

deeply into the fantasy as possible to conceptualise and understand it fully. This participant believed that therein lay the proper focus of the therapy. One component within the correctional services setting that impacted the treatment's prognosis and effectiveness was contraband, such as pornography. This form of contraband was found to limit therapeutic growth. Further, if an individual had carried out a sexual act with a minor versus only having the ideation, the prognosis of treatment is then much poorer and the chances of reoffending increase.

The idea of castration as a treatment measure was viewed poorly. This is because this treatment does not prevent individuals from using objects or other means, such as digital penetration, when committing sexual acts. There was evidence supporting the use of chemical castration under very specific conditions. One was in conjunction with long-term therapy. This indicated that a therapeutic process is the best chance for treatment over chemical or medical interventions. However, further consideration through a correctional lens leans toward the absence of therapy once the individual is released on parole, potentially leading to reoffending.

In terms of psychological intervention, the best outcome for assisting individuals with paedophilic disorder and paedophilic ideation is a combination of group therapy and individual therapy. However, most of the weight resides in the individual therapeutic process, with a group process being more of a supporting base externally to individual therapy and more of a space to feel less isolated and consumed by the pathology. Therefore, the group process would be long-term and a closed group to ensure cohesion and maintenance of the group rules and goals.

It was found that the skills required by a psychologist to treat this population lay in being comfortable in oneself and having a support structure or supervisory context, debriefing and brainstorming. However, there is uncertainty about where one would find sufficient experts to offer this support and supervision due to a lack of psychologists who treat individuals with paedophilic disorder and paedophilic ideation. The two psychologists who have worked in this area for 30 years or more feel they are unsupported and require more understanding of treatments, relying on trial and error as well as outcomes based on each case to the next.

5.2.3 Theme Three: Therapeutic Approaches and Theoretical Models with Subthemes Training and International Guidelines, Organisations and Models

The third theme, therapeutic approaches and theoretical models highlighted that participants in this study were critical of current training protocols. It was evident that the participants felt they had not received adequate training through their formal master's degree training. They also felt a dire lack of training on paedophilic disorder and paedophilic ideation, especially within a South African context, not only from their tertiary studies but also from their professional qualifications. For this reason, healthcare professionals rely on implementing protocols, programmes and models formulated for other countries such as New Zealand and Canada. This was found across the six participants of this study, all of whom had extended their knowledge based on international populations. However, findings suggest that an eclectic or integrative approach is indicated when formulating an understanding of the individual with paedophilic disorder as well as their treatment thereof, but significantly that this framework be based on the specific presentation of each individual in therapy.

The theoretical framework for addressing cognitive structures and behaviour was CBT. However, its efficacy is mainly associated with a correctional service setting, given that it is a short-term approach and that therapeutic intervention needs to be quick within these contexts. However, the prognosis for CBT is said to be minimal for this population. Positive psychology was another framework which attempted to develop social skills and build relationships, which was seen as more effective for a correctional services population but not for non-offenders. A psychoanalytic theoretical framework was said to be the only modality which has a clear understanding of sexuality. It is also carried out over a long-term therapeutic process, as well as being a modality which looks to an individual’s past and how that past affects the here and now. Canadian-based models have been implemented and adapted by psychologists, such as the good lives model grounded in positive psychology. Other international guidelines which have been adapted are rehabilitative programmes from Canada and New Zealand. However, these are not specific to paedophilic disorder or paedophilic ideation but more as programmes for offenders as a whole, alluding to the severe lack of treatment approaches and models or contextual understanding for a South African population.

Therapeutic interventions did differ among the participants, given that some worked in correctional services and some in private practice. The psychologists who treated individuals within the correctional setting alluded to struggling to treat these individuals for various reasons. This is mainly due to the systemic stigma associated with having paedophilic disorder. Still, further, these settings are extremely under-resourced, and it would be impossible to offer long-term therapeutic interventions for these individuals. Usually, short-term therapy or an assessment is done closer to parole dates, as offenders cannot get parole if they have not attended therapy. Often, these offenders have comorbid antisocial personality traits/disorders as well as depression and anxiety.

Within private settings, individuals with paedophilic disorder attend longer therapy processes. They typically fit the profile of a "true paedophile" in that they fit the DSM-5-TR criteria for paedophilic disorder or paedophilic ideation. They do not have sadistic traits, being softer, gentler typologies with less antisocial traits. Therapeutic intervention explores fantasy, looking at the individual in therapy from a regressive stance by considering the first point of fantasy development in earlier life and working through fantasy production. However, approaches do become eclectic depending on the presentation of the individual in therapy. The predominant modalities were that of a psychoanalytic perspective and a cognitive behavioural perspective. Group therapy was indicated as part of the therapeutic process in conjunction with individual therapy but not on its own. Treatment success for paedophilic disorder and paedophilic ideation was reported to be higher in cases where the individual had not acted on their compulsions.

Within the private sector and specifically within the positive and psychoanalytical approaches, there was a sense of humanising the individuals in therapy and specific to the psychoanalytic approach, exploring deeper internal structures of the individual's psyche and addressing their own sexuality and perversions with the ripple effect of empathy creation, trauma reduction and a more profound sense of self-understanding. While this approach is long-term, it does seem that long-term, if not lifelong, therapy is recommended.

In terms of assessments, there are no South African-based ones other than those within correctional settings. However, the risk assessments used in correctional settings form part of a standard risk assessment of offenders not specific to paedophilic disorder and not focused on evaluating for paedophilic disorder. Due to

no assessments being available to evaluate this population of society, psychologists rely on international assessments and attempt to use these within a South African population. Otherwise, projective testing is done. However, these are subjectively scored and are not as reliable as objective tests. Another issue the participants raised regarding the treatment of paedophiles in correctional settings was linked to resources.

Participants stated that any inmate convicted of any form of child sexual abuse, even if not labelled a paedophile, was considered the dregs of society. Training individuals to run workshops to provide skills in correctional settings was viewed as a valuable resource and not to be wasted on these offenders. This is linked to the wider systemic issue of lack of training on paedophilic disorder and ideation that participants had discussed.

5.2.4 Theme Four: The Law with Subthemes Correctional Services and Mandated Therapy

This theme illuminated the impact of the law with regard to understanding paedophilia in general and how this oversees the therapeutic stance needed when treating paedophilic disorder and paedophilic ideation. Within private settings, participants mentioned that they would often have to find a way to create their own boundaries in treating paedophilic disorder and paedophilic ideation. This is because, during treatment, they encounter ill-defined situations, i.e. grey areas. However, legally and according to rules by the HPCSA, they would be obliged to report their client and terminate therapy in certain instances. The participants explained that if they had some room to set their own boundaries based on the grey areas, therapy could continue. As long as no crime had been committed and thus reported, the individuals were given therapy. This is contentious, and it could be argued that it contravenes laws and codes of conduct. Plus, individual psychologists setting boundaries could be problematic given subjectivity.

Often, therapy only takes place at the end of an offender’s sentence to get parole, which essentially alludes to enticement and not “true” reform or intervention. The onus is on the inmate to join a rehabilitation programme because the idea is that it is a prerequisite that rehabilitation follows incarceration. However, the inmates’ aim is often to achieve parole and not help as such. Offender programmes are often offered by correctional staff, not psychologists. Although these are mandatory, they are focused on risk behaviour as a whole and not on paedophilic disorder and paedophilic

ideation specifically. There is a false sense of rehabilitation taking place because there is a lack of access to minors. In reality, they have been isolated for some time with no therapeutic intervention. Instead, they are further victimised and traumatised, which would exacerbate their history of trauma and associated beliefs and experiences around that trauma if they had experienced it. Not all individuals attracted to children have been traumatised or sexually abused as children. Participants agreed that these individuals should be placed in psychiatric institutions; however, given systemic problems, this would not happen and, therefore, borders on being unethical. Further, once their sentence is finished, these traumatised individuals are released into general society, and the chances of them reoffending then increase as there is no therapeutic support through this entire cycle.

A further main finding relates to the objective of key issues that emerged in clinical and counselling psychologists' interactions regarding treating individuals suffering from paedophilic disorder or paedophilic ideation. It also impacted present treatment protocols as one needs to consider self-stigma, stigma from others and stigma towards therapists treating individuals with this disorder.

Offenders might not attend therapy in correctional services setting even if they wanted to. This is due to a complex hierarchy within the correctional services centre, with offenders who have sexually harmed children placed at the bottom of the hierarchical chain of criminal offences, thus often targeted and victimised. For this reason, denial of their paedophilic disorder and paedophilic ideation is high. This is further exacerbated by parole requirements. Individuals must stay with family members during parole and cannot exit correctional services if they have nowhere to reside. If individuals admit to having sexually abused a child, their family will most likely reject them, meaning they do not qualify for parole. Therefore, these offenders would deny any attraction to children, any fantasy about children and any sexual behaviour with children, as the stigma associated at various systemic levels has a severe impact on their survival and well-being. This created a further obstacle within this context, which is already under-resourced and has significant limitations to therapy.

5.2.5 Theme Five: Stigma with Subthemes Stigma toward the Individuals with Paedophilic Disorder and Paedophilic Ideation and Stigma Toward the Professionals who Treat Individuals with Paedophilic Disorder and Paedophilic Ideation

Theme five, stigma, was an overarching theme that had a severe impact on therapeutic intervention. There are various levels of stigma which negatively impact this process. One is the individual with paedophilic disorder, or paedophilic ideation, who must deal with their own anxiety and depression before committing to any therapeutic process. This is exacerbated by laws criminalising their attraction to minors. This leaves a grey area for therapists treating these individuals as mentioned above. These therapists might need to step into unethical or ethical grey areas in order to treat these clients because, legally, child abuse or intent to commit child abuse must be reported. However, no therapeutic process can unfold then, and this leaves a stalemate to intervention. Psychologists in private practice could step into this grey area within their own moral boundaries to assist the individuals.

Paedophiles are viewed by society as the worst of all criminals, not deserving of care. This, however, refers largely to males as the idea of female paedophiles does not fit with the way women are socially constructed. It is accepted that females can be paedophiles if they are coerced by men. This study found that females could be paedophiles but that their rates of offending would be significantly lower than males, given the social lens of females being nurturers.

Another area of stigma to consider is professional stigma, in that mental health practitioners are often unwilling to treat individuals with paedophilic disorder and paedophilic ideation. One reason for this is the severe lack of training and awareness around this pathology, and the other links to broader societal stereotyping. Those who do treat these individuals are seen as working on the edge of societal acceptance and suffer from stigma, often struggling for support from others within their field. From a broader social perspective, it would be challenging to change the stigmatisation of paedophilia, particularly as the media contributes to it as opposed to playing an educational role. However, the crucial part of therapy is aiding clients and seeing them as more than the disorder but seeing their humanness. For there to be a therapeutic change, broader social stigmatisation needs to be challenged, and more training on the disorder implemented, leading to more understanding and empathy toward this population. The key here would be to address therapy primarily for those individuals

who have paedophilic ideation and have not acted on their attraction to minors, as well as empathy development and insight into the impact of their sexual attractions and the ramifications this would have on others.

5.2.6 Strengths and Limitations of the Study

This study's limitations were its small sample size and that four of the six participants were white. In addition, four of the participants worked in correctional services setting, with two in private practice. One participant was located in both contexts. Thus, most of the participants’ knowledge and experiences were influenced by working with sexual offenders in correctional services, where individuals with paedophilic disorder were not identified any differently from sexual offenders per se.

A strength of this research was the researcher’s ability to adapt the data collection strategy. Initially, I planned to send an email to all psychologists registered with the HPCSA, but this was not allowed, given laws which protect the sharing of individuals' personal information within this database. Hence, I relied on personal networks with psychologists and advertising on various social media platforms, inviting participants to the study who fit the criteria to participate. This led to six participants taking part. Given that the sample size comprised six participants, the findings are not generalisable, even though the population of psychologists who treat individuals for paedophilic disorder and paedophilic ideation is very low. However, this was an in-depth qualitative study located within social constructionism. Thus, the nature of the participants’ realities was important to understand. It drew on the participants’ experience in their own words, yielding rich data that served to answer the research question of how psychologists in South Africa treat paedophilic disorder and paedophilic ideation. It also illustrated that paedophilic disorder and ideation are not well understood, training is lacking, and stigmatisation impacts treatment.

Another strength of this study was that it paves the way for a discussion on paedophilia in South Africa to be considered in terms of creating treatment modalities specific to a South African population. The implications this will have on the therapeutic process would be significant as it would give a better understanding of the pathology being dealt with and allow for the evolution and creation of treatments which are more effective in treating this population, especially within a South African context.

5.3 Recommendations

The findings suggest that recommendations would look to South Africa to create its own modality for treating paedophilic disorder and paedophilic ideation. This

could be based on international models being successfully implemented within those countries, but it would be vitally important to adapt these models and therapeutic modalities to a South African context and within the resources available in South Africa.

Training at a master's level and beyond on a continuous basis, as research evolves, would see more focus on the area of paedophilic disorder and paedophilic ideation and further research into specific understandings of these categories. It is, therefore, necessary to collate therapists' training and develop supervision programmes applicable to the South African context. South African-based interventions should also consider indigenous practices and must be sensitive to the diversity of South Africa's cultures and ethnicities.

Therapeutic interventions should be lifelong and incorporate both individual therapy (as primary support) and group therapy (in combination). However, the group therapeutic process should be a long-term, closed group. The theoretical modality should be dependent on the presentation of each individual. However, a psychoanalytic framework could be used as a therapeutic modality in a private setting. This is because it yields better results and is longer term, allowing psychologists to work holistically with an individual's timeline. In contrast, CBT is short-term and more conducive to the restraints of a correctional setting. Further incorporating risk needs responsivity and offence cycles as models within correctional settings, which contribute to the therapeutic approaches and theoretical models but, importantly, adapt these effectively into a South African context.

Within a correctional setting, there is a severe lack of psychological resources. Changes at systemic levels would see offenders being transferred to psychiatric institutions to better assist with treatment not only of paedophilic disorder and paedophilic ideation but of overall mental health. Further, more psychologists and mental healthcare professionals need to be appointed within these contexts. Currently, there are impossible ratios to offer effective therapeutic treatment over long periods of time, alluding to an increase in recidivism rates. Providing specialised training for mental health professionals working with sexual offenders and individuals with paedophilic disorder and paedophilic ideation is needed. This is required both in and outside of the correctional services setting, i.e. for private practice.

Psychoeducation is needed at various societal levels, challenging the taboo of disclosure of paedophilic disorder and paedophilic ideation to assist these individuals and create spaces where they feel safe enough to ask for and receive therapeutic support.

The evolution of laws must take its course, allowing for fewer restrictions in therapy when assisting individuals with paedophilic ideation. Currently, therapists have to negotiate the need to assist their clients with rigid laws that might prevent clients from disclosing their thoughts honestly for fear of a breach of confidentiality and being reported. This is a deterrent for clients who then never receive treatment and might commit offences. However, this must be balanced against the rights of the minor, who has the right to be protected.

5.4 Conclusion

The study draws on the experiences of six psychologists in South Africa, under the category of either clinical or counselling psychology, who treat individuals with paedophilic disorder or paedophilic ideation. The research aimed to examine and understand current therapeutic practices engaged in by psychologists in South Africa who treat clients who have paedophilic disorder or paedophilic ideation.

Paedophilic disorder and paedophilic ideation were examined using a qualitative approach, which allowed for natural and purposeful dialogue to occur during semi-structured interviews. Data were analysed and reviewed using a thematic analysis of the data collected. The thematic analysis process involved a process whereby data was broken down into phases because the different phases of data analysis in qualitative research are a bridge between a more abstract theory and practical reality. Insight was gained using a thematic analytical approach, systematically identifying, organising, and providing an understanding of the thematic patterns that arose from the data collected from the semi-structured interviews.

Findings indicated that currently, there are no treatment protocols specific to a South African population in treating paedophilic disorder and paedophilic ideation. There are no assessments with specific administration for paedophilic disorder and paedophilic ideation. The psychologists adapted and implemented those used, leaving them open to questioning regarding reliability and validity.

There is a dire lack of training in the area of paedophilic disorder and paedophilic ideation, with no indication of professionals who could carry out specific training for psychologists. Nor are there adequate platforms to supervise current

psychologists treating individuals with paedophilic disorder and ideation. In correctional settings, CBT is the most effective modality, given the short-term therapy required in these institutions. However, long-term therapy is recommended with a combined approach of individual therapy as a primary treatment approach but with the addition of group therapy, both from a psychoanalytic perspective. Recommendations were provided first to better understand how to implement change to the understanding of paedophilic individuals. Second, to look at how treatment protocols could be created based on international guidelines and current treatment modalities which have been successful in other countries. However, the important factor is to adapt these in a meaningful way to ensure their implementation is specific to a South African population. A further recommendation is that due to the lack of research in this area of study, more research would be recommended to understand paedophilia and the treatment thereof, which may be further complicated by societal stigma as well as punitive implications from a legal and judicial system, which would require a change of these systems to better allow for more transparent therapeutic protocols and processes. Furthermore, a better understanding of female paedophilia is needed to address this population systemically and therapeutically.

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Appendices

Appendix A: Ethical Clearance

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

10 March 2020

NHREC Registration # : Rec-240816-052
CREC Reference # : 2020-PsycREC-36083321

Dear Calvin James Pienaar

Decision:
Ethics Approval from 10 March 2020 to 30 June 2023

Researcher(s): Calvin James Pienaar

Supervisor(s): Prof. J. Nel & Prof. M. Terre Blanche

Treating paedophilic disorder and paedophilic ideation: current interventions among South African Psychologists.

Qualification Applied: Master's Degree in Psychology

Thank you for the application for research ethics clearance by the Unisa Department of Psychology College of Human Science Ethics Committee. Ethics approval is granted for three years.

The ***low risk application was reviewed and*** **expedited** by Department of Psychology College of Human Sciences Research Ethics Committee, on the **(10 March 2020)** in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.

Appendix B: Recruitment Advert/Email

Good day,

I trust you are well.

I am currently doing my MA clinical psychology through the University of South Africa (Unisa). I am looking for participants for my mini-dissertation. I have included relevant information below as well as in the attached recruitment advert. I require 10-12 registered clinical and/or counselling psychologists, practicing in South Africa, who would be willing to participate in my study.

Title of the study: Treating paedophilic disorder and paedophilic ideation: current approaches among South African psychologists.

The Aim of the study: To describe current therapeutic practices carried out by South African Registered Clinical and Counselling Psychologists who treat individuals for paedophilic disorder or paedophilic ideation. Data collection will be obtained by the conducting of semi-structured interviews (60 to 90 min max) either in person (if participants are in Johannesburg or Pretoria) otherwise via Zoom (online platform).

Inclusion Criteria:

Participants must be registered with the Health Professions Council of South Africa (HPCSA) (2008) as a clinical or counselling psychologist, practicing in South Africa.

Participants must have treated individuals with paedophilic disorder or paedophilic ideation in accordance with their scope of practice, even where this was not the main presenting problem.

Please could any interested participants email me on calvin@calvinpienaar.co.za and if I could ask that this email please be passed on to anyone who fits the criteria and is willing to participate.

Thank you very much for your time.

Kind Regards

Calvin Pienaar

RESEARCH PARTICIPANTS NEEDED

Treating Paedophilic Disorder and Paedophilic Ideation: Current Approaches Among South African Psychologists

Inclusion Criteria:

- Participants must be registered with the HPCSA as a Clinical or Counselling Psychologist, practicing in South Africa.
- Participants must have treated individuals with paedophilic disorder or paedophilic ideation, for more than six therapeutic sessions, and in accordance with their scope of practice, **even where this was not the main presenting problem**.

The aim of this study is to describe current therapeutic practices carried out by South African Registered Clinical and Counselling Psychologists who treat individuals for paedophilic disorder or paedophilic ideation, to evaluate these practices in order to assist with the development and implementation of South African treatment protocols, as well as therapeutic interventions, frameworks and techniques that could be used by psychologists. Data collection will be obtained by the conducting of semi-structured interviews (60 min max) either in person (if participant is in Johannesburg or Pretoria) otherwise via Zoom (Online platform).

Contact Information – Calvin Pienaar: calvin@calvinpienaar.co.za (UNISA MA Clinical Psychology Student / Researcher)

Please pass this advert on to anyone you know who may be interested and willing to participate.

Appendix C: Consent Form to Participate in this Study

I, ____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.
I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I am aware that the findings of this study will be processed into a dissertation, journal publications and/or conference proceedings but that my participation will be kept confidential unless otherwise specified.

I agree with the recording and note-taking of the interview.
Participant Name and Surname: ……………………………………………
Date: ……………………………………………
(Please print)
Participant Signature: ………………………………
Date: ………………………………
Researcher's Name and Surname: ………………………………
(Please print)
Researcher's Signature: ………………………………
Date: ………………………………

Appendix D: Information Sheet

Dear Participant

Thank you for agreeing to participate in this research study, Treating paedophilic disorder and paedophilic ideation: current approaches among South African psychologists

Researcher's information:

My name is Calvin James Pienaar. I reside in Pretoria, Gauteng. I am studying my master's in Clinical Psychology at the University of South Africa (Unisa). Previously, I completed my B. Psych and HPCSA registration as a registered counsellor in 2011. I have worked for various organisations as well as headed up a remedial and special needs school (Radix James Remedial School) in Durban. I am doing a research dissertation (UNISA) under the supervision of Prof J Nel and co-supervised by Prof M Terre Blanche.

Contact Information

Calvin Pienaar: calvin@calvinpienaar.co.za (Researcher)
Prof J. Nel: Nelja@unisa.ac.za (Supervisor)
Prof M. Terre Blanche Terremj@unisa.ac.za (Co-Supervisor)

Research information:

Sexual abuse towards a child is a global concern, affecting countries all over the world (Verrijdt, 2019). While not all child sexual abuse is committed by individuals with paedophilic disorder, a significant amount of this abuse is (Schmidt et al., 2013). There is a dire need for treatment protocols that are not only client-centred but also free from stigma. However, given the suicide risk, due to the stigma associated with paedophilic disorder and paedophilic ideation, these clients are less likely to get the much-needed therapeutic intervention. Interestingly, the present DSM-5-TR states that paedophilic disorder is not amenable to psychotherapy, although many methods have been tried, including a relapse-prevention model and CBT (American Psychiatric Association, 2013).

The aim of this study is to describe current therapeutic practices engaged in by South African clinical and counselling psychologists who treat individuals for paedophilic disorder or paedophilic ideation, to evaluate these practices in order to assist with the

development and implementation of South African treatment protocols, as well as therapeutic interventions, frameworks and techniques that could be used by psychologists.

The objectives of the study are as follows:

- Establish how psychologists in South Africa who participated in the current study conceptualise paedophilic disorder, paedophilic ideation and its treatment.
- Identify which interventions psychologists in South Africa who participated in the current study use when dealing with paedophilic disorder and paedophilic ideation.
- Establish the key challenges experienced by psychologists in South Africa who participated in the current study who have dealt with paedophilic disorder and paedophilic ideation.
- Identify how psychologists in South Africa who participated in the current study draw on existing treatment protocols or fail to draw on such protocols in their interaction with clients with paedophilic disorder and paedophilic ideation.

Ethics

In conforming to the requirements of the HPCSA and to protect participants from any harm or misconduct, ethical approval has been awarded for this study. According to Rubin and Rubin (2012), participants who partake in a research study must be protected, understandably so. In order to ensure the protection of participants' and confidentiality, each participant is assigned a pseudonym. Participants are asked to please use pseudonyms for clients to ensure their confidentiality, should it come up during the data collection. In addition, transcribers are asked to sign a non-disclosure agreement protecting participants and all data. All data that is voice recorded on the Zoom platform, as well as any notes taken by the researcher, will be securely kept in a safe to ensure the security of all data. This safe is kept on the premises where data will be analysed. All data that is transcribed will be kept on a laptop computer in a secure folder. The laptop computer has a security code for access. As an extension

of your autonomy, each participant in this study will further be supplied with a consent to participate form.

The consent form, in conjunction with the information sheet, explains the purpose of this study and describes your right to withdraw from the research study at any time. Participant involvement is voluntary and in the sole interest of research. You will receive information explaining the purpose of this study, the role of interviewees, the benefits of participating and the contact details of supervisors are given (above) should you require to be in contact with them.

Conducting the interviews

In conducting a semi-structured interview with you, I would like to hear about your personal journey and experience in treating clients who have paedophilic disorder or paedophilic ideation. Preceding the interview, please could you answer the below questions and email them back to me, thus saving time for the face-to-face interview/video call interview.

- What are your qualifications and registration category?
- How long have you been in practice?
- How long have you been treating individuals with paedophilic disorder or paedophilic ideation?
- In which area is your practice geographically situated?
- Will you be able to allocate at least sixty minutes of your time for the interview?

Should you have any questions at this stage, please send these through with this form, and I will address them before the interview takes place.

Thank you very much for your time and for agreeing to take part in this study.

Appendix E: Non-Disclosure Agreement

This non-disclosure agreement is used for individuals hired to conduct specific research tasks, e.g., note-taking, co-facilitation, recording, transcribing, interpreting, translating, entering data and destroying data.

Project title: Treating paedophilic disorder and paedophilic ideation: current approaches among psychologists in South African

I…………………., the ………………………………… (specific job description, e.g., interpreter/translator) have been hired/asked/or is the supervisor of the research student to ____________________________

I agree too:

- keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g. tapes, transcripts) with anyone other than the researcher(s).
- keep all research information in any form or format (e.g., tapes, transcripts) secure while it is in my possession.
- return all research information in any form or format (e.g., tapes, transcripts) to the researcher(s) when I have completed the research tasks.
- after consulting with the researcher(s), erase or destroy all research information in any form or format regarding this research project that is not returnable to the researcher(s) (e.g. information stored on a computer hard drive).

(Print Name) (Signature) (Date)

_______________________ _______________________ _______________

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Research Ethics Board of Psychology at the University of South Africa. For questions regarding participant rights and ethical conduct of research, contact the Chairperson at the Research Ethics Office Prof E L Kempen via email: kempeel@unisa.ac.za

Appendix F: Interview Schedule

Background Information

Below is the semi-structured interview schedule which was used to guide the interview process with participants.

Interview Schedule

Opening

Welcome

Confidentiality will be re-explained, including how recordings will be kept safely, the participant has the right to withdraw from the study at any given time, explanation around the fact that the information obtained from participants will be formulated into research findings, possible publication and/or conference presentation(s).

Questions from participant.

Signing of informed consent form.

Interview schedule

It is key to note that additional, unstructured questions will be asked during the interview as relevant themes to the research study reveal themselves. Key concepts of this study include: opinions towards people with paedophilia, stigmas associated with the treating of individuals with paedophilia, clinical and counselling psychologists experience in treating clients with paedophilic disorder or paedophilic ideation, clinical and counselling psychologists' training and education at a tertiary level as well as post-qualification training, around the concept of paedophilia, and psychotherapeutic interventions used in approaching paedophilia.

1. What is your understanding of the differentiation between paedophilic disorder, paedophilic ideation and a client having a history of sexual contact with a child?
2. What are your professional and personal opinions about clients who have paedophilic disorder, paedophilic ideation and a client having a history of sexual contact with a child?
3. What is your opinion on the tertiary training offered to psychologists in terms of clients with paedophilic disorder or paedophilic ideation?
4. What therapeutic frameworks and specific interventions do you use in your approach to providing psychotherapy to individuals with paedophilic disorder or paedophilic ideation?
5. Please could you elaborate on your confidence to provide psychotherapeutic interventions with individuals where paedophilia may be an issue?

6. How many clients have you engaged with and/or treated where paedophilia may be an issue, and in what context were these engagements?
7. Have you come across any stigma, prejudice or ostracising from other mental health providers or stakeholder groups regarding you having treated paedophiles or child sexual offenders? If so, please explain.
8. Could you please tell me more about your experiences with the clients you have treated, where paedophilia may be an issue? However, this does not need to have been the primary complaint.
9. In addition to the individual you just mentioned, have you seen others? If so, please could you elaborate on the overview of their case and your therapeutic approach?
10. Were the individuals you assisted mandated to therapeutic intervention, or how were they referred to you for psychotherapy?
11. How did you manage the ethics of reporting child sexual abuse and other ethical issues such as anonymity?
12. What do you feel are the possible implications of incarceration of individuals with paedophilic disorder?
13. Given the various experiences you have had with individuals where paedophilia may be an issue, what are your overall impressions regarding how one should approach this kind of client? In other words, what seems to work and what doesn't?
14. Have you relied on any local or international literature, guidelines, protocols, support programmes or institutions to assist these individuals? If so, give specific details of these, also, please speak to their utility/effectiveness.
15. What do you feel ought to be developed or available regarding the possible treatments of paedophilia?
16. Are you aware of any South African programmes which work specifically with people with paedophilia, and if so, please could you describe how these are run or what their therapeutic modality/programme entails?
17. Are you aware of the treatment possibilities offered by international programmes such as B4U-ACT, Help Wanted or Dunkfeld Prevention Project?
18. Do you feel group therapy would assist in the treatment of paedophilia and please state your reasoning?
19. Would a combination of individual and group therapeutic processes be prescribed or suggested? Please state reasons for your answer.
20. Some research has suggested chemical and surgical castration as treatments for paedophilia. What are your thoughts on this?
21. Would you suggest a combination of either of the aforementioned with psychotherapy?
22. Do you believe other possible treatments are available to treat paedophilia besides psychotherapy or any treatments mentioned thus far?
23. Have you experienced any reoffending from clients who have attended psychotherapy?

Probing questions

1. How did you first come to contact the client(s) or vice versa?
2. At what point in your therapeutic process did the issue of paedophilia arise?
3. How did your sessions unfold from this point on?

4. Did the disclosure of their paedophilic interests change the therapeutic session or relationship?
5. In what way, if any, did your patient change through the course of your sessions with them?
6. Did you notice any of your feelings or ideas about the client(s) change regarding paedophilia through the course of your sessions with them?
7. Did you notice any changes on their behalf once they had expressed their paedophilic interests?
8. Did you use a specific approach or therapeutic style when treating clients who have expressed paedophilic interest?
9. How did the therapy come to an end?
10. What is your sense regarding the relative success of your interactions with the client(s)?
11. Do you have any questions or comments to add?

Closing

Thank you for your time and valuable input. From this point on I will compile all the data and once completed, I will be sure to send you a synopsis of the outcomes of this study.

Close interview

Appendix G: Editing Certificate

Tel:	073 276 8899
Email:	vanessalynnneophytou@gmail.com
Client:	C. J. Pienaar
Title:	Treating paedophilic disorder and paedophilic ideation: Current interventions among psychologists in South African
Institution:	Unisa
Degree:	Master of Arts in Clinical Psychology
Supervisor:	Prof J. A. Nel
Co-Supervisor:	Prof M. Terreblanche
Date:	27 July 2023

Declaration of professional edit

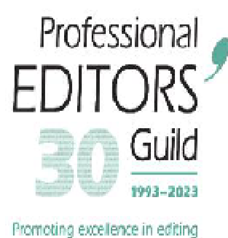
I declare that I have edited the above thesis. My involvement was restricted to language usage and spelling, completeness and consistency, referencing style of the references in the thesis and reference list, formatting of headings, table captions, automated page numbering and automated table of contents. I did no structural re-writing of the content. After my language editing, the author can accept or reject suggestions/changes before submission.

This thesis was duly edited by me using track changes. I make no claim as to the accuracy of the research content. It is not the responsibility of the editor to check for plagiarism. I am not accountable for any changes made to this document by the author or any other party subsequent to my edit.

Yours sincerely

VLNeophytou

Vanessa-Lynn Neophytou MSocSc (Sociology), UKZN
Associate Member – Professional Editor's Guild



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Institution:	Unisa
Degree:	
Supervisor:	Prof J. A. Nel
Co-Supervisor:	
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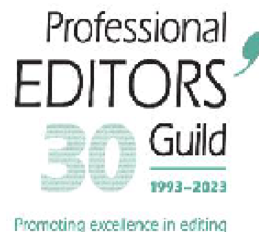

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TREATING PAEDOPHILIC DISORDER AND PAEDOPHILIC IDEATION:
CURRENT INTERVENTIONS AMONG PSYCHOLOGISTS IN SOUTH AFRICA

By

CALVIN JAMES PIENAAR

Student Number: 38083321

submitted in part fulfilment of the requirements
for the degree of

MASTER OF ARTS IN CLINICAL PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF J. A. NEL

CO-SUPERVISOR: PROF M. TERREBLANCHE

MAY 2023

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