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Barriers to Sex Offender Reintegration

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This is to certify that the doctoral dissertation by

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Abstract

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MA, Washington State University, 2016

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Dissertation Submitted in Partial Fulfillment

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Abstract

Barriers to successful offender reintegration are important to address in treatment approach, and most of the information known about risk to reoffend is created by researchers, treatment providers, and victim experiences. Exploring and learning about the barriers experienced by sex offenders during the reintegration process can provide additional insight into sex offender treatment approaches, reentry processes, community beliefs, and legislation. The purpose of this qualitative study was to identify barriers that sex offenders experience during the reintegration process that may lead them to reoffending. The risk-need-responsivity framework was used to guide the interpretation of identified barriers. The sample consisted of 10 treatment providers who have worked with recidivated male sexual offenders. Thematic analysis was used to generate barriers from in-depth semi structured interviews to collect data from treatment providers who have worked with recidivated sex offenders. The participants were asked to provide barriers that were disclosed to them by sex offenders about their experience reintegrating, as well as their own observations about specific sex offender experiences. Findings indicated that the major barriers sex offenders mentioned experiencing were dynamic barriers rather than static barriers and are largely affected by external variables such as lack of community acceptance, lack of social/family support, decreased self-esteem, lack of purpose, and other barriers associated with restrictions placed on rehabilitating sexual offenders. These findings can be used to create improved treatment approaches, reentry plans, legislation, and preventative measures to reduce sexual offender recidivism.

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Dedication

This dissertation is dedicated to my grandfather, Dr. Allen Minor, for always encouraging me to pursue my passion and enhance my education, and for providing me with the best examples of work ethic, dedication, perseverance, professionalism, and moral standard.

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I would like to acknowledge my dissertation chair, Dr. Eric Hickey and committee member, Dr. Jerrod Brown. The guidance they provided allowed me to enhance my work and exceed my own previous expectations. Their expertise and experiences led my dissertation to be better organized and well-rounded, making the research balanced and impactful. Both Dr. Hickey and Dr. Brown share my passion within the field, and helped me incorporate the mission of positive social change.

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Chapter 1: Introduction to the Study

Introduction

In 2017, there were approximately 747,408 sex offenders registered in the United States, with 265,000 of those incarcerated or under supervision (Rosselli & Jeglic, 2017). That number does not account for sex offenders who have not been identified. There will never be a time when 100% of sex offenders will be incarcerated with lifetime sentences, meaning there will always be sex offenders in the community (Viki et al., 2012). This emphasizes the importance of research regarding rehabilitation. In this chapter, I identify both the problem and the known characteristics of sex offender rehabilitation. Furthermore, I explore known treatment methods, including the influence of current laws regarding sex offenders, and known barriers to successful rehabilitation and reintegration. I also discuss current recidivism rates and societal beliefs regarding the ability of sex offenders to successfully rehabilitate. I analyze strategies for sex offender treatment and management. In addition, I mention in this chapter the positive social change impact of explaining the barriers sex offenders are experiencing when trying to reintegrate.

For this study I used the phenomenological qualitative design to understand reported experiences of sex offenders during their attempt to reintegrate into society. Treatment providers had the opportunity to anonymously share sex offenders' experiences regarding treatment and the barriers they believe led them to reoffending. There is no past research about barriers to sex offender reintegration that includes the sex offenders' experiences.

Background

The major treatment for sex offenders occurs in a prison setting, and although punitive in nature, prison is also supposed to include treatment and rehabilitation preparation. Most sex offenders are required to participate in sex offender treatment in order to get a chance at parole, but the issue remains that the major source of treatment is in a setting where the sex offender has no ability or means to reoffend; therefore, the environment is not generalizable to one that includes triggers. Overcoming the impulse to reoffend is guaranteed when reoffending is not possible. Research shows that the influences of incarceration may reinforce subsequent reoffending (Hsieh et al., 2018). This study did not focus on the well-researched criteria for treatment while incarcerated and but rather on the potential barriers to reintegration following incarceration. Instead of examining the potential barriers of prison setting treatment, in this study I examined the barriers to reintegration in the environment in which sex offenders have the means to reoffend.

Harper and Harris (2017) used both the sex offender registry viewpoints of sex offenders and the viewpoints of the community members in their research. The sex offender registry, commonly known as Megan's Law, is a requirement of reintegrating sex offenders. Having to register as a sex offender is a known barrier to reintegration because it restricts the opportunities and support of the sex offender. However, the registry is in place to increase the safety of the community and protect community members from the chance of being victimized by reintegrating offenders. Harper and Harris (2017) found that community members believe that sex offenders cannot be healed

and that the registry is their only means of protection. When the sex offenders had the opportunity to share their thoughts regarding the registry, they stated that due to the resultant decrease in support and resources, the registry may be detrimental to their success at reintegration (Harper & Harris, 2017).

Community attitudes regarding sex offenders may also impact sex offender related laws and legislation (Wevodau et al., 2016). Similar to the study mentioned above by Harper and Harris (2017), the research suggested that legislation is based on the opinions and research of those who have not gone through the experience of reintegration. Cognitively, reintegration is experienced and explained differently by those who have gone through it than those who have only studied it, yet research does not exist that includes the sex offenders' experience throughout the process. This illuminated the need for this research because a majority of resources and treatments created with the goal of preventing sex-offender recidivism do not include the direct needs of sex-offenders themselves. Most legislation, laws, treatment efforts, and reintegration protocols and procedures focus on the safety of society rather than the healing and rehabilitation of the sex offenders (Youssef et al., 2017).

The sex-offender registration laws help the community become aware of sex offenders in their area to best protect themselves; however, there is a lack of community awareness regarding the spectrum of sexual offenders as well as the ability of sex offenders to rehabilitate (Sigre-Leirós et al., 2016). Typically, there is a homogeneous assumption that all sexual offenders will reoffend. While some types of offenders are more likely to reoffend then others, there is a large spectrum of types of offenders, types

of offenses, and risk of reoffending. Researchers break down the sexual offenders into the following categories: rapists, pedophilic child molesters, and nonpedophilic child molesters (Hickey, 2006). Hickey (2006) explained the differences between typologies and includes subtypes regarding the style of offender. Some sexual offenders may not be sexual predators, yet the lay person may define all sex offenders as sexual predators. Sigre-Leirós et al. (2016) suggested that the cognitive schemas may affect different types of offenders differently, and this may be significant for sex offender-specific treatment and rehabilitation strategies.

In 2010, Ward and Casey elaborated on cognitive aspects of sex offenders. Through their research, they found that it is possible that cognitive distortions related to childhood victimization and current offending continue to exist during the rehabilitation process. This suggests that sex offenders endure urges that may be psychological in nature. Psychological aspects of sexual offenders are not heavily emphasized in current research regarding treatment or legislation and are not identified or challenged throughout the reintegration process.

Based on the lack of understanding about the sex offender reintegration experience, Youssef et al. (2017) identified the need for more programs that focus on community maintenance as well as treatment programs that are sex offender specific. Their recent research suggested that sex offenders are the most vulnerable shortly after release from prison; however, there are limited programs aside from the sex offender registry that reintegrating offenders are required to participate in. Without supervision and without being detained, sexual offenders now have the means to reoffend; however,

the main contribution to reoffense may be more psychological in nature than the static factors commonly associated with reoffending. (McMunn, 2019). Sex offenders are released from prison where there is 24-hour supervision and few triggers related to sexual offending, and they enter a community where sexual triggers are uncontrolled. Lack of support, limited financial resources, damaged personal relationships, and lack of acceptance into the community may lead to difficulty reintegrating successfully, but these components have not been studied thoroughly.

There is limited research on the effects of combining assessments despite the high validity of instruments such as the Static-99 and Rapid Risk Assessment for Sex Offender Recidivism (Babchishin et al., 2012). Furthermore, the researchers identified the lack of psychological measures for the sex offender population. “Cures” for pedophilia and other sexual issues have been tried in the forms of castration and other medical procedures, and in some states, chemical castration is permitted. However, while the major treatment strategy is of a psychological nature, there are limited measures to evaluate effectiveness.

Statement of Problem

Treatment during incarceration has been shown to be helpful in reducing recidivism for sex offenders. The current rate of recidivism for sex offenders is around 17.94% without treatment and 13.12% for those who completed treatment during incarceration (Soldino & Carbonell-Vaya, 2017), although it is important to note that the studies on recidivism are inconsistent, and some show both higher and lower rates of recidivism. A popular myth and misconception about sex offenders is that they are all similarly at high risk for reoffense, violent, and resistant to treatment. Furthermore, the

general public believes that around 75% of sex offenders recidivate and are dangerous (Payne et al., 2010). Legislation that relates to treatment and sex offender registration can be negatively affected by these misconceptions (Mancini & Budd, 2016). The idea that no sex offender can be treated aligns with the "nothing works" philosophy, which as shown by research is believed by a significant number of laypersons (Payne et al., 2010). This may be a barrier to implementing or continuing sex offender treatment programs in the community. The research that has created these perceptions, however, while evidence-based and supported, has been created from one side of the equation, that of those who have not recidivated or offended. The goal of this research was to analyze similar data but from the perspective of sex offenders currently incarcerated for a repeated sex offense. These sex offenders are part of the recidivism statistic, and they described their experiences attempting to reintegrate into society prior to reincarceration.

There is research completed from the sex offender point of view that suggests that social acceptance from the community can benefit the sex offender reintegration experience (Elisha et al., 2012). Structure, stability, and support found with faith-based organizations and programs can help them reintegrate (Kewley et al., 2015). Without an understanding of the sex offenders' individual experiences, there is less of an opportunity to alter the resources, legislation, and treatment for the population to be more effective. The intention of understanding direct experiences is to use the data to influence other reintegrating sex offenders and decrease the chances of recidivism. The specific gap in the research that I addressed is the experience of, and barriers to, the reintegration process for sexual offenders. As noted, research suggests that although communities are

implementing legislation based on a nonoffender perception, such efforts may be benefiting neither the community nor the sex offenders who are attempting to reintegrate.

Purpose of Present Study

Sexual violence is a worldwide problem that creates a lifetime of repercussions for both victims and offenders. There is much research on and resources for victims of crime, although the treatment for victims is only an option after the individual becomes a victim by experiencing a perpetrated crime. This research is a way to prepare, educate, and prevent against individuals becoming victims in the future. In the present study I examined the offenders rather than the victims to aid in prevention of sexual offenses. The purpose of this research was to identify barriers to rehabilitation through the personal reintegration experiences of sex offenders. Furthermore, the research serves to increase the understanding of misconceptions and how they may affect sex offender recidivism in the communities. The research can be used to identify barriers and create a basis for overcoming these barriers. New treatment suggestions as well as recommendations for reintegration strategies developed in this study are based sex offender thoughts and experiences. Unfortunately, because the ability to interview incarcerated sex offenders is limited, the data was collected through the interviews of the treatment providers who have worked with them.

Empirical research has identified differences between subtypes of sex offenders; however, there is more research needed to understand the specific needs of each subtype (Sigre-Leirós et al., 2014). Through interviewing treatment providers who work with

recidivated sex offenders, the actual experiences of sexual offenders attempting to reintegrate were emphasized and understood.

Research Questions

A qualitative method design was used to research the experiences sex offenders had during their reintegration experience. The qualitative structure serves to analyze information received by interviewing sex offenders with open-ended, conversation style interviews. Phenomenological researchers who study subjective evidence may aid understanding of maladaptive interpersonal behaviors, antisocial personality behaviors, lifestyle types, and perceived commonalities through raw observations (Moustakas, 1994). This qualitative research tested the following research questions:

RQ1: According to treatment providers, what are the barriers experienced by sex offenders attempting to reintegrate into the general population?

RQ2: How do variables such as family support, financial status, community acceptance, and treatment influence barriers?

Definitions of Terms

Civil commitment: A state can move convicted sex offenders who are transferred from prison to mental hospitals to delay their reintegration (Chittom & Cushman, 2018).

Dynamic factors: Characteristics of an individual that can change over time such as thoughts, feelings, personality, and so forth (Andrews et al., 2006).

Paraphilia: Sexual attraction to and obsession over unusual stimuli. Fetishism, voyeurism, and exhibitionism are included (Hickey,2006).

Pedophilia: A persistent and recurrent sexual attraction to prepubescent children (Seto, 2009).

Predictive validity: Predictive validity refers to the extent to which the risk assessment instruments accurately differentiate recidivists from non-recidivists (Mossman & Somoza, 1991).

Repeat sex offender: An offender who has committed multiple sexual assaults (Chittom & Cushman, 2018).

Sexual predators: Offenders who are typically repeat offenders who have a pattern of victim choosing and perpetrating (Chitton & Ames, 2018).

Static factors: Characteristics of an individual that will not change over time (Hanson & Thorton, 1999).

Significance of the Study

This research study addressed the gap between sex offender experienced barriers and nonoffender perceived barriers to successful reintegration. Currently, legislation and treatment suggestions are based on those who have not offended, meaning community perceptions, politicians' positions, and treatment providers' opinions (Mancini & Budd, 2016; Wevodau et al., 2016). A goal of this study was that it may increase the awareness regarding true experiences of the individuals regarding whom the legislation, treatment suggestions, and general opinions are aimed. Most individuals believe that the sex offender population is hopeless, therefore creating a cycle of failure (Mancini & Budd, 2016). Those who do not believe they can be different, will not be. Reaffirming positive beliefs or disproving negative beliefs may create social change.

Risk assessments that currently identify sex offenders' potential risk of reoffense are devised of static factors and dynamic factors. Static factors are those that will not change over time (a criminal record, juvenile delinquency, onset of offending, sentencing dates, and victim and offender relationships (Hanson & Thornton, 1999). Dynamic factors, those that will be examined in this study, can be described by the *central eight* domains: antisocial behavior, antisocial personality patterns, antisocial cognition, antisocial associates, family and/or marital, school and/or work, leisure and/or recreation, and substance abuse (Andrews et al., 2006). There are also dynamic factors that are specific to sexual reoffending. These include child molesting attitudes, rape attitudes, sexual entitlement, and sexual preoccupations that are common in reference to sex offender specific dynamic factors; however, research shows that these factors are less frequently used in risk assessment instruments (Storey et al., 2012). This study was focused on dynamic factors rather than static factors related to the experience of reintegration. There is a need to increase the understanding of sex offenders' interpretations of what risk factors and barriers most influence reoffense.

Limitations of the Study

Inmates are a vulnerable population, meaning there are special circumstances to consider before beginning research. The treatment providers interviewed may not have had conversations about dynamic barriers with the sex offenders they work with. Patenaude (2004) discussed potential limitations and barriers when conducting research in the prison population showing that access to the actual recidivated sex offenders would

be unlikely. Possible limitations include difficult inmates and staff, multiple institutional review boards (IRBs), and distrust from administration of outside researchers.

The participants in this study were not representative of the entire United States because of the limited number of participants. The sample consisted of treatment providers who have worked with recidivated male sex offenders, and their opinions are therefore not be generalizable to female sex offenders. The nature of the interviews was limited as well due to the current COVID-19 pandemic. Furthermore, with qualitative data there is always a possibility of confirmation bias or fabrication of events on behalf of the sex offenders who shared their experience with their provider, and also when the information is translated through a third party such as the provider. Due to the nature of the interview questions, rapport building was crucial to establish trust and comfortability with the provider so they can safely share the inmates' story. Furthermore, there was no separation regarding type of sexual offense, and there may be different barriers for different types of offenders.

Transition

The following chapters explain the procedure for collecting data, the theoretical framework used throughout the study, and the goals for testing the research questions. The literature review serves to identify and understand previous research related to sex offender recidivism and risk assessments.

Chapter 2: Literature Review

Introduction

Sex offender recidivism rates have been a difficult phenomenon to measure. Psychologists and researchers have been studying the concept for decades but have been unable to understand the phenomena of sex offender recidivism. There have been instruments created that attempt to predict sex offender recidivism and treatment that has the goal of reducing recidivism for sex offenders, yet nothing has solved the problem. There are many reasons why researchers have a difficult time understanding sex offender related concepts. A barrier to collecting research is that there are many sex offenses are never reported and many sex offenders never identified. Furthermore, of those sex offenses that are reported, the result does not always include the arrest of the perpetrator. These barriers dilute the sample viable for research purposes. The purpose of this research is to identify the barriers of sex offender reintegration, and without significant research on this concept, the sex offenders themselves have the most accurate information.

Literature Search Strategy

The information gathered from the research below may serve to increase the correlational studies on the population of sex offenders. To grasp the best understanding of the sex offenders' reintegration experience, it is important to understand the current barriers and resources encountered after incarceration. EBSCOhost and ProQuest were the primary electronic database systems used for this literature search. Furthermore, I used PsychARTICLES, PsychINFO, Academic Search Complete, and the Criminal

Justice Database for a majority of the articles. The limiters used on the searches included full-text articles that had been published in scholarly peer-reviewed journals. I used basic internet searches for statistical purposes and included nationally recognized sources such as the Bureau of Justice Statistics through the U.S. Department of Justice.

The search terms used varied based on the specific topic being explored. Primary terms used in the search were *sex offender* with the addition of terms such as *barrier(s), experience(s), legislation, opinion(s), recidivism,* and *treatment.* For each search I reviewed titles of articles for relevance followed by a review of the article's abstract. Following that, I read the chosen article in its entirety and answered questions specific to this dissertation in order to determine the article's potential use for this research.

Theoretical Foundation

A theoretical framework typically used with sex offenders is the risk-need-responsivity (RNR) model (Wilpert et al., 2019). This is the theory that best suited the present research study, as it features a heavy emphasis on barriers that lead to recidivism. The RNR model is designed to coordinate the treatment with the sex offender's risk level. The RNR primarily focuses on dynamic factors rather than static factors. The central eight domains—antisocial behavior, antisocial personality patterns, antisocial cognition, antisocial associates, family and/or marital, school and/or work, leisure and/or recreation, and substance abuse (Andrews et al., 2006)—are directly related to the RNR model and are broken down further into the *big four* and *moderate four* domains. The big four consist of antisocial cognition, antisocial associates, antisocial personality patterns, and

history of antisocial behavior; The moderate four consist of family/marital, school/work, leisure/recreation, and substance abuse (Bonta et al., 2014).

The RNR model, the theoretical framework that guided the present study, serves to emphasize dynamic risk factors including psychological aspects of sex offender reintegration. Most of the research regarding treatment and recidivism of offenders is guided by static risk factors, which do not include thoughts, beliefs, and present aspects of the offenders' reintegration, but rather the unchanged aspects of the offender that were mostly focused on in past research. The framework may guide sex offender treatment providers to attend to the parts of the reintegration experience that may have led to reoffense rather the unchanged data of the offender's past. Past offenses, delinquencies, and time served cannot be changed or influenced in the present, so research cannot depend on those factors to change outcomes for current sex offenders.

The RNR model is a popular model used for treatment of sex offenders (Andrews et al., 1990). This model emphasizes both static and dynamic factors in recidivism, or risk for reoffense. This model best serves the current study due to the emphasis on dynamic factors related to risk for re-offense. The original principles that guide the model are the following, quoted by Andrews et al. (2011, p. 735):

- risk principle (match level of program intensity to offender risk level; intensive levels of treatment for higher risk offender and minimal intervention for low-risk offenders),
- need principle (target criminogenic needs of those offender needs that are functionally related to criminal behavior), and

- responsivity principle (match the style and mode of intervention to the offender's learning style and abilities).

These principles seem to apply sex offenders' individual needs to the goals of rehabilitation; however, there is concern that the RNR is being applied without the consideration of individual differences among sex offenders on a rather large scale (Andrews, 2006). The RNR model's goals and principles seem to negate some of the barriers related to sex offenders' individual needs being met; however, there is more research needed to accurately and appropriately apply the model with the treatment of sex offenders.

Literature Review

Sex Offenders

Sex, when consensual, is associated with love, pleasure, intimacy, and bringing life into the world. Unlike other crimes, sex offenders turn something that is societally appropriate into one of the most hated crimes in the world. The healing of sex offenders has the added challenge of finding the line between appropriate and inappropriate sex rather than abstaining completely. Thieves' healing includes the goal of never stealing again, and while never engaging in sexual activity may be a goal of sex offenders, trying to abstain from a socially acceptable act makes treatment more difficult. Sex offenders in general are a very diverse population, making the research difficult to organize. No two sex offenders are exactly the same, and although they may have similar characteristics, there is a huge variety of motivational characteristics, risk factors, types of victims, types of offenses, and potential for healing (McMunn, 2019).

Society has prevailing beliefs about sex offenders and their crimes. However, treatment developers have not experienced rehabilitation or treatment themselves. Sex offenders are a very diverse population, making research difficult. While sex offenders remain a single category of offenders, there are multiple kinds of sex offenses, sexual predators, and motives for offending. Although there has been no identified cause of sexual offending, some types of predators or offenders may have risk factors that make them more likely to offend sexually.

Sex offender typologies include rapists, child molesters, pedophiles, and incest perpetrators (McGowan, 2006). Within each typology there are different motives, characteristics, and intentions. This research included all typologies of sex offenders because as of yet, treatment is not typology specific, and therefore rehabilitation and reintegration processes are similar for all types of sex offenders. There are also noncontact sex offenders. These are sex offenders who are sexually deviant without actually touching another person. “Peeping Toms” would be considered noncontact. Voyeuristic crimes, pornography related crimes, and virtual or photographic crimes do not require the offender to touch a victim. Contact offenders and noncontact offenders are two very different categories of sex offenders. Jung et al. (2013) divided their research into contact offenders, noncontact offenders, and child pornography offenders. Although child pornography can be a noncontact crime, it is one with its own characteristics. The researchers found that the categories of offenders were more alike than different when it comes to their shared characteristics, but child pornography offenders have been shown

to have greater academic and vocational attributes. The child pornography offenders also had fewer behavior problems as children (Jung et al., 2013).

Pedophiles differ from other types of offenders because the root of their sexual behavior comes from a sexual interest in children (Blagden et al., 2018). Child molesters who are not pedophiles may have other motives including power, control, trauma-related mechanisms, and other types of influences. Similar to the lack of control in what type of age-appropriate individual may be sexually attractive to individuals of the general population, a sexual attraction towards children may never go away (Blagden et al., 2018). Research identifies the need for alternate treatment methods for sex offenders who have a sexual interest in children compared to those who perpetrate children with other motives (Schmidt et al., 2013). Pedophilia, a unique category of sexual offenders, can be further divided into categories. Hall and Hall (2007) broke down pedophilia into exclusive pedophilia and nonexclusive pedophilia. Exclusive pedophilia means the individual is *only* attracted to children, whereas nonexclusive pedophilia means the individual is attracted to *both* children and adults (Hall & Hall, 2007). Subdivided further, pedophilia can be described by the gender of interest as well. Some prefer females or males exclusively, while some do not have a gender preference (Blagden et al., 2018). It is clear that pedophiles, while a unique type of sex offenders, are extremely diverse when looked at exclusively as a population. Research is contradictory when arguing the potential for healing or change in pedophilia. Cantor (2014) compared pedophilia with sexual orientation, similar to how individuals may be attracted to same sex, different sex,

or be more fluid in their desires, but Müller et al. (2014) discovered that pedophilic interest may be changeable.

Sex offenders who offend elderly victims can also be in their own category of offenders. There is limited research on this group of offenders, but Brown et al. (2018) studied the difference between this type of offender and those who offend with children. The researchers used interview methods to compare and contrast the types of offenses and the risk factors of the different offenses. The results showed that the male offenders who offend with elderly women tend to be a younger age than those who offend with children (Brown et al., 2018). These offenders also tend to be more violent and they may be more likely to offend with a dangerous weapon or cause injury. The male offenders that had child victims are more likely to plan their offense and they are more likely to groom their victim. Furthermore, child sex offenders are more likely to admit to sexual arousal and sexual motivation related to the offense (Brown et al., 2018). Brown et al., (2018) focus on sex offenders who have two significantly different aged victims, which shows there are countless differences between sex offenders that at this time have not been completely researched.

Furthermore, any types of sex offenders may have intellectual disabilities, other mental health concerns, or traumatic experiences that make them more likely to offend (Cuddeback et al., 2019). Any of these additional variables make the concept of sexual offending more complex. Alish et al. (2007), state that sex offenders with severe mental illness cause additional reason for concern within the public, legal, psychiatric, and treatment communities. In efforts to identify and understand recidivism rates, researchers

have identified a recidivism rate of around 60% for general offenders, and an increase to about 68% for general offenders with severe mental illness (Cloyes et al., 2010). Despite the research showing that mental illness increases risk of re-offense in general offenders, it is not on commonly used risk assessments (Bonta et al., 2014). People with intellectual disabilities are at higher risk for being both a perpetrator and a victim (Nixon et al, 2017). While there is limited research on the impact of intellectual disability on perpetrators, research shows that intellectual disabilities may lead to an alternate understanding of sexual interactions, moral compasses, and understanding of the law. Therefore, those with intellectual disabilities are at a higher risk of both victimization and perpetration of violent sexual crimes (Nixon et al., 2017). Trauma has shown to create problems with arousal control in general, which may impact those with mental illness or intellectually disabilities more significantly (Creeden, 2009).

McMunn's (2019) Walden University dissertation focused on the psychological characteristics of sex offenders. His research suggests that personality traits may be more important to identify than behavioral patterns. Personality traits often come from the environment and experiences of an individual, rather than behaviors that can come from a variety of experiences, thoughts, coping mechanisms, and purposes. Psychopathology may be a strong risk factor for sexual offenders, due to the lack of empathy and impulse control. Chan and Beauregard (2016) identify the difference in psychopathology between non-homicidal sexual offenders and homicidal sexual offenders. The results showed that sex offenders who were homicidal are more likely to choose their victims, have deviant sexual fantasies, are more likely to mutilate their victims, and admit their offenses. The

research also showed that violent or homicidal offenders have a higher correlation with personality disorders such as schizotypal personality disorder, borderline personality disorder, histrionic personality disorder, narcissistic personality disorder, and obsessive compulsive personality disorder. Violent offenders also show higher prevalence of impulsive personality traits (Chan and Beauregard, 2016). Sex offenders who use violence against child victims are significantly higher on the Psychopathy Checklist-Revised than child sex offenders who did not use violence (Rosenburg et al., 2005).

Any recidivism rates are difficult to calculate due to the uncontrolled variables that impact the studies. Many crimes are not reported, and some that are reported due not result in incarceration which are likely not included in the following study. The U.S. Department of Justice examined the recidivism rates of all prisoners during a 9-year period (2005-2014) and found that 83 percent of state prisoners were re-arrested at least once after their release from incarceration. Furthermore, about 44 percent of these prisoners were arrested during their first year of release. The crimes that have the highest recidivism currently are drug crimes (31.9%), property crimes (29.7%), and violent crimes (25.7%), according to the U.S. Department of Justice. Violent crimes may include a variety of sex offenses, but the specific amount of sex crime recidivism is not mentioned in the study.

There have been many studies that attempt to identify the true recidivism rate of sexual offenders. A meta-analysis conducted by Soldino and Carbonell-Vayá (2017) concluded that the average sexual recidivism is 13.12% with treatment, and 17.94% without treatment. The violent recidivism rated were shown to be higher at 25.5% with

treatment, and 29.1% without. The general recidivism rates for sexual offenders, not including violent or sexual re-offense, were shown to be 46.53% with treatment, and 52.1% without (Soldino and Carbonell-Vayá, 2017). It is important to note that there are many studies regarding sex offender recidivism that do not have significant results, however the analysis of studies suggests that psychological treatment likely reduces recidivism rates. A study related to sex offender recidivism identifies a recidivism rate of 38.6% based on a 3-year follow-up period, with 5.3% who recidivated sexually (Langan et al., 2003). Jung et al. (2013) found that the recidivism rates are low for all types of sex offenders, including non-contact sex offenders, contact child molesters, and child pornography offenders. The sample used by Langen et al., (2003) included 9,691 male sex offenders. Most research on recidivism does not surpass five years, which is a barrier to understanding recidivism. Langon et al., (2003) found that after 3-years following their release from prison, 5.3% of the entire sample recidivated sexually. The amount of sex offenders that reoffended violently were 17.1%, and 43% of offenders recidivated overall. A limitation of this study is the lack of motive identified, or reason for reoffense. Without understanding the reason sex offenders end up back in prison or reoffend, we are limited in our attempts to decrease the amount of offenses.

Psychological and biological theories related to sex offenders have been created to attempt to understand the thoughts and behaviors of sex offenders. There are neuropsychological models that mainly focus on antisocial behaviors (Kandel & Freed, 1989). Kandel and Freed (1989) also found that the frontal lobe's functioning is directly related to antisocial behaviors commonly associated with sex offenders. The research

shows that dysfunctional frontal lobes are associated with conscientious decision making and one's ability to do so. Miller (1998) explained that the neuropsychological models resulted in sex drive reducing drugs as a treatment approach. Polasheck (2003) revealed that motivational characteristics of sex offenders can be similar to those involved with addiction and impulsivity. Other theories related to sexual offending are cognitive-behavioral models. The more modern cognitive-behavior models focus on the concept of past experiences and their effects on an individuals' thoughts and behaviors (Jeglic et al., 2016).

Sex offenders are extremely diverse. Our ability to understand sex offenders has been derived of research that professionals have gathered, but in no way have we developed an understanding adequate enough to solve the problem. There is not much research regarding sex offenders' input on the data, or sex offenders' ideas about how to solve the problem. Information on sex offenders cannot be generalizable in any circumstance due to the intense diversity of the population, but including sex offender input and experience data provides another source of information.

Personal Experiences of Sex Offenders

Existing information on the personal experiences of sex offenders is extremely limited. The ability to gather data regarding personal experiences is limited as well based on the availability of sex offenders willing to provide information, and the researchers' access to sex offender. Sex offenders are rarely asked about their views (Brown et al., 2017). There is no research done on sex offender perceptions and experiences of

recidivism or rehabilitation, but there is research regarding sex offenders' experiences of treatment, incarceration, and the beliefs they may hold.

One of the earliest studies related to any kind of sex offender perception was completed by Day (1999). Although the study is dated and did not use interviews as a method of data collection, the data provided insight regarding the views sex offenders had about their treatment. The results of the study concluded that the actual content of sex offender treatment programs may be less valuable than the social interactions experienced during the course of the program (Day, 1999). It is interesting to note that the only way to study interpersonal reactions of sex offenders is to gather information from the sex offenders themselves, yet since 1999 when these results were discovered, the majority of sex offender research still does not include this type of data collection. The research by Day (1999) was supported by Collins et al., (2010) when they also discovered the strong influence of social and interpersonal aspects of the treatment process.

Williams (2004) completed a study examining nine sex offenders and their personal treatment experiences. The following was one of the participants' backgrounds:

> "Daniel" is a 65-year-old divorced, bisexual parolee who was convicted of child sexual abuse. Daniel had one victim (11-year-old male) whom he repeatedly molested over a two-year period. He attended several years of sex offender therapy at Utah State Prison (USP) before being transferred to a community correctional center. Daniel spent 11 months at this center before being sent back to USP because of failure to progress. He was later released from USP and sent to

> a second community correction center (11 months) where he failed to successfully complete that program. He eventually completed his third community correctional center program, and has attended the current outpatient treatment program for eight months. Daniel reports being raised by a "violent father and a narcissistic mother." And he was sexually abused at age 13 by a 30-year old man. He does not have significant substance abuse history. He reports that loneliness has always been problematic for him, and he now feels more comfortable interacting with age-appropriate peers. Dan has worked much of his life in the area of technical woodworking, and he seems to enjoy this work. (Williams, 2004, pp. 148-149).

Clinicians and researchers may create a representation of potential risks as well as potential causes of sexual offending based on the information regarding "Daniel's" past, but based on that information there is no clear picture of "Daniel's" perspective of his rehabilitation, risk, or cause for offense. For the purpose of understanding, it is encouraged to read the information about "Daniel" above and create answers regarding risk and cause with only the criteria that has been provided by clinicians and other researchers. Based on what we know about sex offenders; can we confidently provide these answers? "Daniel" describes his thoughts as the following: "*It was a 'one size fits all' program… they used the treatment team like a weapon, which caused me to feel threatened and insecure. I requested to go to _____ because I had been told by numerous inmates that it was fair and honest"* (Williams, 2004, pp. 155). Based on this information, the true reason "Daniel" was not able to complete his first treatments due to feelings of insecurity and fear, yet there is little research suggesting that the practitioners

are at fault for recidivism or failed treatment programs. However, this *is* fact for sex offenders. Another sex offender's response included "_____ *was very threatening. Motivation was for me to keep from going to prison rather than changing and improving for myself"* (Williams, 2004, pp. 156). These two accounts of experiences had by sex offenders provided so much valuable insight regarding potential changes and improvements to the sex offender treatment approach that cannot be found by studying quantitative data related to static factors. The results of this qualitative study suggested that offenders' trust toward professionals, motivational climate, and openness and acceptance majorly effected the nine sex offenders' ability to complete and benefit from sex offender treatment programs (Williams, 2004).

More recently Thomas et al., (2015) completed a study that examined treatment experiences of sex offenders who committed sexual crimes against children specifically. Thomas et al., (2015) provided individual sex offender experiences that ring with positivity. Most participants stated they were in denial prior to treatment, and that they weren't able to recognize they were abusive. Participants also mentioned that they engaged in a lot of self-exploration and were able to learn about themselves. The experience of being able to be open with others was another theme in the research by Thomas et al., (2015). With sex offenders being ostracized there is no opportunity for sex offenders to tell their stories without fear of retaliation or consequences, treatment was the place for that for these participants to do just that. Another important theme was the support that participants found in treatment. Finally, participants stated that the treatment was the opportunity to be better, and have a second chance (Thomas et al., 2015).

Police officers and the justice system are an important piece of sex offender rehabilitation as well as sex offender incarceration. Brown et al. (2018) completed a study related to sex offenders' perceptions of the justice system, including police interviewers and the court system. The participants were 116 adult male sex offenders who were incarcerated for a sexual offense. The research showed that offenders who experienced guilt at the time of the interview with police had more positive perceptions of the officers they encountered. The participants identified the demeanor of the officer as something that makes them more or less likely to be authentic during their interview, or to disclose the facts of the crime (Brown et al., 2018).

There are a significant amount of suicide attempts by known sex offenders (14%) (Jeglic et al., 2013). Out of the 14% of offenders who have attempted suicide, the authors identified that 11% of these offenders had a suicide attempt before they went to prison, 0.5% attempted during incarceration, and the remainder attempted both prior and during incarceration (Jeglic et al., 2013). Earlier research examines the psychological risk factors of history of sexual abuse and physical abuse. Levenson et al. (2014) examine the prevalence of childhood trauma in sex offenders. The researchers found that male sex offenders were three times more likely than males in general to have experienced childhood sexual abuse. They also found that the male sex offenders were twice as likely to have experienced childhood physical abuse, and 13 times more likely to have experienced verbal abuse as a child (Levenson et al., 2014). A meta-analysis that includes 17 studies compared rates of childhood trauma regarding sex offenders and non-sex offenders (Jespersen et al., 2009). The research confirmed that sexual abuse, physical

abuse, and childhood neglect are common among male sex offenders, however, the research suggests that although sex offenders are more likely to have been sexually abused than non-sexual offenders, they were not more likely to have experience physical abuse. Furthermore, sex offenders who offend children had a higher likelihood of experienced sexual abuse in childhood, and those who sexually offended other adults were more likely to have experience physical abuse as children (Jesperson et al., 2009).

Unfortunately, as Thomas at al. (2015) remind us, there are very few attempts to explore sex offenders qualitatively using the perceptions of offenders themselves. The few research studies that include sex offenders' experiences or perceptions provide a wide range of risk factors, motives, rationales, and potential treatment strategies. There is a plethora of conflicting research comprised of treatment providers' perceptions, law enforcement perceptions, prison staff experiences, community perceptions, and any other individuals that may encounter sex offenders personally or professionally. It is interesting to note that we have so much research including those who are not sex offenders while trying to solve a problem regarding sex offenders. It seems as though we are lacking research on the very population we are attempting to study.

Community Perceptions

Research suggests that sex offenders are the most despised group of offenders within the criminal justice system (Olver & Barlow, 2010). It is also true that the public believes that the recidivism rates of sex offenders are more than three times higher than the rates found in empirical research (Levenson et al., 2007). There is also a common misconception about "stranger danger" meaning it is assumed that most sex offenders

victimize strangers, when in fact only about 13.8% of sex offenses are committed by a stranger of the victim (Snyder, 2000). Throughout research history regarding sex offenders, researchers have identified multiple perceptions about the ability of sex offenders to heal, change, or feel remorse. There is no clear representation of sex offenders because there are so many different types of offenders and offenses. It also needs to be considered that those within the community are different as well, and therefore have a different way of creating their opinions and perceptions. Similar to how everyone has different opinions about supporting police, the death penalty, abortion, crimes, and other punishments, it makes sense that individual possess different beliefs about sex offenders. It is important to keep in mind that it is very natural for past experiences to mold perceptions about the criminal justice system (Payne et al., 2010). It is possible that individuals that have been sexually victimized will have different perceptions of offenders than those who have not had an encounter. Similarly, it is possible that sex offender treatment providers will have different perceptions based on the potential for healing they have or have not seen.

There are many studies that explore opinions of the community related to sex offenders (Rosselli and Jeglic, 2017; Payne et al., 2010; Kernsmith et al., 2009; Craun & Foster, 2009). Kernsmith et al. (2009) discovered that pedophiles and child molesters are associated with the most public fear, however there are studies to show that among different types of offenders, sex offenders do not generate the most fear among the community. Research suggests that there is more fear associated with a murderer living in the neighborhood than a sex offender, however studies show that there is more anger

associated with child molesters than with murderers (Redlich, 2001). Dum et al. (2020) explore the opinions of the public regarding registered sex offenders in places of worship. The results suggested that the stronger the individual's faith, the less likely they are to accept a registered sex offender in their place of worship. The research also suggested that those that were more educated, liberal, or older tended to be more accepting (Dum et al., 2020). Faith can be a crucial part of a rehabilitating sex offender's healing, and not being accepted into a place of worship can be a major barrier to reintegration and rehabilitation.

In 1999, when the community was asked if they believed in sex offender treatment, the results showed that only about 4% of those who responded believed that treatment can definitely help sex offenders reduce reoffense (Brown,1999). The majority of these respondents believed that treatment can be effective sometimes, and the remaining 28% argued that treatment is not helpful at all because sex offenders do not have control of their behaviors (Brown, 1999). Furthermore, Brown (1999) identified that of these respondents, a majority of 64% said they would not like to have a sex offender treatment facility in their area. More recent recent research confirms that the majority of individuals do not believe that sex offenders can rehabilitate (Payne et al., 2010). The researchers were unable to identify the many variables that could have caused these perceptions. They did discover that two life experiences influenced the idea that sex offenders could not be rehabilitated; being spanked as a kid, and using force against a partner. However, other than those two variables there were no variables that significantly influenced the negative perception, making researchers believe it could be

irrational cognitive processes (Payne et al., 2010). There is more research to support the negative perception of sex offenders' ability to rehabilitate, however there is no clear representation of where the perception is coming from.

There is research that explores the potential source of the belief that sex offenders cannot rehabilitate. It is possible that an influence of this belief comes from the experts who have the belief; such as treatment providers, police officers, corrections officers, probation, and parole (Ward & Eccleston, 2004; Williams, 2004). Researchers found that 63 percent of the Association of Treatment of Sexual Abusers believed that there is no hope for healing of sex offenders (Engle et al., 2007). The association was created to treat sex offenders, but the majority of them do not belief that is possible. Some researchers identify punitive values in general, considering the potential for individuals to believe that more criminals cannot be rehabilitated (Payne et al., 2003). However, when that research was compared to research that included sex offenders specifically, rather than a general representation of crime, sex offenders have a larger stigma associated (Payne et al., 2003).

Research proves the dissonance between fact and perception. The actual recidivism rates, although higher than some, do not reflect the idea that "no" sex offenders can heal or rehabilitate. It is also true that sex offenders have lower recidivism rates than other offenders (Langan et al., 2003; Rosselli & Jeglic, 2017). Rosselli and Jeglic (2017) evaluate the idea that the community's beliefs about sex offenders come mostly from myths and misperceptions. The myth that most sex offenders are strangers to their victims is a common belief held by community members (Rosselli & Jeglic, 2017;

Calkins et al., 2015). Another common belief about sex offenders is that the recidivism rates are very high (Rosselli and Jeglic, 2017). Research negates both of these misconceptions by discovering that sex offenders have some of the lowest rates of recidivism (Vess & Skelton, 2010; Langen et al., 2003). It is also known through research that the majority of sex offenders perpetrate against someone they know (Meloy et al., 2008). Oliver and Barlow (2010) identify the stigma against sex offenders as one that creates feelings of fear, disgust, and anger. However, Willis et al. (2010) identified that community members and students held more of a stigma against sex offenders than did those that work with sex offenders such as the police, treatment providers, prison officers, and other professionals. The research suggests that interpersonal contact with sex offenders may reduce the negative stigma (Sahlstom and Jeglic, 2008). Sahlstom and Jeglic (2008) identified the possibility that those who know a sex offender may have endorsed less of a stigma and hold more positive views about the whole of the individual, rather than categorizing by the offense. However, the findings on sex offender stigma have been inconsistent. Researchers have also found that contact with offenders may not related at all with sex offender stigma (Willis et al., 2013). Furthermore, Deluca et al. (2017) explore the relationship between views of sex offenders and political identity, specifically those who identify as politically conservative. Researchers illuminate the importance of this relationship because specific laws and policies regarding sex offenders legitimatize certain stigmas (Deluca et al., 2017). The research suggested that a specific category of conservative ideology, right-wing authoritarianism, shows to predict more negative thoughts and beliefs associated with sex offenders. Right-wing authoritarianism

also shows to predict more social distancing regardless of other predictors including prior contact and education (Deluca et al., 2017).

Jung et al. (2012) studied the difference in perceptions between the common layperson and those who work with sex offenders (parole officers and therapists). The researchers found that both professionals and laypersons view child molesters more negatively than other type of offenders. However, the professionals' opinions about recidivism remained consistent among different types of sex offenders, whereas the laypersons identified different ideas based on the type of offense (Jung et al., 2012). Interestingly, and contrary to recidivism rates, laypersons believed that exhibitionists are less likely to offend compared to other contact offenders, while the professionals do not associate this group of offenders with lower risk (Jung et al.,2012). Consistently, both the laypersons and the professions viewed child molesters the most unfavorably, and both groups assigned the exhibitionists (someone who engages in inappropriate nudity for sexual arousal) with less severe sentences than other groups of offenders (Jung et al., 2012).

The containment model includes participation from multiple facets of the criminal justice system, treatment providers, and other professionals. Most who use the containment model approach are satisfied with the collaboration efforts and the idea of recidivism reduction (McGrath et al., 2010). However, researchers have found that the different providers involved may have different ideas about the effectiveness of treatment and collaboration efforts. Law enforcement are usually the first responders to sexual offenses, and therefore may development a different opinion on the population. Day et

al., (2014) identified through research that law enforcement officers have a more negative ideas and attitudes than other providers, especially therapists. Therapists' goals are directly focused on the healing and recidivism of sex offenders, while the law enforcement officers' primary goal is keeping the community safe. This representation of sex offenders as "dangerous" rather than able to change may also be held by probation officers. Researchers have found that probation officers are more focused on control and order, while the therapists are more focused on increasing change and autonomy (D'Amora & Burns-Smith, 1999). Despite the possible beliefs of probation officers, Day et al., (2014) found that the probation officers involved in the rehabilitation of sex offenders had more positive ideas than those who were not.

There is a lack of research regarding therapists and treatment providers' subjective opinions about sex offenders' willingness and ability to change. Research about therapists' perceptions started around the 1990's and consisted mostly of research regarding *positive* perceptions vs. *negative* perceptions. Elias and Haj-Yahia (2016) examined the opinions of therapists who encounter sex offenders. The participants of the study consisted of 19 social workers who have encountered sex offenders during their career. The results suggested many themes. First, the study revealed that the therapists reflected a belief system that portrays a desire to protect the community and prevent new victimizations (Elias & Haj-Yahi, 2016). Kadambi and Truscott (2003) identified a similar pattern in their research that practitioners who work with sex offenders establish a sense of purpose with the idea that they are protecting innocent victims and helping sex offenders change. Both of the aforementioned studies reflect the idea that therapeutic

practitioners may be working with sex offenders for the benefit of the community rather than the sex offenders themselves. Another theme identified in the research by Elias and Haj-Yahi (2016), is the tension and moral dilemma that can be had when working with sex offenders who were shaped by the childhood experiences. The therapists who provided their input in the study identified the conflict of protecting the community from the perpetrator while at the same time having responsibility to care for the sex offender they are working with. There is research regarding therapist and practitioners' perceptions of motive for sexual offending, which again might be easier to comprehend if we had the perceptions of the offenders themselves. Elias and Haj-Yahia (2017) identify the confusion that arises when therapists are continuously exposed to a range of sexual behaviors and desires. Furthermore, therapists are able to view sex offenders dichotomously; narcissistic, manipulative, and lacking remorse, but also individuals whom have suffered trauma in which they learned to cope with in these ways (Elias and Hah-Yahi, 2016). Conflict arises when therapists are expected to empathize with sex offenders who may be in denial of their crimes (McGrath et. al, 2010).

There is a significant amount of research surrounding sex offender legislation and community opinions. Spoo et al., (2018) study victims' attitudes about sex offenders and the associated legislation. The researchers found that of the participants, those who were victimized sexually showed more support for mandated treatment than those who were note victimized. The participants who were victims also showed less support for community notification laws (Spoo et al., 2018). Meloy et al.,(2013) examine the history

of sex offender legislation and found that most are based off of providing justice for a single victim or group of victims. Spoo et al., (2018) note the following:

> While current legislation has consistently shown to be ineffective at preventing recidivism, enactment of these laws may serve as a way to protect and support victims and to help with their healing process. However, if victims—arguably the largest stakeholders in the development of such laws—are not supportive of the legislation, then we should work together to develop evidence-based laws that make sense and are informed by those who are most affected (Spoo et al., 2018, p. 3388).

It is clear that there is a gap in the research between what the community believes, what is true, and what sex offenders believe. More research regarding the sex offender viewpoint and the effects of victim-based legislation has on recidivism is necessary. The present research study will provide information regarding the sex offender perception of treatment and legislation, while at the same time identifying the similarities and differences between community views and sex offender views.

Sex Offender Legislation

There are many laws effecting the sex offender population. Mentioned briefly above, most of these laws are derived from the experiences of victims with the purpose of serving justice (Meloy et al., 2013). Research shows that these laws are based off of inaccurate beliefs and misconceptions about the amount sexual offenders who reoffend (Sample & Bray, 2003). These laws may impact offenders that are in prison serving time, or those that have been released but may still be facing barriers. There is a lot of debate

surrounding the questions of proper legal sanction. Chittom & Cushman, (2018) identify the two sides of the sex offender laws debate. Similar to the "nothing works" philosophy that is said to be held by communities, one side of these argument consists of those that believe lifetime incarceration is the only course of action for violent sex offenders. Conversely, the other side of the argument is that violent sex offenders can be treated via psychological treatment and medication. This side of the argument also believes that there should be a time that these offenders return to society once they show remorse for their actions. Chittom & Cushman, (2018) also mention the importance of sex offender laws grouping together all types of sex offenders despite the wide divergence between them. Child molesters that have raped or murdered their victims are categorized similarly with offenders who may be young and convicted of statutory rape. Statutory rape's major component is age, whereas if the sex may otherwise be consensual. If a 19 year-old boy has sex with his 16 or 17-year old girlfriend is it possible that he can be convicted depending on the state. This created a blurred line in terms of intent when compared to other types of sexual offenses. Unfortunately, putting all sex offenders under the same umbrella leads to these younger offenders having to register as a sex offender and may affect the rest of their life.

Historically, as early as the 1930's, civil commitment laws supported the major treatment strategy, allowing states to transfer sex offenders, then called "sexual psychopaths" to a mental institution until they were no longer a threat (Chittom & Cushman, 2018). In later years these treatment centers were specifically designed to treat sex offenders, showing progress in the understanding of sexual offending. The following

laws and amendments were created with the goal of prevention and protection. One of the first national laws, the Wetterling Act, enacted in 1994, required sexually violent offenders to register in their state (Petrunik, 2002). The Jacob Wetterling Act was one of the first to require sex offenders to register. The Act was inspired by a brutal kidnapping and murder of a young 11- year old boy, Jacob Wetterling. There is no evidence to suggest that Jacob Wetterling was sexually assaulted, however, his perpetrator admitted to the kidnapping and sexual assault of another young boy, Jared Scheierl. This caused the addition of the sex offender registry in the Jacob Wetterling Act, which was required of all 50 states (Jacob Wetterling Act, 1994). The sex offender registry became a nationally organized effort following the rape and murder of 7-year-old Megan Kanka. Megan's attacker was already a convicted sex offender at the time. This brought attention to the issue and encouraged the addition of Megan's law to the Jacob Wetterling Act. Megan's law was officially enacted in 1996 (Calkins et al., 2014). As a subsection of the Jacob Wetterling Act, Megan's law required states to not only maintain a sex offender registry, but to make it available and easily accessible to the public. More recently, the Adam Walsh Child Protection and Safety Act, also known as SORNA, which stands for the Sex Offender Registration and Notification Act, was passed in 2006. Freeman and Sandler (2010) explain that this Act is also based on the justice of a single victim. Adam Walsh was 6 years old when he was kidnapped and murdered, there is limited evidence to suggest that there were any sexual assaults against Adam Walsh. The perpetrator(s) was never identified in the name of the law, the perpetrator was thought to be Ottis Toole

(Freeman and Sandler, 2010). Finally, in 2016 Megan's law became recognized internationally – which requires sex offenders to give notice before traveling.

Along with the notification laws and registration laws, there are other restrictions on sexual offenders attempting to recidivate. SORNA requires sex offenders to register as an offender and notify those around them of their residence (Levenson et al., 2007). In many states there are residence restriction statues that limit the areas sex offenders are allowed to live in. In 2007, there were 24 states that had residence or employment restrictions during the probation or parole time period, and 19 states that extended the restrictions past the probation and parole period (Lester, 2007). These statues also limit the proximity they have to remain in and out of. Lester (2007) identifies the restrictions ranging from 500 feet to one mile away from areas where minors may congregate. The idea of these statutes is to limit sex offender exposure to children (Colombino et al., 2009). Calkins et al. (2014) specify that the permanent residence of a sex offender cannot be within a certain distance of exclusionary zones. These zones are defined by the law and may include schools, bus stops, playgrounds, parks, day care centers, and churches. Some rehabilitating sex offenders may lose the support of their religion and become unable to use their faith in an organized setting. The idea of the restrictions on sex offenders is to limit exposure and reduce recidivism, which some research supports. However, the majority of studies suggest that the distance between offenders and areas where children congregate does not increase perpetration by sex offenders (Barnes et al., 2009). In conjunction with residency restrictions there are also employment restrictions in some states and local communities. Similar to the residency restrictions, there are

zones in which sex offenders are not allowed to be employed in, specifically those that are commonly associated with minor children (Lester, 2007).

Most legislation was created using the victim's experience as motivation, but prevention of reoffense as the goal. These laws are also created with the idea that the majority of sex offenders recidivate (Sample & Bray, 2003). It is also suggested that sex offender laws are ineffective and may actually increase the risk of reoffending (Bonnar-Kidd, 2010). Hanson and Morton-Bourgon (2005) studied the misconception that most sex offenders re-offend by completing a meta-analysis of 82 different recidivism studies. The researchers found that about 13.7% of sex offenders recidivate sexually, while about 36.2% recidivate generally (Hanson & Morton-Bourgon, 2005). While any recidivism is unfortunate, the recidivism rates of sex offenders are one of the lowest among other offenders (Center for Sex Offender Management, 2000). The recidivism rate for burglary and larceny are over 75%, which is more than triple the rates of sex offenders recidivating sexually (Levenson & D'Amora, 2007).

There is very limited research on the opinions of sex offenders regarding SORN policies and/or the sex offender registry itself. Tewksbury and Lees (2007) identify the opinions of sex offenders that are required to register. Most of the offenders participating in the research believed that the registration policies should not apply to them. Furthermore, the results of the study show that sex offenders fear what the public may do with the information on the registries due to the hostile opinions that can be associated with sex offenders in the community (Tewksbury and Lees, 2007). There have been many studies researching the attitudes had by the community about sex offender

legislation. Levenson et al., (2007) identified that about 83% of community members believed that sex offender notification laws were effective in increasing safety and reducing sex offenses. Conversely, Schiavone and Jeglic (2009) found that although most of the community supports sex offender registration laws, they do not necessary believe that they are effective in reducing sex offenses, nor do they take advantage of the opportunity to use the registry. Levenson et al. (2007) also studied how community members felt about residence restriction laws. Out of 193 participants, 58% believed that residence restriction laws are effective in reducing recidivism. Another study discovered that only 37% of the respondents in an online survey supported the residence restrictions and their effectiveness (Schiavone & Jeglic, 2009).

Interestingly, the majority of those working in the sexual abuse field are less likely to believe that the notification laws are effective (Levenson et al., 2010). However, research about professionals' opinions of sex offender management policies is mixed. The researchers examined the responses of 261 professionals in the sexual abuse field. Professionals in this field show to be more hopeful about the potential for sex offenders to benefit from treatment. Levenson et al., (2010) also found that although about 25% of the respondents did not want sex offenders to live in their communities, most of the respondents believe that housing restriction and notification are not effective in making the community safer or reducing reoffense. Malesky and Keim (2001) looked at the perspectives of mental health professionals related to the online sex offender registry. There is public access to the sex offender registry, meaning that anyone can have access to whom the convicted sex offenders are as well as where they live, their current

occupation, and more. The 133 mental health professionals who participated in the study all worked with sex offenders, and over 80% of the participants believed that the online sex offender registry does not affect the sexual abuse numbers or prevent victims (Malesky and Keim, 2001). Furthermore, the majority (70%) of participants also believed that the registry creates a false representation of safety in the community. The research also suggests that the online sex offender registries can pose safety risks for offenders Additionally, 60% of the professionals that responded believed it makes rehabilitating offenders targets (Malesky and Keim, 2001).

In an effort to understand more about opinions of sex offender legislation, Meloy et al., (2013) studied the opinions of policy makers who have sponsored sex offender bills. The results showed that although the policy makers supported policies with the goal of keeping the community safe, there were many identified barriers and complications to the policies. The research showed that the policy-makers questioned if the policies were doing their job in keeping the communities safer than without the policies (Meloy et al., 2013).

The research makes the intent of sex offender legislation unanimous in keeping the community safe. Although some of the legislation was created based on a victim's experience, the impact on sex offenders is not talked about much. The intent of learning the perspectives of sex offenders is to provide more information in order to increase our prevention efforts as a society. Victims may have the best information about the victim's experience, but offenders will likely have the best information about their experience as a perpetrator.

Sex Offender Treatment

The current research on sex offender treatment remains inconsistent. There are multiple types of sex offender specific treatment, however the impact of the treatment remains controversial. Treatment during incarceration is likely required, but treatment after incarceration may not be as likely depending on the sex offender and his barriers. The most recent research suggests that treatment in the form of a Cognitive Behavioral Therapy/Risk-Needs-Responsivity (CBT/RNR) has been effective in reducing recidivism (Olver et al., 2020). This model is used during incarceration by using the principles of RNR with a CBT approach. Three components of the RNR model that were focused on in treatment were identification of resources, focusing on dynamic risks, and providing treatment in an empathetic and respectful way (Olver et al., 2020). Combining treatment during incarceration with continued treatment after incarceration may be most helpful in reducing recidivism. Hanson et al., (2002) found that sex offenders who receive treatment after incarceration are less likely to recidivate. Day et al. (2017) completed a literature review regarding timing and intensity characteristics of sex offender treatment to identify the most effective characteristics for reducing sex offender recidivism. Clinicians had the opinion that early treatment during incarceration for sex offenders is beneficial, but there is no substantive evidence that treatment later in the sentence produces any different results. Day et al. (2017) emphasized that the type of treatment, duration of treatment, and commencement of treatment should be based on the specific needs of each sex offender. Some sex offenders may benefit more from treatment that is towards the end of their sentence so that they are able to directly apply the therapeutic skills developed

during treatment (Day et al., 2017). A perceived benefit of starting treatment early in the sentence is that a long-term maintenance program is then required. Different types of offenders will require different treatment approaches (Day et al., 2017).

Glaser (2009) placed concern on the idea that treatment is punitive rather than reintegrative or rehabilitative in nature. He emphasized the fact that most therapy is chosen by the clinician rather than the sex offender, and there is little confidentiality if any. Researchers talk about the problem clinicians working sex offenders have; satisfying the goal of community safety as well as their client's treatment needs (Glaser, 2009). It is important to note that although the American Psychological Association (APA, 2003) provides many guidelines and ethical codes for general therapists, it does not provide much of anything for therapists that may be working with sex offenders. This leaves no ethical boundaries or guidance when faced with difficult decisions related to client needs vs. community safety. For example, if a sex offender mentions a child of interest, but has not offended them nor does he plan to, what is the clinician's ethical duty? Some may say to report the concerns, and others may say to keep confidentiality and work with the offender so that he does not offend the child of interest. The problem is, there may not be right answers to many of these dilemmas. Mandated reporting is relevant only when there has already been a child harmed (APA, 2003). Sex offenders may face boundaries such as this, where the beneficial treatment approach would include expressing these desires, but the action of the therapist is unknown. Glaser (2009) recommended ethical guidelines that enable providers to promote respect for offenders' rights while also justifying the clinician's infringements on those rights.

As early as the 1990s, sex offender treatment programs (SOTP) mainly consisted of group-based cognitive behavioral therapy during incarceration. This type of treatment remains the main form of treatment for sex offenders, however it is not altered for the different types of sex offenders (Patterson, 2018). Before this time, treatment approaches were unethical in nature. Both aversion therapy and masturbatory reconditioning were used. Aversion therapy served to decrease inappropriate sexual arousal, and masturbatory reconditions served to increase appropriate sexual arousal. (Patterson, 2018). SOTP are typically required to be eligible for parole, but there are criteria the offender must meet in order to be able to participate. The criteria may include an IQ over 80 to be able to comprehend the cognitive nature of the group (Patterson, 2018). This may present a barrier for those with intellectual disabilities who may not be offered another form of treatment. The only research to support the efficacy of cognitive behavioral-based sex offender treatment has been completed using case studies or quasi-experimental designs (Patterson, 2018). There is limited research on the components of sex offender treatment aside from being cognitive behavioral methods. Andrews et al., (2011) outline some of the essential features of sex offender treatment programs: delivered to high risk offenders, target criminogenic needs for change, emphasize behavioral and social learning principles, and identify and target offender responsivity needs.

Parole and probation are common for sex offenders just released from prison. This may be the only type of accountability the sex offender is responsible for due to lack of support and other resources. Not all sex offenders are on probation or parole, but most have to register for the sex offender registry. Some contemporary sex offender models led

to collaboration between probation officers and therapists (Newstrom et al., 2019). There is long-standing evidence that prosocial change is more likely when the professional providing treatment is trusted, provides hope, promotes self-regulation, and challenges dysfunctional thoughts (McGrath et al., 1998). There is much research to support the collaborative relationship between treatment and surveillance. Stalans (2004) suggested that the combination of supervision and therapeutic treatment reduces sex offender recidivism more than a supervision-only approach. The research also suggested that not only does the collaboration benefit the risk of recidivism, but it enhances the general functioning of rehabilitating sex offenders.

The containment model is used as an alternative to standard probation or as a basis for sex offender specific treatment in some states. The containment model advocates for the importance of collaboration between therapists, probation officers, victim advocates, police, and polygraphers. (D'Amora & Burns-Smith, 1999). There are five major components of the containment model. *Victim and public safety philosophy* is the first component of the containment model. This philosophy, although it may not be effective in the treatment of offenders, it is necessary for the safety of the community to be a priority. The next component of the model is *multidisciplinary collaboration*, which includes intra- and inter-agency teams that communicate frequently with the best interest of the offender in mind. The third component consists of *containment strategies*. These strategies may include community supervision, treatment that is specific to sex offenders, group therapies, and maintenance polygraphs (English et al., 2016). Not many of these strategies have evidence to support or disprove the effectiveness in reducing recidivism,

and much more research is needed. The next component of the containment model consists of sex offender management strategies using *public policies and agency protocols*. These policies may include funding for treatment, assessment tools for risk of re-offense and dangerousness of the sex offenders. The final component of the model is *quality control mechanisms*. Quality control mechanisms may include case review meetings between agencies, data collection, offender tracking mechanisms such as Megan's law, dropout-revocation data, and staff training (English et al., 2016). Researchers found that the collaborators within the containment model such as the probation officers and treatment providers, were positive about the partnership. Researchers agree that appropriate two-way communication between the treatment providers and officers assists in reducing a sex offenders' risk for recidivism (McGrath et al., 2010). Furthermore, it is interesting to note that the collaboration efforts increase when mental health services are led by law enforcement or corrections officers (Wilson & Draine, 2006).

There are interventions and treatment strategies specifically focused on reducing sex offender recidivism. Circles of support is a model that includes a community approach to treatment. The model was created after researchers acknowledged the lack of support that rehabilitating sex offenders have (Clarke, et al., 2017). Originally, the support group was created to provide support to sex offenders because the community was so hostile to them. The original group showed to be effective and then created a movement. Circles of support is now used all around the world as an intervention for rehabilitating sex offenders (Clarke et al, 2017). A key difference between circles of

support and other treatment interventions is that circles of support is run by volunteers rather than paid professionals. Another big piece of circles of support is accountability. The volunteers hold the sex offenders accountable for their own reintegration while providing the support and resources that might be helpful. The intervention is not mandatory and not punitive (Clarke et al, 2017). The circles of support model has the unique emphasis on support rather than other interventions, compared to other treatment models that are purely focused on internal beliefs, thoughts, and desires (Clarke et al, 2017).

Overall, there is more research needed to support the efficacy and effectiveness of sex offender specific treatment. There is limited information available about the treatment provided during incarceration. The majority of research on treatment effectiveness uses recidivism data, may not include other barriers to recidivism (Hsieh et al., 2018).

Identified Barriers to Successful Reintegration

Clearly there are barriers to successful reintegration, because the recidivism rates are consistently too high at 13.12% sexual recidivism with treatment, 17.94% sexual recidivism without treatment (Soldino and Carbonell-Vayá, 2017). Violent and general recidivism rates are higher than the previously mentioned sexual recidivism (Soldino and Carbonell-Vayá, 2017). Although the containment model and certain types of collaborative approaches have shown positive effects in regards to recidivism, there are still barriers to those models. There are dynamic factors that may be major barriers to reintegration including support, financial status, barriers to employment, residency restrictions, and treatment effectiveness or availability to treatment. There is limited

research assessing the dynamic barriers of reintegration, although there is significant but inconsistent research related to the static factors.

Research shows that the recidivism rate for sex offenders is at its highest the first two years after release from incarceration (Harris & Hanson, 2004). It is important to take into account all of the rebuilding that needs to be done in the first two years. Any criminal released from prison typically has to figure out their housing needs, financial stability, employment, and support network. Sex offender legislation puts a lot of restrictions on sex offenders that other types of criminals may not have to face during this phase of rebuilding (Winters et al., 2017). Winters et al., (2017) identified four elements of social control, which has shown to be an important part of rehabilitation for criminals attempting to rehabilitate. The four pieces of social control are as follows:

- attachment—the link between the individual and society such as relationships with friends, family, and religious institutions that would make individuals want to follow the rules and norms of society;
- commitment—the time, energy and commitment one has dedicated to an institution or career that has a place for them;
- involvement—the level of interaction with school, employment for example, such that those that are more involved have little time to engage in delinquent behavior; and
- beliefs—the shared values and morals of society at large (Winters et al., 2017, p. 204).

The social control constructs mentioned above illuminate the categories that specific barriers might affect during the reintegration process. Take note that none of the aspects of social control are included on most risk assessments, but are included in the treatment process. Keep in mind that all registered sex offenders must abide by the similar restrictions, and therefore experience similar barriers.

Each of the constructs related to social control may be highly impacted for sex offenders as compared to other types of offenders. Tewksbury and Levenson (2009) identified the sex offenders' hindered ability to obtain attachment needs because of the negative consequences the sex offender registry has on families of offenders. There may be other barriers to attachment with family, friends, and the community due to the residency restrictions. Rolfe, Tewksbury, and Schroder (2016) pinpoint the residency restrictions as being one of the most profound barriers of rehabilitation for sex offenders. Some sources have found that residency restrictions may likely increase the risk of re-offense by limiting the sex offenders' ability to obtain social bonds and known support (de Vries et al., 2015; Farmer et al., 2015). Family support may also be decreased due to the fact that some sex offenders may no longer be allowed to live with their family because of where the home is located or if there are minor children (Huebner et al., 2014). The residency restrictions may create the inability for sex offender to return to their previous residence if they had a stable residence prior to incarceration. Research completed in the state of South Carolina shows that approximately 20% of sex offenders on the registry who have a 1000 foot restriction are unable to return to their current residence. Furthermore, the same research study shows that if the residency restriction is

one mile, 80% of registered sex offenders are unable to return to their most recent residence (Barnes et al., 2009). If a sex offender violates the residency or employment zone restrictions, they may be subject to a felony on their first offense, which is common for most states (Lester, 2007).

The inability to return to previous housing creates barriers such as not being able to find affordable housing, and not being allowed to find housing in an area that is suitable to the needs of the sex offender. Having to move further away into rural areas or disorganized neighborhoods may create transportation barriers, social support barriers, and employment barriers (Mustaine, 2014). Unfortunately, due to residency restrictions, there are many sex offenders that are homeless (Rolfe et al., 2016). Despite the unfortunate deficit of homeless shelters for the general population, many homeless shelters will not allow convicted sex offenders to benefit from their services. Goldstein (2014) discovered that only 14 out of 270 New York City homeless shelters allowed sex offenders, leaving registered sex offenders with absolutely no option other than the streets. If they can afford it, it is possible for sex offenders to take advantage of public housing opportunities, however the federal law does not allow sex offenders that are registered for life to have this option. Rolfe et al., (2016) believed that residency restrictions in combination with the sex offender registry may regulate sex offenders to homelessness. Zandbergen & Hart (2006) emphasize that some sex offenders' only option is to be homeless if they want to avoid violation of SORN. Furthermore, Tewksbury (2012) identified the impact that public perception and stigmatization may

have on whether or not homeless shelters allow registered sex offenders, especially if they receive public funding.

Another common barrier for sex offenders is employment – which is crucial for all of the social control elements. Winters et al., (2017) identified in their study that about 55% of sex offenders had full-time employment before they were incarcerated. Similar to the residency restrictions, there are limitations regarding location of employment. Mentioned previously, depending on the state sex offenders may not be able to work at or near areas that children frequent (Lester, 2007). Lester (2007) validates the need for child molesters and pedophiles to be restricted from working in a place where they may form a bond or relationship with a minor, such as working in a school or childcare position. However, when the law also places a barrier around major sections of the community because there is a school or playground nearby, it places huge limitations on the ability to find an employer. Furthermore, the barriers to employment that apply to the general public also apply to sex offenders. Lack of education or employment history may be added barriers, especially when research shows that those convicted with felonies are less likely to have the same education and employment history than average (Bureau of Justice Statistics, 2000). All of these barriers are in place along with the common restrictions some employers have related to criminal history. Jobs that typically hire those with felonies or a criminal record may not be suitable or possible if the sex offender requires travel. Positions like electricians, construction, technology related positions, delivery positions, are not allowed do to the travel to unknown individuals' residence (Lester, 2007). These restrictions also create barriers for the 55% of sex offenders who

previously had a job because higher positions such as doctors, attorneys, and other white-collar jobs may by in a restricted area. Not being able to find employment may result in economic marginalization, which may increase the risk of reoffending (Rakis, 2005). Lester (2007) sums up the unintended consequences of the barriers placed on sex offenders by stating the following:

> There are unintended consequences of the residence and employment restrictions that may actually exacerbate the problem that the laws were intended to correct. Because these laws are often passed without much consideration as to the results of implementation, there have been many negative consequences. The shortsightedness of these laws is that, in their zeal to protect, they give sex offenders little hope of redemptions. We express a desire for rehabilitation of the individual, while simultaneously we do everything to prevent it… We tell him to return to the norm of behavior, yet we brand him as virtually unemployable; he is required to live with his normal activities severely restricted and we react with sickened wonder and disgust when he returns to a life of crime (p. 14).

Sex offender legislation creates psychological barriers as well (Farmer et al., 2015). The inability to live with supportive family members creates barriers related to support. Psychological consequences may include feelings of shame, harassment, decreased self-efficacy, and limited ability to create and maintain social relationships (Jeglic et al., 2012). The public belief that sex offenders don't benefit from psychological interventions limits the availability and drive to be able to find and commit to an effective psychological treatment (Viki et al., 2012). Sex offenders are frequently labeled as a

population that does not have the ability to change, therefore separating them from other humans. There is no current empirical research examining the effects of dehumanizing language as related to attitudes about sex offenders. However, dehumanizing language is frequently used to describe sex offenders. According to Haslam (2006), dehumanization has two contextual formats: animalistic and mechanistic. Animalistic dehumanization refers to the lack of moral sensibility, while mechanistic dehumanization refers to interpersonal and cognitive deficits. The dehumanization related to sex offenders is more focused on the animalistic type. Research shows that community support and good relationships with correctional staff/treatment professionals may increase sex offender chances at successful rehabilitation (Viki et al., 2012). Unfortunately, these two components are not prevalent because the sex offender population is one of the most hated compared to other types of criminals. The researchers aimed to identify the role of dehumanization in relation to the two aforementioned factors, community support and relationship with correctional staff. The findings suggest that dehumanization has significant effects on sex offenders' ability to reintegrate successfully by decreasing community support (Viki et al., 2012). Specifically, the research identified that those who dehumanized sex offenders did not support rehabilitation but supported exclusion from society. Furthermore, individuals who dehumanize sex offenders are more likely to support violent ill treatments (Viki et al., 2012).

More recent research illuminates the effects of the labels we place on sex offenders, specifically related to the term "sex offender". Lowe and Willis (2020) identify the influence that defining sex offenders as anything on than a person makes individuals

less likely to volunteer to help them. Their study included randomly assigned participants in which half asked if they would volunteer to work with a labeled offender such as murderer or sex offender, and the other half were given a non-labeled type of offender such as “person or people who have committed crimes of sexual nature”. The results showed that participants who had the labeled condition were much less willing to volunteer (Lowe and Willis, 2020). This serves to acknowledge the barrier that the label alone puts of sex offenders attempting to rehabilitate.

Aside from the barriers that sex offenders may be facing after incarceration, there are also barriers for those who have deviant sexual interest that have not offended. Keep in mind that the barriers for those who have not yet offended are also present for those who have and are attempting to resist during reintegration. The problem may be solved if we are somehow able to stop the initial offending by offering those who have notoffended, but are at risk, the help they need. A study was conducted to discover the ability of sex offenders to reach out for help before they offend, and the results are concerning. The results showed that most of the 372 respondents did not seek any counseling due to the shame and secrecy associated with sex offenders (Levenson et al.,2017). Specifically, only 20% talked to anyone at all about the desires they were having prior to their initial arrest. Confidentiality concerns were a barrier that many sex offenders identified (Levenson et al., 2017). A breach in confidentiality, whether required or not, can then lead to both legal and social consequences, which the respondents emphasized as another barrier. Some of the respondents identified confusion about their feelings and interest that may include shame because of the deviant desires. Finally, the

research showed that there are significant barriers to finding an affordable treatment provider, along with a professional that is willing and competent enough to work with them (Levenson et al., 2017). Another study surveyed convicted sex offenders about their availability and interest in seeking treatment prior to their original offense. The results showed that there was a lack of awareness regarding potential counseling services, or they did not have access to services. Furthermore, there was significant fear about being reported to authorities that led to the failure to seek counseling (Piché et al., 2016). It seems as though the individual fears they will end up in jail whether they resist their desires and seek help, or if they offend anyway.

Further psychological barriers are recognized based on the effects of unhealthy social influence. Lussier et al., (2010) identifies lack of social support as one of the greatest risk factors and predictors of sex offender recidivism, which creates more confusion as to why these things are not assessed and planned for prior to release. Winters et al., (2017) identified that about 67% of sex offenders stated that they were not able to count on their families for any type of support after release from incarceration, and around 40% of the sex offenders in the study felt completely rejected by their families. A sex offender describes his experience as "being demonized as an evil person for something you have no control over (Levenson et al., 2017, p. 112)". Another states "People with those urges get burned at the stake. You can't come forward without being ostracized and handicapped to the point [that] living is nearly impossible (Levenson et al., 2017, p. 112)." Other references were made that identify the experience of being treated like a monster and labeled as unable to change (Levenson et al., 2017). The labels,

stigma, and fear associated with sex offenders may create similar internal beliefs that restrict the sex offender from believing they are capable of seeking treatment or resisting reoffense. Research shows that internal beliefs about oneself have a greater impact on seeking help than external factors (Andrade et al., 2014).

It is important to be mindful of the barriers that all consumers have when seeking treatment. Without the appropriate insurance, therapy can be hundreds of dollars an hour. The resources have to be available in terms of where to go for treatment, the availability of transportation, and the specialty of the therapist. These barriers, in conjunction with the added barriers of being a convicted sex offender, may significantly limit the ability to be successful at reintegrating. At this time, it seems as though the barriers to being successful at reintegration are created by the same society that is trying to prevent sexual recidivism. This study aims to identify these barriers from the viewpoint of the sex offenders who experience them.

Summary

It is clear that every sexual offense is one that ultimately needs to be prevented to solve the problem of sexual offending and victimization. There have been attempts to decrease the recidivism through treatment during and after incarceration, legislation with the goal of community safety, and increased research and education regarding sexual offending. Although the problem is not solved, our response as society has evolved. This research project serves to increase awareness and the information needed to solve this problem. Understanding the problem from a different perspective will increase the amount of information about how to solve the problem of recidivism, and potentially

decrease original offenses. The community deserves to feel safe, and the sex offenders deserve the opportunity to succeed in that goal. Unfortunately, at this time those two goals are not mutually exclusive, and our attempts to increase community safety may be creating more barriers to successful reintegration for sex offenders. The field of psychology has made generous improvements on the topic, let's not stop there.

Chapter 3: Methodology

Introduction

The recidivism of sex offenders poses many barriers and challenges for researchers and other clinical professionals. This qualitative study served to help understand the experience of sex offenders who have tried to reintegrate into the community but ultimately ended up reoffending and returning to prison. The purpose of this qualitative research was to increase knowledge and understanding that may prevent other sex offenders from recidivating. The literature has shown that professionals have limited understanding of what sex offenders experience, as well as their interpretations of what their risks are compared to frequently used risk assessments. The research on this topic includes research on effectiveness of treatment, community opinions about sex offenders, professional opinions about sex offenders, and protocols and assessments related to sex offenders.

Research Questions

RQ1: According to treatment providers, what are the barriers sex offenders experience while attempting to reintegrate into the general population?

RQ2: How do variables such as family support, financial status, community acceptance, and treatment influence barriers?

Research Design

To understand the experience of the sex offenders, the method of research I intended was to conduct face-to-face interviews with treatment providers. However, due to the coronavirus pandemic, there were barriers to face-to-face interviews. The

interviews were therefore done via video interface or phone. Due to the limited research on sex offender experiences and opinions, the interview questions were general but specific enough to grasp the complete story of their experience. The sex offender treatment providers provided narratives of sex offenders' rehabilitation experiences without being prompted by hypothesized themes. Additionally, I asked follow-up questions to identify specific barriers that may have been faced, as well as specific resources that may have been helpful. I provided all interested treatment providers with information allowing them to make an informed decision about participation, including a consent form that contained the IRB approval number: 12-09-20-072943.

A theoretical framework typically used with sex offenders is the RNR model (Wilpert et al., 2019). This is the theory that best suited the present research study based on the theory's heavy emphasis on barriers that lead to recidivism. The RNR model is designed to coordinate the treatment with the sex offender's risk level. The RNR primarily focuses on dynamic factors rather than static factors. The central eight domains—antisocial behavior, antisocial personality patterns, antisocial cognition, antisocial associates, family and/or marital, school and/or work, leisure and/or recreation, and substance abuse—(Andrews et al., 2006) are directly related to the RNR model and are broken down further into the big four and moderate four domains. The big four consist of antisocial cognition, antisocial associates, antisocial personality patterns, and history of antisocial behavior; The moderate four consist of family/marital, school/work, leisure/recreation, and substance abuse (Bonta et al., 2014).

The RNR model, the theoretical framework that guideed the present study, serves to emphasize dynamic risk factors including psychological aspects of sex offender reintegration. Most of the research regarding treatment and recidivism of offenders is guided by static risk factors, which do not include thoughts, beliefs, and present aspects of the offenders' reintegration, but rather focus on the unchanged aspects, mostly past data of the offender. The framework may guide sex offender treatment providers to focus on the parts of the reintegration experience that may have led to reoffense rather the unchanged data of their past. Past offenses, delinquencies, and time served cannot be changed or influenced in the present, so research cannot depend on those factors to change outcomes of current sex offenders.

Study Setting and Population

The qualitative research was conducted via telephone and/or video interface with sex offender treatment providers who have worked with recidivated sex offenders. Fusch and Ness (2015) described saturation as the point at which the researcher is not obtaining any new data. The number of treatment providers interviewed was 10.

The inclusion criteria of the study were treatment providers who have worked with sex offenders who have recidivated. Understanding barriers leading to all types of recidivism is necessary to understand the experiences reintegrating sex offenders. The providers only shared experiences of sex offenders whose index offense was sexual, meaning their first conviction was a sexual offense. The sex offenders whose index offense was not sexual were not included in the study because they were not labeled as a sex offender at the time of rehabilitation.

The treatment providers included were individual counselors, psychologists, and group counselors. The treatment providers were briefed with the inclusion criteria of the study to give them time to identify sex offenders who have recidivated. Approximately a week before the interviews, I contacted the treatment providers to explain the purpose of the study and the criteria that satisfies it. This gave the treatment providers the opportunity to ask questions about the study as well as gather thoughts about relevant barriers that recidivated sex offenders have brought up.

Interview

The interview used for qualitative data collection was an in-depth semistructured interview. The time allowable for the interview was 1 hour. Most of the interview was used for the narrative of the sex offender experience(s) that treatment providers have learned about. After the initial narration, I asked the treatment providers necessary follow-up questions regarding the barriers that may have increased the sex offenders' risk for recidivism. All questions in the interview were open-ended.

My role as the researcher was to ask few open ended questions and allow the interviewee to answer the question without restrictions. The purpose was to gather information about barriers that had not yet been identified in qualitative research. Due to the fact I was not working directly with the incarcerated sex offenders, there were no conflicts of interest or power differentials between me and the incarcerated sex offenders. The main interview question was as follows: What are the reasons sex offenders have returned to prison, or recidivated, according to the sex offenders you have worked with? The rest of the research questions were focused on more specific barriers (external and

internal) and the treatment providers' observations. All interviews were recorded with the permission of the treatment providers. The treatment providers were also asked to keep sex offender names anonymous or use an alias to create anonymity and confidentiality on behalf of the offenders. The interview process ended with debriefing and any questions associated with the purpose of the study.

Data Analysis

I used thematic analysis to identify the common themes in the narrated experiences of the offenders during attempted reintegration. Thematic analysis is used to identify main points, themes, and patterns within the data, including perceptions and experiences. This type of analysis helped identify barriers as well as areas that are most beneficial to the participants and will hopefully allow for a general representation of the sex offender experience. Braun et al. (2014) specified strategies for using thematic analysis with interview data. The steps of the analysis consisted of data collection, coding and grouping data, identifying potential themes, reviewing and refining themes, giving meaning to themes, and formally documenting those themes. I used Microsoft Excel to organize the data. Some of the major themes in the data were static barriers (those that remain unchanged, such as a felony or sex offender registry), dynamic barriers (those with potential to change, such as support, treatment, and finances), and potential aids (those that sex offenders think may have helped).

Ethical Considerations and Limitations

Inmates are a vulnerable population, meaning there are special circumstances to consider before beginning offender research. Patenaude (2004) discussed potential

limitations and barriers when conducting research in the prison population. Possible limitations include difficult inmates and staff, multiple IRBs, and administration distrust of outside researchers. It is important to consider other potential barriers related to the sex offender population. There are a wide variety of variables that may not be recognized through treatment providers' narrations such as offenders with special needs, disabilities, and/or severe mental health concerns, including those caused by trauma. However, some of these variables may also be considered during the interview process as a perceived barrier to reintegration.

The participants were treatment providers who have worked with male sex offenders who have recidivated, so the research is not generalizable to female sex offenders. The nature of the interviews may pose some limitations as well due to the current COVID-19 pandemic. Furthermore, with qualitative data there is always the possibility of confirmation bias or fabrication of events on behalf of the offenders the providers are talking about. Treatment providers may have had a hard time recollecting specific barriers related to sex offenders' experiences and may share opinions about barriers rather than those that come for actual experiences.

Summary

The qualitative methodology of this study served to gather all components of the sex offender experience postincarceration. The results of the study were compared to the current research regarding sex offender barriers in order to challenge the validity of the current understanding of the effectiveness of current prevention strategies. The information in the study was gathered based on actual sex offender experiences rather

than the thoughts and opinions of the treatment providers. Limited prompts during the interview ensured that the data was coming from the experiences specific to sex offenders. I use the RNR model in the following chapter to examine each barrier presented during the interviews. Furthermore, the next chapter is categorized using prominent and major themes presented to organize the results.

Chapter 4: Results

Introduction

The most commonly used risk assessments with sex offenders in the United States emphasize static factors, those that are unchanging, rather than dynamic factors (Storey et al., 2012). The purpose of this study was to identify barriers to reintegration from the perspective of sex offenders themselves. This would allow inclusion of all types of barriers to reintegration in treatment and rehabilitation efforts. The purpose of this study was addressed through interviews with sex offender treatment providers. I sought responses to the following research questions:

RQ1: According to treatment providers, what are the barriers sex offenders experience while attempting to reintegrate into the general population?

RQ2: How do variables such a family support, financial status, community acceptance, and treatment influence barriers?

This chapter contains a description of the setting of the study, including COVID-19 restrictions. The demographics of the research participants are outlined, as well as other criteria regarding the treatment providers that is meaningful to the data. The study included 10 sex offender treatment providers who have worked with recidivated sex offenders. This chapter contains an in-depth explanation of the data analysis, including thematic analysis strategies following the interview and demographic survey. In addition, I summarize evidence of trustworthiness. I then present the results using themes recognized during data analysis, and each theme is analyzed. Finally, a summary concludes the chapter.

Setting

Due to COVID-19 restrictions the study was completed virtually. I emailed participants the survey and then participated in a virtual interview, using the technology of their choosing. Any treatment provider that had worked with recidivated sex offenders was included regardless of their level of education or licensure.

Demographics

The sample of the study included 10 sex offender treatment providers who have worked with recidivated sex offenders. The sample of the study was selected through outreach via the Sex Offender Assessment Board and sex offender treatment provider forums through social media. I assessed each interested participant for inclusion prior to data collection. The treatment providers ranged from having obtained associates degrees to PhDs and from 3-17 years of experience working with sex offenders.

Each treatment provider met with the same recidivated sex offender more than 5 times per month for 1-3 hours and averaged about 24 recidivated sex offenders per week. The ages of sex offenders the participants worked with ranged from 18-89 years of age.

Data Collection

Following the demographic survey, I completed semistructured interviews virtually with each treatment provider. I invited potential participants through the Sex Offender Assessment Board and asked each participant to forward information about the study to any other professionals they thought would be interested. I also used Facebook groups for sex offender treatment providers and groups for forensic psychology research to identify and reach out to more participants. I was in contact with participants prior to

the interview to answer any questions they had about the study and tosend enough information for them to make an informed decision about participating. I included a copy of the consent and survey in the original email and allowed them to ask any questions regarding the informed consent, including about the rights of the participants, the voluntary nature of the study, and the limits and scope of participation. After I was able to provide information about the intent and purpose of the study, and the participant had given consent to participate, I set up a time convenient for each participant to engage in the virtual interview. I recorded interviews over the phone as well as through Zoom, depending on the participant's choice of interview means.

Each interview was completed individually and was semistructured. The questions were left open ended to provide the participants with as much freedom as possible when answering the questions. Participants were asked to only give information that was said to them by the sex offenders they worked with and not information they believe themselves. There was a portion of the interview devoted to treatment provider observations and thoughts so as to not confuse this information with the sex offenders' experiences. The interviews lasted from 30-45 minutes, but each participant was given an hour in total. I transcribed each recording immediately after the interview and saved it to a secure solid-state drive.

Data Analysis

I used thematic analysis to interpret the data and identify common themes presented by the sex offenders' experiences. The themes were used to identify barriers to reintegration that sex offenders have experienced that may have led them to recidivating.

The themes also included observations made by treatment providers leading them to believe a barrier was significant in the experience of the sex offender.

Member checking commenced the data analysis process. I followed up with participants through email and phone to assure that the understanding I had of their interpretation was accurate. Following verification from the participants, I proceeded to code the data and develop categories and themes.

The first step of this process including rereading transcripts and creating bullet points related to each barrier mentioned in the interview. For this I only included barriers that were identified as those mentioned by sex offenders and not the observations or thoughts of the participants. After I created a list of mentioned barriers for each interview, I identified duplicates to create an inclusive list of all barriers. Once I had a list of all barriers mentioned in the interviews, I created an Excel spreadsheet with a column for each barrier. After this step, I went through the interviews another time, created a row for each interview, and put a (1) in each column with a barrier mentioned. This way I was able to visualize all the barriers mentioned specific to each interview. The barriers were then compared to the themes presented in the RNR model. After compiling the data this way for the sex offender experience barriers, I did the same for treatment provider observed barriers.

After I created a visible representation of the barriers, I compared them to identify relationships between them. The barriers mentioned and the relationships between them were then used to answer RQ1.

The process for RQ2 was simpler. Again, I went through the transcript of each interview, and compiled the answers to the specific question. I included this information in the Excel spreadsheet related to treatment provider observations, and simply put the participants' response in the final column of the spreadsheet. Following the data analysis process, I sent the participants an email to verify the themes and barriers to make sure it reflected the experiences of sex offenders they had worked with as well as their own observations. The participants verified that the themes accurately represented their experiences and reflected the purpose of the study.

Evidence of Trustworthiness

Member checking, data saturation, and repeated self-inquiry were involved in the evidence of trustworthiness. Member checking is a way to validate participant data to insure credibility.This process including sharing a transcript and information gathered from the interview with participants to verify accuracy. I continuously assured that I was not including my bias during the data collection and interpretation by self-inquiry performed during each step.

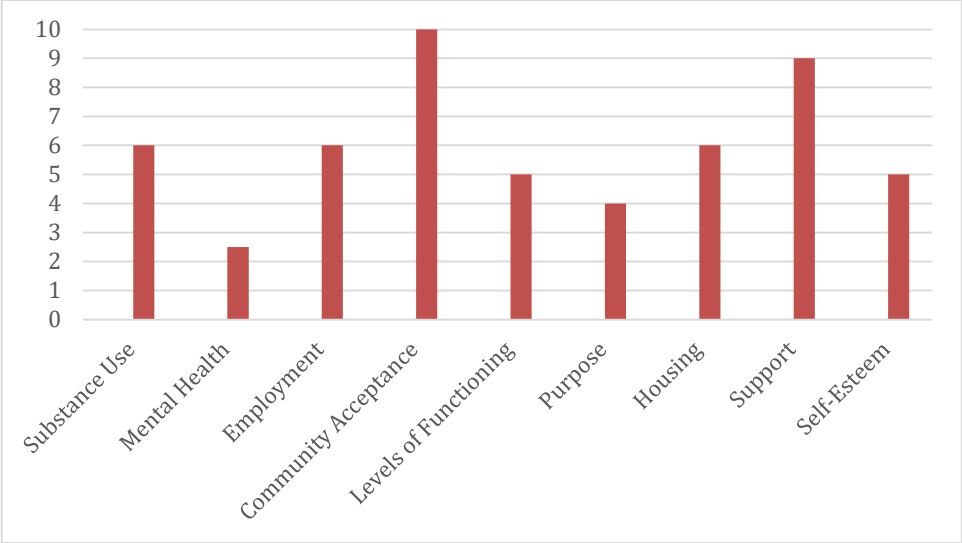
Results

Included in this section are the results, presented in the form of identified barriers. The barriers are described, and excerpts from sex offender experiences are included along with the prevalence of the barrier mentioned. The participants were asked what the barriers are that sex offenders described as the major influences on their recidivism. The participants were not asked about specific barriers, meaning barriers they mentioned were

mentioned without prompting. The frequency of barriers mentioned as well as the correlations made by participants are portrayed (see Figure 1).

Figure 1

Frequency of Barriers Mentioned



Barrier 1: Community Acceptance

Community acceptance was mentioned as a barrier in all 10 of the interviews. It is the only barrier that was identified as significant by all participants, whether through the sex offender experiences or the treatment provider's observation. The participants each referenced the sex offender label being life-long and creating a stigma associated with being a predator. Sex offenders mentioned being afraid that people were going to fear them or treat them with disgust and hatred. Participant 01 referenced the following experience of a sex offender related to this barrier:

> The sex offender was released and immediately unable to engage in any of the hobbies he had previously enjoyed. He disclosed to me that he used to engage in recreational sports leagues, but all of the games were held at local parks. His former teammates would no longer allow him to play on the team, and they would not answer his attempts to get involved. He received texts telling him that he should not be allowed to play because then teammates would feel uncomfortable bringing their families. The sex offender who experienced this eventually became very isolated and ended up reoffending.

Participant 01 mentioned that this specific sex offender was very dedicated to rehabilitation and living a productive life. According to the participant, this sex offender did very well in treatment during his first incarceration. Other participants mentioned community acceptance by talking about social support as a barrier. Participant 02 shared that most of the sex offenders mentioned fear related to being hated and not having access to hobbies or leisure activities.

Participant 02 stated that "sex offenders are generally treated worse than other offenders." Participant 03 emphasized lack of support in the sense that sex offenders feared not being accepted, and the participant believe that this is what pushed them back into the cycle of reoffending. Participant 05 shared similar thoughts in mentioning that sex offenders believe that the community has preconceived ideas about them not being able to heal or be successful. Participant 05 also mentioned that some of the sex offenders would reoffend on purpose because prison was the only place they felt comfortable. "This has happened in two cases I'm aware of, they say I'll get out and do what I want to do, a

bit of free time." Furthermore, Participant 05 summarized that community beliefs and ideas related to community acceptance led sex offenders he worked with to label themselves "I am a sex offender" and believe that they were not able to change. Participant 09 shared a specific sex offender experience related to community acceptance:

> I remember a specific sex offender I worked with a few years ago who was very devoted to changing the stigma. He said that the registry did not do anything but limit his ability to be successful. He was not a child molester, but parents in the community would tell their kids not to go near the house because a bad man lived there. In fact, his offense was statutory, his girlfriend was 16 or 17 and he was 21, and someone pissed off the parents. Again, statutory is wrong, but it is also much different than being a child molester. He was in college and his girlfriend/victim was planning on joining him there after high school. Now that she is over 18, they are together again and happy. He had to relocate because the community treated him so poorly and he felt judged wherever he went. It was sad, a lot of us that had worked with him were upset to see that his life was ending up this way.

Participant 09 followed up with that in mentioning that although statutory rape is an offense, and wrong, that if the stigma is so high for that offense, how are any sex offenders supposed to get better even if they want to? As a treatment provider, participant 09 believes that sex offenders can be better, and they can successfully rehabilitate.

Each participant referenced community acceptance as a major barrier to successful reintegration of the sex offenders they've worked with. The label of a sex

offender is sometimes the only way a sex offender is able to function. Participants mention that they are unable to establish themselves in any other way, because the label follows them wherever they go. Multiple participants mentioned times when the sex offender label has been associated with violence, harassment, and discrimination against the rehabilitating offender. One of the participants even mentioned a time when the sex offender label created a violent situation for supportive family members of the rehabilitating offender. Though community acceptance is the barrier mentioned most frequently, it is not the sole barrier experienced by sex offenders trying to reintegrate back into society.

Barrier 2: Support

Family support was mentioned by 70% of participants, and social support related to friends was mentioned a total of 6 times. Support in general was referenced by 9 out of 10 participants. Each time that family support was mentioned as a barrier, it was because prior to the index offense, the sex offenders mentioned had family support. Participant 06 mentioned that the only time family support was not a barrier was if the family was not a support prior to the index offense. Therefore, it can be reframed that the real barrier is loss of family support.

For example, participant 03 mentioned that most of the offenders where family support was a barrier, had lost the support because of their offense:

> Some of the offenders had a great family support network until they offended, but sexual offenses are hard to process. What do you do if you find out someone you love has done something so terrible? Could you still support them? I don't think

> this is a question we can answer until it happens, but I know that the offenders I worked with had a really hard time losing their families. A lot of the other offenders came in without ever having family support, which could actually be a risk for offending in general. People do crazy things when they don't have people they love. Anyways, I remember spending a lot of time with some offenders just trying to grief the loss of their family, which usually led to losing purpose or desire to change at all, because they didn't believe their family would ever forgive them, and sometimes that all that mattered to them.

Participant 05 mentioned family support as a barrier based on what the sex offenders disclosed and based on observations during treatment with those who have recidivated. He described the following:

> The family is the biggest one, when they say "I don't need family, I can do this on my own" or "I don't need anyone around me, I can do this on my own". Especially common when they first go into prison and they say they don't want family or friends visiting given the shame they feel, um, it's very much "I don't need help, I can do this on my own, this is just a one-time thing, and it tends to, well sometimes they do fine, but for others it's a much much higher risk factor when the day before they leave they don't have anyone to call. Sometimes they self-sabotage because it's not they their family won't support them, but that they push their families away.

Though most participants referenced family support as a barrier mentioned by sex offenders, some also believe it is a barrier based on behaviors they have witnessed during

treatment. Participant 06 mentioned family support as a barrier based on observation, because the sex offenders that successfully rehabilitated or were the most active in treatment tended to have the best support networks. However, the participant could not distinguish a significant correlation between treatment as the barrier, or the support, since most sex offenders either did well in both, or neither. The participant stated:

> Lack of support, lack of support from family members, lack of support from friends. sometimes their belief systems, you know what they did sometimes with the lower offenders, it wasn't as bad. They would believe that it's not that bad, and the barriers for themselves would be their own belief system. They would write letters to their families about their goals and treatment progress, they were excited to see them again and set their life back on track.

Participant 06 aligned family support with purpose in regards with treatment, which will be further described in the "Purpose" section of this chapter. Participant 08 also mentioned a specific experience related to a social network:

> I worked with a pedophile who had both contact and non-contact offenses. This was his first time back in prison. I remember the first thing he said to me when he started treatment here. He said, "What's the point, nobody out there cares about me". I tried to help him find a purpose, but he hated himself just as much as others hated him. The social support barrier created many other barriers for him because he just didn't care about getting back out there and being productive. He said he had no intent of re-offending, but he also had no intent on really doing

anything at all. He said if he had just had friends then he would have a reason to be better.

Participant 06 explained more that he tried to recommend different groups and ways to develop a support system, but at this point all the mentioned sex offender really wanted was to stay in prison. He didn't believe he could function outside of it all by himself.

Each time support was mentioned by participants in the interview, it was mentioned as a significant barrier, and one that general influenced other barriers including self-esteem, purpose, and treatment.. The research did not serve to correlate barriers in terms of which barrier is the leading barrier, but the participants referenced support as being one that impacts other barriers strongly.

Barrier 3: Self-Esteem

Self-esteem overlapped with a lot of other barriers during the interview process, but was mentioned specifically by 5 out of 10 participants. Though, this barrier was frequently mentioned as one that resulted from lack of community acceptance of social support. Self-esteem was also mentioned as one that lead to barriers related to purpose and treatment. Self-esteem includes the labels that sex offenders placed on themselves, as well as their beliefs and ideas about their ability to reintegrate.

Participant 01 had an experience during treatment with a sex offender and it was portrayed as a very significant experience for both the participant and the sex offender. Participant 01 shared the following:

Self-esteem is for sure a barrier. I remember one inmate specifically. The first time he entered my office he was willing to get started and really wanted to work on himself. This was for his first offense so he had not yet re-offended, but he was so sure that he never was going to. He would say things like “I want to be different” or “I’m going to make something of myself”. He wanted to go back to school and become a writer. Treatment went great the first time. He had learned so much about his triggers and deviant sexual interested that he wanted to write a book about it so that he could help others prevent sexual offending. He even had ideas about what he was going to do if he was triggered once he got out. He was planning on finding a therapist and working through past trauma, and really just starting over. He was released and I felt confident that he was going to do it all. Then about 2 years later he came back, and I’ll never forget my first meeting with him. He was a whole different person, he would barely even lift his head. All of the ideas he had about his future were gone. I don’t understand how he left with such motivation and empowerment, but then returned believing that he was nothing. He just said “I can’t do it, I’m not strong enough”. He mentioned that his family even was hopeful that he was going to change, so I’m not sure where these ideas came from. He said “As I kept trying to be better, I kept hearing the group talk about their experiences, and I feel like I just had to change the ideas about myself to get through group”. He went on to say that if he didn’t somehow define himself as a bad person, then he was being ignorant. Truly, I think the labels came from treatment, which is sad to say.

The biggest part of self-esteem, according to participants, is the label associated with sex offenders. Participants used examples where the sex offender used a label to define themselves, or when the label was placed on them in another way and then affected their own beliefs. It is important to consider how self-esteem may affect other barriers, or how other barriers can lead to decreased self-esteem. Participant 05 also referenced self-esteem related to a label. The participant mentioned a specific sex offender who stated "I am a sex offender and I am not allowed to be more than that." The participant validated this and said "this is constantly on their minds. Always a label, yeah. Always someone watching you as well."

Barrier 4: Sense of Purpose

Sense of purpose refers to the desire of the sex offender to make something of themselves. Whether it is a career they want to pursue, or the progress they want to make, they have something to work towards, and a reason to be better. Some participants used the term "motivation to change" in the interview, when talking about sense of purpose. Sense of purpose or motivation was mentioned in 4 out of 10 interviews.

Participant 03 correlated lack of purpose with other barriers, saying that other significant barriers may lead to a lack of purpose: "With lack of employment or support, it leads to a lack of purpose in the community, they end up going into their cycle, and their triggered, and then they use unhealthy coping, and utilize a lot of thinking errors, and then they're unable to stop that cycle". Furthermore, participant 06 referenced a specific offender:

> I remember a specific guy who tried really hard, but ultimately lost his purpose. We can help them create all the goals in the world, but if the environment doesn't support those goals, how can we expect them to meet them? He wanted to find a job but had a really hard time, he tried to stick with treatment but was getting push-back from his outside provider. It just seemed like all the goals he had were made impossible for him. I support the registry and keeping the community safe, but in some ways the system is set up for them to fail. I can't help them establish goals and purpose if they are ultimately not going to be allowed to pursue or meet those goals. It creates a set-back for devoted treatment providers too, because we don't know how to help them create a positive purpose without knowing all the barriers they are going to face.

Participants 05 and 09 referenced purpose in terms of treatment goals. Participant 05 talked about not being about to encourage the treatment goals of some of his sex offenders because there were just too many barriers to allow that goal to be possible. The participant said "I hate to doubt them, but sometimes I just know that they are setting their expectations too high and ultimately it is going to lead to failure". Participant 09 mentioned that sometimes sex offenders just can't find the motivation to be better because they don't believe in themselves.

Barrier 5: Financial Status and Employment

Financial status and employment were mentioned 6 out of 10 times by participants. Employment was commonly mentioned in relation to the restrictions placed

on sex offenders, and background checks in general. Some participants also mentioned employment in terms of jobs that the sex offenders were able to enjoy.

Participant 02 stated that "financial is always a concern" when talking about recidivism in general, not just for sexual offenders. Participant 03 mentioned that sex offenders have had a hard time getting employment which leads to a lack of purpose in the community. Participant 03 also mentioned that if a sex offender comes in with a career already established, it is likely that they won't be able to return to it. This leads to a lot of other barriers for the sex offenders. Participant 05 said:

> A lot of them believe they have to disclose for employment, or the offense is going to be disclosed for them. I remember one of my clients saying, "I have a sexual offense, therefore I can't work with children, which I get, but I also can't work anywhere near children, so it makes it hard to even find a physical location that's considered appropriate, let alone a job I actually enjoy". It makes sense, and even as a treatment provider sometimes I just think they have to settle for a basic job. They're essentially paying for their offense for the rest of their lives if you consider all the barriers to just being normal again. They have to consider both the restrictions to employment but also their triggers if there aren't any restrictions in place. It creates a lot of barriers; it can be quite stringent and quite punitive.

Participant 06 said that sex offenders mentioned having a hard time finding employment during group sessions, because of their statis as a sex offender. "Nobody wants to hire them, so they don't have any healthcare, so sometimes this led to health

barriers as well." Participant 08 referenced employment as a barrier for educated sex offenders and stated the following:

> I think that employment and finances can be a barrier for even an index offense. If they aren't in a job they enjoy, or don't have a desire to better themselves, there isn't enough motivation to stay out of trouble. If they have a good job that they can't go back to, then it is even worse. Where do they go? One guy was a teacher, and obviously he offended a student so he wouldn't go back to teaching but imagine going from a teacher to a fry cook. I want to keep everyone safe and sending him back to a school wouldn't be safe, but it also seems like it's just one hit after another for these guys, so I don't know how we expect them to get better instead of worse. We have to figure something out and I hope with this research your able to suggest some things.

Barrier 6: Housing

Housing was mentioned as a barrier 6 out of 10 times and was commonly associated with employment. The residency restrictions and substance use were also mentioned with the barrier. Participant 05 mentioned it and emphasized the forced change in residency leading to other barriers. Participant 05 said:

> Their housing determines who they're around, and sometimes they're not associating with the right people. If they live in a hostel with other sex offenders, that can sometimes not be the best depending on the dedication of each offender. Even the way they have to live is very punitive. A lot of times their home plan may not be supportive but actually more enabling because the healthy options are

> no longer available based on either the location of the residence or the support of those who would have previously allowed them to stay.

Both Participants 04 and 05 talked about the barrier related to the home-plan. It is common that any type of offender needs to have a home-plan before they can be released from prison. Participant 07 also mentioned that this can be a barrier even though the goal is so that they can be effectively monitored and they're not going on the streets. Participant 07 stated: "We obviously don't want them to be homeless, because that wouldn't help them, but with the restrictions of sex offenders, it is even harder for them to find a home-plan, so sometimes they will stay with anyone who will let them". Participant 04 talked about the home plans and said:

> Most of the time they will go anywhere they can to get out of jail. A lot of the time the people that allow them to come live with them are people that have been in jail too or were friends before the offense. One of the men said that the only options he had were people he knew sucked already, but that was the only way he could get out of jail. His family wouldn't take him, and his friends didn't care. He was also a [substance] user in the past and said that those friends were high all the time, so they probably didn't care if he offended again or not.

Barrier 7: Mental Health

Mental health was mentioned as a barrier in 3 out of 10 interviews, but participant 07 said it is only a barrier half of the time. Mental health is mentioned other ways in the midst of other barriers, including self-esteem and substance use, so for the purpose of understanding, these mental health barriers only references *severe mental health*.

Participant 02 said that severe mental health was a major barrier for certain offenders:

> Mental health can be a barrier if it's something that creates the risk of offense. Like, obviously if they're having delusions or hallucinations that lead to offending that's a different story. We can set them up with all the treatment and medication they need but sometimes those kinds of things are just unpredictable right? If they can't control it there's really nothing that can be done except for them to stay in a long-term treatment center.

Participants 03 and 09 talked about mental health in terms of emotions. Participant 03 referenced severe depression, and participant 09 mentioned pedophilia as a mental health disorder. Participant 03 said the following:

> I think a lot of just, you know, their negative thought process too, "I'm never going to be able to find a job, people are never going to be able to accept me", so they internalize a lot of this negative self-talk and they're unable to cope with this in a healthy manner, so they lack coping skills. They utilize a lot of those thinking errors. "Well, you know I'm just going to do this once", or they're having cravings and urges and think they can look at porn just once and be okay.

Participant 09 mentioned pedophilia and said "if they want children then they want children, it might just be a desire they can't control. With some, we won't know if they're smart enough to get through treatment knowing they will re-offend, or if they really think they can do it but end up not being able to resist. That's why is in the DSM I guess, we just don't know."

Barrier 8: Levels of Functioning

Levels of functioning refer to intellectual and cognitive delays but does not include physical disability as it was not mentioned as a barrier. Levels of intellectual or cognitive functioning were references as barriers in 50% of the interviews, however it was not mentioned as a barrier through sex offenders' experiences, but only as an observation by treatment providers. Participant 01 referenced levels of functioning and said "If they can't understand the offense, how can they understand the treatment?" Participant 02 mentioned lower intellectual abilities, lower IQ, and lower emotional functions as barriers to rehabilitation. Participant 03 stated the following:

> Well, I mean a lot of them have poor insight, a lot of them think they're not going to offend again, and this is a one-time thing, or they're not even aware of raping somebody. Even after the fact, after group and treatment, they say like "Well yeah I told them I had sex with the kid" and don't see that it is wrong.

Participant 07 said that it only matters some of the time, "I have guys who have a very low IQ, but they are still able to know the difference between right and wrong, so I think depending on the type of delay and offense it may be a factor, but not always". Participant 06 relayed something similar: "They don't have the comprehensive of something with a higher ability, but on the flip side of that you can have someone who has a lesser ability vs. a higher ability, but their can still be a deviant sexual interest they choose to act on."

Barrier 9: Substance Abuse

Substance abuse was mentioned a total of 6 times. Each time the barrier was mentioned, the sex offenders had a history of substance use or addiction prior to their index offense. Substance abuse was not mentioned as a new barrier during the rehabilitation process. Substance abuse was also commonly associated with housing as a barrier. Participant 04 talked about the prevalence of a home plan being with other users leading the cycle of addiction to start, and the cycle of sexual offending. Participant 01 reference substance use as a significant barrier:

> Depending on the drugs they use, sometimes rape or something happens just because they are in a whacky state of mind, but if it's happened before it can happen again, actually one of mine said that he would always want to rape the same person when he was high on meth I think it was, but he would never act on it, he doesn't even remember the whole story but he knew that he went through with it.

Participants 06 and 08 believe that addiction is a barrier leading many other barriers. Participant 06 said that there have been many sex offenders that have failed in their recovery because of the other barriers related to sex offender reintegration:

> Who knows which one comes first. They come in addicted, and we work to get them clean and healthy but we also have to do sex offender treatment which is great but it would be nice to know which one is leading which. Do the drugs lead to offense or do the sexual desires lead to drugs? I've seen so many sex offenders turn to drugs because they have no support or because they can't find work, but

> then they say that's why they turn to drugs. But then do the drugs lead to re-offense? Or is that just another way of them giving up once they've already decided to use again? There's really no way to know how drugs impact rehabilitation, addiction is its own battle. It's just extra tough to have to battle addiction with all of the added restrictions of being a sex offender too.

Participant 08 shared something similar in saying:

> Drugs then sex offense, then more drugs, or the other way around. Sure, addiction is a huge barrier to reintegrating successfully, but I think that is the case for any offender, just doubly hard for sex offenders because I'd imagine they have the hardest time rehabilitating in general.

Treatment Provider Thoughts: Treatment

The treatment providers were not asked to share their thoughts regarding sex offender treatment programs during incarceration or otherwise, but some of the treatment providers shared information regarding treatment that may better help with the understanding of barriers. Participant 05 talked about the how triggers to sexual offending are much different during incarceration than they are in the real world:

> They can throw programs at people, but if they're not willing to take it on, or if they feel they are self-sufficient, and they don't need it. There's no support around the sub-skills needed to live in society unfortunately. For a lot of people, especially those who have served a substantial sentence, they may not know how to use an iPhone. It can be really scary adjusting to a new society. Technology creates a whole new method of offending, especially for non-contact offenders

Participant 06 talks about similar issues when it comes to the differences during treatment and after treatment:

> Some of them, treatment in itself, some of them responded well and some of them didn't respond well at all. They have this whole persona that they're a sex offender so they can never change. And that's not the case 'cause we know that if they choose to change they can change. They're behaviors on the street um, they think they're down 15-20 years and they don't have access to children or whatever their deviant sexual attraction is too, and they're cured overnight. They test themselves the minute they get back on the street. They're seeming unimportant decisions, or SUDS, and their high-risk factors, even though they do well in group with them, the SUDS not so much, it really takes a lot for somebody to understand what a SUD really is. There's walking at night, instead of going straight, you take a left and don't know that there is a daycare right there, that's the SUD that a lot of them don't think about.

Treatment Provider Thoughts: Risk Assessments

At the close of the interview, participants were asked if any of the risk factors on their most commonly used risk assessment were believed to be accurate in assessing true risk. All of the risk assessments used only assessed static factors. There were only two mentioned items. One of the participants said that the substance use item was accurate in predicting risk, and another participant said the age of the offender at release was accurate in assessing risk.

Participant 02 stated that none of the items on the Static-99 have been associated with actual barriers to recidivism in their experience. Participant 02 responded further with the following:

> I don't like the Static-99; I think there's a lot of interrater reliability issues there. We use it because our referral sources require it, but I frankly don't personally put much weight into it. I mean obviously it's static, so it doesn't take into account the numerous factors upon discharge because when done correctly, it's based on the day of release from prison.

Participant 03 stated the following regarding the risk assessments used: "They don't bring up history of say… abuse. It brings up substance use, but again that's after they had difficulties with internal and external barriers that turned them to substance use". Participant 06 did say that their age of release may be accurate after reviewing the Static-99 during the interview. Participant 06 stated: "Their age maybe, the older they get, the less likely they are to reoffend, even though their first offense could happen at a later age".

Other than the two participants that each mentioned one item, all other participants said that there were no items on the risk assessment that they believe accurately represented true risk. Many of the participants mentioned the risk assessment being part of procedure more than actually identifying risk.

Summary

This chapter presented the results, addressing the purpose of identifying barriers during the reintegration process of sex offenders. The following research questions were answered:

RQ1: According to treatment providers, what are the barriers sex offenders experience while attempting to reintegrate into the general population?

RQ2: How do variables such a family support, financial status, community acceptance, and treatment influence barriers?

A majority of the barriers mentioned were dynamic barriers, rather than static or unchanging barriers. Other than the barriers mentioned in this chapter, there were not any other specific barriers mentioned regarding recidivism of sex offenders, either by the treatment providers' observation or the sex offenders themselves. Community acceptance was mentioned in every interview as a significant barrier to recidivism. Support, including family and social support, was mentioned by 9 out of 10 participants as being significant. Substance use, employment, and housing, were each mentioned by 6 out of 10 participants as significant barriers to rehabilitation. Self-esteem and levels of functioning were each mentioned in 5 out of 10 interviews, followed by purpose mentioned 4 out of 10 times. Mental health was mentioned the least, but still mentioned 3 times with one participant saying that it is only a barrier half of the time. The frequency of mentioned barriers to recidivism from ten participants. The frequency includes both barriers mentioned by sex offenders and those observed by treatment providers through specific sex offender experiences.

During the interviews, participants also correlated barriers to one another, since many of the barriers mentioned are experienced in conjunction with other barriers. Community acceptance and support were both commonly mentioned as a barrier leading to both self-esteem barriers and barriers related to lack of purpose. Housing, financial, and employment barriers were commonly mentioned as influencing one another. Substance use was mentioned as influencing mental health.

The barriers and correlations presented in this chapter are further discussed in the following chapter. The discussion serves to identify correlations between the results, existing literature, and the framework of the study. Furthermore, the next chapter presents recommendations, implications, and conclusions of this research study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Although sex offenders' recidivism rates are not the highest compared to other types of offenders, they are still regarded with the most community ill will and face the most limitations to reintegration (Rosselli & Jeglic, 2017). Though sex offenders are believed to be at high risk for recidivism, the recidivism rate does not correlate with the assumed risk. When assessing risk of sex offender recidivism, static factors are usually assessed. Rarely are there dynamic barriers assessed in a professional setting.

The purpose of this research study was to examine and identify the barriers sex offenders experience while trying to reintegrate into society. The intent was to explore the barriers specifically mentioned by sex offenders, and not those assumed by professionals. I created the following research questions to address this purpose:

RQ1: According to treatment providers, what are the barriers sex offenders experience while attempting to reintegrate into the general population?

RQ2: How do variables such a family support, financial status, community acceptance, and treatment influence barriers?

I completed interviews with 10 sex offender treatment providers who have worked with recidivated sex offenders to answer the research questions. The treatment providers provided experiences that were told to them by sex offenders themselves, and nine significant barriers emerged from the interviews. The barriers identified through the interviews are all dynamic barriers, meaning they can all change over time.

The most prevalent barrier mentioned was community acceptance, and it was mentioned in each interview as being a significant barrier to sex offender rehabilitation and reintegration. The second most prevalent barrier mentioned was support, including family support and social support. Housing, substance use, and employment barriers were presented as barriers in six out of 10 interviews each, followed by levels of functioning and self-esteem, mentioned five out 10 times each. Sense of purpose was mentioned four times, and mental health approximately three times. Finally, I explored treatment provider thoughts regarding treatment effectiveness and the risk assessments.

The barriers are discussed in detail and correlated with literature and the RNR model in the following section. After the interpretation of the barriers, I discuss the limitations of the study, recommendations for further research, and the implications of this current study. The chapter ends with a summary.

Interpretation of the Findings

In this section I explore the barriers mentioned by participants. The findings are correlated to previous findings from literature to identify relevance in the present. The nine barriers represent barriers disclosed by sex offenders themselves, along with those observed by treatment providers as being significant barriers leading to recidivism.

Barrier 1: Community Acceptance

Community acceptance, or lack thereof, was shown to be a significant barrier creating risk to recidivism. Each participant identified community acceptance as a barrier mentioned by sex offenders themselves. Olver & Barlow (2010) validated that sex offenders are the most hated group of offenders out of all different kind of offenders.

Previous research shows that sex offenders generate fear, disgust, and anger in the community (Olver & Barlow, 2010). In the current study, participants validated this belief by mentioning the many sex offender experiences in which the community's ideas about sex offenders affected them. In all of the participants' stories about the sex offenders they worked with, the community's beliefs changed the sex offenders' beliefs, rather than the other way around. In some cases, the sex offenders were very motivated to change, and positive about their recovery, but the barriers set forth by the community made it too hard to succeed. Most of the community do not believe that sex offenders can rehabilitate (Payne et al., 2010). This belief may have power over a sex offender's willingness and capability of rehabilitating successfully. Viki et al., (2012) identified that community perceptions limit the availability and drive of sex offenders to find and commit to treatment. Viki et al., (2012) also emphasized the role of dehumanizing language and beliefs held by the community, leading to increased shame, which was validated in sex offenders' stories.

Previous research shows that the ideas about sex offender recidivism and success may have come from treatment providers themselves (Williams, 2004). However, the current research identifies that the belief held by treatment providers and the community could actually be creating the risk more than it is validation preexisting risk.

In the RNR model's central eight, community effects are not mentioned. However, antisocial cognition, school/work, and leisure/recreation can all be closely related to the effects of the lack of community acceptance disclosed by sex offenders. The RNR validates the risk of dynamic factors rather than purely static factors. Andrews

(2006) identified the potential that the RNR model may sometimes be applied without consideration of individual differences among sex offenders. However, the original principles that guide the RNR model are risk, need, and responsivity (Andrews et al., 2011), and these three factors can be adapted to serve the barrier of lack of community acceptance.

Barrier 2: Support

There is little to no research identifying the potential of lack of support being a barrier to reintegration. The current study identifies lack of support as a significant barrier to sex offender reintegration, and it was mentioned to be a barrier by seven out of 10 participants. However, in research not related to sex offenders, lack of family and social support is shown to be a barrier in other types of treatment, including substance use and mental health rehabilitation. Suicide is also commonly associated with lack of support, and research shows that about 14% of sex offenders attempt suicide (Jeglic et al., 2013). It is important to note that some may seek support in terms of religion or faith but may not be able to engage in church groups because of restrictions set forth by exclusionary zone legislation. However, there were no specific mentions of support related to religion from participants. Lussier et al., (2010) identified social support as one of the most significant risk factors for re-offense, and Levenson et al., (2017) confirms this in validating sex offenders' perceptions of being demonized.

Family and social support is also known to be crucial when recovering from trauma, which is prevalent with sex offenders. Zalta et al. (2021) mentioned that social support is a "robust" predictor of PTSD. The researchers stated:

> Social support protects or buffers individuals from the pathogenic influence of trauma by enhancing individuals' perceived ability to cope with the trauma, reducing negative appraisals of the trauma, and reducing harmful physiological responses to the trauma. Thus, following trauma exposure, the expectation is that individuals with higher levels of social support will be less likely to develop PTSD symptoms. (Zalta et al., 2021, 34)

In fact, male sex offenders were 3 times more likely than other males to have experienced childhood sexual abuse, twice as likely to have experienced childhood physical abuse, and 13 times more likely to have experienced verbal abuse in childhood (Levenson et al., 2014). This correlates symptoms of trauma with sex offenders, enhancing the need for social support during recovery.

Family and social support overlaps with other known barriers to treatment and recidivism and is heavily emphasized in other types of healing. Visher and O'Connell (2012) concluded that correctional facilities that incorporate family support during incarceration may lead to increased optimism among individuals returning to the community postincarceration. However, there is little research to validate the present study's findings that lack of family support and social support lead to an increased risk in sexual offender recidivism. It is important to note that in considering the sex offender experiences of the present study, lack of support was mentioned as a significant barrier to reintegration a majority of the time and may be heavily influenced by other barriers related to sexual offender risk and recidivism.

The RNR model emphasizes family and/or marital as one of the central eight and one of the moderate four domains. Though this factor is not predominantly mentioned in research as a barrier, it is used in the RNR model in an attempt to coordinate treatment with the individual needs of each sex offender. Without family support or social support, there may be increased risk of failure in terms of treatment as well.

Barrier 3: Self-Esteem

The idea of lack of self-esteem being a barrier is essentially nonexistant in previous literature related to sex offender barriers to rehabilitation or related to sex offenders at all. However, low self-esteem during adolescence and child sexual abuse history have been found to be associated with sexual violence in adulthood (Reckdenwald et al., 2014). There is research to support that low self-esteem is associated with the severity and frequency of violence as well (Ostrowsky, 2010). Loinaz et al. (2021) described self-esteem as being a U-shaped variable, meaning there is supporting research suggesting that both low self-esteem and high self-esteem can be predictors when it comes to sexual offending. Despite the conflicting research related to self-esteem and sexual offenders, it is clear that self-esteem needs to be addressed more thoroughly during treatment for sexual offenders.

Self-esteem can be closely associated with treatment effectiveness (Eberl et al., 2018). Research shows that although self-esteem did not predict the actual course of therapy, those with higher self-esteem improved more quickly and had less severe symptoms throughout the course of therapy. The research also showed that self-esteem did not predict the stability after treatment (Eberl et al., 2018). Most sex offenders are

engaging in treatment both before and after incarceration, during the reintegration process. If self-esteem affects symptoms during treatment, it is likely that this may then affect sex offenders' ability to engage in treatment as well as apply aspects of treatment during reintegration.

The RNR model includes antisocial patterns, antisocial behaviors, antisocial cognitions, and antisocial associates. Any antisocial patterns can be associated with low self-esteem. The research suggests that low self-esteem can be related to antisocial behavior and delinquency (M. Rosenberg et al., 2005).

Barrier 4: Sense of Purpose

Sense of purpose is another barrier that is not referenced in literature regarding sex offenders, but it is in the literature regarding well-being overall. Pfund et al. (2021) emphasized the impact of purpose on psychological well-being, and in their previous research they have also found that life satisfaction, positive affect, grit, and hope can all be positively affected by a higher sense of purpose. Pfund et al. (2021) also mentioned that a higher sense of purpose can be related to less negative daily symptoms, more beneficial cognitive outcomes, and greater longevity.

It may also be true that other barriers mentioned may lead to a lack of purpose, if the restrictions imposed on sex offenders limit their availability of acceptable ways of living in their perspective. It may be beneficial to explore potential for life purpose and purpose identification during treatment with sex offenders.

Barrier 5: Financial Status and Employment

There are many barriers related to financial status and employment placed on sex offenders attempting to recidivate. Research suggests that 55% of sex offenders had full-time employment prior to incarceration (Winters et al., 2017). Levenson et al., (2007) emphasize the many restrictions placed on sex offenders by the registration and community notification laws. The financial status and employment barriers are created by legislation based on the experiences of victims rather than offenders (Meloy et al., 2013). Others say that these laws are based on off misconceptions about the frequency of sex offender recidivism Morton-Bourgon (2005). Sex offenders may be limited by employment barriers in reference to zone restrictions, meaning sex offenders are not allowed to work in certain areas of the community, regardless of the type of position (Lester, 2007). Rakis (2005) suggested that the many restrictions placed on sex offenders after incarceration may lead to economic marginalization.

Most participants mentioned employment as a barrier in the sense that sex offenders were not able to engage in a career that they enjoyed or felt useful at. In reference to financial status, many of the jobs available and identifiable by sex offenders in the community, may be limited in terms of income or opportunities for growth.

The RNR model includes school and/or work in the central eight, suggesting that employment barriers should be considered when assessing a sex offender for appropriate treatment. Identifying appropriate employment prior to reintegration may be helpful in securing employment post-release, and may give the sex offender an opportunity to

assess the choices available to make an informed decision regarding their success and potential.

Barrier 6: Housing

Housing is another barrier that can influence the possibility of other barriers arising. It is also a known barrier to reintegration according to researchers (de Vries et al., 2015; Farmer et al., 2015; Mustaine, 2014. Most housing barriers are set forth by legislation, again associated with misconceptions about sex offenders re-offending (Morton-Bourgon, 2005). However, research has also shown the possibility that sex offender laws may be ineffective and possible increase the risk of re-offense (Bonnar-Kidd, 2010). This can be because through the registry, sex offenders' locations are made public, putting them at higher risk for violence against them as well as isolation. This may also be because the laws limit the availability of housing based on residency restrictions.

Participants mentioned that housing becomes a barrier when sex offenders are forced to live in unhealthy relationships, or have unhealthy social interactions do to the lack of availability for appropriate and affordable housing. This especially became a risk when sex offenders had substance use issues and had to live with other substance users.

Community acceptance can also be influencing barriers associated with housing. Kunstler and Tsai (2020) found that only 8% of landlords reported that they would rent to sex offenders, and 36% of landlords would only be open to it depending on strict predictors of good tenancy including history of housing, credit, and timely payments. However, it is important to recognize that incarceration may impact predictors of good

tenancy for any type of offender. This research highlights the challenges of finding appropriate housing for anyone with a history of sexual offense.

Barrier 7: Mental Health

Mental health was mentioned in 3 out of 10 interviews, and each time it was mentioned, the barrier was present prior to reintegration, but presented as a barrier limiting success. Depending on treatment availability and the type of mental health barrier, different mental diagnosis present as barriers to any individual. Research shows that reintegration barriers experienced by any type of offender, impacts both physical and mental health (Semenza and Link, 2019). It is unclear what the correlation between mental health and reintegration barriers is, but research shows that they significantly affect one another (Semenza and Link, 2019) This makes it harder for anyone with a mental health diagnosis to reintegrate into society.

Vollm et al., (2019) mention that not all sex offenders have a mental disorder, but around half of sex offenders can be or are already diagnosed with a personality disorder. Aside from the other mental aspects that can affect barriers related to recidivism, mental diagnosis that increase risk for re-offending may require special treatment. Certain personality disorders and mental health diagnoses related to sexual deviancy, including pedophilia, already require a specialized type of treatment. However, the other barriers mentioned in this research study suggest that there may be other mental health diagnoses, including depression, that may significantly impact a sex offender's chances at rehabilitating successfully.

Barrier 8: Levels of Functioning

Levels of functioning, related to intellectual disabilities, were mentioned in half of the interviews, but were mentioned as observations by treatment providers, and not sex offenders themselves. There is limited to no research validating these observations. There is research to support that dynamic risk assessments are more effective in identifying risk of sex offenders with intellectual disabilities than static risk assessments (Lofthouse et al., 2013). The risk assessment used in the study was The Assessment of Risk and Manageability for Individuals Who Offend Sexuallly. The items on the risk assessment cover both stable and acute dynamic items. This assessment is geared to those with intellectual disabilities and is shown to be significant in assessing risk. Family situation or problems, social interactions, self-efficacy, and cognitive distortions are all assessed through this assessment and correlate with other barriers mentioned in this study. However, most individuals with significantly low levels of functioning are likely to be in some type of residential facility, and those barriers to sexual reoffending would not directly apply to offenders attempting to reintegrate into society.

It may be the case that treatment providers perceive levels of functioning to be a barrier related to treatment effectiveness, or comprehension of treatment. Existing research does not support the treatment providers' observations regarding levels of functioning as a barrier to reintegration, but it may be a barrier related to sexual re-offending in general, including those in residential facilities.

Barrier 9: Substance Abuse

There is existing research to support the results of this study, presenting substance use as a contributor to recidivism (Abracen et al., 2017). Research shows that substance use, especially alcohol abuse, is prominent in moderate to high risk sexual offenders. "Intimacy deficits, negative emotionality and expectancies have all been identified as influential factors contributing to sexual offending and there is reason to believe these factors may act synergistically with alcohol within high-risk groups of offenders" (Abracen et al., 2017, 240). Abracen and Looman (2016) mention that alcohol also magnifies any cognitive distortions or negative affect that are already existing in sexual offenders.

Substance use is not assessed on the popular risk assessment Static-99, but is assessed in other risk assessments for sexual offenders. Researchers recommend a combined treatment approach for sex offenders who have a history of substance use, and this recommendation aligns with the RNR model. The RNR model includes substance use as one of the factors to incorporate into treatment.

Treatment and Risk Assessments

The participants of the study provided their thoughts regarding risk assessments and treatment approach to for sexual offenders. There are many different treatment approaches when it comes to sexual offender treatment. The impact of sexual offender treatment is controversial, and the research is inconsistent. However, CBT/RNR types of treatment have shown to be effective in reducing recidivism (Olver et al., 2020). The participants of this study believed that the expectations of sexual offenders during

treatment while incarcerated do not validate the potential barriers that sex offender may face while attempting to reintegrate into society. Based on the results of the study, the major barriers to recidivism are dynamic in nature, meaning that they will need to be assessed at the time of treatment or release, rather than assumed. The RNR model provides a background of factors that may be helpful in assessing individualized need for assessment.

The most popular risk assessments are static in nature, however none of the barriers sex offenders mentioned as significant were static. Storey et al., (2012) emphasizes the lack of dynamic factors assessed on common risk assessments. The majority of participants in this study were most accustomed to the static-99, which has no dynamic barriers. According to participants, both in their experience and through the experiences they have heard from sex offenders, the items on that assessment were non-existent in terms of actual barriers. Treatment approaches cannot be designed to treat static factors, and are created with the intent of changing thoughts and behaviors. This research supports the need for risk assessments that better align with the dynamic barriers and factors related to sexual offending, in conjunction with individualized treatment approaches.

Limitations of the Study

Due to the qualitative nature of this study, and the small number of participants, the results may not be representative of the entire population of sex offenders attempting to reintegrate. The results also do not include female sex offenders. Mentioned in the first chapter, it is possible that confirmation bias and/or fabrication may exist regarding the

sex offenders who disclosed their experience to treatment providers. Additionally, it is hard to verify information translated through multiple sources, so the data acquired from the treatment provider may not be entirely representative of the sex offender's actual experience. Furthermore, the experiences were not separate based on the type of offense, location of the offender, or any other specific demographics of each offender. This includes specific mental health diagnosis, intellectual or cognitive disabilities, or any other variables that may create additional barriers for the individual.

Additionally, treatment provider thoughts may not be generalizable to all treatment providers. There are a wide range of risk-assessments and treatment approaches, which may not have been accurately represented in the sample. COVID-19 created additional limitations regarding the interview process. All interviews were conducted over the phone or through Zoom, and demographic information was received via electronic survey.

Recommendations

Based on the results of the study, it may be beneficial to emphasize the existence of individual dynamic barriers during treatment both during and after incarceration of sexual offenders. While addressing the sexual nature of offending along with the barriers that decrease the potential for sustainability. Identifying resources and creating action plans to deter from the impact of dynamic barriers on their success with treatment and reintegration may be crucial. Research on treatment approaches and identification of sexual offender risks to recidivism is necessary to better serve the sex offender

population and the community. The barriers identified in this study also need to be studied and examined more thoroughly to ensure credibility.

The current study did not consider individual differences of sex offenders related to the barriers identified. Identifying dynamic factors prior to reintegration, and then assessing barriers after recidivism will provide the most information about the impact of specific barriers. For example, a quantitative study that examines potential barriers before release from prison and after recidivism. Larger scale qualitative surveys may provide a more generalizable assessment of significant barriers, especially surveys completed by sex offenders themselves rather than the treatment providers.

Implications

The experiences provided by sex offenders regarding barriers leading to recidivism creates many implications on different levels. The findings show that the significant barriers may not be accurately represented or assessed related to reintegration. The barriers mentioned by sex offenders and treatment providers are predominantly dynamic barriers. This finding indicates that the factors that create the most risk for reoffense may not be included in preventative treatment, or in risk identification. This data may encourage positive social change by encouraging treatment providers and treatment approaches to include dynamic barriers in prevention strategies.

On an individual level, the research shows that assessing dynamic factors may better individualize treatment approach, resource identification, and support networks. Including dynamic barriers in a more systematic way reinforces the RNR model, but also may decrease the amount of setbacks faced by sex offenders attempting to reintegrate

successfully. The findings that dynamic barriers have such a crucial impact on recidivism for sex offenders may change societal believes about sexual recidivism, community safety, the ability of sexual offenders to change, and legislative policies limiting sex offender resources. The findings may also increase the potential for community acceptance and social/family support, which have both been shown to have an impact. Ultimately, the findings create potential for a reduction of sexual offender recidivism.

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Conclusion

Sex offenders are widely hated by society, and are widely believed to be unchangeable or incapable of successful reintegration (Harper & Harris, 2017; Rosselli & Jeglic, 2017). This common belief effects treatment approaches, risk assessments, and legislation, but may be based on misconceptions about reasons sexual offenders recidivate. Treatment effort, legislation, and reintegration protocols are largely more focused on the society rather than the healing and rehabilitation of individual offenders

(Youssef et al., 2017). The findings from this study suggest that treatment approaches, risk assessments, and legislation may be based on the perceived risk of others rather than the true barriers causing sexual re-offense.

The barriers identified through sex offender experiences are lack of community acceptance, lack of support, low self-esteem, lack of purpose, difficulties with financial status and employment, and difficulty finding appropriate housing. These factors are minimally assessed in current treatment or risk assessments. Factors identified by treatment providers as potentially significant were mental health and levels of functioning. The barriers identified in this study are predominantly dynamic and mostly external, meaning that the most significant barriers to sexual offender reintegration were caused by the impact of others, including the community, societal, and familial influence. The misconceptions held by the community, creating a lack of support and increased hatred, may actually be creating a higher risk for re-offense, rather than preventing re-offense and keeping the community safe.

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Appendix A: Survey

1. What is your gender? _____

2. Have you worked with sex offenders who have recidivated or reoffended? _____
3. How many years of experience as a sex offender treatment provider? _____
4. What is your highest level of education? _____
5. Do you have any professional licensures or certifications? If so, please describe.
6. How many sex offenders do you meet with individually in a week? _____
7. Do you facilitate any sex offender groups? If so, how often does your group meet? How many sex offenders attend the group?
8. How many times do you meet the same sex offender in a month?_____
9. On average, how long are your interactions with each sex offender? _____
10. What is the primary age of the sex offenders you work with? Please circle or highlight:

- 18-24
- 25-39
- 40-64
- 65+

11. Are you familiar with the Risk-Need-Responsivity Model (RNR)? If so, please describe how you use it in your profession.

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Once you have completed the survey please send to Brittney.wolf@waldenu.edu. You may also use this email if you have any questions or concerns about the study.

Appendix B: Interview Questions

1. What are the reasons sex offenders have returned to prison, or recidivated, according to the sex offenders you've worked with? In other words, what barriers have sex offenders disclosed to you?
2. Tell me some specific sex offender stories related to the barriers they've disclosed.
3. What were significant external barriers mentioned by sex offenders?
4. What were significant internal barriers mentioned by sex offenders?
5. What are some of the barriers you observed through sex offenders' experiences that they may not have recognized?
6. On the risk assessments you currently use with sex offenders, what items, if any, do you believe are associated with the actual barriers disclosed by sex offenders?
7. Is there any other information you'd like to provide about sex offenders' experiences?