Preventing Child Sexual Abuse: Exploring Public Support for the Concept of Prehabilitation Services

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Child sexual abuse (CSA) is a significant concern affecting approximately 20% of children worldwide. Since most recorded CSA is committed by those without sexual convictions (84%), prevention efforts must be broad. Secondary prevention focuses on preventing escalation to harmful behaviour from at-risk individuals; approaches involving therapy can be termed 'prehabilitation.' Whilst there are limited examples internationally, prehabilitation viability in broader settings is unclear. One challenge could be public support. The aim of this study was to explore public opinion towards CSA prehabilitation amongst a sample from the general population in New Zealand (*N* = 721). Results showed that the majority were supportive: 82.6% following sample weighting procedures. Therefore, such services may be viable in New Zealand and potentially in other similar settings, and at minimum should not be challenged by a lack of public support.

Key words: *Child sexual abuse, Prevention, Prehabilitation, Survey, Public support.*

INTRODUCTION

Approximately one in five children experiences sexual abuse (Finkelhor et al., 2024), and many of these individuals face profound and lasting consequences. Impacts include higher rates of psychiatric disorders such as depression, anxiety, post-traumatic stress disorder, and substance use disorders, as well as interpersonal difficulties, diminished physical health, increased risk of revictimisation, and impaired sexual well-being (Fergusson et al., 2013; Macintosh et al., 2021). In fact, sexual victimisation during childhood has been considered the single most preventable contributor to child and adult mental illness (De Bellis, 2001). Given its high prevalence and severe consequences, preventing child sexual abuse (CSA) is a critical public health goal (Levenson & Grady, 2019b).

Societal approaches to reduce the occurrence of CSA often focus on tertiary level prevention (Leclerc et al., 2016). Tertiary prevention involves providing rehabilitative treatment or therapy (e.g., cognitive-behavioural therapy) to those convicted of CSA, with the aim of preventing further offending (World Health Organization, 1998). Meta-analytic research has demonstrated the effectiveness of this approach in terms of reduced recidivism (e.g., Gannon et al., 2019; Schmucker & Lösel, 2015). However, the majority of convictions for instances of CSA (approximately 84%) are received by individuals with no prior record of sexual offences (New Zealand Ministry of Justice, 2016). This figure could be even higher if offending that is never reported or recorded were taken into account. Therefore, while tertiary prevention efforts are vital, they fail to prevent the vast majority of child sexual offending that occurs (Beggs Christofferson, 2019).

Knack et al. (2019) argued that, due to the complexity of CSA, any effective prevention strategy must include primary, secondary, and tertiary prevention initiatives. Primary prevention refers to wide-scale initiatives aimed at the general public (e.g., enhanced sex education in schools), whereas secondary prevention involves interventions that are more closely targeted for those who are at-risk of engaging in sexually abusive behaviours towards children (Knack et al., 2019). While research has shown that not everyone who commits CSA has an enduring sexual interest in children (Gerwinn et al., 2018), sexual attraction to minors remains one of the most strongly supported empirical factors linked to the risk of sexual offending (Mann et al., 2010). Attraction to children can also be self-identified, regardless of whether an individual has ever acted on these attractions or been noticed by authorities for doing so (key for tertiary prevention access).

Secondary prevention efforts might maximise their impact by making therapeutic services available, not only at an earlier stage than tertiary, but specifically for individuals who experience sexual attraction towards children (sometimes referred to as "minor-attracted persons" or MAPs, e.g., Levenson & Grady, 2019b). Such a secondary prevention approach, involving therapy, has been termed *prehabilitation* (Beggs Christofferson, 2019) to highlight both the similarities and differences with tertiary, prison-based rehabilitation. Indeed, preliminary research in Germany has demonstrated some success when prevention efforts are targeted towards minor-attracted persons (Beier et al., 2015). However, there are many barriers to implementing this type of prehabilitation approach in a broader setting (e.g., stigma, limited public and political support, funding restraints, legal complexities, and confidentiality concerns; Parr & Pearson, 2019). In this study, we focused on the potential barrier of public opinion. Specifically, we explored whether the public supported the establishment of a prehabilitation service in New Zealand.

Minor-Attracted Persons (MAPs)

MAPs can be defined as "adults who experience feelings of preferential sexual attraction to children or

adolescents under the age of consent" (B4UAct, n.d.). The term MAP provides an alternative to highly stigmatised diagnostic labels such paedophile, often misunderstood by the general public (Combridge & Lastella, 2022). MAPs may differ from those convicted of sexual offences in many ways; most importantly, MAPs may not have acted upon their attraction to minors (Cantor & McPhail, 2016). Researchers have estimated that approximately 3%-5.5% of adult men in the general population report some level of sexual attraction towards children (Alanko et al., 2013; Dombert et al., 2016).

The small but growing body of literature regarding MAPs as a group has revealed that these individuals are often distressed by their sexual interest (Schaefer et al., 2010) and will engage in preventative help (Beier et al., 2009), but ultimately are faced with many obstacles in seeking treatment. Samples of MAPs have reported that barriers to seeking and receiving help include concerns around confidentiality, fear of negative reactions and judgment, societal stigma, inability to find an appropriate therapist, unaffordability and unavailability of help (Levenson & Grady, 2019b; Levenson et al., 2017). Unfortunately, many MAPs who had sought counselling services reported negative experiences, such as judgmental therapists, breaches of confidentiality, lack of compassion, and assumptions of criminal behaviour – factors that have deterred them from seeking further help (Houtepen et al., 2016; Levenson & Grady, 2019b).

In response to the barriers faced by help-seeking MAPs, Prevention Project Dunkelfeld (Beier et al., 2009) was established in Germany, as an early example of therapeutic secondary prevention or prehabilitation. Dunkelfeld was run within a university hospital-based outpatient clinic, and provided an alternative, specialist treatment approach that MAPs in the community could self-refer to. Dunkelfeld offered confidential treatment on a voluntary self-referral basis to individuals who were sexually attracted to children and feared they might act on that attraction by engaging in sexual offending against a child or children. Treatment was offered in group and individual settings and included cognitive-behavioural, sexological, and medicinal approaches (Beier et al., 2009). An evaluation of the programme revealed that participants who received treatment reported lower levels of loneliness, emotion-oriented coping, victim empathy deficits, pro-CSA attitudes, coping self-efficacy deficits, and sexual preoccupation, compared to their pre-treatment scores. The effect sizes for these improvements ranged from medium to large and were still present at one-year follow-up (Beier et al., 2015).

Barriers to the Implementation of Prehabilitation

Although a few systemic prehabilitation approaches have shown promise internationally, their broader viability remains unknown. Legal barriers, funding, and public support comprise just some of the many challenges associated with potential implementation (Christofferson, 2017). For instance, unlike Germany, New Zealand's legislation regarding CSA and confidentiality is comparatively unclear, with confidentiality essentially left to the discretion of the practitioner under the provisions of legislation including the Privacy Act (2020), and the Health Information Privacy Code (2020). Given that concerns about confidentiality are a critical issue affecting help-seeking likelihood among MAPs (Levenson et al., 2017; Levenson & Grady, 2019b), prehabilitation viability may depend on practitioner norms for discretionary decision-making placing a high value on therapeutic confidentiality and taking a research-informed (rather than knee-jerk) approach to considerations of risk (Beggs Christofferson, 2019). Another challenge relates to the substantial resources and funding required to establish and operate such a service. Finally and relatedly, public support, or lack of it, may also act as a challenge to the establishment of prehabilitation services (Christofferson, 2017).

Public Opinion

Public opinion refers to the collective opinion of many individuals on specific issues or problems, and in a democratic society, is often very persuasive in influencing change (Burstein, 2003). In relation to prehabilitation establishment, public opinion could have a direct influence on implementation (e.g., directly impacting government-level decision-making), as well as an indirect influence on implementation and maintenance (e.g., influencing the likelihood of public funding).

The importance of public opinion has become increasingly apparent in policies and laws regarding those convicted of sexual offences (Socia & Harris, 2016). In the US, for example, public concern has influenced the creation of non-evidence-based laws such as Megan's Law (1996), which requires authorities to make information about those convicted of sexual offences available to the public. Public fear has also initiated policies such as the widespread use of community notifications, restrictions on where convicted individuals can reside and work, as well as lifetime monitoring of their internet use (Socia & Harris, 2016). Public concern around perceived risk has meant that many such laws and policies have remained in place for decades, despite such concerns being based on misperceptions and myths with little empirical evidence to support policy efficacy (Socia, 2012). In fact, in some instances, research has indicated that over-restrictive laws and policies may be compromising public safety by preventing the reintegration of those convicted of sexual offences back into society (Levenson, 2008).

Not only has public opinion promulgated an array of non-evidence-based and potentially harmful laws and policies, but it has also contributed to the cessation of evidence-based treatment programmes aimed at those convicted of sexual offences. In the UK, for example, local opposition and public protests resulted in the cessation of a residential treatment programme, leaving the country without this necessary facility for a time (Brown, 2013). Similarly, McPherson et al. (1994) noted that many community-based sex offender treatment programmes in the US had closed in the ten years prior due to persistent public complaints. In the UK, public campaigning has also impeded attempts to obtain planning permission for evidence-based residential treatment clinics for those convicted of sexual offences (Brown, 2013). Overall, it is clear that public opinion can have an important influence on outcomes and has the potential to act as a barrier to implementing change,

particularly when the issue at hand is controversial and/or involves stigmatised populations. No studies to date have explored public opinion towards prehabilitation services aimed at MAPs.

This study sought to explore public support for the potential establishment of prehabilitation services. Such knowledge will (1) provide preliminary estimates of the current level of public support, (2) indicate whether such a service may be viable in New Zealand and similar settings, and (3) potentially provide a data-based resource to help make the case for prehabilitation establishment. In addition, the present study also explored public perceptions of the various benefits and concerns relating to such a service. Given the potential influence of public concerns, it is important to understand specific concerns the public may have regarding prehabilitation, particularly if overall support is low. It is also important to understand the perceived benefits of the service; such knowledge may provide information to assist in garnering further support from the greater public, and policy-makers.

METHOD

Participants

A total of $N = 721$ participants aged 18 years or older and residing in New Zealand took part in the survey. Sample description information is presented in the results section below. Participants were recruited from across New Zealand via online social media platforms, including Twitter, Neighbourly, and Facebook. Facebook advertising consisted of researcher-placed advertisements (i.e., posting on various community-based pages in New Zealand), and paid advertising to specifically target underrepresented groups. This study was approved by the University of Canterbury Human Ethics Committee (Ref. 2017/43). All participants provided informed consent and were offered an incentive of entering into a draw to receive one of five gift voucher prizes.

Materials and Procedure

A survey was designed using the Qualtrics platform. The survey took approximately 10 minutes to complete, and assessed four general areas: support for prehabilitation services; perceived benefits and concerns around the service; personal relevancy of CSA; and demographic information. Survey content was devised by the authors but influenced by information from previous studies regarding public opinion towards sex offenders (e.g., Brown, 1999; Levenson et al., 2007).

Upon clicking through to the survey, participants were initially presented with an information sheet on the study. In addition to providing information necessary for informed consent, the information sheet also provided a consistent description of a prehabilitation service for all participants to read before progressing to respond to survey questions. A prehabilitation service was described as a service allowing individuals who experience child-related sexual thoughts and fantasies to receive confidential treatment on a self-referral basis. To attempt to minimise the common general public conflation between minor-attraction and abusive behaviours amongst participants, the information sheet further clarified that a prehabilitation service was targeted at those who had not committed an offence, but may be at risk given their experience of child-related thoughts and fantasies.

Support for the idea of prehabilitation services in New Zealand amongst survey respondents was initially gauged using a simple multiple-choice response option of *yes*, *no*, or *maybe*. To provide further insight, participants were then asked to rate the extent of their support or non-support. Those who had initially stated *yes* or *no* responded to a 5-point polar Likert-type scale ranging from *somewhat* to *strong* regarding the extent of either their support or non-support (respectively). Those who had initially stated *maybe* responded to a 10-point (i.e., forced-choice) scale that merged both polar scales. This design allowed an analogous representation to be collected regarding all participants' extent of support.

To capture perceived benefits and concerns of participants regarding prehabilitation, all participants (regardless of their initial response regarding support) were presented with a list of potential benefits and concerns and asked to select all they agreed with. The benefits and concerns presented can be viewed in Table 2 of the Results section.

Participants were then asked to provide demographic information (i.e., age bracket, gender, ethnicity, education level, and current child-caregiver status) and were lastly asked whether the subject of CSA was personally relevant to them, with the option to select as many as applicable from the following: *yes, I was a victim*; *yes, someone close to me was a victim*; *yes, someone close to me would be within the target population for this prehabilitation service*; *yes, I would be within the target population for this prehabilitation for this prehabilitation service;* and *no, this topic has no personal relevance to me*.

Analyses

All data were analysed using SPSS version 23. First, simple descriptive analyses (i.e., frequencies and proportions) were produced to explore sample breakdowns on demographic variables and CSA personal relevance, as well as prima facie support for prehabilitation.

Given that participants were a self-selected convenience sample from the general population, as opposed to randomly or representatively sampled, chi-square analyses were used to: 1) explore whether any differences in prehabilitation support were evident across demographic variables including gender, ethnicity, age, education, child caregiver status, and CSA personal relevance; and 2) explore sample representativeness relative to what would be expected based on publicly available data on actual New Zealand population breakdowns (Statistics New Zealand, 2014a). These procedures allowed case weightings to then be applied to the data where appropriate, in order to produce a weighted estimate of the true proportion of prehabilitation support.

Frequency of endorsement was analysed for the benefit and concern variables. Differences in the likelihood of support linked to endorsement of each of the benefit and concern variables were examined using chi-square comparisons. Finally, chi-square analyses were performed to examine differences in benefits and concerns across demographic variables.

RESULTS

Sample Description

Demographic information for the sample is presented in Table 1. As can be seen, the majority (80.6%) identified as female, and the most common age bracket was 18-25 years (38.7%). Nearly three-quarters (73.9%) identified as Pākehā/New Zealand European ethnicity, and 12.1% Māori, with smaller proportions identifying as Asian, Pasifika, other European, and other ethnicities (participants could select multiple ethnicities therefore total percentages sum to greater than 100%). Most participants reported their highest qualification was high school level (41.8%).

Almost a third of participants (31.4%) reported currently being a primary caregiver to one or more children under the age of 16.

Table 1. Sample Demographics (N = 721)

Characteristic	*n*	%
Gender		
Female	581	80.6
Male	134	18.6
Other	6	0.8
Age		
18-25	279	38.7
25-39	175	24.3
40-54	145	20.1
55-64	78	10.8
65+	44	6.1
Ethnicity		
Pākehā/NZ European	591	82.0
Māori	97	13.5
Pasifika	15	2.1
Asian	29	4.0
Other European	37	5.1
Other	32	4.4
Education		
Did not Complete High School	54	7.5
High School Qualification	301	41.7
Bachelor's Degree	254	35.2
Postgraduate Degree	112	15.5

Regarding personal relevance of child sexual abuse, a large proportion of participants (54.3%) reported that the topic of CSA had no personal relevance for them. Approximately one fifth (18.0%) stated they had personally experienced child sexual abuse as a victim/survivor, while 29.9% of participants reported that someone close to them had been victimised. Smaller proportions reported that either themselves or someone close to them would be within the target population for this service (i.e., MAPs; 2.4% and 4.4% respectively). It is notable that sample proportions of personal CSA victimisation histories and personal MAP status both mirrored published international general population estimates (Alanko et al., 2013; Finkelhor et al., 2024). Across the personal relevance variables, again, since participants could select more than one option, percentages total greater than 100%.

Support for Prehabilitation

The prima facie (i.e., unweighted) proportion of support for prehabilitation implementation in New Zealand amongst the sample was 85.3%, with $n = 615$ of the $N = 721$ total sample responding *yes* (and $n = 11$ and $n = 95$ responding *no,* or *maybe*, respectively).

When asked to rate the extent of their support, supportive participants ($n = 615$) on average reported that they were strongly supportive of prehabilitation services ($M = 4.32$, $SD = 0.94$). In contrast, non-supporting participants ($n = 11$) tended to only moderately oppose the idea ($M = 2.45$, $SD = 1.64$).

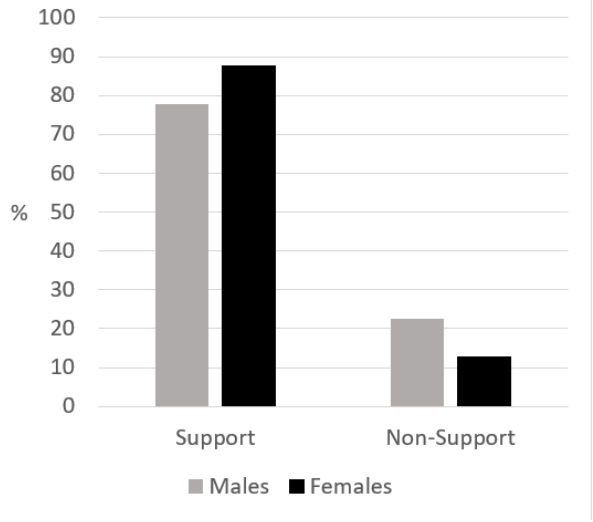
On the merged 10-point forced-choice Likert-type scale ranging from strongly oppose to strongly support, participants who initially responded *maybe* swayed on average towards support ($M = 5.92$, $SD = 1.72$). Combining all 721 participants' responses onto the 10-point scale revealed a clear skew towards the strongly supportive pole, with 92.8% choosing a response option above the midpoint (i.e., between 6 and 10 on the scale; $M = 8.77$, $SD = 1.76$).

Differences in Support Across Demographic Variables

To enable chi-square comparisons across demographic variables and avoid low expected cell sizes where possible, some variables were first re-coded and some categories collapsed. Specifically, given the small number of participants identifying their gender as "other" ($n = 6$), analyses involving gender only compared between those who identified as male or female. Age was reduced to four categories, with individuals aged *50-64* and *65+* being collapsed into one group, given the relatively small proportion of participants across these brackets. *Other* and *Other European* ethnicity categories were collapsed to reduce to five categories. Participants who had identified as multiple ethnicities were allocated to a single ethnicity category for chi-square analyses using a prioritisation approach (see Cormack & Robson, 2010), prioritising allocation to, in order, Māori, Pasifika, Asian, Pākehā, and lastly, Other. Education was re-coded across two levels: those who completed tertiary education (bachelor's and postgraduate degrees); and those who did not (did not complete high school and high school qualification). Finally, given that only eleven participants indicated that they did not support the implementation of prehabilitation services, to enable chi-square analyses individuals who indicated either *maybe* or *no* in terms of support were collapsed into a single group, which will be referred to as "non-support."

Chi-square tests revealed significant differences in likelihood of prehabilitation support between males and females (χ^2 (1, 715) = 8.52, p =.004), indicating an interaction effect in which females were more likely to support the implementation of prehabilitation services relative to males (the interaction effect is depicted below in Figure 1).

Figure 1. Prehabilitation Support for Males (n = 134) and Females (n = 581)



No significant effects were found for any of the other descriptive variables in terms of differences in prehabilitation support versus non-support. Results showed that the likelihood of support did not differ between age category (χ^2 (4, 715) = 4.73, p =.19), education status (χ^2 (1, 715) = 3.80, p = .65), child caregiver status (χ^2 (1, 715) = 0.01, p = .93), or any of the CSA personal relevance variables (all p's > .05). Ethnicity differences in support were approaching significance (χ^2 (4, 715) = 9.07, p = .06), with a non-significant trend for those identifying as Pākehā/New Zealand European to support prehabilitation more so than other ethnic groups, particularly those who identified as Pasifika.

Sample Representativeness

Our sample was comparable to general population distributions in many regards, however overrepresentation and underrepresentation of specific groups were apparent for certain variables. Compared to general population data (Statistics New Zealand, 2014b), females were overrepresented in our sample, leaving males underrepresented (χ^2 (1, 715) = 261.97, p < .001). Significant differences in the sample breakdown of age were also found relative to what would have been expected if our sample was representative of the New Zealand population (χ^2 (4, 715) = 421.19, p < .001). Relative to what would have been expected, significant differences in the sample breakdown of ethnic identity were also apparent (χ^2 (4, 715) = 398.24, p < .001).

Weighted Support

Considering that the likelihood of support significantly differed between males and females in our sample, coupled with the over-representation of females compared with the New Zealand population, case weightings based on gender were applied to the data set to provide a more representative estimate. This procedure produced a lower estimate of 82.6% support, compared to the aforementioned unweighted result of 85.3%.

Although sample overrepresentation and underrepresentation were also evident in relation to age, and ethnicity, given that these demographic variables did not significantly impact prehabilitation support, no further case weightings were applied.

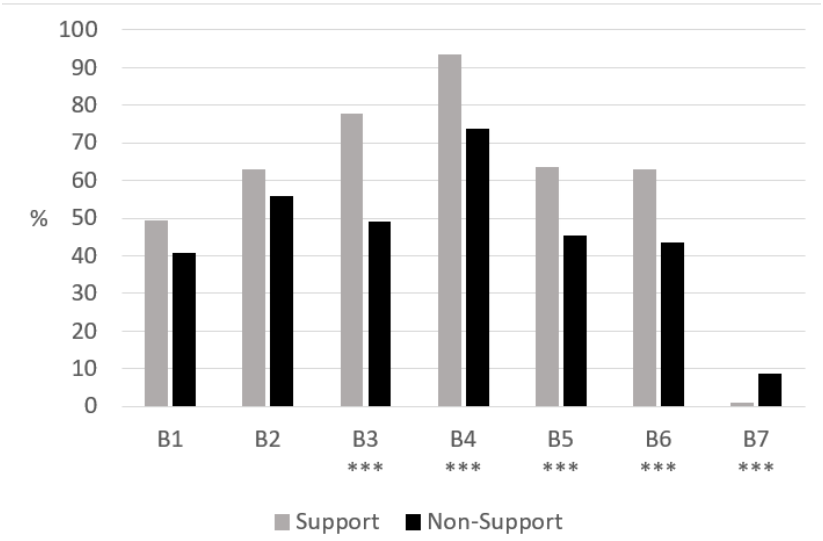
Benefits and Concerns

Table 2 displays the proportion of the sample who reported that they agreed with the various benefits of and concerns about prehabilitation services presented to them in the survey. As can be seen, while endorsement of benefits was typically high (ranging between approximately 50-90% of the sample), endorsement of concerns tended to be lower. The one exception was the concern that the individuals most in need may not use the

Table 2. Proportion of Sample Agreeing with Benefits and Concerns Regarding Prehabilitation (N = 721)

Benefits	%	Concerns	%
B1 It may decrease the risk of sexual abuse for myself/family	48.1	C1 It may not be successful in reducing child sexual abuse	52.7
B2 It may provide a sense of safety to caregivers and children	61.7	C2 It may require public funding and compete with other essential resources for funding	51.5
B3 It may improve quality of life (QOL) for individuals at risk of offending (MAPs)	73.4	C3 I wouldn't want this service located in my community	13.5
B4 It may reduce the number of new child sexual abuse incidents	90.3	C4 I wouldn't want these individuals to remain anonymous in my community	25.0
B5 It may reduce child sexual abuse more so than other prevention methods	60.7	C5 It may induce a false sense of safety, evoking complacency and reducing awareness of dangerous situations	45.4
B6 It may reduce the amount of public funding spent on offender incarceration and victim recovery	60.1	C6 The individuals most in need may not use the service	77.0
B7 I do not agree with any of the potential benefits above	1.8	C7 It may not be as successful as other prevention programmes	23.2
		C8 It may be a waste of time and resources; child sexual abuse is not a significant problem in New Zealand	3.5
		C9 I do not agree with any of the potential disadvantages above	6.7

Figure 2. Support Differences Across Benefits (N = 721)



Note. Asterisks indicate a significant difference between those who indicated support for prehabilitation and non-supporters in agreement with a benefit based on chi-square analyses; see Table 2 for full wording of benefits; *p < .05. **p < .01. ***p < .001.

service, which over three-quarters (77.0%) of the sample agreed with.

Differences in Benefits and Concerns Across Support

Chi-square tests were performed for each benefit and each concern to explore whether differences were apparent in patterns of endorsement between those who supported prehabilitation and non-supporters. As might be expected, individuals who initially indicated support for prehabilitation services were generally more likely to agree with the benefits relative to the non-supporters. Specifically, prehabilitation supporters were significantly more likely relative to non-supporters to agree that prehabilitation may improve the quality of life for MAPs (B3; χ^2 (1, 715) = 37.60, p < .001), may reduce the number of new CSA incidents (B4; χ^2 (1, 715) = 39.57, p < .001), may reduce CSA more so than other prevention methods (B5; χ^2 (1, 715) = 12.47, p < .001), and may reduce offending-related public costs (B6; χ^2 (1, 715) = 14.38, p < .001; see Figure 2). Unsurprisingly, compared to non-supporters, supporters were significantly less likely to indicate that they did not agree with any of the benefits (B7; χ^2 (1, 715) = 31.39, p < .001). Differences for B1 and B2 were non-significant.

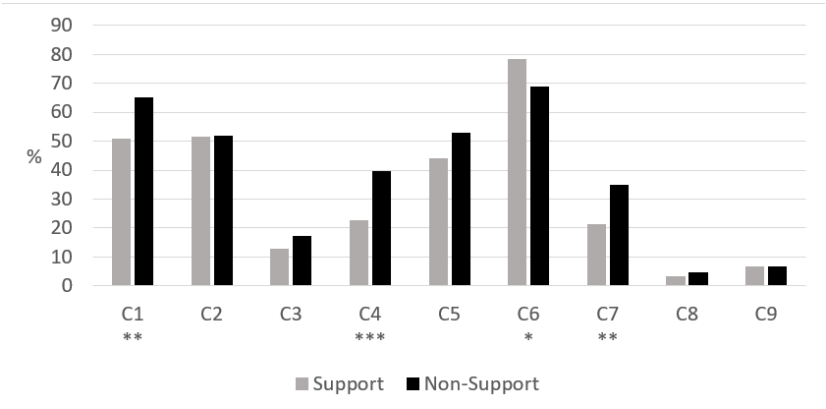
Those who indicated their support for prehabilitation were significantly more likely to endorse the concern that the individuals most in need may not use the service (C6; χ^2 (1, 715) = 4.61, p = .032). In relation to the other concerns, however, the trend was the opposite, with non-supporting individuals tending to indicate greater concern endorsement relative to supporters. These differences were significant for the concerns that prehabilitation may not be successful in reducing CSA (C1; χ^2 (1, 715) = 7.65, p = .006), that it may not be as successful as other prevention programmes (C7; χ^2 (1, 715) = 9.63, p = .002), and that respondents would not want MAPs to remain anonymous in the community (C4; χ^2 (1, 715) = 14.25, p < .001; see Figure 3 below).

Differences in Benefits and Concerns Between Males and Females

Given that gender was found to be associated with likelihood of support, a final set of chi-square analyses were carried out to compare benefit and concern endorsement between males and females. Significant differences were found for a number of variables. Females were significantly more likely than males to agree that prehabilitation may reduce new CSA incidence (B4; χ^2 (1, 715) = 11.23, p < .001) and that it may reduce the amount of public funding spent on offender incarceration and victim recovery (B6; χ^2 (1, 715) = 7.28, p = .007). Females were also more likely than males to agree with two concerns, specifically, that prehabilitation may compete with other essential resources for funding (C2; χ^2 (1, 715) = 5.60, p = .018), and that the individuals most in need may not use the service (C6; χ^2 (1, 715) = 8.09, p = .004).

In contrast, males were significantly more likely relative to females to indicate that they did not agree with either any of the potential benefits (χ^2 (1, 715) = 7.83, p = .005), or any of the concerns (χ^2 (1, 715) = 7.19, p = .007).

Figure 3. Support Differences Across Concerns (N = 721)



Note. Asterisks indicate a significant difference between those who indicated support for prehabilitation and non-supporters in agreement with a concern based on chi-square analyses; see Table 2 for full wording of concerns; *p < .05. **p < .01. ***p < .001.

DISCUSSION

This study sought to explore public support amongst people living in New Zealand for the establishment of prehabilitation services. We found evidence for a high level of general public support in the current setting, such that even after applying case weightings to account for sample over-representation of females (who were more likely than males to indicate support for prehabilitation), more than four out of every five individuals on average expressed support (82.6%). Furthermore, the degree of that support appeared to be strong, whilst for the non-supporting individuals, strong disapproval was seldom reported. Overall, it appears that the general public may be rather accepting of prehabilitative initiatives aimed at the prevention of CSA.

Prehabilitation support appeared consistent across demographics, with the exception of gender; as noted, females were more inclined to be supportive of prehabilitation relative to males. This difference could be a function of perceived treatment efficacy, given the finding that females as a group showed greater confidence than males in the potential success of prehabilitation for reducing CSA (as a benefit). Another possibility, however, is that males in the sample were less conscientious about filling out the survey, or simply less interested in the subject at hand, perhaps making them more inclined to indicate "maybe." This explanation could be viewed as reinforced by the counterintuitive finding that despite males in our sample being less likely than females to support prehabilitation establishment, males were also less likely to agree with any of the potential concerns – note that the same was true of benefits. As such, it could be that there are no true gender differences in prehabilitation support, or at least less pronounced than our findings suggested. Given that ethnic group differences in support were approaching significance, it could be that significant differences would emerge with a larger sample. Future research should examine this possibility, particularly given the ethnic diversity of the New Zealand population. If particular communities are more likely to oppose the concept of prehabilitation, this would be important to be aware of and could highlight the need for culturally responsive awareness campaigns to reduce stigma-related barriers to access for MAPs in these settings.

The current sample endorsed several potential benefits of a prehabilitation service, and some concerns, to varying degrees. Given that more than half of the participants in this study (both supporting and non-supporting) expressed concern that prehabilitation may not be successful in reducing CSA, and may not be utilised by those who need it, it is possible that many individuals may be concerned with treatment efficacy. Public awareness campaigns that highlight the utilisation rates and positive effects of existing services, such as Prevention Project Dunkelfeld, could prove useful in further increasing and strengthening support. Future research evaluating any new prehabilitation initiatives would also be important. Given that CSA incidence reduction was the most commonly endorsed benefit across all participants in the current study, this suggests that the general public sees value in an effective and successful service.

While many respondents agreed with the personal and societal benefits of prehabilitation (i.e., reduction in personal risk of sexual abuse, overall reduction in CSA incidence, increased sense of safety, reduction in offending-related expenses), the majority also agreed with benefits relating to the intended clientele. Overall, nearly three-quarters (73.4%) agreed that prehabilitation services may improve the quality of life for MAPs. This indicates that, to some extent, New Zealanders have a basic level of understanding and compassion towards this group and consider them worthy of help. Such findings are promising in light of previous research regarding negative attitudes held towards individuals who had committed a sexual offence (Thakker, 2012; Willis et al., 2013) and towards MAPs (Combridge & Lastella, 2022). While it would seem, therefore, that MAPs tended to be perceived as worthy of help by the sample overall, there were significant differences between supporters and non-supporters (77.8% vs 49.5% agreement with B2, respectively). Perhaps non-supporting individuals hold some degree of stigma towards MAPs, given that they were substantially less likely to endorse improved quality of life for MAPs as a potential benefit. Thus, initiatives designed to reduce such stigma (such as via a media campaign) may be another useful starting point to increase general levels of support. It is important to note that reducing stigma towards MAPs may also be important for increasing the likelihood that these individuals will seek help from such services (Grady et al., 2018).

Brown (2013) highlighted the problematic nature of particular public concerns regarding treatment for those convicted of sexual offences, for example, people not wanting the service in their own community. Brown concluded that widespread adoption of such attitudes had the potential to terminate existing community-based programmes. Fortunately, such attitudes regarding prehabilitation services were evident for a minority of the current sample only, with 13.5% indicating that they did not want this service located in their community. What may be problematic, however, is the fact that 25.0% of the sample did not want individuals receiving prehabilitation services to remain anonymous in their community, despite therapeutic confidentiality being a potentially essential component of prehabilitation success (Levenson & Grady, 2019b). Again, this concern was disproportionately endorsed by the non-supporters, further highlighting the potential importance of a stigma-reducing initiative for this group.

Overall, our results indicated that the general public, in New Zealand at least, is rather accepting towards the idea of prehabilitation, and would support its implementation to benefit themselves, their society, and those MAPs in need. Consequently, prehabilitation services may indeed be a viable prospect to work towards, and at minimum, should not be negatively affected by a lack of public support. This high level of public support, to the extent that this knowledge is disseminated and widely understood, may also minimise the other barriers apparent in establishing a prehabilitation service. For example, In New Zealand, where confidentiality is at the discretion of the practitioner, practitioners' awareness of high public support for prehabilitation may reduce the likelihood of them taking a blanket highly risk-averse stance in relation

to client disclosures of sexual attraction towards children (i.e., they may feel more supported and thus confident in seeking to address questions of potential risk through therapeutic means as opposed to through breaches of confidentiality). The high level of public endorsement that the current study has shed a light on may therefore increase the viability and likelihood of prehabilitation service establishment both directly and indirectly, and ultimately potentially contribute to reducing the incidence of CSA.

Limitations

Although attempts were made to provide an accurate and representative estimate of prehabilitation support within the current setting, New Zealand, and particularly to account for the impact of the underrepresentation of males, selection biases may still have influenced results. Participants were self-selected volunteers recruited via social media (i.e., a convenience sample), and consequently, the sample may overrepresent individuals who have strong views one way or another regarding prehabilitation services or MAPs. To avoid problems associated with such selection bias, future research could endeavour to recruit participants on a randomised basis (for instance, randomly recruiting based on eligible registered voters, following Levenson et al., 2007). Doing so would provide greater confidence in the generalisability of the sample and findings.

Furthermore, the survey content itself may have shaped the results. Although attempts were made to ensure that only neutral and factual information was presented to participants prior to the survey questions, it cannot be precluded that the information sheet contained an unintended persuasive tone. To the extent that this was the case, participants' responses may have been influenced in the direction of being more inclined to indicate support. In addition, participants' responses were restricted to the provided survey answers. Consequently, other potential concerns and benefits that the public may hold regarding the service remain unknown. Future research could explore these more in-depth, perhaps qualitatively. It may also be useful to ask additional questions in relation to behavioural intentions. For example, would prehabilitation supporters be willing to sign a petition for implementation initiation? Would non-supporters be motivated enough to protest and press complaints? Understanding how such attitudes may translate into real-world behaviour would be valuable to capture when determining prehabilitation support. It is also possible that the decision to collapse the *no* and *maybe* support groups into a single group representing "non-support" for the purposes of chi-square analyses may have masked the extent to which the *no* group opposed the service, since higher levels of support amongst those who indicated *maybe* could have increased the group average.

Overall, the current research has explored in depth one of the key potential barriers to prehabilitation establishment and has shown some encouraging preliminary results. With such high levels of support, perhaps public opinion in relation to prehabilitation is not a barrier at all, but rather a facilitating mechanism. Research should progress to address other identified barriers to prehabilitation implementation (i.e., legal concerns in specific jurisdictions and funding), to truly understand and progress its viability. Combined, such research could provide a powerful data-based resource to instigate the establishment of a promising new approach to CSA prevention. Given that the plague of child sexual abuse continues to exist after decades of tertiary prevention efforts, prehabilitation may be a fundamental part of the answer for reducing this detrimental epidemic.

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