The Impact of Psychiatric Labels and Sexual Orientation on Attitudes Toward People With Pedophilic Attractions

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The Impact of Psychiatric Labels and Sexual Orientation on Attitudes Toward People With Pedophilic Attractions

Senior Project Submitted to
The Division of Science, Math, and Computing
of Bard College

by
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### Table of Contents

**ABSTRACT**  
1

**INTRODUCTION**  
2
  Stigma  
3
  Current Work on Attitudes Toward PPA  
4
  Three Dimensions of PPA Stigma  
7
  Dimensions 1: Criminality  
7
  Dimensions 2: Pathology  
12
  Dimensions 3: Sexual Perversion  
19
  Current Study  
24

**METHODS**  
27
  Participants  
27
  Procedure  
28
  Materials  
29

**RESULTS**  
33
  Primary Analyses  
33
  Exploratory Analyses  
41

**DISCUSSION**  
45
  The Sexual Orientation of PPA  
45
  Pathological Language  
47
  Exploratory Analyses  
50
  Limitations and Avenues for Further Research  
52
  Conclusions  
54

**REFERENCES**  
56

**APPENDICES**  
65
  Appendix A: Participant Sociodemographic Characteristics  
65
  Appendix B: Institutional Review Board Approval  
66
  Appendix C: Experiment Preregistration  
67
  Appendix D: Survey Items  
75
  Appendix E: Experiment Vignettes  
83
Abstract

This study explores whether framing pedophilic attractions as a mental disorder and/or manipulating the sexual orientation of these attractions impacts attitudes toward people with pedophilic attractions (PPA). This study used an experimental 2 (Pathological Language vs. Non-Pathological Language) by 2 (Heterosexual vs. Homosexual) between-subjects design, in which online participants read a vignette describing a fictional subject’s pedophilic attractions. Both independent variables were manipulated within the vignette, in that the subject’s attractions were either given a pathological or non-pathological explanation, and were either heterosexual or homosexual. To assess stigmatizing attitudes, participants reported their affective responses, agreement with beliefs/stereotypes about the individual, and their preferred degree of social distance. Sexual orientation played a key role in determining attitudes toward PPA—participants had more negative emotional responses when the subject’s attractions were heterosexual (i.e., toward prepubescent girls), and this pattern was also demonstrated by the perceived dangerousness of the subject and the desire for social distance from him. Whether the subject’s attractions were presented as a mental disorder had less bearing on the participants’ attitudes toward him, although participants reported more negative emotional responses to the subject when his attractions were described as non-pathological. The study’s results provide novel insights about how we conceptualize the stigma of mental illness labels—for example, recognizing that applying pathological language to a phenomenon does not always result in different attitudes—as well as for understanding how the child’s gender in pedophilic attractions contributes to attitudes about PPA.

Keywords: stigma, mental illness stigma, pedophilia, pedophilic disorder, sexuality
The Impact of Psychiatric Labels and Sexual Orientation on Attitudes Toward People With Pedophilic Attractions

What causes people to feel anger and disgust toward people with sexual attraction to children, rather than pity or empathy? When does medicalizing behaviors and thoughts promote sympathy or connection and when does it contribute to stigma? It is clear that persons experiencing mental illness are subject to widespread stigma. The same is true for people with pedophilic attractions (PPA), but little is known about how the diagnostic label of pedophilic disorder or sexual orientation influences attitudes toward PPA.

In recent years, there has been a lively debate about the controversial decision to include pedophilic disorder in the American Psychiatric Association’s (APA) fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; 2013). This discourse primarily addresses whether this disorder is misaligned with the APA’s guidelines for what constitutes a “mental disorder” because, in some cases, the symptoms in question merely pose a risk toward others but not the afflicted individual (Malón, 2012; Münch et al., 2020). But most, if not all, of these arguments rest on conceptual issues, rather than empirical evidence of the social repercussions of this pathologization.

The current work is necessary for discerning whether the inclusion of pedophilic disorder in the DSM has influence over attitudes in the first place and in what ways, which is imperative to create truly sound arguments about whether or not to preserve this mental disorder category.

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1 The term “people with pedophilic attractions” or “PPA” will be used to describe individuals with sexual attractions to prepubescent children. The first “P” in “PPA” may stand for “person” or “people” depending on the context in which it is used, but overwhelmingly, the term is intended to encompass both singular and collective references. These persons are referred to in many different ways in existing literature (e.g., people with pedophilia, pedophiles, etc.). Throughout this paper, “PPA” will be used to describe this group, with exception to citing work on minor-attracted people (MAPs), as this is a broader and more encompassing term.
Moreover, understanding whether perceptions of these individuals are malleable is critical for the fight against child sex abuse (CSA). The attitudes toward PPA are deeply intertwined with the interventions created to prevent CSA and the willingness of PPA to be open about their attractions, receive therapeutic support, and maintain a support system. Many researchers with expertise working with PPA assert that the stigma of pedophilic desires carries unintended dangerous effects on CSA because it reinforces risk factors for committing sexual offenses (e.g., heightened levels of isolation, stress, alienation, low self-esteem, barriers to coping mechanisms; Walker, 2021).

In the current study, I investigate whether labeling pedophilic attractions as a mental disorder and manipulating the PPA’s sexual orientation influences stigmatizing attitudes, measured by affective responses, endorsement of stereotypes, and desired social distance.

**Stigma**

Stigma can appear in overt ways, like an unwillingness to hire an individual because of an attribute that they possess (e.g., their gender), or it may be more subtle, such as a person discouraging their friend from seeking treatment because their mental health is “not that bad.” Regardless of its magnitude, stigma carries drastic consequences—including negative effects on mental health, physical well-being, social status, housing and employment opportunities, economic disparities, access to health care, familial strain, and experience with the criminal justice system (Major & O’Brien, 2005). The origins of stigma research are frequently traced back to Erving Goffman, a highly influential sociologist in the twentieth century (Major & O’Brien, 2005). In his foundational book, *Stigma: Notes on the Management of a Spoiled Identity* (1963), Goffman describes stigma as a term “used to refer to an attribute that is deeply
“discrediting” and how stigmatized people are “reduced in our minds from a whole and usual person to a tainted, discounted one” (p. 3). These attributes, Goffman claims, can be classified as “physical deformities,” “tribal stigma[s] of race, nation, and religion,” and “blemishes of individual character” (p. 3)—the last of which includes mental disorders or sexual interests that are seen as deviant.

Generally speaking, social psychologists point to three cognitive, emotional, and behavioral components of stigma: stereotypes, prejudice, and discrimination (Corrigan & Watson, 2002; Rüsch et al., 2005). Stereotypes are preconceived ideas about groups of people (e.g., that eating disorders are more common among women and girls than men) that are largely agreed upon or known (Corrigan & Watson, 2002). They are not inherently negative sentiments and being aware of a stereotype does not necessarily indicate that a person endorses it. Being prejudiced describes the agreement of negative stereotypes (e.g., people with mental disorders are dangerous) and typically accompanies negative emotional responses (e.g., fear, anger, disgust) (Corrigan & Watson, 2002). Prejudice can be a catalyst for behavioral reactions known as discrimination (e.g., fear leading to avoidance/ostracization, anger leading to physical harm or punishment). Quantifying stigma requires an acknowledgment of the stereotypes, prejudices, and discriminations at play. Thus, in the following pages, any reference to “stigma” or “stigmatizing attitudes” should be understood as encompassing these three components, as well as negative affective responses.

**Current Work on Attitudes Toward PPA**

People with pedophilic attractions (PPA) are heavily condemned in contemporary America. This is evident from popular culture, where numerous television shows and movies
have been dedicated to showcasing self-proclaimed “Pedophile Hunters,” or where one can easily purchase stickers that say “Save a deer; hunt a pedophile” on Amazon (Unique Decals, 2012). It is common for pedophilic sex offenders to be physically attacked, sexually abused, harassed, and murdered at higher rates than those sentenced for other crimes (James, 2015).

Anti-pedophilia (and more specifically, child sex offender) vigilante groups—for example, The Blue Angel Association, Perverted Justice, Letzgo Hunting, etc.—have formed across the world to “expose” child sex offenders, and in some cases, physically attack or threaten them. These groups have persisted despite many instances of false accusations (Allison, 2000; “Mob mistakes man for sex abuser”, 2000) that have carried monumental effects on these individuals.

These negative attitudes are also documented empirically. Feldman and Crandall (2007) conducted an experiment where participants read one of 40 case studies about a person with a mental disorder (i.e., each of the 40 vignettes depicted a unique disorder). Participants were then asked to rate these subjects along 17 dimensions (e.g., degree to which the disorder is the individual’s “fault,” how effective medication is for treating it, how dangerous the individual is, etc). Out of the 40 disorders they included, pedophilic disorder was among the most stigmatized group, second only to those with antisocial personality disorder. In terms of stereotypes and beliefs, there is a widespread belief that PPA are dangerous and have some control over whether or not they have pedophilic desires (i.e., they are “at fault”), which may contribute to moral condemnation (Feldman & Crandall, 2007; Imhoff, 2015; Imhoff & Jahnke, 2018; Jahnke et al., 2014; Jahnke et al., 2015b; Richards, 2018; Wurtele, 2018).

There is mixed data on the stigmatizing attitudes that psychologists and other mental health professionals hold. Some researchers argue that many of these mental health professionals
report an unwillingness to provide care for minor-attracted people (MAPs) or do not hold acceptable training. For example, in a sample of 427 Swiss therapists, Schmidt and Niehaus (2022) found that 47.6% of their participants were unwilling to treat non-offending MAPs, 62.7% were unwilling to treat people who have committed a sexual offense, and 87.5% of therapists with no previous experience treating MAPs reported not having any general MAP-treatment skills. In contrast, 80% of psychotherapists being trained for cognitive-behavioral therapy (CBT, \(N = 137\)) were willing to treat non-offending PPA (Jahnke et al., 2015b). When asked whether they would be willing to treat a previously-offending PPA, however, this number dropped to about 37%. Affective responses were mixed, too, with 40% of these therapists-in-training reporting feeling angry when asked to think about PPAs and about 37% feeling sympathy.

People with pedophilic attractions are attuned to and frequently internalize the stigma and shame regarding their attractions. For example, in Walker’s (2021) book, *A Long, Dark Shadow*, they describe one participant’s experience with sharing her sexual identity online. Walker writes, “[she] told me that she needed a ‘strong stomach’ to read the comments, stating: ‘I’m so used to all of the arguments and all of the, like, death threats, even…we all get a lot of ‘kill yourself.’ You get used to that phrase’” (p. 77). Many of Walker’s 42 minor-attracted participants shared that in considering whether or not to disclose their sexual attractions to friends, family members, or others, they “felt at risk of facing suspicion, fear, disownment, or being outed to others” (p. 48) as well as physical violence (p. 52). These fears were solidified by experiences of judgment, familial abandonment, being asked to leave educational programs, public outing, being reported to the police, and being denied mental health care (similar fears have also been reported in

**Three Dimensions of PPA Stigma**

The stigma prescribed to those with pedophilic attractions is derived from three main aspects of the constructed image of “the pedophile”: (1) the assumption of criminality, (2) the relationship to pathology, and (3) the perception that their attractions are “sexual perversions.” In order to understand the stigmatization of PPA, it is critical to acknowledge how these dimensions operate individually and as a group. In different places at different times, certain dimensions of the pedophile’s image have taken prominence (See Harkins, 2020 for a detailed history). The tension between these dimensions has left many unanswered questions like: are PPA sick or are they predators? Do we respond with treatment or punishment (Harkins, 2020, p. 32)? Ultimately, while certain notions have waxed and waned with time, it is clear that “the pedophile” is undoubtedly situated in the center of psychiatry, criminality, and perversion.

**Dimension 1: Criminality**

People typically hold one of the following beliefs about pedophilia: (1) the word “pedophile” is synonymous with a child sex offender (i.e., someone who has committed a crime), or (2) people with pedophilic attractions will sooner or later assault children. The following paragraphs will substantiate these claims.
1. The Conflation of “Pedophile” with Child Sex Offender (i.e., The Belief That PPA Are Criminals)

Some researchers believe that the stigmatization of pedophilic interests is largely rooted in the misperception that the word “pedophile” is synonymous with a “child sex offender” or a “child molester” (i.e., someone who has acted on their romantic/sexual desires) (Imhoff, 2015; Richards, 2011; Walker, 2021). This misperception is well documented, even in peer-reviewed research—phrases such as “the crime of pedophilia” and “victims of pedophilia” appear in hundreds of academic articles published after 2015—and news sources that are widely deemed credible, like CNN (Walker, 2021). Walker et al. (2022) provide evidence that the word “pedophile” is interpreted as a sex offender by demonstrating that simply alternating language between “pedophile” and someone who is “sexually attracted to children” evokes vastly different attitudes. Using a sample of future mental health providers (N = 200), 54% agreed or strongly agreed that “if their client disclosed ‘being a pedophile,’ they would have to make a police report”, compared to just 7% when they used the phrase “someone who is sexually attracted to children” (Walker et al., 2022, p. 62). In a subsequent free-text response, 40% of their participants clearly stated a belief that having pedophilia entails committing sexual offenses. This line of thought is well documented in other empirical projects (Goode, 2009, as cited in Walker et al., 2022; Freimond, 2013; Seto, 2018).

2. The Perception That PPA Will Sooner or Later Assault Children (i.e., The Belief That PPA Will Eventually be Criminals)

There is a widespread assumption that PPA—who have not already done so—will eventually commit a sexual offense against children (Grady et al., 2019; Walker, 2021). This is
likely due, at least in large part, to how narratives and research about PPA frequently rely on incarcerated sex offenders. This has been a prominent issue for research on a myriad of deviant sexual interests: “people think ‘perverts’ are dangerous, one of the reasons for their belief being that they are never told about perversions except when they read about sexual offenses in the papers” (Ullerstam, 1966, p. 41). Because of possible social repercussions, it is rare for non-offending PPA to discuss their attractions openly (Walker, 2021). In turn, there is an overestimation of the proportion of PPA that sexually offend. In the opposite direction, it is also well established that CSA frequently goes undetected and unreported, which further makes it difficult to pin down how many people experience pedophilic attractions and how many of them act on them (in a legal sense; Hall & Hall, 2007).

Taking these points into consideration, there is a strong assumption that PPA have committed or will commit sex-related crimes. But, the assumption of crime extends beyond sexual offenses—during the late 20th and early 21st centuries, massive amounts of news coverage responded to instances of child abduction, sexual assault, and murder. The phenomenon of the “sexual psychopath” best highlights how the media helped construct PPA as life-threatening criminals.

The image of the “sexual psychopath” emerged in the 1930s, immediately leading to an “explosion of discourse” about this threat (Harkins, 2020, p. 42). For decades, this idea that PPA were sadistic, monstrous, “sex maniacs” persisted. The language for this type of criminal evolved over time, but the concept of the murderous-pedophile is “often considered a key precursor to the late twentieth-century focus on stranger danger” (Harkins, 2020, p. 42). At the turn of the 21st century, reports of children being abducted, sexually assaulted, and murdered
gained considerable attention in the U.S., prompting many “apostrophe laws”—laws that are named after high-profile victims—that were direct extensions of the sexual psychopath statues in the 1930s to 1960s. Some of the most famous laws instated at that time include: “the Jacob Wetterling Act (1994), Megan’s Law (1994), Ashley’s Laws (1995), the AMBER Alert (1996), the Jessica Lunsford Act (2005), and the Adam Walsh Act (2006)” (Harkins, 2020, p. 71). These high-profile cases and the legacy that these laws leave behind have likely played an important role in cementing the notion of the person with pedophilic attractions as a violent criminal, whose pedophilic acts cannot be disentangled from murder.

Interpreting The Role of Criminality

Despite the clearly important context of the law, we should be cautious when discussing the directionality of criminal status and stigma as it relates to attitudes toward PPA. As it stands, it is unclear whether people take issue with PPA because of the assumption that they have broken the law (i.e., the moral transgression here is that PPA have presumably broken a social contract), or whether their beliefs about pedophilic acts inform the law (and, therefore, their criminal status simply implies immorality). It is probable that these two factors have a bi-directional relationship.

Many people in the fields of psychology, sociology, and criminology have put considerable work into dispelling this conflation of “pedophile” with “child molester” in an attempt to decrease the stigma of having pedophilic desires. This initiative has proved controversial, as people sometimes assume that decreasing the stigma of having pedophilic attractions might exacerbate child sex abuse (CSA). But, researchers like Walker (2021) believe that the current attitudes towards MAPs—that is, the tendency to cast shame not only toward
MAPs who have committed crimes, but also those who have not—are not effectively preventing CSA. They cite empirical work suggesting that people cannot be “cured” of pedophilic desires, and, as such, state that “shaming them is an ineffective method of keeping children safe” (Walker, 2021, p. 9). Moreover, Walker contends that shaming non-offending MAPS prevents them from creating support systems (e.g., friends, family, other MAPs, psychologists, etc.) where they can share openly about their desires, among other related experiences of depression, guilt, anxiety, and more. In turn, this stigma may contribute to greater levels of mental illness in MAPs, increased risk of offending, and ultimately unsuccessful efforts to curb CSA that rely on teaching children that they must protect themselves from abuse (Walker, 2021).

We must also recognize, however, that criminality does not entirely account for the antagonistic mindsets about PPA, because even in cases where PPA have not committed sex-related crimes (or any other crimes, for that matter), attitudes toward them remain very negative. Researchers have found that people experience high levels of anger, disgust, and fear toward PPA (Jahnke et al., 2014; Jahnke et al., 2015b; Russell & Giner-Sorolla, 2011; Russell & Giner-Sorolla, 2013). These affective responses appear to robustly predict the desire to maintain social distance from them (Feldman & Crandall, 2007; Jahnke et al., 2014; Jahnke et al., 2015b) and/or punish them (Imhoff, 2015; Imhoff & Jahnke, 2018; Richards, 2018; Wurtele, 2018). Jahnke et al. (2014) found that, compared with “people who abuse alcohol” (Study 1), “sexual sadists” (Study 2), and “people with antisocial tendencies” (Study 2), people are much more likely to endorse that PPA “should be incarcerated” (39% in Study 1, 49% in Study 2) and would be better off dead (14% in Study 1, 28% in Study 2), even though “the questionnaire made it clear that the person had never committed a crime” (p. 30).
So, while the arguments for distinguishing pedophilia as solely an attraction to prepubescent children (that may lead to action, but not always) have merit and certainly positive intentions at the very least, it remains unclear whether the separation of action and attraction, alone, will alter attitudes towards those with pedophilic desires. Although some of the work cited above (e.g., mental health practitioners’ willingness to treat non-offending vs. offending MAPs) suggests that people experience higher levels of anger and disgust when the MAP is a child sex offender, other literature described demonstrates fervently negative attitudes towards people with pedophilic attractions, even when these attractions are never acted on. It is extremely difficult to determine, however, whether these attitudes are so negative because people widely assume that PPA who have yet to criminally offend will eventually abuse a child, or, if they believe that having pedophilic desires in the first place warrants roughly the same amount of condemnation as pedophilic actions. Because of the common misperception that pedophilia is equivalent to CSA, the participants in the present study were given explicit statements about the subject’s resistance to criminal acts.

**Dimension 2: Pathology**

**Pathology and Pedophilic Attractions**

Pedophilia was first introduced as a diagnostic category in 1886 by the Austro-German psychiatrist Richard von Krafft-Ebing in *Psychopathia Sexualis*—a work that is now considered an inaugural text in forensic psychiatry (Harkins, 2020). Pedophilia has since been included in every edition of the APA’s *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, though the specific terminology and diagnostic criteria have evolved somewhat over time.
The retention of pedophilic disorder—and the overarching paraphilic disorder category—in the DSM-5 (APA, 2013) has spurred controversy. Researchers in the fields of mental health and sexuality have not reached an agreement about whether pedophilic attractions are a clinical entity or a social deviance (De Block & Adriaens, 2013). Many of these arguments either rest on conceptual issues with how the APA situates the diagnoses within their overarching classification of mental disorders (Malón, 2012; Moser, 2016), direct attention to how the psychiatric labeling uncritically pathologizes social norms and biases (Sandfort et al., 1990), or critique how, in the case of pedophilia, the clinical categorization “directs concern toward individualized pathology and away from the interpersonal and institutional networks where the vast majority of sexual abuse takes place”, thus posing serious issues for curbing CSA (Harkins, 2020, p. 15). The question of whether pedophilic attractions constitute a psychiatric illness is also debated among MAPs, as demonstrated in Walker’s (2021) research, where “participants themselves were split between those who regarded their attractions as a sexuality or sexual orientation…and those who regarded them as a problem or an illness” (p. 35). Despite these divided perspectives, it is undeniable that attitudes toward PPA are, in part, impacted by the historical and contemporary classification of these attractions as a mental illness.

The Stigma of Mental Illness

From the inception of mental disorder categories to the present day, there has always been a pervasive stigma toward people with mental illnesses. This claim is supported by many psychologists and sociologists, and it is even explored in books dedicated to the specific topic (e.g., Roy Grinker’s How Culture Created the Stigma of Mental Illness, 2021). Grinker (2021) writes that, since the genesis of mental disorders, “the mentally ill were a society’s undesirable,
physically excluded from the community as a novel kind of human being” (pp. 24-25). The historical stigma toward those with mental illnesses is captured by accounts of institutionalization, imprisonment, abuse, neglect, and sterilization (Rössler, 2016). Despite how the treatment of those with mental illness has evolved over centuries, the stigma of mental health continues to be a popular field of study. As a testament to this claim, simply searching “stigma” AND “mental health,” “mental disorders,” OR “mental illness” in PubMed produces over 370,000 results as of November 2022.

Researchers have established that mental disorders remain highly stigmatized in the present day and these attitudes carry direct harm to those afflicted by mental illness, as well as other people in their lives. In fact, some studies even provide support that public attitudes in the U.S. have become more stigmatizing toward people with mental illness in recent decades (Rüsch et al., 2005). These stigmatizing attitudes about mental illness are widely endorsed by the general public, and even those in mental health professions (Corrigan & Watson, 2002; Rössler, 2016). One consensus among researchers is that mass media has played a significant role in perpetuating this stigma by providing “consistently and overwhelmingly negative and imprecise” media coverage of mental illness (Rössler, 2016, p. 1251). There is a pervasive sentiment that those with mental illness should be feared, and therefore excluded from society, are at fault for their illness, are unable to take care of themselves, and are unable to make responsible decisions (Corrigan & Watson, 2002; Rüsch et al., 2005). People generally feel less pity and more anger towards those with mental illness compared to those with physical disabilities. These stigmatizing attitudes contribute to overt instances of discrimination in which people are less likely to rent apartments to mentally ill candidates or employ them, for example. Feldman and
Crandall (2007) also point to how mental illness-related stigma contributes to familial strains, decreased life satisfaction, lower self-esteem, and difficulty with social adjustment.

Stigmatizing attitudes are received by people experiencing mental illness and can be internalized through the process of self-stigma (Rössler, 2016). This can weaken self-esteem, ultimately worsening symptoms and reducing the likelihood of remission. People struggling with mental illness may also delay seeking mental health services, end treatment prematurely, or reject the prospect of mental health care altogether in an attempt to distance themselves from negative attitudes and discriminatory actions (Rüsch et al., 2005). Consequently, stigma around mental illness may have downstream effects, like increased risks of hospitalization and suicide.

One of the overarching goals of the current study is to explore the extent to which framing pedophilic desires as a mental disorder influences attitudes. This is an open question because diagnoses evoke a wide range of reactions and carry different levels of stigma (Rössler, 2016). Feldman and Crandall (2007) suggest that the more stigmatized mental illness groups are “perceived to be high in personal responsibility, dangerousness, rarity, or some combination of the three” (p. 148). As they expressed it, “not all deviances are equal” (Feldman & Crandall, 2007, p. 138). While this is closely related to the topic at hand, I am invested in exploring the effects of pathologizing labels, not comparing viewpoints toward different clinical groups. It is important, however, to raise the point that mental disorders are not stigmatized equally, because the reason(s) for these differing levels of stigma may guide answers to one of the natural follow-up questions for this study: why do pathology labels have the effects they do (and, in what cases)?

*The Effects of Pathology/Psychiatric Labels*
There are strong reasons to believe that framing pedophilic attractions as a disorder could be advantageous or disadvantageous for social support. In some situations, labeling a phenomenon as a mental disorder may instill negative emotions and beliefs that the symptoms are simply in the afflicted individual’s nature (in other words, that the symptoms are innate and immutable) (Imhoff & Jahnke, 2018). Ohan et al. (2013) demonstrate that diagnostic labels increase parents’ stigma—which they define as a combination of stereotypes, prejudice, and social distance—toward children with symptoms of either ADHD or depression.

Others have found that pathology labels have negative effects on attitudes, though the degree of this effect is dependent on contextual factors, such as the symptoms at hand. For example, Angermeyer and Matschinger (2003) discovered that psychiatric labels for schizophrenia symptoms were strongly associated with a greater belief that the subject was dangerous, higher levels of fear and anger, less pity, stronger endorsement about dependency on others, and greater desire for social distance from the subject. Psychiatric labels for depression, on the other hand, were not associated with any more/less agreement with stereotypes; labels were only significant for anger, where those who perceived the subject as mentally ill were less prone to react with anger. These conclusions are corroborated by Manago and Mize’s (2022) study, where they found that fear plays a critical role in whether mental illness labels increase or decrease stigma. When fear-inducing deviant behaviors are given psychiatric labels, stigma increases (they quantify stigma by desire for social distance). Conversely, deviant behaviors that are non-fear-inducing become less stigmatized when accompanied by a psychiatric label. Manago and Mize hypothesize that psychiatric labels imply that the deviant behavior is out of the subject’s control. Thus, when the behavior is fear-inducing, this absence of control may
intensify beliefs that the subject is dangerous, whereas, in the case of non-fear-inducing behavior, the perception of uncontrollability may dampen moral criticisms and blame.

Many other researchers contend that disorder schemas, and biomedical explanations of illness more generally, evoke more tolerant emotions—less anger, greater pity, and willingness to help—and promote the belief that remission is possible. This effect is particularly salient when the cause of the disorder is perceived as uncontrollable (Weiner et al., 1988). Morse (2011, Chapter 7) echoes this sentiment about the “disease model” as it pertains to addiction:

The disease model is so powerful that people who are ill are not in general considered responsible for the signs, symptoms, and consequences. The dominant image of people with diseases is that they are the victims of pathological mechanisms who deserve sympathy and help and do not deserve condemnation. (p. 163)

The extent to which this is true is still very much contested, particularly given the myriad of information about how stigmatized mental illnesses are (see the section entitled The Stigma of Mental Illness), but Morse is not alone in this stance.

Moreover, despite the widespread stigma of mental disorders, it is important to note that these negative attitudes are not ubiquitous. The perception that mental disorders represent a dysfunction or deficit resembles the medical model of disability, which is the sentiment that disability (including mental illness) indicates an inherently negative abnormality that should be treated or cured if possible (Amundson, 2000). This model also asserts that the limitations that disabled people face are the direct result of their abnormality. In more recent years, scholars and disability activists have put forth other models that diverge from this way of thought, like the social model of disability or the Mad Pride movement. The former posits disability as an issue of
social context; in other words, an individual is disabled merely by the inaccessibility (or attitudes) of their environment (Amundson, 2000).

The Mad Pride movement challenges social norms about “mental disorders” and “mental illness” and reclaims the ideas of “madness,” “mad,” “psycho,” and other related terms in a positive light (Rashed, 2019). This discourse centers neurodiversity (for example, experiencing hallucinations or intensified sensory perception) as remarkable and even advantageous in some instances, not as psychopathology. Because newer ways of thinking about disability and mental disorders—like the social model or the Mad Pride movement—are entering social consciousness, researchers may see a decrease in negative attitudes towards people with mental disorders. With that said, the extent to which advocates of the social model of disability or the Mad Pride movement find pedophilia part of their cause is unclear.

The work summarized above demonstrates conflicting findings regarding whether applying pathology labels to a behavior (or other symptoms) will incite harsher attitudes or have the opposite effect. But, in the context of the present study, where the symptoms (i.e., sexual attraction to prepubescent children) are likely fear-inducing (relative to generalized anxiety or depression, for example), these findings generally suggest that pathology labels will elicit more stigmatizing attitudes, as captured by affect, endorsement of stereotypes, and desire for social distance (Manago & Mize, 2022). Now we will turn to PPA-specific research on clinical labels.

Much of the research on attitudes toward PPA either positions the sexual attraction as non-pathological but socially deviant or as a mental disorder (e.g., comparing attitudes toward those with pedophilic disorder to those with other disorders). Only a few researchers have investigated the importance of language when describing these subjects, like “pedophiles,”
“people with pedophilia,” “people with sexual interests in children,” and more along these lines. Of this research, the more clinical labels (e.g., “pedophilia”) were, on average, associated with a greater endorsement of negative stereotypes and more negative emotional responses.

Imhoff (2015) and Imhoff and Jahnke (2018) investigated the influence of using “pedophilia” vs. “sexual interest in (prepubescent) children.” In both studies, they found that the labels influenced participants’ attitudes toward PPA, in that attitudes were more negative when the term “pedophilia” was used. The researchers point to the clinical nature of “pedophilia” as the cause of this effect. Although Imhoff and Jahnke assert that this terminology is a clearly psychiatric (i.e., clinical, pathological, etc.) concept, the term is frequently used in non-psychiatric contexts by the media, law enforcement, and others in daily life, which has “brought this term to outside the exclusive purview of psychiatric diagnosis” (Lanning, 1992, p. 2). Because the term has diverged from the clinical entity it initially represented and now exits with a colloquial meaning in the collective consciousness, Imhoff’s and Jahnke’s claim that “pedophilia” strictly evokes a clinical schema needs strengthening. Moreover, the common conflation of “pedophile” with a sexual abuser (described previously) calls into question whether it is the psychiatric aspect of the term or the assumption of abuse driving this effect. These issues are mitigated in the current study, where the pathological language independent variable includes a wide range of psychiatric terminology and a clinical setting (or neither, depending on their condition), and the participants answer a factual attention check about whether the subject has committed a crime.

Dimension 3: Sexual Perversion
Adjacent to the legal and psychiatric purview, pedophilic attractions have been framed in American society as “perversions.”\(^2\) This conceptualization differs from how other domains have classified these attractions (e.g., crimes or paraphilias) in its immediate ties to morality and religion.\(^3\) Wrapped up in morality and religion are two important concepts: perversions are (1) unnatural and (2) disgusting (Freud, 1977, as cited in Airaksinen, 2019; Nagel, 1979, as cited in Airaksinen, 2019; Ullerstam, 1966). De Block & Adriaens (2013) echo this sentiment, describing the historical entanglement between “divine laws” and “natural law[s]”—where perversions like pedophilia would conflict with both (p. 278). Despite the ties to so-called “natural law[s],” the degree to which “aberrant sexual practice[s] or interest[s]” are considered perversions (as the Merriam-Webster dictionary defines them; Merriam-Webster, n.d.) are tied to time and place, with many becoming more acceptable over time (e.g., sodomy) and others continuing to be met with reprobation (e.g., pedophilia).

The term “perversion” implies a condemnatory attitude, even though it is sometimes passed off as though the disapproval is objectively warranted and not bigoted (Airaksinen, 2019). Counterintuitively, the notion is simultaneously culturally and historically relative, while also established as an inherent quality in nature, connected to some greater truth about what is right and wrong, what is natural and unnatural (Peakman, 2009). In spite of these incongruent principles, perversions carry weight in the collective consciousness (although, in recent years, they might be described in more fashionable terms, like “sexual taboos”). Even in

\(^2\) This is not to say that the concept of perversions has not veered into the scientific domain; it has certainly been used in the fields of medicine, psychology, and sexology. For the present purpose, I am describing the foundational understanding of perverse sexual behavior as it is “viewed as the unspeakable incarnation of evil…considered sinful, blasphemous, immoral, corrupt, and illegal” (Travin & Protter, 1993, p. 17).

\(^3\) Morality and religion also play critical roles in the construction of laws and pathology, but I have chosen to separate perversions as a third dimension because of its distinct relationship with these constructs.
unconventional sexual practices that are explicitly described as consensual, private, and causing no negative consequences for others, there is typically still a presumption of harm (described as a violation of symbolic values and moral norms rather than actual harm) and reactions of “moral anger” and “moral disgust” (Gutierrez & Giner-Sorolla, 2007). It is difficult to fully capture the social effects of labeling a sexual interest “perverted,” but, put simply, we might understand it as an effective tool of social control and punishment. When it comes to the image of “the pedophile,” the figure is understood through the lenses of perversion (“evil,” “disgusting,” etc.), mental illness (“sick”), and criminality (“child molester”) (Harkins, 2020).

Under the overarching umbrella of perversions, homosexuality and pedophilia have been intertwined, essentially harnessing panic about both queer people and PPA. In the early-to-mid twentieth century, “sexual psychopathology mobilized fears of homosexuality and other alleged perversions to make sex predators into national threats” (Harkins, 2020, p. 29). This proclamation suggests an important directionality: there were negative attitudes towards homosexuals, and these attitudes were utilized to bolster fear and condemnation of sexual psychopaths. In more recent decades, the directionality seems to have switched—in order to leverage stigma against homosexuality (or queerness, more generally), people have ascribed pedophilic acts or intentions to homosexuals. Anita Bryant’s 1977 U.S. movement, “Save Our Children,” is a notorious example of this. The Christian singer-turned-orange-juice-spokesperson felt called by her “love for Almighty God” to enter politics and stand up against gay rights activism (Bryant, 1977, p. 13). In doing so, she famously conflated homosexuals with sexual abusers of children, all the while referring to them as “pervert[s]” (Bryant, 1977, p. 142). One of her central concerns about “homosexual school-teachers” was that “a particularly
deviant-minded teacher could sexually molest children” (Bryant, 1977, p. 114). Bryant made it clear that predation was a tenant of homosexuality and her attempt to harness anxiety about it was effective on a national scale (Harkins, 2020). In the present day, teachers who so much as mention gender identity or sexual orientation are being accused of “grooming” children for sexual abuse, eerily resembling Bryant’s motives over 45 years later (Natanson & Balingit, 2022).

**The Effects of Sexual Orientation on Attitudes Toward PPA**

Ultimately, the idea of perversion has had a significant influence on societal responses to both homosexuality and pedophilia. From the example of Bryant’s “Save Our Children” campaign—as well as an abundance of instances where gay activist groups have publicly signaled their distance from organizations like the North American Man/Boy Love Association, condemned pedophilia, and were still met with accusations of CSA (Harkins, 2020)—it is undeniable that allegations of pedophilia have been weaponized to sustain homophobia. But, there are conflicting findings about how attitudes toward PPA are affected by whether the PPA is heterosexual or homosexual. In other words, because both pedophilic attractions and homosexuality are sometimes intertwined and condemned—albeit to different degrees and frequently for different reasons—it is difficult to disentangle whether the assumption of homosexuality increases the perversion of pedophilia. This study will attempt to explore this question by manipulating the PPA’s sexual orientation in a vignette that participants read.

It is possible that homosexual PPA will face more negative attitudes than heterosexual PPA, given the stigma of both aspects of their attractions (homosexuality and pedophilia). With this said, it is well known that stigma does not usually work in a precise, additive manner.
Nevertheless, this hypothesis is supported by numerous studies indicating that homosexual child molesters face harsher prison sentencing than heterosexual child molesters in actual (Walsh, 1994) and mock (Wiley & Bottoms, 2009) trials. And, while incarcerated, researchers contend that “[child molesters] are the most despised offenders within the prison subculture, especially if the offense was known to be homosexual” (Walsh, 1994, p. 340). In a study where the genders of both a fictional PPA and child were manipulated, Maynard and Wiederman (1997) found that participants rated an instance of CSA as more abusive when it depicted a same-gender pairing (male child with male adult, or female child with female adult), and less abusive when it was a different-gender pairing (male child with female adult, or female child with male adult). This is one of the few studies that manipulated the genders of both parties, not just the child, which provides important results about attitudes toward homosexuality/heterosexuality in general, not just in the case of male PPA.

The research on the victim’s gender in cases of CSA complicates the narrative around PPA sexual orientation. Edelson and Joa (2010) found that boys who were sexually abused had poorer legal outcomes (i.e., a smaller percentage of their cases were filed with the District Attorney and they had fewer criminal counts charged) than girls who were sexually abused (all by male perpetrators). One consideration is that participants may extend more negative attitudes toward victims who are boys, as demonstrated in some literature on the topic (Davies et al., 2001), and conversely, project more negative emotions onto PPA whose prospective victims are girls. That being said, the present study focuses on PPA who have not committed any sex-related crimes, so it is possible that the gender of the prospective CSA victim may play a less important role compared to instances where CSA has actually occurred. Moreover, it is possible, though
maybe not as intuitive, that people can hold harsher attitudes toward homosexual PPA in conjunction with harsher attitudes toward male victims of CSA, both being driven by homophobia. Another consideration is that there might not be a strong victim (or, in this case, potential victim) gender effect, as demonstrated in other research (Voogt & Klettke, 2017).

It is conceivable that incidence rates of CSA will affect attitudes toward PPA, too. One could argue that, because CSA predominantly impacts girls (Hall & Hall, 2007), people see heterosexual PPA as more dangerous than homosexual PPA. Although the statistics are firm in that young girls are sexually abused at higher rates, there may be misconceptions about this generated by anti-gay rhetoric and the sensationalization of homosexual CSA (e.g., Albert Fish, Dennis Nilsen, Jeffrey Dahmer, John Wayne Gacy, Congressman Mark Foley, Michael Jackson, members of the Catholic Church). Future studies would benefit from asking participants who they believe is most widely impacted by CSA to determine if this is a factor in attitudes toward homosexual vs. heterosexual (vs. bisexual, etc.) PPA.

The available research on this topic does not paint a clear picture of how sexual orientation will impact attitudes toward PPA, but we might infer that participants will express more stigma toward PPA with homosexual attractions, given the vast number of studies demonstrating this trend.

**Current Study**

As described previously, there is a myriad of research showing the association between pathological ascriptions of behavior and stigmatizing attitudes. But, beyond Imhoff’s (2015) and Imhoff and Jahnke’s (2018) articles, there is little existing research on whether contextualizing pedophilic desires, specifically, as pathological influences attitudes toward PPA. And, to my
knowledge, there is no research to date that goes beyond simply using “pedophilia” or “pedophile” to paint the desires as clinically relevant. This study will address this question, and, to maximize any possible effect, the Pathological Language condition will be exposed to a far greater range of psychiatric terminology (e.g., “pedophilic disorder,” “symptoms,” “psychologist,” etc.). With regard to sexual orientation, the majority of the research summarized above points to harsher attitudes toward homosexual PPA, although, like pathological language, there are conflicting findings about this effect.

In order to contribute to this area of inquiry, the overarching research questions for the present study are: Do people’s attitudes toward people with pedophilic attractions change depending on whether the individual’s attractions are painted as a mental disorder? Do they change depending on whether the pedophilic attractions are toward children of the same gender or a different gender? I have split my hypotheses into two groups: those pertaining to mental disorder labels (H1a-f), and those pertaining to sexual orientation (H2a-d). Given the previous research on the effects of pathologizing language and sexual orientation, I formulated the following hypotheses:

Compared to the Non-Pathological Language condition, the participants in the Pathological Language condition will report…

**H1a:** greater degrees of negative emotions (i.e., anger, disgust, fear, sadness, sickness) toward the subject

**H1b:** more moral disapproval toward the subject on Gutierrez and Giner-Sorolla’s (2007) acceptability/approval scale

**H1c:** the subject as more dangerous on the Jahnke et al. (2015) scale of dangerousness
**H1d**: a stronger desire for social distance from the subject as measured on the Jahnke et al. (2014) adapted social distance scale

**H1e**: blame the subject less for their attractions on the Jahnke et al. (2015) scale of controllability

**H1f**: a belief that the subject’s attractions are more treatable with medication and psychotherapy on the Feldman and Crandall (2007) scale

Compared to the Heterosexual condition, the participants in the Homosexual condition will report…

**H2a**: greater degrees of negative emotions (i.e., anger, disgust, fear, sadness, sickness) toward the subject

**H2b**: more moral disapproval toward the subject on Gutierrez and Giner-Sorolla’s (2007) acceptability/approval scale

**H2c**: the subject to be more dangerous on the Jahnke et al. (2015) scale of dangerousness

**H2d**: a stronger desire for social distance from the subject as measured on the Jahnke et al. (2014) adapted social distance scale

The exploratory variables in this study deal with the degree to which demographic variables influence attitudes toward people with pedophilic attractions. Specifically, I am interested in whether the participants are parents and whether they have close proximity to sexual trauma. As stated in the preregistration, I hypothesize:

**H3a**: Compared to non-parents, parents will endorse more negative attitudes toward the subject, as measured by their negative emotions, moral disapproval, belief about Dangerousness, and desire for greater social distance
H3b: Compared to people who have not been closely impacted by sexual trauma, participants who report that they or someone close to them has experienced sexual trauma will endorse more negative attitudes toward the subject, as measured by their negative emotions, moral disapproval, belief about dangerousness, and desire for greater social distance.

Methods

Participants

Participant Recruitment and Characteristics

A total of 538 participants were recruited through Prolific, a recruitment website for online tasks. To be eligible for the experiment, participants must have been between the ages of 18 and 40, residing in the United States, and fluent in English. Participants were compensated at the rate of $8/hr for an approximately seven-minute survey. Using a Qualtrics tool, participants were randomly assigned to one of the four total conditions: Pathological Language × Heterosexual (n = 122, 24.3%), Pathological Language × Homosexual (n = 128, 25.5%), Non-Pathological Language × Heterosexual (n = 125, 24.9%), or Non-Pathological Language × Homosexual (n = 127, 25.3%). The demographic information for the sample is presented in Appendix A. An ANOVA demonstrated no significant difference in ages between the four conditions. Chi-square tests indicated no significant differences between the groups for any of the other demographic factors (ps > .05), with the exception of education, $X^2 (15, N = 502) = 825.36, p = .045$.

Participants were excluded from data analyses if they met one or more of the following criteria: (1) Participants who did not correctly answer two factual attention checks (“Has James committed an illegal sexual offense?” and “Which of the following is not a fruit?”); (2)
Participants who responded to fewer than 80% of the survey’s total items; (3) Participants who completed the experiment considerably faster than the average completion time (outliers were determined using two median absolute deviations from the median); and (4) Participants who selected “You should not include my survey answers in this study” at the end of the experiment. Of the 538 participants who completed the experiment, 36 (6.7%) participants were excluded because they met at least one of the four exclusion criteria, leaving 502 participants in the final sample.

**Power and Effect Size Considerations**

This study used an experimental 2 (Pathological Language vs. Non-Pathological Language) by 2 (Heterosexual vs. Homosexual) between-subjects design. Both independent variables were manipulated within the vignette, which is described in more detail below. An a priori power analysis was conducted using R (Version 4.2.2; R Core Team, 2022) for an analysis of variance (ANOVA) with four conditions. This analysis determined that the minimum sample size required to detect a small effect ($F = .15$) with 80% power and an alpha level of $\alpha = .05$, was 123 people per condition, or a total of 492 people. Given that the final sample size ($N = 502$) exceeded this number, the present experiment demonstrates adequate statistical power to detect the primary effects of interest.

**Procedure**

Participants were directed from Prolific to a Qualtrics survey, where they gave informed consent and responded to an additional acknowledgment of the study’s topic. Using a Qualtrics tool, participants were randomly assigned to one of the four possible conditions. At this time, they were unaware of the manipulations and the hypotheses for the study. Participants read a
vignette—one of the four corresponding to their condition—about a fictional subject who experiences attraction to prepubescent children. After reading the vignette and answering a factual question about the subject, participants completed survey items to assess their attitudes toward this PPA, measured by participants’ self-reported affective responses (anger, disgust, fear, pity, sadness, sickness, sympathy), agreement with beliefs/stereotypes about the subject (moral disapproval, dangerousness, blame, effectiveness of psychotherapy and medication), and their desired social distance from the subject. Next, participants answered demographic questions (e.g., age, race, gender, religion, etc.) and were provided with a debrief. The Bard College Institutional Review Board approved this study prior to data collection (See Appendix B) and all hypotheses were preregistered (See Appendix C). All survey items can be found in Appendix D.

Materials

Vignettes

I created four vignettes that describe a fictional subject’s sexual attraction to prepubescent children (see Appendix E). Both independent variables (Pathological/Non-Pathological Language and Heterosexual/Homosexual attractions) were manipulated in these vignettes. In the Pathological Language conditions, the vignette describes the subject’s—James’—attractions as caused by pedophilic disorder and includes a notable amount of psychiatric terms (e.g., the subject’s “symptoms”, “psychologist”, “diagnosed”). In the Non-Pathological Language conditions, the subject’s attractions are identical, but there is no mention of mental disorders, psychopathology, or other related terms (e.g., “sexual interest” or “attraction” in place of “symptoms” or “disorder”). Half of the participants read that the subject’s attractions are
exclusively toward children of a different gender and the other half read that the subject’s attractions are exclusively toward children of his own gender.

**Affective Responses**

Participants completed some of the items from Gutierrez and Giner-Sorolla’s (2007) scale for studying emotional states. Initially, Gutierrez and Giner-Sorolla included 17 emotions in their scale, but I retained fewer items in order to reflect my narrower research question (anger, disgust, pity, sadness, sickness, and sympathy). I have also added one emotion they did not initially include: fear. Participants reported the intensity of their emotions from 1 (*not at all*) to 8 (*very much*). Each of the 7 emotion items included in the present study thus had a score between 1 and 8. The 5 negatively valenced items (anger, disgust, fear, sadness, and sickness) demonstrated strong internal consistency ($\alpha = .83$). Because the internal consistency for this measure exceeded $\alpha = .80$ (as stated in the preregistration), all negative emotion responses were averaged and this composite score was the outcome variable for an ANOVA. There was good internal consistency for the other two emotion items (pity and sympathy) ($\alpha = .80$), so the mean of both items was similarly used as the outcome variable for an ANOVA.

**Moral (Dis)approval**

Participants responded to Gutierrez and Giner-Sorolla’s (2007) brief 4-item questionnaire about moral approval. Each item was scored from 0 to 6, where higher scores indicate a greater level of moral disapproval. In the original scale, the researchers asked participants to respond using a 9-point bipolar semantic scale. In the current study, I have modified this to be a 7-point scale. Additionally, the wording of each item has been adjusted to refer to the specific fictional subject in this experiment (i.e., “James”). Using Gutierrez and Giner-Sorolla’s original items, the
participants in the current study were asked to indicate the extent to which James’ attractions were completely right/completely wrong, good/bad, correct/incorrect, and positive/negative. In previous research, Gutierrez and Giner-Sorolla found that this scale had robust internal consistency (α = .90), which was also demonstrated in the present study (α = .95). Because this exceeded the pre-registered cutoff of .80, the participants’ scores across all items were averaged and used as the ANOVA outcome variable.

**Dangerousness & Blame**

Participants completed the Jahnke et al. (2015b) questionnaires about perceived levels of dangerousness (four items) and controllability/blame⁴ (three items). In these scales, participants were given statements and asked to rate how much they agreed with them on a 7-point scale, from 0 (do not agree at all) to 6 (completely agree). For the dangerousness scale, two items (the first and fourth items) were reverse-scored, so that higher scores indicate a higher level of perceived dangerousness. The two questionnaires were designed to evaluate perceptions of people with sexual interests in children, and, as such, the only modification that I have made is to tie each item back to the subject in the present study (e.g., use of the subject’s name instead of general phrasing like “many people” or “somebody”). Jahnke et al. found the reliability of both scales to be strong (α = .70 for dangerousness, α ≥ .82 for blame). Internal consistency was greater in this experiment (α = .82 for dangerousness, α = .94 for blame). Thus, all responses on the dangerousness scale and all responses on the blame scale were averaged (i.e., one averaged...

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⁴ For the remainder of this paper, I will refer to this measure as “blame.” Although Jahnke et al. (2015) describe their scale as assessing “controllability,” this may be misleading to readers, who could conceivably interpret this as PPA’s controllability over their actions (instead of blame for having pedophilic desires).
score for dangerousness and one averaged score for blame per participant) and these scores were used as the outcome variables in data analyses.

*Effectiveness of Psychotherapy and Medication*

The participants answered two items from Feldman and Crandall’s (2007) scale (originally 17 items), created to assess stigma toward those with mental disorders, including pedophilic disorder. These two items asked the extent to which the subject’s sexual attractions were “treatable” with (1) medication and (2) psychotherapy. These items had 7-point bipolar semantic differential response options and each item was scored from 0 to 6. I have modified the wording to include the subject’s name. For example, for the first item, participants were prompted with: “James’ sexual attractions are:” before selecting a number between 0 (*not treatable with medication*) and 6 (*treatable with medication*). Cronbach’s alpha demonstrated low consistency between these items (α = .54), and as such, each item was used as a separate outcome variable in the ANOVAs.

*Social Distance*

To assess the desired social distance from the subject, participants completed the Social Distance Scale, originally created by Bogardus (1933), and more recently adapted by Jahnke et al. (2014). This Likert-style questionnaire contained six items and the responses were given on a 7-point scale, with answers ranging from 0 (*do not agree at all*) to 6 (*completely agree*). The positively formulated items were reverse-coded such that higher scores represent a higher level of desired social distance. I have modified the initial prompt and individual items to include the subject’s name in place of more general terminology (e.g., “Would have James as a friend” instead of “Would have these persons as friends”). I have also changed the wording of the last
item to improve clarity—I altered the wording from “These persons should better be dead” to “James would be better off dead”. Jahnke et al. found that their adapted version of the Social Distance Scale had good internal consistency ($\alpha = .82$), which was also demonstrated in the present study ($\alpha = .88$). Participants’ scores across all items were averaged and this composite score was used as an outcome variable in an ANOVA. As planned in the preregistration, I also performed analyses on individual items from this scale.

Results

Primary Analyses

**Affect - Hypothesis 1A and 2A**

A two-way ANOVA model was used to evaluate the participants’ negative affect toward the subject (see Figure 1). This model yielded statistically significant main effects of both pathological language and sexual orientation. Participants in the Non-Pathological Language group reported more negative emotions ($M = 4.69, SD = 1.72$) than those in the Pathological Language group ($M = 4.33, SD = 1.80$), $F(1, 492) = 5.33, p = .02$. Participants also reported more negative emotions toward the heterosexual subject ($M = 4.72, SD = 1.70$) than the homosexual subject ($M = 4.31, SD = 1.82$), $F(1, 492) = 6.50, p = .01$. The ANOVA indicated no significant interaction effect on the participants’ negative emotions toward the subject ($F(1, 492) = 0.001, p = .97$).
Contrary to my hypotheses, there was not a significant main effect of sexual orientation on participants’ levels of pity and sympathy toward the subject, $F(1, 497) = 3.41, p = .066$.

Although there was a trend whereby participants expressed less pity and sympathy toward the heterosexual subject ($M = 3.71, SD = 2.04$) than the homosexual subject ($M = 4.05, SD = 2.04$), this trend was ultimately non-significant. The main effect of pathological language was non-significant, $F(1, 497) = 0.05, p = .82$, and there was a non-significant interaction effect, $F(1, 497) = 0.03, p = .85$. These findings are presented in Figure 2.
Note. This figure shows the participants’ pity and sympathy toward the subject. Responses for the pity and sympathy were averaged and this composite score is the dependent variable. Error bars represent standard errors.

**Moral Disapproval - Hypothesis 1B and 2B**

In contrast to my hypotheses, neither pathological language nor sexual orientation had a significant effect on the degree to which participants expressed disapproval of the subject’s attractions \( (p > .05) \). The ANOVA also yielded a non-significant interaction effect on this dependent variable, \( F(1, 494) = 2.68, p = .10 \). In comparing the average disapproval rating across all participants \( (M = 5.59, SD = 0.89) \) to the scale’s upper-limit of 6, it is clear that there was a ceiling effect for this measure.

**Perceived Dangerousness - Hypothesis 1C and 2C**
Consistent with my hypothesis, sexual orientation did have an effect on the perceived dangerousness of the subject, however in the opposite predicted direction (see Figure 3). Participants reported that the heterosexual subject was more dangerous ($M = 3.35$, $SD = 1.32$) than the homosexual subject ($M = 3.03$, $SD = 1.32$), $F(1, 496) = 7.72$, $p = .006$. The two-way ANOVA showed that there was not a statistically significant interaction effect on the perceived dangerousness of the subject, $F(1, 496) = 0.57$, $p = .45$. Contrary to my hypothesis, a main effects analysis demonstrated no significant effect of pathological language on this variable either, $F(1, 496) = 0.007$, $p = .93$.

**Figure 3**

*Perceived Dangerousness of Subject*

- Pathological Vs. Non-Pathological Language
  - non-path
  - path

*Note.* This figure shows the perceived dangerousness of the subject, using participants' average score across all items of the Jahnke et al. (2015) scale of dangerousness. There was a main effect of sexual orientation. Error bars represent standard errors.

$$** p < .01.$$
**Social Distance - Hypothesis 1D and 2D**

There was a main effect of sexual orientation on the participants’ desire for social distance from the subject (See Figure 4). In opposition to my hypothesis, participants desired more social distance from the heterosexual subject \((M = 3.60, SD = 1.30)\) than the homosexual subject \((M = 3.35, SD = 1.30)\), \(F(1, 492) = 4.74, p = .03\). The pathological language variable had a non-significant effect on this measure, \(F(1, 492) = 3.00, p = 0.08\). It is worth noting, however, that there was a trend whereby participants in the Pathological Language group desired more distance from the subject \((M = 3.57, SD = 1.31)\) than those in the Non-Pathological Language group \((M = 3.37, SD = 1.29)\). This trending effect was driven by responses to the sixth item on the adapted Social Distance Scale, which was the only item where pathological language had significant impact on responses. For this item, there was a main effect of pathological language on agreement with “James would be better off dead”, \(F(1, 497) = 6.10, p = .01\). Participants in the Pathological Condition agreed that the subject would be better off dead more \((M = 1.42, SD = 1.77)\) than those in the Non-Pathological Language condition \((M = 1.04, SD = 1.67)\). The ANOVA indicated no significant interaction between pathological language and sexual orientation, \(F(1, 492) = 0.37, p = .55\).
Note. This figure shows participants’ desired social distance from the subject. Participants’ scores across all items of the Jahnke et al. (2014) adapted version of the Social Distance Scale were averaged, and this composite score is the dependent variable. There was a main effect of sexual orientation. Error bars represent standard errors. *p < .05.

The descriptive findings for the individual social distance items are presented in Table 1. Notably, across all conditions, 15.4% of the participants agreed that the subject should be incarcerated (defined as a score of 4-6 on the Likert scale of 0-6), while 12.8% were uncertain or neutral about this (defined as a score of 3 on the Likert scale of 0-6), despite all of them acknowledging that he had not committed an illegal offense.
<table>
<thead>
<tr>
<th>Item</th>
<th>N</th>
<th>M (SD)</th>
<th>Agree&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Uncertain/Neutral&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would have James as a friend</td>
<td>500</td>
<td>4.91 (1.35)</td>
<td>84.2% (n = 421)</td>
<td>10.6% (n = 53)</td>
</tr>
<tr>
<td>Would accept James in my neighborhood</td>
<td>500</td>
<td>4.72 (1.50)</td>
<td>77.0% (n = 385)</td>
<td>13.4% (n = 67)</td>
</tr>
<tr>
<td>Would accept James as a colleague at work</td>
<td>501</td>
<td>4.36 (1.70)</td>
<td>67.9% (n = 340)</td>
<td>16.2% (n = 81)</td>
</tr>
<tr>
<td>Would talk to James</td>
<td>498</td>
<td>4.03 (1.88)</td>
<td>59.8% (n = 298)</td>
<td>17.5% (n = 87)</td>
</tr>
<tr>
<td>James should be incarcerated</td>
<td>501</td>
<td>1.62 (1.79)</td>
<td>15.4% (n = 77)</td>
<td>12.8% (n = 64)</td>
</tr>
<tr>
<td>James would be better off dead</td>
<td>501</td>
<td>1.23 (1.73)</td>
<td>11.2% (n = 56)</td>
<td>10.8% (n = 54)</td>
</tr>
</tbody>
</table>

<sup>a</sup> Agreed is defined as a score of 4-6 on the Likert scale of 0-6

<sup>b</sup> Uncertain/Neutral is defined as a score of 3 on the Likert scale of 0-6

**Blame - Hypothesis 1E**

There was a non-significant interaction between the pathological language and sexual orientation variables on the degree to which participants blamed the subject for his attractions, $F(1, 497) = 2.90, p = .089$. Simple main analyses revealed no main effects of pathological language or sexual orientation on blame ($p$s $> .05$). Across all groups, participants ascribed very little blame to the subject for his attractions (mean scores were approximately 1.5-2 out of 6). The trending interaction effect is depicted in Figure 5.
**Figure 5**

Blame Assigned to Subject For His Attractions

Note. This figure shows the degree to which participants blamed the subject for having pedophilic attractions, measured by the participants’ average score across all items of the Jahnke et al. (2015) scale of blame. Error bars represent standard errors.

**Effectiveness of Psychotherapy and Medication - Hypothesis 1F**

In opposition to my initial hypothesis, participants in the Non-Pathological Language condition reported a greater belief that psychotherapy could treat the subject’s attractions ($M = 4.18$, $SD = 1.67$) compared to the participants in the Pathological Language condition ($M = 3.80$, $SD = 1.68$), $F(1, 496) = 6.57, p = .01$. There was no significant main effect of sexual orientation on this measure, $F(1, 496) = 0.97, p = .33$, or an interaction between both independent variables, $F(1, 496) = 0.17, p = .68$. The perceived effectiveness of psychotherapy is illustrated in Figure 6A.

There was a statistically significant interaction on the participants’ perceived
effectiveness of medication for treating the subject's attractions, $F(1, 494) = 5.72, p = .02$ (see Figure 6B). Simple main analyses revealed no main effects of pathological language or sexual orientation on this measure ($ps > .05$).

**Figure 6**
Perceived Effectiveness of Therapy and Medication

**A**

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Non-Pathological</th>
<th>Pathological</th>
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<td>Effectiveness of Therapy</td>
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**B**

<table>
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<th>Pathological Vs. Non-Pathological Language</th>
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<td>Effectiveness of Medication</td>
<td>Heterosexual</td>
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<td><img src="#" alt="Bars" /></td>
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*Note. This figure shows the degree to which participants believed the subject's attractions were "treatable" with therapy (Figure 6A) and medication (Figure 6B). There was a main effect of pathological language in Figure 6A and an interaction effect in Figure 6B. Error bars represent standard errors.

* $p < .05.$

**Exploratory Analyses**
Parents vs. Non-Parents - Hypothesis 3A

To investigate Hypothesis 3A, I limited the sample to those who explicitly indicated either being a parent \((n = 98)\) or not a parent \((n = 395)\) (i.e., I removed those who did not answer this item or responded with “I prefer not to answer”). I then performed \(t\)-tests between these two groups \((N = 493)\). Consistent with my exploratory hypotheses, parents expressed more negative emotions toward the subject \((M = 4.89, SD = 1.74)\) than non-parents \((M = 4.41, SD = 1.78)\), \(t(486) = -2.41, p = .02\). Conversely, parents expressed less pity and sympathy \((M = 3.50, SD = 2.04)\) than non-parents \((M = 3.96, SD = 2.04)\), \(t(491) = 1.98, p = .047\). In line with my hypothesis, parents perceived the subject as significantly more dangerous \((M = 3.52, SD = 1.21)\) than non-parents \((M = 3.11, SD = 1.34)\), \(t(490) = -2.79, p = .005\).

In contrast to my hypothesis, parents did not exhibit significantly different moral disapproval toward the subject \((M = 5.68, SD = 0.62)\) than non-parents \((M = 5.57, SD = 0.95)\), \(t(488) = -1.06, p = .29\). The parents also did not exhibit a significantly different desire for social distance \((M = 3.67, SD = 1.12)\) than non-parents \((M = 3.43, SD = 1.34)\), \(t(486) = -1.61, p = .11\).

Upon exploring the social distance items at an individual level, I found that all but one were significant: parents reported a greater resistance to accepting the subject in their neighborhood \((M = 5.13, SD = 1.28)\) than non-parents \((M = 4.63, SD = 1.53)\), \(t(490) = -3.03, p = .003\).

Close Proximity to Sexual Trauma vs. No/Distant Proximity to Sexual Trauma - Hypothesis 3B

In the demographic portion of the experiment, participants were asked: “Have you, or someone you are close to, experienced sexual trauma?”. To investigate Hypothesis 3B, I limited the sample to those who responded “yes” or “no” to this item (i.e., I removed those who did not
answer this item or responded with “I prefer not to answer”). 199 participants indicated having close proximity to sexual trauma and 280 participants indicated not having close proximity to sexual trauma. I then performed $t$-tests between these two groups ($N = 479$).

As predicted, participants with close proximity to sexual trauma expressed more negative emotional responses to the subject ($M = 4.80, SD = 1.76$) than those without close proximity to sexual trauma ($M = 4.34, SD = 1.75$), $t(472) = 2.85, p = .005$. Upon looking at the individual items, this effect was most pronounced for sadness and anger. In contrast to my hypothesis, participants with close proximity to sexual trauma reported marginally higher levels of pity and sympathy toward the subject ($M = 4.07, SD = 2.16$) than those without close proximity to sexual trauma ($M = 3.75, SD = 1.96$), $t(477) = 1.66, p = .10$. Whether or not the participants had close proximity to sexual trauma did not significantly impact their moral disapproval of the subject, perceived dangerousness of the subject, or overall desire for social distance ($ps > .05$). As indicated in the preregistration, I also examined the social distance items individually. A $t$-test determined that participants with close proximity to sexual trauma reported a marginally smaller, but non-significant, belief that the subject should be incarcerated ($M = 1.47, SD = 1.73$) than those without close proximity to sexual trauma ($M = 1.77, SD = 1.83$), $t(477) = -1.81, p = 0.07$.

**Participant Gender**

I also explored whether the participants’ gender had any effect on their attitude measures for exploratory purposes (these analyses were not preregistered). To do so, I limited the sample to the three largest gender groups: those who selected “Woman” ($n = 172$), “Man” ($n = 297$), and “Non-binary / gender-fluid / otherwise outside of the gender binary” ($n = 22$). Using these three
gender groups, I performed one-way ANOVAs on all of the dependent measures mentioned above.

There was a significant difference between these groups on negative affect, $F(2, 483) = 14.48$, $p < .01$. A post-hoc Tukey HSD (Honestly Significant Difference) test revealed a significant difference between women and men, $p < .01$, 95% C.I. = [0.50, 1.28], where women reported higher levels of negative affect ($M = 5.08$, $SD = 1.63$) than men ($M = 4.19$, $SD = 1.77$). There was no significant difference between non-binary people and men, or non-binary people and women, $ps > .05$. The amount of pity and sympathy that participants felt toward the subject did not significantly differ between gender groups, $F(2, 488) = 1.04$, $p = .36$.

An ANOVA found a significant effect of gender on participants’ moral disapproval toward the subject, $F(2, 485) = 3.17$, $p = .04$. Tukey’s HSD test for multiple comparisons found that responses were significantly different between women and men, $p = .04$, 95% C.I. = [0.008, 0.41]. Participants who were women expressed more moral disapproval ($M = 5.73$, $SD = 0.72$) than participants who were men ($M = 5.52$, $SD = 0.97$). There was no significant difference between non-binary people and men, or non-binary people and women, $ps > .05$. The perceived dangerousness of the subject also significantly differed by gender, $F(2, 487) = 5.93$, $p = .003$. The post-hoc test showed a significant difference between men and women, $p = .005$, 95% C.I. = [0.10, 0.70], where women perceived the subject as more dangerous ($M = 3.46$, $SD = 1.29$) than men ($M = 3.06$, $SD = 1.35$). There was no significant difference between women and non-binary people, or men and non-binary people, $ps > .05$.

The amount of social distance that participants desired from the subject did not significantly differ between gender groups, $F(2, 483) = 1.85$, $p = .16$. In looking at the social
distance items on an individual level, an ANOVA demonstrated a significant difference between genders in agreement with “James should be incarcerated”, $F(2, 488) = 3.53, p = .03$. Tukey’s HSD test revealed that women and non-binary people significantly differed in their agreement with this item, $p = .049$, 95% C.I. = [0.0002, 1.90]. Participants who were women endorsed that the subject should be incarcerated more ($M = 1.86$, $SD = 1.82$) than participants who were non-binary ($M = 0.91$, $SD = 1.44$). There were no significant differences between the gender groups on any other individual social distance item.

**Discussion**

The purpose of this study was to gain a better understanding of the ways in which pathologizing language and the PPA’s sexual orientation influence attitudes toward people with pedophilic attractions. The results provide supporting evidence that, on many of the dependent measures, one or both independent variables influenced the participants’ attitudes toward PPA.

**The Sexual Orientation of PPA**

The sexual orientation of PPA played a key role in determining attitudes toward the subject in this study, although this occurred in unexpected ways. Contrary to my hypothesis, participants had more negative emotional responses (affect) when the subject’s attractions were heterosexual (i.e., toward prepubescent girls). This pattern was also demonstrated by the perceived dangerousness of the subject and the desire for social distance from them. This was surprising because previous studies have found that homosexual PPA who commit illegal offenses face harsher punitive measures (Walsh, 1994; Wiley & Bottoms, 2009) and are viewed as more abusive (Maynard & Wiederman, 1997).
In my view, the most compelling explanation for this finding involves a combination of beliefs that minimize the harm experienced by boys who have suffered from CSA, while prioritizing the preservation of girls’ innocence and the perception of their fragility. Although this variable is framed as examining the PPA’s sexual orientation, it is very possible that it was not sexual orientation, per se, that the participants picked up on. Instead, the differences observed from this variable might be due to a focus on the child’s gender, rather than the relational aspect of gender between PPA and the children they are attracted to. For this reason, it is impossible to determine whether attitudes toward the subject in the Heterosexual condition were more negative because of some factor pertaining to heterosexuality (as opposed to homosexuality), or because their potential victims are girls.

That being said, there are reasons to believe that the child’s gender may very well be instrumental. Several studies have demonstrated that men hold harsher attitudes toward male victims of CSA carried out by male perpetrators (Davies et al., 2001) as a result of gender-role or homophobic attributions (e.g., belief that the child is weak, feminine, or gay). Donnelly and Kenyon (1996) write that rape crisis counselors, law enforcement officers, and mental health professionals upheld the notion that boys and men are hardly ever sexually assaulted, and, in cases where abuse has allegedly occurred, they expressed unsympathetic attitudes, at times claiming that the victims likely enjoyed the sexual assault. In contrast, girls are more frequently constructed as passive agents—lacking in agency, sexual knowledge, and sexual desire—whose innocence should be protected such that they will not assume long-term “damage” that impacts their adult sexual lives (Smith & Woodiwiss, 2016). The assumption here is that this “damage” would inadvertently affect heterosexual men.
Additionally, perhaps these beliefs about dangerousness, desire for social distance, and negative emotional responses are driven by the understanding that young girls are affected by CSA at much higher rates than boys. Researchers have found that the percentage of CSA victims that are girls ranges from 69-91%, depending on the age group, which may lead people to view girls as more vulnerable and in need of protection (Hall & Hall, 2007, p. 526). Although it is possible that this prevalence rate carries sway in attitudes toward heterosexual vs. homosexual PPA, it is worth noting that the PPA in the current vignette had not committed any offense. The harm here might better be understood as moral, symbolic, or proactive. The vast majority of the research about attitudes toward heterosexual and homosexual male PPA describes instances where people have carried out sexual abuse (in contrast to PPA who have never committed a crime). It is a worthwhile consideration to question whether this distinction of action vs. attraction plays a role in these attitudes. Researchers should consider using this as an independent variable in future work.

**Pathological Language**

Whether or not the subject’s attractions were presented as a mental disorder had less bearing on the participants’ attitudes toward him, with the exception of affect and perceived effectiveness of therapy and medication. Whereas previous researchers have found that people exhibit harsher attitudes toward PPA when the clinical term “pedophilia” is used (Imhoff, 2015; Imhoff & Jahnke, 2018), the present study shows that participants reported more negative emotional responses to the subject when his attractions were described as non-pathological. One possible explanation for these diverging results is that participants in the previous studies may have conflated the terminology in their pathological condition—“[person with]
pedophilia”—but not the terminology in their non-pathological condition—“[person with] sexual interest in children”—with being a sex offender. This interpretation is substantiated by Walker et al.’s (2022) findings that alternating language between “pedophile” and someone who is “sexually attracted to children” elicited markedly different assumptions of criminality. In the present study, participants’ data were excluded if they reported believing that the subject had committed an illegal offense. It is, therefore, possible that the effect of “pathological language” in previous literature was actually driven by beliefs about criminal actions (i.e., CSA). Alternatively, one may think that the reduced ascriptions of blame toward those with pathologized behaviors might lend itself to less harsh attitudes toward pathologized PPA (Weiner et al., 1988), but, as described in more detail below, pathological language did not affect the participants’ tendency to blame the subject for his attractions. This leaves us with an open question of what mechanism was responsible for the differences in affective responses.

Surprisingly, the participants reported a stronger belief that therapy would be effective for treating the subject’s attractions when they were presented as non-pathological. This may come across as unintuitive, given that we might expect that a pathological phenomenon warrants treatment in the psychiatric sphere. However, it may be that this result occurred because the pathologized subject was described as being in therapy (and yet still had persistent symptoms), while the non-pathologized subject had never discussed his attractions with a mental health professional. There was a significant interaction between both independent variables on the perceived effectiveness of medication for treating the subject’s attractions. When the subject’s attractions were homosexual (i.e., toward prepubescent boys), participants perceived medication to be more effective for the non-pathologized subject. In contrast, when the subject’s attractions
were heterosexual (i.e., toward prepubescent girls), participants perceived medication to be more effective for the pathologized subject. Even though this finding was surprising and warrants some consideration, participants expressed an extremely minimal belief that medication would successfully “treat” the PPA’s attractions—across all conditions, the mean responses ranged from 2.11 to 2.63 out of a Likert scale of 0 to 6. So, while it may be the case that this interaction was statistically significant, overall, there is a firm perception that medication is not an effective remedy for PPA and the observed differences may not be meaningful or substantial in terms of their real-world impact.

Contrary to my hypotheses, neither sexual orientation nor pathological explanations of the attractions impacted the participants’ levels of moral approval or their ascribed blame to the subject for his attractions. These findings may be explained by the ceiling effect for moral disapproval (i.e., very high levels of disapproval) and the floor effect for blame (i.e., very low ascriptions of blame). Put in other words, because these responses were at the highest/lowest ends of the spectrum, there was not much room for differences between the groups. These ceiling and floor effects fit within existing evidence that attitudes toward PPA are very negative, which is likely driven by and/or driving moral disapproval (Feldman & Crandall, 2007; Imhoff, 2015; Imhoff & Jahnke, 2018; Jahnke et al., 2014; Jahnke et al., 2015b; Richards, 2018; Wurtele, 2018). As such, it would be counterintuitive to blame someone for a heavily condemned attribute.

The presentation of the subject’s desires as pathological or non-pathological did not affect how dangerous they perceived him to be or their desired social distance from him. This is inconsistent with a good deal of previous literature (Angermeyer & Matschinger, 2003; Imhoff &
Jahnke, 2018; Manago & Mize, 2022; Ohan et al., 2013), but upon further post hoc research, these findings are corroborated by Jorm and Griffiths (2008), who contend that the stigma of those with mental illness is driven primarily from the belief that the illness-related behavior is caused by personal weakness, rather than the biomedical conceptualizations of the psychiatric condition. This argument may account well for the findings in the current study, especially considering that blame did not differ between the Pathological and Non-Pathological Language groups.

On the whole, the current sample expressed a smaller desire for social distance compared to previous research that used similar materials (e.g., Jahnke et al., 2014). This may be due to some shift in societal attitudes toward PPA in general, given that some of the relevant research was conducted nearly a decade ago. Alternatively, this difference might be driven by the specific materials in the present study (i.e., the three-paragraph vignette about a particular PPA) compared to previous work, where participants were asked about their attitudes toward PPA as a collective, impersonal, group. Even though these findings point to evolving perspectives of PPA, we should not overlook that, despite how all participants clearly acknowledged that the subject had not committed a crime, 15.4% reported a belief that he should be incarcerated and 11.2% of participants endorsed the idea that he would "be better off dead."

**Exploratory Analyses**

With regard to the exploratory analyses, participants’ status as a parent or non-parent did, for the most part, play an important role in their attitudes toward the subject. The data strongly imply that parenthood is associated with harsher attitudes toward PPA, as demonstrated by the
significant effects of negative affect, sympathy/pity, perceived dangerousness, and resistance to accepting the PPA in their neighborhood.

One’s proximity to sexual trauma had more surprising results. Although heightened negative emotional responses were predicted, those with close proximity to sexual trauma also reported marginally higher levels of sympathy and pity, and a marginally smaller belief that the subject should be incarcerated. Perceived dangerousness and overall desire for social distance did not differ for this factor. Although it is beyond the scope of this paper, it is worth posing that these conflicting results may be due to the complicated nature of sexual abuse, and particularly pedophilia, in that child sex abuse is most often committed by a family member, family friend, or other person known to the child (Hall & Hall, 2007). Thus, while negative emotions may be more prominent for those with a history of sexual trauma, it also makes sense for these individuals to experience higher levels of pity/sympathy and a smaller desire to punish offenders through incarceration. Future research may benefit from specifically asking about the nature of trauma (e.g., whether it involves pedophilia or whether the perpetrator was well known). Moral disapproval was not affected by parenthood or proximity to sexual trauma, likely for the reasons described above.

Participants’ genders were associated with noteworthy differences across several dependent variables. Women reported significantly higher levels of negative affect, moral disapproval, and perceived dangerousness of the subject compared to participants who were men. This finding is consistent with existing work on the topic, showing that men tend to express less empathy toward victims of CSA, discredit victims at higher rates, and convey less negative attitudes toward sexual abuse (i.e., perceptions of legitimacy, severity, etc.) than women (Roger
& Davies, 2007; Bottoms et al., 2007). Interestingly, the sample of women in the current study agreed that the subject should be incarcerated significantly more than the non-binary sample did. This is partially\(^5\) substantiated by other researchers, like Wiley and Bottoms (2009), who found that jurors who were women were more pro-prosecution than were men. It is worth mentioning that the sample size of the non-binary group \((n = 22)\) in this study was quite small in comparison to the other gender groups \((n = 172\) for women and \(n = 297\) for men). Consequently, these conclusions should be interpreted cautiously. Nevertheless, this result about incarceration does point to interesting differences between gender groups beyond “Man” and “Woman,” which are frequently excluded in mainstream research. Thus, in addition to the novelty of this finding, it also underscores the importance of actively seeking and including non-binary perspectives in research.

**Limitations and Avenues for Further Research**

Although these findings substantiate the importance of pathological language and PPA’s sexual orientation, it is necessary to recognize several potential limitations of this study. The results should be interpreted with the understanding that the study relied on non-probability sampling. Online samples from sites like Prolific and Amazon Mechanical Turk are generally more heterogeneous populations than, say, samples entirely composed of undergraduate students. They may also have more sincere responses, as participants have more confidence in their anonymity. With this said, Prolific users (in general and those in this particular study) do not

\(^5\) “Partially” in the sense that it highlights a trend for women endorsing the prosecution of CSA perpetrators at higher rates than people of other genders. In this case of Wiley & Bottoms (2009) work, however, the comparison group was men. In the present study, there was no significant difference between men and women on this variable; there was only a statistically significant difference between the women and non-binary participants. And, another critical difference is that the PPA in the present study was not a CSA perpetrator.
represent the United States population—this is with regard to specific demographic variables, as well as the likelihood that they have a greater interest in sexuality-related topics or research, more generally, compared to the broader population. As such, it is imperative to frame the present findings within this particular sample.

I aimed to provide insight into the role of pathology in determining attitudes toward PPA, which was accomplished by manipulating the descriptions of pedophilic attractions in vignettes. Although these vignettes were noticeably different in terms of pathological/non-pathological language, it may be the case that participants’ preconceived notions about whether pedophilic attractions are pathological were not malleable (or not very malleable). Future studies should take this consideration into account and include manipulation checks to determine whether those in the Pathological Language condition viewed the phenomenon as more psychiatric than those in the Non-Pathological Language condition before exploring attitudinal measures.

This study serves as a starting point for understanding the ways that PPA’s sexual orientation influences attitudes toward them, but an important limitation is that homosexuality and heterosexuality were confined to male PPA. Because there are different stereotypes and schemas attached to subgroups in the queer community, there is much work to be done on this topic, including manipulating the PPA’s gender in more expansive ways (e.g., manipulating pronouns like he/him, she/her, and they/them). Given that this was an initial investigation of the topic, I prioritized having fewer conditions in order to maintain robust statistical power. The literature on attitudes toward female PPA and CSA involving women perpetrators is rich and points to a trend of negating abuse of underage boys by adult women. There is much work to be
done to determine whether the PPA’s gender impacts the findings about sexual orientation that I have presented.

**Conclusions**

This study provides insight into ongoing questions regarding which factors contribute to the stigma of those with pedophilic attractions, and, specifically, what the roles of sexual orientation and pathological language are in determining these attitudes toward PPA. Attitudes toward PPA were more negative—generally speaking—when the male subject’s attractions were toward young girls compared to young boys. Given the difficulty in discerning if the PPA’s sexual orientation or the child’s gender was more salient, there is considerable room for future research. Whether or not the subject’s attractions were presented as pathological influenced attitudes to a smaller degree, although participants had more negative emotional reactions to the subject whose attractions were described as non-pathological. This may be due in large part to the complex nature of psychiatric labels and how, across different circumstances, pathological explanations for deviant behavior may either be exculpatory or inculpatory.

It is imperative to amass research about the effects of pathology labels to discern if and how the inclusion of pedophilic disorder in the *DSM-5* impacts people’s attitudes toward PPA. This knowledge is critical to have informed arguments for or against retaining the mental disorder category, as well as demonstrating what sort of power the APA has on influencing attitudes toward groups like PPA. Taking the results of this study into consideration, it is tempting to say that framing pedophilia as a pathological entity does not have a substantial impact on attitudes toward people with these attractions. Furthermore, when it did impact attitudes in this experiment, the pathological labels dampened negative affective responses. This
finding is an important consideration in the ongoing debate about whether pedophilia should be pathologized.

Overarchingly, these findings have consequences for how we conceptualize the stigma of mental illness labels—for example, recognizing that applying pathological language to a phenomenon does not always result in harsher attitudes—as well as for understanding how the child’s gender in pedophilic fantasies or (theoretically) pedophilic actions contributes to attitudes about the PPA, their perceived dangerousness, and their desire for social distance.
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Appendix A

Participant Sociodemographic Characteristics

Table 1
Participant Sociodemographic Characteristics

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<th>Variable</th>
<th>N</th>
<th>n (%)</th>
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</tr>
<tr>
<td><strong>Gender</strong></td>
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<tr>
<td>Woman</td>
<td>172</td>
<td>(34%)</td>
</tr>
<tr>
<td>Man</td>
<td>297</td>
<td>(59%)</td>
</tr>
<tr>
<td>Non-binary</td>
<td>22</td>
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<tr>
<td><strong>Race &amp; Ethnicity</strong></td>
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<tr>
<td>Biracial or Multiracial</td>
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<td>(6.2%)</td>
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<tr>
<td>Black or African American</td>
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<td>(6.2%)</td>
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<tr>
<td>Hispanic, Latinx, or Spanish</td>
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<td>Middle Eastern</td>
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<td>(0.6%)</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>3</td>
<td>(0.6%)</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>(0.2%)</td>
</tr>
<tr>
<td>White</td>
<td>327</td>
<td>(65%)</td>
</tr>
<tr>
<td>Wish not to disclose</td>
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<td>(0.8%)</td>
</tr>
<tr>
<td><strong>Education Level</strong></td>
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</tr>
<tr>
<td>Some high school</td>
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<td>(3.0%)</td>
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<tr>
<td>High school or equivalent</td>
<td>91</td>
<td>(18%)</td>
</tr>
<tr>
<td>Some college</td>
<td>123</td>
<td>(25%)</td>
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<tr>
<td>Associate degree</td>
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<td>(9.2%)</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
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<td>(35%)</td>
</tr>
<tr>
<td>Graduate degree</td>
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<td>(10%)</td>
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1Mean (SD)

Table 1
Participant Sociodemographic Characteristics

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<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
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<td><strong>Parent or Non-Parent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>98</td>
<td>(20%)</td>
</tr>
<tr>
<td>Non-Parent</td>
<td>395</td>
<td>(79%)</td>
</tr>
<tr>
<td>I prefer not to answer</td>
<td>6</td>
<td>(1.2%)</td>
</tr>
<tr>
<td><strong>Religion Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not religious at all</td>
<td>276</td>
<td>(55%)</td>
</tr>
<tr>
<td>Not very religious</td>
<td>93</td>
<td>(19%)</td>
</tr>
<tr>
<td>Somewhat religious</td>
<td>99</td>
<td>(20%)</td>
</tr>
<tr>
<td>Very religious</td>
<td>33</td>
<td>(6.6%)</td>
</tr>
<tr>
<td><strong>Trauma Experience</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Close proximity</td>
<td>199</td>
<td>(40%)</td>
</tr>
<tr>
<td>No proximity (or distant)</td>
<td>280</td>
<td>(56%)</td>
</tr>
<tr>
<td>I prefer not to answer</td>
<td>22</td>
<td>(4.4%)</td>
</tr>
</tbody>
</table>
Appendix B

Institutional Review Board Approval

Bard College

Date: 12/15/2022
To: Gabriel Traub
Cc: Justin Dainer-Best; Nazir Nazari
From: Ziad M. Abu-Rish, IRB Chair
Re: Attitudes Toward People's Sexual Interests

DECISION: APPROVAL

Dear Gabriel Traub,

The Bard IRB committee has reviewed your revised proposal. Your application is approved through December 15, 2023. Your case number is 2022DEC15-TRA.

Please notify the IRB if your methodology changes or unexpected events arise.

We wish you the best of luck with your research.

Ziad M. Abu-Rish, Ph.D.
IRB Chair
Associate Professor of Human Rights and Middle Eastern Studies
Bard College
zaburish@bard.edu

Email: irb@bard.edu | Website: https://www.bard.edu/irb | Phone: 845-758-6822
PO Box 5000, Annandale-on-Hudson, New York 12504-5000
Appendix C

Experiment Preregistration

Preregistration Based on The OSL/OT Template

Preliminaries

Study Title:
- Attitudes Toward People’s Sexual Interests

Investigator’s Name and Affiliation:
- Gabriel Traub, Psychology Department at Bard College

Date of Preregistration:
- 02/09/2023

IRB Status (Choose one and delete the others):
- Approved, date: 12/15/2022

Variables

What are your independent/grouping/predictor variables (including mediators and moderators)? Explain how you operationalize each variable.
- The overarching research questions are: Do people’s attitudes towards pedophilic attractions change depending on whether the individual’s attractions are painted as a mental disorder? Do they change depending on whether the pedophilic attractions are toward children of the same gender? To answer these questions, this experiment will have a 2x2 between-subjects design in which the two independent variables are medicalized language (pathological, non-pathological language) and sexuality (heterosexual, homosexual). All participants will read one of four vignettes that briefly describe a fictional character’s pedophilic attractions. Half of the participants will be randomly assigned to the “pathological” condition—they will read materials that describe these attractions as caused by “pedophilic disorder” and include a notable amount of psychiatric terms. In the “non-pathological” condition, the character’s attractions will be identical, but there will be no mention of mental disorders, psychopathology, or other related terms. Half of the participants in each of these conditions will read that the subject’s attractions are exclusively toward children of a different gender, and the other half will read that the subject’s attractions are exclusively toward children of their own gender.

What are your dependent/outcome variables? Explain how you operationalize each variable.
- The dependent variable is attitudes, measured by participants’ self-reported affective responses (anger, disgust, fear, pity, sadness, sickness, sympathy), agreement with beliefs/stereotypes about the subject (acceptability, dangerousness, controllability, effectiveness of psychotherapy and medication), and their desired social distance from the subject. These variables will be measured with pre-validated instruments used in published research.
• **Affective responses:** For affective responses, participants will complete some of the items from Gutierrez and Giner-Sorolla’s (2007) scale for studying emotional states. Participants will report the intensity of their emotions from 1 (*not at all*) to 8 (*very much*). Each of the 7 emotion items included in the present study will thus have a score from 1 to 8. I will find Cronbach’s alpha for the 5 negatively valenced items (anger, disgust, fear, sadness, and sickness). If Cronbach’s alpha suggests robust consistency (> .80), I will average these 5 items and use this score as the outcome variable for a 2x2 ANOVA. If these items have a lower Cronbach’s alpha, each emotion will be input as a separate outcome variable in the ANOVA. I will use this same procedure for the two other emotions (pity and sympathy).

• **Acceptability/moral disapproval:** Participants will respond to Gutierrez and Giner-Sorolla’s (2007) brief 4-item questionnaire about moral approval/disapproval. Each item will be scored from 0 to 6. Higher scores indicate a greater level of moral disapproval. I will calculate Cronbach’s alpha to determine the consistency of this scale. If Cronbach’s alpha suggests robust consistency (> .80), the participants’ scores across all items will be averaged, and this composite score will be used as the outcome variable for a 2x2 ANOVA. If these items have a lower Cronbach’s alpha, each item will be input as a separate outcome variable in the ANOVA.

• **Dangerousness & Controllability:** Participants will respond to the Jahnke et al. (2015) questionnaires about perceived levels of dangerousness (four items) and controllability (three items). Participants are given statements and asked to rate how much they agree with them on a 7-point scale, from 0 (do not agree at all) to 6 (completely agree). For the dangerousness scale, two items (the first and fourth items) will be reverse-scored, so that higher scores indicate a higher level of perceived dangerousness. Similar to the previously mentioned scales, I will calculate Cronbach’s alpha to determine the consistency of all items (twice—once for each scale). If Cronbach’s alpha suggests robust consistency (> .80), the participants’ scores across all items (in one scale) will be averaged, and this composite score will be used as the outcome variable for a 2x2 ANOVA. If these items have a lower Cronbach’s alpha, each item will be input as a separate outcome variable in the ANOVA.

• **Effectiveness of psychotherapy and medication:** Participants will be presented with two items from Feldman and Crandall’s (2007) scale (originally 17 items) created to assess stigma toward those with mental disorders, including pedophilic disorder. These two items refer to how treatable the subject’s sexual attractions are with (1) medication, and (2) psychotherapy. Each item will be scored from 0 to 6. I will determine the consistency of these two items using Cronbach’s alpha. If Cronbach’s alpha is > .80, I will average the items and this composite score will be used as the outcome variable for a 2x2 ANOVA. If these items have a lower Cronbach’s alpha, each item will be input as a separate outcome variable in the 2x2 ANOVA.

• **Social distance:** Participants will be asked to complete the Social Distance Scale, originally created by Bogardus (1933), and more recently adapted by Jahnke et al. (2014). This Likert-style questionnaire contains six items and the responses are given on a 7-point scale, with answers ranging from 0 (do not agree at all) to 6 (completely agree). The positively formulated items will be reverse-coded such that higher scores represent
a higher level of desired social distance. I will calculate Cronbach's alpha for all items in this scale. If it is greater than .80, I will create a composite score that averages the scores from all items, and this will be used as an outcome measure in a 2x2 ANOVA. If Cronbach's alpha is lower, I will separate out the last two items, creating two composite (averaged) scores: (1) for the first four items; and (2) for the last two items. This is because the last two items are more extreme and they were added to the original Social Distance Scale (Bogardus, 1933) by Jahnke et al. (2014). For a finer-grained analysis, I will also separate all items and input each individually as an outcome measure in a 2x2 ANOVA.

List any exploratory variables. These are variables that you include in your study, but are not central to your main predictions.

- The exploratory variables in this study pertain to the degree to which demographic variables influence attitudes toward people with pedophilic attractions. These variables include age, gender, race, ethnicity, nationality, education level, whether the participant is or is not a parent, religion, and whether the participant or someone close to them has experienced sexual trauma.

Did you create new, or modify existing, variables for this study?

- Some variables were modified from their original form
- Some variables were created for this study

If you indicated above that 'Some variables were modified,' describe how you modified existing variables here:

- **Affective responses**: Initially, Gutierrez and Giner-Sorolla included 17 emotions in their scale, but I will retain fewer items in order to reflect my narrower research question (anger, disgust, pity, sadness, sickness, and sympathy). I will also add one emotion they did not initially include: fear.
- **Acceptability/moral disapproval**: In the original scale (Gutierrez & Ginger-Sorolla, 2007), the researchers asked participants to respond using a 9-point bipolar semantic scale. In the current study, I will modify this to be a 7-point scale. Additionally, the wording of each item will be adjusted from the original to refer to the specific fictional subject in this experiment (i.e. “James”). Gutierrez and Giner-Sorolla briefly explain their moral disapproval items: “the questionnaire contained four moral evaluation items: completely right/completely wrong, good/bad, correct/incorrect, and positive/negative” (p. 860). Using these items, the participants in the current study will be asked to indicate the extent to which James’ attractions are completely right/completely wrong, good/bad, correct/incorrect, and positive/negative. For example, participants will be given the following prompt for the first item “James' sexual attractions are.”.
- **Dangerousness & Controllability**: The two questionnaires from Jahnke et al. (2015) were designed to evaluate perceptions of people with sexual interests in children, and, as such, the only modification that I will make is to tie each item back to the subject in the present study (e.g. use of the subject’s name instead of general phrasing like “many people” or “somebody”).
- **Effectiveness of psychotherapy and medication**: Two items will be drawn from Feldman and Crandall’s (2007) scale that originally included 17 items: effectiveness of psychotherapy and medication for "treating" the subject's sexual attractions. Like the original scale, these items will have 7-point bipolar semantic differential response options. I will modify the wording to include the subject's name. For example, for the first item, participants will be prompted with "James' sexual attractions are:" before selecting a number between 0 (not treatable with medication) and 6 (treatable with medication).

- **Social distance**: All items from Jahnke et al.'s (2014) adapted version of the Social Distance Scale will be included in the present study. Instead of initially being prompted with "How do you feel about interacting with people who are dominantly sexually interested in children, but have never committed a crime?", participants will read "How do you feel about interacting with James?". I will modify this scale to include the character's name (e.g. "Would have James as a friend" instead of "Would have these persons as friends"). I will also change the wording of the last item to improve clarity—I will alter the initial wording from "These persons should better be dead" to "James would be better off dead".

If you indicated above that ‘Some variables were created for this study,’ list and describe the variables that you created for this study:

- I created four vignettes that describe a fictional subject's sexual attraction to prepubescent children. I manipulated two aspects of these vignettes: whether there were medicalized descriptions of these desires, and whether the attractions were heterosexual or homosexual. For the former, participants either read that the subject—James—has "Pedophilic Disorder" (pathological condition) or "sexual interest" or "attraction" to prepubescent children (non-pathological condition). In addition to these terms, the vignette for the pathological condition will include terminology related to psychiatry (e.g. symptoms, psychologist, etc.), and the vignette for the non-pathological condition will refrain from using these terms. With regard to sexuality, half of the vignettes include reference to James' desires as heterosexual (heterosexual condition) while the other half describes his attractions as homosexual (homosexual condition). This is achieved by alternating whether the children are described as “boy” (or “male”) or “girls” (or “female”). I have also created the items concerning demographic information.

**Hypotheses**

What are your primary study hypotheses / research questions?

*Mental illness labels*
- **Hypothesis 1a:** Compared to the non-pathological condition, the participants in the pathological condition will report greater degrees of negative emotions (i.e. anger, disgust, fear, sadness, sickness) toward the subject.

- **Hypothesis 1b:** Compared to the non-pathological condition, the participants in the pathological condition will exhibit more moral disapproval toward the subject on Gutierrez and Giner-Sorolla’s (2007) acceptability/approval scale.

- **Hypothesis 1c:** Compared to the non-pathological condition, the participants in the pathological condition will endorse the subject as more dangerous on the Jahnke et al. (2015) scale of dangerousness.

- **Hypothesis 1d:** Compared to the non-pathological condition, the participants in the pathological condition will desire more social distance from the subject as measured on the Jahnke et al. (2014) adapted social distance scale.

- **Hypothesis 1e:** Compared to the non-pathological condition, the participants in the pathological condition will blame the subject less for their attractions on the Jahnke et al. (2015) scale of controllability.

- **Hypothesis 1f:** Compared to the non-pathological condition, the participants in the pathological condition will endorse the subject’s attractions as more treatable with medication and psychotherapy on the Feldman and Crandall (2007) scale.

**Sexual orientation**

- **Hypothesis 2a:** Compared to the heterosexual condition, the participants in the homosexual condition will report greater degrees of negative emotions (i.e. anger, disgust, fear, sadness, sickness) toward the subject.

- **Hypothesis 2b:** Compared to the heterosexual condition, the participants in the homosexual condition will exhibit more moral disapproval toward the subject on Gutierrez and Giner-Sorolla’s (2007) acceptability/approval scale.

- **Hypothesis 2c:** Compared to the heterosexual condition, the participants in the homosexual condition will endorse the subject as more dangerous on the Jahnke et al. (2015) scale of dangerousness.

- **Hypothesis 2d:** Compared to the heterosexual condition, the participants in the homosexual condition will desire more social distance from the subject as measured on the Jahnke et al. (2014) adapted social distance scale.

**Do you have any exploratory hypotheses / research questions? If so, describe them below:**

**Demographics**

- **Hypothesis 3a:** Compared to non-parents, participants who are parents will endorse more negative attitudes toward the subject, as measured by their negative emotions, moral disapproval, belief about dangerousness, and desire for greater social distance.

- **Hypothesis 3b:** Compared to people who have not been closely impacted by sexual trauma, participants who report that they or someone close to them has experienced sexual trauma will endorse more negative attitudes toward the subject, as measured by their negative emotions, moral disapproval, belief about dangerousness, and desire for greater social distance.
At the time of preregistration, describe the status of data collection:
  ● Data collection has not started for this study.

Sampling
What is your target sample size?
  ● The target sample size for this project is 650 participants

How was your target sample size determined?
  ● An a priori power analysis was conducted using R (Version 4.2.2; R Core Team, 2022) for an ANOVA with four conditions. This analysis determined that the minimum sample size required to detect a small effect ($f = .15$) with 80% power and an alpha level of $\alpha = .05$, was $n = 123$ per condition.
  ● Target sized based on constraints / convenience (i.e. available money to pay participants)

How will you determine when to stop collecting data (i.e. your stopping rule)? (Delete all that do not apply)
  ● When the target sample size is reached or after the date of March 1, 2023.

Research Design
What type of research design are you using?
  ● Experiment

If you are conducting an experiment, what is the nature of the manipulation? (Delete all that do not apply)
  ● Between-participants

What is the total number of conditions in your study? (e.g. a 2 x 2 design that has 4 total conditions):
  ● There are four total conditions. This experiment has a 2 (pathological language, non-pathological language) x 2 (heterosexual, homosexual) design.

Will the experimenters be aware of the condition to which a particular participant has been assigned?
  ● Yes, the experimenter will be aware of the condition to which a particular participant has been assigned; however, the experimenter is not directly involved in the administration of the survey.

Will participants be randomly assigned to the condition?
  ● Yes
Data Analysis Plan

What will be your criterion for determining statistical significance?
- $p < .05$

Will your tests of significance be:
- Two-tailed

Will you exclude participants from data analysis based on any of the reasons listed below? (Delete all that do not apply)
- (1) Failed attention check. Participants who do not correctly answer a factual attention check ("Which of the following is not a fruit?") will be excluded from all analyses.
- (2) Missing data. Participants will be excluded from statistical analyses if they respond to fewer than 80% of the survey’s items. Participants who respond to greater than 80% of the survey’s total items will be excluded from statistical analyses for individual scales if they fail to respond to all items on a particular scale.

Describe any additional exclusion criteria here
- Participants must reside in the United States, be proficient in English, and be between the ages of 18 and 40.
- Participant’s data may be excluded if they complete the experiment considerably faster than the average completion time. Participants are outliers if the length of time that it takes them to complete the survey is greater than 2 median absolute deviations from the median.
- Participants who indicate that their data should not be used will also be excluded from all analyses.

What criterion (if any) will you use to determine whether a participant is an outlier? (Delete all that do not apply)
- Greater than 2 median absolute deviations from the median.

What statistical tests will you use to conduct your data analyses?
- Hypothesis 1a & Hypothesis 2a: I will conduct a 2x2 ANOVA.
- Hypothesis 1b & Hypothesis 2b: I will conduct a 2x2 ANOVA.
- Hypothesis 1c & Hypothesis 2c: I will conduct a 2x2 ANOVA.
- Hypothesis 1d & Hypothesis 2d: I will conduct a 2x2 ANOVA.
- Hypothesis 1e: I will conduct a 2x2 ANOVA.
- Hypothesis 1f: I will conduct a 2x2 ANOVA.
- Hypothesis 3a: I will conduct a two-sample t-test.
- Hypothesis 3b: I will conduct a two-sample t-test.

If relevant, describe what types of follow-up tests you will perform (e.g. Tukey post-hoc; simple main effects). If you will conduct planned comparisons, explain the nature of those comparisons below:
• If there is a 2x2 interaction, I will look at simple main effects.

For the analyses listed above, will you include any covariates or control variables? If so, describe them below and provide a justification

• The demographic variables will be used as covariates, particularly whether the participant is a parent or not, how religious they rate themselves to be, and whether the participant or someone close to them has experienced sexual trauma. These variables are of great interest to the present study given their empirically supported relationship to attitudes toward deviant sexual interests, including pedophilia.
Appendix D

Survey Items

INFORMED CONSENT

Principal Investigators
Gabriel Traub and faculty advisor Justin Dainer-Best, Ph.D.
Psychology Program
Bard College

Study Title
Attitudes Toward People’s Sexual Interests

Welcome to our study! Please read the following information carefully before proceeding.

Purpose & Study Procedure
The purpose of this project is to explore the perception of people with [sexual interests in children / pedophilic disorder]. If you agree to participate, you will be asked to read a fictional story. Afterward, you will be asked to complete a questionnaire about your feelings in response to this story. You will also be asked to provide us with basic demographic information, including your age, race, gender, nationality, religious identification, level of education, whether you are a parent, and whether someone you know has experienced sexual trauma. The total experiment should take approximately seven minutes. Your participation in this study is entirely voluntary and you may refuse to answer particular questions or withdraw completely from the study at any time without penalty.

Risks and Discomforts
We do not foresee any notable harm occurring as a result of this study. It is possible that the topic matter may feel uncomfortable or upsetting. If you find yourself in significant distress, please be aware that there are numerous resources that may be able to help you. For example, organizations like NAMI (https://nami.org/home) and the National Crisis Lifeline (able to call at 988) are available. If you anticipate experiencing considerable discomfort or upset at the prospect of reading about an adult’s sexual attraction to children, you should not proceed to the study. As a reminder, you may exit the study at any time by closing the browser window.

Benefits
The overarching goal of this study is to contribute to preexisting knowledge about attitudes towards people with [sexual interests in children / pedophilic disorder]. Although you are not likely to benefit directly from your participation, it is our hope that you will find the objective interesting and important to the field of psychology.

Compensation
This study should take approximately 7 minutes to complete. You will receive $1.00 in compensation for your time.

Confidentiality
In order to protect your anonymity, you will not be asked for any data that can be used to identify you. When completing the survey, all data will be automatically assigned a random participant ID that cannot be linked to your personal information. Additionally, all survey responses will be consolidated into password-protected locations and data will be deleted from Qualtrics servers. Although some data may be shared with other researchers, it will never be identifiable in any way.

Questions
If you have any questions about the study, you can contact Gabriel Traub at gt4552@bard.edu or Justin Dainer-Best, Ph.D. at jdainerbest@bard.edu. If you have questions about your rights as a participant, you can contact the Bard College IRB at irb@bard.edu.

By clicking the box below, you confirm that you are 18 years of age or older and you affirm your consent to participate in this study.

☐ I agree and wish to participate

(Additional acknowledgment of content)
I understand that by continuing to participate, I will be asked to read and respond to a brief description of a person with [a sexual interest in children / pedophilic disorder].

☐ I understand and wish to participate
☐ I do not wish to participate

(Vignettes)
ATTENTION CHECK

Has James committed an illegal sexual offense?
☐ Yes
☐ No

SCALES

Affective responses
From Gutierrez & Ginger-Sorolla (2007, p. 858)

On a scale ranging from 1 (not at all) to 8 (very much), to what extent did the story make you feel the following emotions?

<table>
<thead>
<tr>
<th></th>
<th>1 - Not at all</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8 - Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disgust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sadness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sympathy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Beliefs/Stereotypes
Acceptability/Moral (dis)approval from Gutierrez & Ginger-Sorolla (2007, p. 860)

<table>
<thead>
<tr>
<th>James’ sexual attractions are:</th>
<th>0 - Completely right</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6 - Completely wrong</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Good</td>
<td>1 2 3 4</td>
<td>5</td>
<td>6 - Bad</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - Correct</td>
<td>1 2 3 4</td>
<td>5</td>
<td>6 - Incorrect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - Positive</td>
<td>1 2 3 4</td>
<td>5</td>
<td>6 - Negative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dangerousness from Jahnke et al., 2015b, p. 4, 6)
### Controllability from (Jahnke et al., 2015b, p. 4, 6) and (Jahnke et al. 2014)

<table>
<thead>
<tr>
<th></th>
<th>0 - Do not agree at all</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6 - Completely agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>James’ sexual attractions are something that he can choose</td>
<td>0 - Not treatable with medication</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6 - Treatable with medication</td>
</tr>
<tr>
<td>James has taken a deliberate decision to have these sexual attractions</td>
<td>0 - Not treatable with psychotherapy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6 - Treatable with psychotherapy</td>
</tr>
<tr>
<td>James has the choice whether he has these attractions or not</td>
<td>0 - Not treatable with medication</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6 - Treatable with medication</td>
</tr>
</tbody>
</table>

### Effectiveness of psychotherapy and medication, adapted from a much longer itinerary from Felman & Crandall (2007, pp. 142-143)

<table>
<thead>
<tr>
<th>James’ sexual attractions are:</th>
<th>0 - Not treatable with medication</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6 - Treatable with medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>James’ sexual attractions are:</td>
<td>0 - Not treatable with psychotherapy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6 - Treatable with psychotherapy</td>
</tr>
</tbody>
</table>

### Action Tendencies

*Social distance* - An adapted version of the social distance scale from Jahnke et al. (2014), originally created by Bogardus (1923, 1295)
<table>
<thead>
<tr>
<th>How do you feel about interacting with James?</th>
<th>0 - Do not agree at all</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6 - Completely agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would have James as a friend</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would accept James in my neighborhood</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would accept James as a colleague at work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would talk to James</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>James should be incarcerated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>James would be better off dead</td>
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**DEMOGRAPHICS**

Please enter your age in years using numbers (e.g. “19”).
[text box]

With which gender do you identify?
- Woman
- Man
- Non-binary / gender-fluid / otherwise outside of the gender binary
- Wish not to disclose
- Other (please specify):

Which category/categories best describe you? Select all that apply.
- American Indian or Alaskan Native
- Asian
- Black or African American
- Hispanic, Latino, or Spanish Origin
- Middle Eastern or North African
- Native Hawaiian or Other Pacific Islander
- White
- Wish not to disclose
- Other (please specify):
What is your nationality (e.g. American)? If multiple, please separate with a comma.
[Text box]

What is the highest level of education you have completed?

☐ Some high school
☐ High school or equivalent (e.g. GED)
☐ Some college
☐ Associate degree
☐ Bachelor’s degree
☐ Graduate degree

The following question is to ensure you are paying attention.
Which of the items in this list is not a fruit?

☐ Banana
☐ Apple
☐ Brownie
☐ Strawberry
☐ Cherry

Are you a parent?

☐ Yes
☐ No
☐ I prefer not to answer

How religious do you consider yourself to be?

☐ Not religious at all
☐ Not very religious
☐ Somewhat religious
☐ Very religious

(If anything except “not religious at all”, ask them the following) What is your present religion?

☐ Protestant
☐ Buddhist
☐ Roman Catholic
☐ Hindu
☐ Mormon
☐ Atheist
☐ Jewish
☐ Agnostic
☐ Orthodox such as Greek or Russian Orthodox
☐ Muslim

☐ Something else (Please specify):

Have you, or someone you are close to, experienced sexual trauma?

☐ Yes
☐ No
☐ I prefer not to answer

DATA QUALITY CHECK

We care about the quality of our survey data. To get the most accurate measures of your opinion, it is important that you paid attention to the survey questions and answered them thoughtfully. Your response to the following question will not affect your compensation.

☐ You should include my survey answers in this study— I paid attention and provided thoughtful responses
☐ You should not include my survey answers in this study
Appendix E

Experiment Vignettes

VIGNETTES

Group 1A (Pathological Language x Heterosexual):

James is a 25-year-old man. Since James was in early adolescence, he became increasingly aware of his attraction to young girls. At first, he was unsure if it would be a phase, but since this period, he has exhibited a stable sexual interest in prepubescent girls and no sexual interest in women his age. He finds himself consistently fantasizing about the girls that he knows, fixating on female children he is attracted to in movies and television, and even volunteering as a mentor in extracurricular activities to be around young girls more.

James was diagnosed with Pedophilic Disorder by his psychologist shortly after graduating high school. This disorder is characterized by intense and recurrent sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children. The diagnosis requires that the individual be at least 16 years old and 5 years older than the children he is attracted to, all of which apply to James. Additionally, to receive this diagnosis, the individual must have either “acted on these sexual urges,” or experience distress related to their sexual attraction to children. James has never sexually offended against a child, but he does exhibit marked distress when he thinks about the people in his life finding out about his disorder.

For the past 5 years, James has attended weekly one-on-one therapy sessions with his psychologist, mainly to talk about coping with pedophilic disorder. This psychologist is the only person that James has disclosed his attractions to, and they have sworn to protect James’s confidentiality, unless they feel that he poses an immediate threat to himself or someone around him. James’s symptoms have been persistent and intense, but he is glad to talk about them with someone.

Group 1B (Pathological Language x Homosexual):

James is a 25-year-old man. Since James was in early adolescence, he became increasingly aware of his attraction to young boys. At first, he was unsure if it would be a phase, but since this period, he has exhibited a stable sexual interest in prepubescent boys and no sexual interest in men his age. He finds himself consistently fantasizing about the boys that he knows, fixating on male children he is attracted to in movies and television, and even volunteering as a mentor in extracurricular activities to be around young boys more.

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**Group 2A (Non-Pathological Language x Heterosexual):**

James is a 25-year-old man. Since James was in early adolescence, he became increasingly aware of his attraction to young girls. At first, he was unsure if it would be a phase, but since this period, he has exhibited a stable sexual interest in prepubescent girls and no sexual interest in women his age. He finds himself consistently fantasizing about the girls that he knows, fixating on female children he is attracted to in movies and television, and even volunteering as a mentor in extracurricular activities to be around young girls more.

James came to terms with his sexual attractions shortly after graduating high school. Upon doing some research, he found other people that have intense and recurrent sexually arousing fantasies, sexual urges, and/or behaviors involving sexual activity with a prepubescent child or children. These people are around his age for the most part (in his experience, they’ve been 16 years of age or older) with similar, if not more pronounced, age gaps between them and the children they are sexually attracted to. James has never sexually offended against a child and he feels considerable distress when he thinks about the people in his life finding out about his attractions.

For the past 5 years, James has attended weekly video calls with his close friend that he met online, mainly to talk about coping with his desires. This friend is the only person that James has disclosed his attractions to, and they have sworn to protect James’s confidentiality, unless they feel that he poses an immediate threat to himself or someone around him. James’s fantasies have been persistent and intense, but he is glad to talk about them with someone.

**Group 2B (Non-Pathological Language x Homosexual):**

James is a 25-year-old man. Since James was in early adolescence, he became increasingly aware of his attraction to young boys. At first, he was unsure if it would be a phase, but since this period, he has exhibited a stable sexual interest in prepubescent boys and no sexual interest in men his age. He finds himself consistently fantasizing about the boys that he knows, fixating on male children he is attracted to in movies and television, and even volunteering as a mentor in extracurricular activities to be around young boys more.
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