3. Analyzing the Offender´s Perspective – Characteristics and Strategies of Sexual Online Grooming

3.1 The Magician – Case Study of a Hebephilic Man with History of Sexual Online Grooming

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The rapid growth of new technology led to an increase of sexual online grooming. Since studies have suggested an association between the sexual preference for early pubescent children (i.e., hebephilia) and sexual online grooming, adolescence has been identified as a key risk factor to being sexually groomed online. Nevertheless, knowledge about motives, therapeutic implications, and preventive strategies of sexual online grooming is still scarce. Therefore, this case study presents the diagnostic procedure and course of therapy of a young man with hebephilic sexual interest and sexual online grooming behavior.
Keywords: case study, sexual online grooming of early pubescent children, hebephilia, treatment course

Introduction

Sexual online grooming

Sexual online grooming (SOG) constitutes a serious problem. A cross-sectional US-American telephone survey of 1,500 Internet users, aged 10 to 17 years, revealed that 9% of those questioned received an unwanted sexual solicitation in recent years. An aggressive solicitation in which offline contact was attempted or took place was experienced by 4% (Jones et al., 2012). A comprehensive definition of sexual grooming is lacking. It is regarded as an online or offline (face-to-face) process by which a child and the surroundings are prepared for the abuse by gaining access and building trust to the child (Craven et al., 2006). Most common methods for SOG are Internet chat rooms (especially chat rooms for children), online profiles, and bulletin boards (DeHart et al., 2017; Malesky, 2007). Briggs and colleagues (2010) conducted a study of 51 men convicted of online sexual solicitation offenses via Internet chat rooms and suggested two subgroups of offenders: (1) the fantasy-driven offenders, who want to engage in cybersex without intent to meet offline, and (2) the contact-driven offenders, who want to

engage in offline sexual behavior. This classification has been extended by means of an in-depth examination of offender chat logs, email threads, and social network posts of 200 offender case files (DeHart et al., 2017). The authors proposed four different offender types: (1) those that engage in, or encourage, real-time masturbation (cybersex-only offenders), (2) those who attempt to schedule but do not engage in real-time masturbation (schedulers), (3) those who both do masturbate online and schedule (cybersex/schedulers), and (4) those that chat with a third party for purposes of child sex trafficking (ibid.)

Hebephilia

The term "hebephilia" denotes the sexual interest toward early pubescent children. Hebephilia is considered as independent sexual preference and is not to be conflated with pedophilia, the sexual interest toward prepubescent minors (Beier et al., 2015a; Blanchard et al., 2009; Seto, 2017; Stephens et al., 2017). Valid prevalence rates of hebephilia are lacking and can only be roughly estimated. Research suggests that hebephilia is more common than pedophilia and less common then teleiophilia (i.e., sexual preference toward adults; Grundmann et al., 2016; Seto, 2017; Stephens et al., 2017). This is consistent with evaluations of the Prevention Project Dunkelfeld (PPD; Beier et al., 2015b). Out of 222 self-identified men who presented themselves at the PPD in Berlin, 69% reported sexual fantasies involving early pubertal minors. Thereof, 16% reported being solely attracted toward early pubertal minors. In comparison, pedophilic sexual interest was reported by 58% (Beier et al., 2015b).

Hebephilia is no prerequisite for engaging in sexual offending behavior, and sexual offending against early pubescent children may not necessarily come along with hebephilia. Seto (2018) concluded that 50–60% of men with child victims did not have a sexual interest toward children. This suggests that sexual offenders exist that abuse children for reasons other than a sexual preference toward children (e.g., antisociality, cognitive impairments, lacking social skills). Hebephilia can still be regarded as major risk factor for committing child sexual abuse (CSA; e.g., Hanson & Morton-Bourgon, 2005; Mann et al., 2010; Neutze et al., 2012) and for the consumption of child sexual abuse images (CSAI; e.g., Seto et al., 2015). As hebephilia is expected to manifest itself during adolescence and to remain relatively stable throughout life (Grundmann et al., 2016; Spitzer, 2012),

hebephilia is additionally associated with an elevated lifetime risk for sexual offending.

In Germany, it has been possible to establish a network of outpatient treatment services for self-identified adolescents and adults with sexual interest toward prepubescent and early pubescent children (Beier et al., 2015b, 2016) that aim to prevent initial or repeated CSA and the consumption of CSAI. The services have been made possible by the anonymity afforded under German law. Unlike many other countries, Germany does not have a mandatory reporting policy, meaning that professionals are not obliged to report actual or suspected past offenses due to therapist-patient confidentiality (in line with § 203 StGB, in English: German penal code). This way, therapeutic offers are also made to individuals who voluntarily seek help concerning their sexual attraction to children, even if they have offended in the past. In many other countries there are mandatory reporting laws. Mandatory reporting laws require certain occupational groups to report actual and/or suspected cases of CSA and the consumption of CSAI to government authorities. Occupational groups that are mandated to report are, inter alia, medical/therapeutic personnel or those who commonly deal with children in their work routine (e.g., teacher, police). Everyone who does not report actual and/or suspected cases will be liable to prosecution (Liu & Vaughn, 2019). Outside Germany, mandatory reporting laws therefore resulted in the establishment of treatment services that primarily address hebephilic individuals without history of CSA or the consumption of CSAI. Hebephilic individuals with history of offending behavior can only take up therapy if the offense(s) is (are) kept secret. However, non-disclosure of past offense behavior impedes therapeutic work and development of behavioral control (e.g., Yates, 2013). For example, behavioral chains that led to past offending behavior could not be identified. In doing so, it would be difficult to assist individuals to identify, anticipate, and prevent risk situations that could lead to re-offending.

It should be noted that not everyone with hebephilic sexual interest requires professional support and that a sexual preference for children is distinct from a hebephilic sexual preference disorder (DSM-5, 2013). As such, there are hebephilic individuals who restrict their desire for sexual contact with children to fantasies only and do not experience distress with regard to their sexual interest toward children (Tenbergen et al., 2015). Nevertheless, hebephilia has to be regarded as an internationally relevant phenomenon. For instance, the first extensive evaluation of Troubled Desire, an online self-management tool for individuals with sexual interest in

children, has revealed more than 4,000 users from more than 70 countries within the first 30 months of existence (Schuler et al., 2021). There is only little awareness of the link between hebephilia and SOG. First results indeed suggest an association between the sexual interest in early pubescent children and SOG (e.g., Schulz et al., 2015). Therefore, adolescence has yet been identified as key risk factor to being sexually groomed online (Whittle et al., 2013). This is in line with Wolak and colleagues (2008) who propose that sexual groomers display rather hebephilic than pedophilic sexual interest – first of all because prepubescent children are less likely accessible online as adolescents. Considering the rapid growth of new technology, attention has thus to be paid to SOG. A better understanding of SOG, its motives, and its courses of action has the potential to derive both treatment implications and preventive strategies to protect children and adolescents online. Accordingly, this case study illustrates the course of therapy for a young man with hebephilic sexual interest and SOG. The client gave written informed consent for the publication of this case study. Details irrelevant to the clinical case were altered in order to protect the client's confidentiality. Quotations have been literally translated.

Background information

Boris is a German 22-year-old man who was accompanied by his parents on the first visit at the Institute of Sexology and Sexual Medicine, at Charité – Universitätsmedizin Berlin. Motives for consultation were a suspected hebephilic sexual interest and suspected SOG behavior, as Boris' parents discovered a collection of pictures of "boys in their early puberty" on Boris' smartphone. Upon detection, Boris' parents deleted the whole collection of pictures.

The initial intake assessment (T0) comprised a clinical interview, interview with parents, and a psychometric test battery including self-report questionnaires and a viewing-time paradigm (Abel et al., 1994), which unobtrusively measures response times while target images have to be evaluated according to their perceived sexual attractiveness. The second assessment (T1) comprised the same psychometric test battery and was conducted 13 months after the intake assessment and 12 months after therapy start.

Assessment (T0)

Clinical interview

Social and psychiatric anamnesis

Boris reported that he grew up in a town in northern Germany with his two older sisters (+2y, +5y) and married parents in a loving and supportive atmosphere. He still lived at home with his parents. His sisters moved away some years ago. He indicated having some loose social contacts. Close friends were negated. Except the connection to his family, he felt socially isolated. He did have a school-leaving qualification but had no vocational training and no job. He had no plan for the future. He felt highly pressurized that he did not have any future plan, especially because his sisters were already (financially) independent. He also had the impression that his parents did not have to worry that much about his sisters. He, in turn, knew that he caused many concerns to his parents. For instance, unlike his sisters, he needed private lessons from early on. He additionally suffered from depression and anxieties and was already in a psychiatric hospital twice. Sometimes he therefore felt inferior and a burden to his family. The clinical picture confirmed a previously assessed below-average intelligence score (IQ: 70–85).

Sexual interest

Since puberty, Boris indicated to exclusively have had sexually arousing fantasies, impulses, and behavior in relation to early pubescent boys. He did not report sexual fantasies with adults or prepubescent minors. He indicated that he felt burdened by his sexual fantasies and sincerely wished for a shift in sexual interest to adult men. There were no indications for any additional paraphilic sexual interests.

Sexual behavior

Boris has not had direct sexual contacts. He reported he had a "huge collection" of pictures of naked early pubescent boys. Pictures were not downloaded from peer-to-peer file-sharing networks. Instead, he contacted unknown boys via social media, groomed and – under false pretenses – requested nude pictures. He mainly used online photo- and video-shar-

ing platforms that are popular with young people, including Instagram, Snapchat, and Facebook. He usually spent seven to nine hours online a day. Most of the time he was on social media and scrolled through other people's profiles. Besides that, he watched videos on YouTube of magic shows and of magicians that reveal magic tricks. Occasionally he used WhatsApp to communicate rather superficially with former acquaintances from school. Online gaming was negated. He always went online with his smartphone. He did not have a laptop, computer, or any other Internet device. To obtain pictures of early pubescent boys, he proceeded as follows: First, he scanned social media profiles of boys for certain characteristics that indicate their higher susceptibility to manipulation. Also he was driven to profiles that allowed him to gain insight into the target's everyday life, hobbies, and area of interests. To him, boys seemed more receptive to SOG strategies if their social media profile had no privacy settings in place and if their profile was rather unfrequented, with few followers, and few likes for postings. Second, if there was enough information available on the target's profile, he sent a friend request and (after acceptance of his request) built online contact by using a false identity. He pretended being a magician who was able to perform magic tricks and was preparing for a huge magic show. On his profile there were no personal pictures available. Instead he uploaded pictures of equipment and accessories for magic tricks such as decks, magic wands, or top hats. Additionally he showed interest in the target's life to build an emotional connection with the boy. He asked several questions, pretended having similar interests, and paid compliments for their appearance and online content. Third, once he felt that he had gained enough trust, he encouraged them to send nude pictures. He used two tactics to ask for sexual images: (1) As a magician, he was looking for assistants for a large-scale magic show. To look good on stage, all assistants should wear comprehensive costumes. To commission costumes, he needed a naked full body picture. (2) He offered magic tricks online. Either as basis or in return for a trick, he was asking for naked full body pictures. The magic trick then comprised an estimation of body size. Time frame varied from minutes to days until he requested nude pictures. Usually, he kept several conversations going at once. As soon as he received the preferred picture, he usually deleted the chat record and blocked the contact. Pictures were collected and used for masturbation.

Boris was able to collect almost 400 pictures of boy victims with a *rate of success* of almost 100%. Hitherto, he had not been reported. Picture 1 (see below) illustrates a typical (Instagram) chat. At the end of the depicted

conversation, the boy sent a naked full-body picture. Upon receipt, Boris blocked the boy, which means that he was not able to find Boris' Instagram profile and therefore was not able to contact Boris anymore.

Boris: Hi, whats up?
Response: Hi
Boris: Nice pics
Boris: WYD?
Response: Nothin much u?
Response: Thanks
Boris: Performing magic tricks
Boris: Cant wait for my upcoming show
Response: Waw thats cool
Boris: Wanne come to my show
Boris: Will be throughout Germany
Response: yea
Boris:
Response: What do u conjure?
Boris: Come to my show
Boris: Mostly card tricks. And many other things
Boris: I ll send you a vid when I am ready
[…]
Boris: Btw your pretty good-looking
Boris: You exercise a lot, huh?
Response: Thanks
Response: Playing soccer
Boris: No way, its my fav sport!!
Boris: Position?
Boris: Im defence
Boris: Always nr 5
Response: Goalkeeper
Boris: Nice. Lets play together soon
[…]
Boris: What youre doing today?
Response: Homework
Boris: Aw
Boris:
[…]

Boris: Your cool
Response:
Boris:
[…]
Boris: Just got a call by my assistant.
Boris: He's sick
Boris: Cannot join me on my show
Boris: Wanne do it?
Response: What do you mean?
Boris: Do you wanne be my assistant on stage?
Boris: I bed you would do great
Response: What do I have to do for it?
Response: Haven't performed any tricks
Boris: Haha no worries
Boris: I'll show you everything
Boris: It will be so cool
Response: ok
Boris: Awesome!!
Boris: You need a costume on stage
Boris: You gotta pic?
Response: What do you mean?
Boris: No selfie
Boris: I need to know how tall you are for the costume
Response: What should I wear?
Boris: You ll look great. No worries. Promise.
Victim: Ok what pic?
Boris: Naked. Not just ur face. Lol
Victim: What do you want to see?
Boris: Full body. Need ur size.
Victim: Im a 60
Boris: Lol need to see by myself
Boris: The costume must fit perfectly
Boris: Ill delete after seeing
Victim: ok

Figure 1: Instagram excerpt from Boris sexual online grooming after his friend request has been accepted

Upon detection, Boris' parents confiscated the smartphone and deleted the whole collection of pictures. In return, he received a replacement phone without Internet access. Three times Boris managed to evade parental rules in order to get a smartphone. Once he stole the credit card of his parents out of their wallet and bought a new smartphone online. The phone arrived a few days after the purchase without anyone's knowledge. After

the parents have discovered the loss of their credit card (roughly a week after the purchase and three days upon arrival of the smartphone) they have their card blocked. As the purchase was retraceable, suspicion quickly fell upon Boris, who promptly admitted the theft and the online purchase and handed in the smartphone. Another two times he saved his pocket money until he had enough money to buy a phone at a local shop. He was caught by his parents as he spent an unusual amount of time alone in his room. Boris' parents checked on him, discovered the phone and collected it. With the three smartphones, Boris had started new Instagram chats with boys at early puberty towards the goal of asking for nude pictures.

Boris indicated having an "intensive urge" he "cannot resist" to reach out to early pubescent boys online. Furthermore, during the clinical interview, Boris' cognitive distortions in relation to his SOG behavior became clear. He did not particularly report feelings of guilt, as he did "not use force" and "boys sent pictures voluntarily".

According to the proposed offender typology (DeHart et al., 2017), Boris would be classified as *cybersex-only offender*. As it was described by the literature (and conducted by Boris), cybersex offenders mostly request sexual photos of the victims, express interest in child-specific themes and have rather protracted conversations with victims. Meetings with victims are hinted without specification of time and place. The only difference is that Boris did not expose himself sexually to the victim, which has additionally been found to be associated with *cybersex-only offenders*.

Interview with parents

The mother had devolved asthma during Boris' pregnancy. Complications during delivery required a Cesarean section. After a burdensome pregnancy, Boris additionally required a high level of support from early childhood on. From age three (until age 11) Boris went to ergotherapy and logopedics because of impaired fine and gross motor skills and difficulties with speech production. Due to undescended testicles and cholesteatoma he additionally had to undergo surgery. After elementary school, he went to a school for children with special needs. He did not connect with peers and was bullied at times. He usually spent his leisure time with his parents. His parents tried to make him interested in several hobbies to get to know age-mates (e.g., theater group, music lesson, soccer). He had started a few things and quickly lost interest. Solely his enthusiasm for magic tricks remained. Since

adolescence he had consistently been in psychotherapy due to a recurrent depressive disorder (tenth version of the International Statistical Classification of Mental and Behavioral Disorders [ICD-10]: F33) and a generalized anxiety disorder (ICD-10: F41.1; Weltgesundheitsorganisation, 2015). A high risk of self-endangerment had led to an in-patient stay for six weeks at a child and adolescent psychiatry at the age of 17 and for four weeks at an adult psychiatry at the age of 20.

At the age of 16, Boris received his first smartphone and directly spent several hours a day with the device. The parents knew about his profiles on Instagram, Snapchat, and Facebook. At the age of 17, they monitored Boris' social media profiles for the first time and noticed that their son was solely chatting with younger boys and not with same-aged peers, as stated previously. They did not find any nude pictures. Boris told his parents that he was only making fun of the boys, without serious intentions. From then on, Boris' parents regularly checked his phone. As the parents did not observe any peculiarities on the phone, the regular checks ended when Boris turned 18. His smartphone consumption had increased continuously up to nine hours a day. At the age of 21, Boris' parents controlled the phone again and discovered hundreds of nude pictures of early pubescent boys. The parents directly deleted both the pictures and Boris' social media profiles. He received a replacement phone without Internet access. Boris did not give reasons for the collection of pictures. He apologized for his behavior and promised that he would never do something like that again. The parents felt highly overburdened by the situation and hoped that without smartphone Boris might lose interest in early pubescent boys. However, as they caught their son three more times with a smartphone, they arranged an assessment at the Institute of Sexology and Sexual Medicine in the hope of finding a quick solution for his behavior. In order to prevent that Boris secretly gets access to a smartphone, they paid close attention that no money was left and locked the wallet away at home. Furthermore he was only given pocket money if he exactly told his parents about the things he wanted to buy. The parents then either controlled the receipt or looked at the purchase.

Overall, the parents indicted that they felt in despair and blamed themselves for the SOG behavior of their son. They were deeply worried about his future and had great fear that he either had already been reported to the police or will be reported when boys confide in their parents.

Psychometric test battery

Results of the viewing-time paradigm and self-report questionnaires confirmed the existence of a hebephilic sexual interest (exclusive type). He indicated that he felt burdened by both his sexual fantasies involving early pubescent boys and the "urge to reach out to boys" in order to request sexual images. Sexual impulses were experienced as "uncontrollable". History of direct offline CSA was negated.

Compared to values of standardization samples (see table 1), Boris showed clinically relevant values of loneliness (UCLA-LS-R; Russell et al., 1980), offense-supportive attitudes (BMS; Bumby, 1996; IBAQa; O'Brien & Webster, 2007), hypersexuality (HBI; Reid et al., 2011), impulsivity (BIS; Reise et al., 2013), and a reduced quality of life (EUROHIS-QOL; Schmidt et al., 2006).

Case conceptualization and treatment planning

Boris' SOG behavior was contextualized as a dysfunctional attempt to self-regulate negative and aversive emotions by means of sexualized coping (Cortoni & Marshall, 2001). As Boris indicated that he felt as an outsider, a burden to his family, and even inferior to others, it has been assumed that he suffered from frustrated basic needs for appreciation and confirmation (Beier et al., 2005). Also he was socially isolated and had no plan for the future. Boris did not learn to deal with these adverse emotions in a functional way. Instead, in order to escape negative emotional states he used sexualized coping strategies and impersonated a magician in order to attract attention and feel valued.

Treatment planning was aligned according to the Good Lives Model (GLM; Ward & Gannon, 2006). The GLM assumes that individuals seek out primary goods (e.g., connection to wider social groups or intimate, romantic, and familial relationships). Secondary goods (e.g., joining a sports club), in turn, provide concrete means of securing primary goods. Within the GLM framework, sexual offending is conceptualized as an inappropriate attempt to satisfy primary goods. Treatment is therefore proposed to aim at satisfying offender's primary goods in socially acceptable ways. Accordingly, therapy focused on Boris' frustrated primary goods (i.e., lack of appreciation, inferiority, lack of connection) and his inappropriate way to fulfill his goods (i.e., SOG). Moreover, based on the risk-need-responsivity

Table 1: Outcome data on psychometric testing

Measure/Scale	Boris		Comparison sample		
	Pretreatment (T0)	During therapy (T1)	Mean (SD)	Cron-bach's alpha	Reliable change index
Quality of Life					
EUROHIS-QOL (Schmidt et al., 2006)	15	25	32.64[a] (4.37)	0.85	6.12*
Loneliness					
UCLA-LS-R (Russel et al., 1980)	54	43	37.06[b] (10.91)	0.94	2.91*
Cognitive distortions					
BMS (Bumby, 1996)	99	79	51.80[a] (10.93)	0.97	7.47*
IBAQa (O'Brien et al., 2007)	107	89	64.0[c] (17.7)	0.70	1.31
Impulsivity					
HBI (Reid et al., 2011)	72	48	66.3[d] (13.8)	0.95	5.50*
BIS (Reise et al., 2013)	78	59	62.8[a] (9.2)	0.83	3.54*

Notes. To determine whether the magnitude of change for the included questionnaires is statistically reliable, reliable change indices were calculated according to Jacobson and Truax (1991). For each questionnaire, scores of Pretreatment (T0) and during therapy (T1), standard deviations, and alpha coefficients of standardized sample were used. Standardized sample refers to: [a] community sample, [b] college students, [c] males convicted of CSAI offenses, [d] participants of outpatient clinics who sought help for issues associated with hypersexual behavior. *Reliable change.

(RNR) principle (Bonta & Andrews, 2016), that proposes that interventions must be tailored to the individual risk factors, the following risk factors were derived that seemed to be relevant for Boris: criminological needs and automatic cognitions (offense-supportive cognitions), self-regulation deficits (emotion regulation deficits, depression, sexualized coping), lack

of emotionally intimate relationships with adults, and sexual problems (hebephilic sexual preference, sexual preoccupation). Given the high risk of relapse concerning Boris' SOG, the treatment plan included medication to reduce pressing fantasies and to increase behavioral control. Furthermore, it has been agreed that Boris receives a smartphone with limited Internet access, as he reported doubts regarding resumption of SOG behavior. Because of the distance between his place of residence and the Institute of Sexology and Sexual Medicine it has been agreed upon monthly appointments.

Treatment course

To the point of drafting this article, Boris has been in treatment for a year. Treatment plan included on-site sessions every month. On request, phone sessions were performed to reinforce progress or troubleshoot obstacles. Because of his cognitive abilities (on the edge of a minor impairment of intelligence), clear and simple language (i.e., easy to read) was used. The following provides an excerpt of treatment components.

Pharmacological intervention

Pharmacological interventions were realized via the in-house medical outpatient department at the outset of therapy. The somatic anamnesis and examination revealed no somatic illness. Treatment was begun with an opioid antagonist (Naltrexone) at 50 mg/d. Based upon the efficacy of opioid antagonists in treating urge-driven disorders (e.g., alcohol dependence), Naltrexone has been off-label-used for the reduction of sexual fantasies and urges to act out sexually (Ryback, 2004; Savard et al., 2020). Boris reported a "big relief" due to the decrease in sexual fantasies and the urge to reach out online to early pubescent boys. Masturbation frequency decreased to twice a week (from multiple times a day). Initial drug side effects included nausea, abdominal pain, headaches, and weight gain, which stabilized after three weeks. Fatigue was persistently experienced. The reduction in sexual impulses was experienced as sufficient for approximately seven months. Thereafter, Boris felt "pressing urges" to reach out online to early pubescent boys in order to receive nude pictures for masturbation. Likewise, his masturbation frequency increased to the level before pharmacological treat-

ment. Concurrently, he secretly purchased a smartphone and started Instagram chats with early pubescent boys (and same-aged peers). He did not impersonate as magician but acted as himself. He has not requested for nude pictures. His parents discovered the phone roughly a week after the purchase and confiscated it. Therefore, treatment with Naltrexone was discontinued. An androgen deprivation treatment was agreed upon, with 100 mg/d of oral cyproterone acetate. After three to four weeks, sexual fantasies involving early pubescent boys were perceived only infrequently and masturbation frequency dropped to once a month. The urge to connect with early pubescent boys online was reduced. He reported being greatly relieved due to this decrease in sexual fantasies and sexual impulses. However, he was initially bothered by an impaired ability to attain an erection and orgasm/ejaculation. During the appointments, both benefits and undesired effects of treatment with cyproterone acetate were discussed in detail. To Boris, advantages of the medication were to better concentrate on other things, and to turn his mind away from sexual urges. Disadvantages were the stated functional impairments (i.e., to get an erection and orgasm/ejaculation) and slight headache. He additionally indicated that he was afraid he might never be able to beget children. He was greatly relieved to hear that fertile sperm production usually re-establishes within a few months after stopping the medication. Hereafter, Boris decided to continue with the drug treatment.

Psychoeducation and individual sexual online grooming pattern

Sessions initially focused on Boris' SOG pattern. Psychoeducation concentrated on the development of sexual fantasies as rather stable phenomenon (Beier et al., 2005) and risk factors for sexual offending to help Boris to gain an understanding of his own SOG behavior. Boris initially perceived his SOG behavior as *Internet addiction*. It was therefore challenging for him to adopt an alternative approach. Yet the following behavioral pattern was formulated: Feelings of loneliness and lack of appreciation made him flee into the Internet where he pretended to be a magician. He soon felt seen and renowned by boys he sexually fantasized. Sexual arousal increased and made him request for pictures. In the short-term, he then felt relieved. In the long-run, he felt confirmed by his feelings of insufficiency. His individual risk factors that support his behavioral pattern were collated to derive concrete strategies for further action. This overview of risk factors

was very useful for Boris and helped him to perceive his SOG behavior not as mere Internet addiction.

Management of risk factors

Self-regulation deficits

Little by little, Boris realized the link between his negative feelings and lack of adequate coping strategies, which resulted in SOG. For clarification, theoretical foundations of the cognitive behavioral therapy were introduced (e.g., the relationship between emotion, cognition, and behavior; Dolan, 2002). During the sessions, alternative strategies for negative emotions were developed. Building up alternative strategies was perceived as highly demanding, as Boris firstly had no ideas on how to handle negative feelings except by SOG. Slowly he thought of strolling around, grabbing a coffee in his favorite café, or listening to his favorite songs. Besides, Boris was encouraged to start looking for a job in order to receive some professional recognition. He found a job as auxiliary gardener in a nearby garden center. He indeed liked the job, yet he felt highly stressed due to the unfamiliar work and heavy workload. He reduced the number of working hours and started keeping a weekly schedule to structure his days.

Lack of emotionally intimate relationships

Boris stated that he had trouble when reaching out to peers. He felt unconformable, got insecure, and did not know what to say. Elements of social skills training were introduced (e.g., role-plays, practice at home; Hinsch & Pfingsten, 2015). At work, he was able to establish initial contacts with peers. Furthermore he took up a hobby (playing a music instrument) with the goal of becoming a member of the music band in his neighborhood. The band already knew about his objective and promised to accept him as member if he played a little better.

Hebephilic sexual preference, sexual preoccupation

The concept of acceptance as opposed to approval was introduced. As such, based on the acceptance and commitment therapy (ACT) it is expected that acceptance of the own sexual preference as a (relatively) stable and

constantly challenging part of one's personality can help to open new ways of thinking and help to refrain from sexual offending. Furthermore, therapeutic setting was consistently characterized by a respectful and non-judgmental communication about his sexual fantasies. Eventually Boris was confident enough to open up to his sisters about his hebephilic sexual preference and SOG behavior. He felt stressed by the fact that his sisters did not know anything about it – as if there was "something between" them. At the same time he was afraid his sisters might reject him. The sisters had no understanding for his SOG behavior. They felt disappointed and hurt that Boris requested nude pictures for sexual satisfaction. However, after long discussions, also together with their parents, they offered support in dealing with his sexual preference, which was highly appreciated by Boris. They, for example, suggested that he might call them when he experiences urges to reach out to early pubescent boys.

Offense-supportive cognitions

Boris' offense-supportive cognitions (e.g., "I did not use force" and "boys sent pictures voluntarily") were challenged by imagery scenes. For example, under a false pretext someone requested a nude picture of you to use it for masturbation. Imagery scenes helped Boris to gradually understand that he misled boys. In this context, sexual rules and boundaries were discussed (Beier, 2018). It was compiled that rules and boundaries referred to the protection of integrity and/or individuality of another individual. Integrity was then violated if, for example, non-consenting individuals were involved (e.g., children) or sexual behavior was covered up. He eventually began to understand that force in the usual sense was not necessary to violate other's integrity.

Parents

Boris' parents had also been integrated in the treatment plan in order to reduce fears and increase family functioning. They initially believed Boris suffered from an *Internet addiction*, which – rather coincidentally – was restricted to SOG behavior to early pubescent boys. Hearing that Boris' SOG behavior was driven by his sexual preference was a shock at first. They blamed themselves and their parenting style. At the same time they expressed fears and feelings of excess strain regarding their son's sexual

interest and SOG behavior. Therefore, sessions with the parents – on-site and/or on the phone – included psychoeducative elements, addressed their feelings with regard to their son's sexual interest and sexual behavior, and helped to understand Boris' development of sexual delinquency. Furthermore the parents were emboldened to supervise and monitor risk factors. They decided to either forgo meetings with family or friends where early pubescent boys were expected or they attended and monitored Boris very closely. Besides, it was agreed that Boris continuously had only limited Internet access. In accordance with Boris, the parents additionally checked his smartphone on a regular but unannounced basis. They gave attention to an open and respectful communication and emphasized that they were at Boris' disposal when he needed someone to turn to. Furthermore the parents were encouraged to support Boris to transfer knowledge learned during sessions into his everyday life. For example, in role plays they together practiced certain social situations and strengthened Boris to find a new hobby. Interviews and phone sessions were discussed with Boris first, in order not to "endanger" the therapeutic relationship.

Interim evaluation and outlook

Boris has been in treatment for 12 months. Treatment has mainly focused on the reduction of Boris' individual risk factors. Here, above all, the development of appropriate strategies to handle negative mood states by pharmacologically reducing Boris' sexual impulses has been emphasized. Moreover, elements of social skills training were introduced to help Boris to better handle social interactions with peers. Sessions with parents have been held in order to increase familial functioning and to monitor risk factors. Overall, a positive interim conclusion can be drawn, as Boris has not requested nude pictures of early pubescent boys since the outset of treatment. Furthermore, scores of the questionnaires that were administered again 13 months after the initial intake assessment showed that Boris' depressiveness, loneliness, hypersexuality, and psychosocial impairment had dropped significantly at the second assessment (table 1). Boris' quality of life had also improved. However, at the second assessment Boris' questionnaire score has still been below average. This can partly be ascribed to Boris' wish for more autonomy and independence. Therefore, in the medium term, a residential program with high key supervision is envisaged. Furthermore, at the second assessment Boris still showed clinically signifi-

cant values of cognitive distortions. Taking the perspective of someone else is highly demanding for Boris. Further challenging his cognitive distortions will therefore be an important next step. Moreover, upcoming sessions will serve to consolidate his knowledge and to further support him to distance himself from SOG behavior. Besides, a relapse prevention plan will be developed including concrete steps to take in risk situations (Pithers, 1990). Such a plan will increase Boris' self-efficacy concerning abstinence from SOG. By virtue of Boris' cognitive abilities and the assumption of a sexual preference as rather stable part of one's personality, a long-term support will presumably be necessary to help Boris dealing with his sexual impulses.

Ethical approval

This case study has been conducted in strict adherence to established ethical guidelines for scientific research. The ethical considerations and principles governing this research align with recognized standards and regulations to ensure the welfare and rights of all participants involved (informed consent, anonymity/ pseudonymity and confidentiality, voluntary participation, beneficence and non-maleficence, transparent communication).

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