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Clinicians' Experiences Working with Noncontact Sex Offenders

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Abstract

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MA, University of North Dakota, 2017

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Dissertation Submitted in Partial Fulfillment

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Abstract

Exploring the unique relationship between therapists and their noncontact sex offender clients can provide additional insight into the complexity of clinicians' occupations. The goal of this qualitative phenomenological study was to explore the personal experiences felt by mental health clinicians (psychologists, social workers, nurses) when working with noncontact sex offenders in a clinical setting. The theoretical framework of this study was guided by a psychosocial approach of cognitive dissonance and self-perception theory, which emphasized the development of defined behaviors and thoughts concerning physical and mental health. The data were collected from in-depth interviews with eight clinicians who treated and assessed noncontact sex offenders. The findings indicated that the participating mental health clinicians shared similar perspectives and clinical attitudes in their support and ability to provide therapeutic intervention to assist in a level of change for noncontact sex offenders. The participants treated and assessed their noncontact sex offender clients using the same strategies as they would with any other client but emphasized the lack of therapeutic and assessment resources available for this population. The clinicians acknowledge that a sex offender's psychological treatment is a controversial topic with negative societal views. However, participants stated the most significant occupational hardship came from dealing with the legal dynamics of working within a correctional system. This study can potentially influence positive social change regarding noncontact offenders by stimulating forensic and correctional clinicians' discussions about the treatment and assessment of individuals from this cohort, which could lead to improved clinical practice.

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Dedication

This dissertation is dedicated to the mental health clinicians working within the forensic and correctional field.

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Chapter 1: Introduction to the Study

The topic of contact sex offenders and the psychosocial impact of therapists on these individuals have been explored in innumerable mental health, psychology, and peer-reviewed academic articles (Baum & Moyal, 2020; Elias & Haj-Yahia, 2019; Way et al., 2004). Existing literature presents studies focused on contact sex offenders and the professionals assigned to work with them, but no investigations have been undertaken and published on the unique relationships between noncontact sex offenders and clinicians. A clinician's role is to assist their clients, irrespective of their status and history, based on their needs through treatment in assessment and counseling.

In general, therapy entails confidential and often intimate interactions between the therapist and the client, in which even the most vulnerable clients feel safe, heard, and validated (Elias & Haj-Yahia, 2019; Muntigl, 2019). While there is an increased awareness of a therapist's experiences and how they can influence the intrapersonal and interpersonal aspects of their life (Elias & Haj-Yahia, 2019), there remains a need for a more in-depth understanding of how treating sex offenders relating to child pornography impacts a therapist, both professionally and personally (Elias & Haj-Yahia, 2019). The Criminal Code of Canada (Criminal Code, RSC 1985, c C-46, s 163.1(1)(a)) defined child pornography as a film, video, and photographic image that displays a person who is under the age of 18 years that is engaging in explicit sexual activity or exhibits characteristics that indicate their use for a sexual purpose. Criminal offenses related to child pornography include making, publishing, or possessing child pornography and transmitting, distributing, selling, and making child pornography available to others to

share or to use (s 163.1(2); (3); (4)). The Criminal Code has established minimum and maximum sentences of imprisonment for individuals who have been convicted of any one of these offenses (s 163.1(2); (3); (4.1)). Possessing and accessing child pornography can have a minimum sentence of 6 months (s 163.1(4)(b); (4.1(b)) to a maximum of 10 years (s 163.1(4)(a); (4.1(a)). Through preliminary investigations of sex offenders convicted for possessing and accessing child pornography, these individuals typically receive shorter sentences than contact sex offenders. Thus, these noncontact sex offenders do not qualify for federally mandated programming and often have greater involvement with the mental health department for intervention and treatment (Krone, 2004; Ly et al., 2018; Winder et al., 2015).

It is essential to recognize that mental health clinicians are frequently exposed to traumatic events within therapy and assessment sessions and can personally undergo significant emotional and psychological distress due to the individuals they support (Michalchuk & Martin, 2019). In recognizing these experiences, clinicians will be better prepared to treat child pornography sex offenders and sustain their careers in the correctional system (Ly et al., 2018; Michalchuk & Martin, 2019). Acknowledging the potential for the moral impact and psychosocial effects a clinician encounters when supporting a noncontact sex offender will benefit the clinician's psychological well-being (Bourke & Hernandez, 2009; Howitt & Sheldon, 2007; Ly et al., 2018).

Background

Mental health professionals working with sex offenders may face adversity during treatment. Baum and Moyal (2020) identified that male clinicians experienced a wider

variety of negative impacts than their female counterparts in emotional exhaustion, distorted cognition, self-esteem, sexual behavior, and intimacy with others (p. 198). The literature emphasized that there needs to be more information regarding clinicians' exposure to sex offenders (Baum & Moyal, 2020). According to Elias and Haj-Yahia, (2019), the areas that need to be investigated to understand better a clinician's professional experience of their daily exposure are the caseloads, work duties, and employment places. These authors investigated the therapist's and contact sex offender's relationship during therapy.

In my study, I examined social workers who work with sex offenders on parole to gain insight into the intrapersonal and interpersonal consequences for the social workers when treating sex offenders in a therapeutic setting. From my results, I found that therapists experience harmful effects on the intrapersonal and interpersonal aspects of their lives.

Similarly, Hardeberg Bach and Demuth (2019) explored the experiences of therapists who primarily worked with individuals who offend against children and how these therapists endured a range of adverse effects. Their results indicated a negative impact on the therapists' emotions and empathy towards their clients. Conversely, Michalchuk and Martin (2019) investigated the positive impacts on psychologists specializing in trauma and how these psychologists experienced resiliency and growth from assisting in trauma inventions and treatment. These authors highlighted the specific difficulties of trauma therapy, such as how this process can be emotionally draining for the therapist and how therapeutic benefits progress slowly regarding a client's ability to

change. Alternatively, Way et al. (2004) compared the personal traumatic experiences of clinicians who treated survivors of sexual abuse with those who treated sex offenders due to their interactions and found that their vicarious trauma ratings did not significantly differ. The rationale for Way et al.'s (2004) results could stem from participants in their study having different individual characteristics that affected their level of susceptibility to vicarious trauma. Therefore, the length of time clinicians provides treatment has been reported by others to be significantly correlated with vicarious trauma (Way et al., 2004).

Studies on the behavioral aspects of noncontact sex offenders are often complicated due to the minimal amount of research that has been undertaken on this subject. Bourke and Hernandez (2009) identified that internet sex offenders tended to minimize their behaviors, and the individuals who accessed sex offender treatment were determined to have used internet images for arousal purposes, not curiosity. This research further acknowledged that if the opportunity were to arise, many internet sex offenders would likely molest children. Babchishin et al. (2015) found no significant differences in psychological variables between contact and noncontact offenders. However, these authors theorized that specific psychological factors might be correlated with different types of sexual offenses, but further evaluations would be needed to compare offenders with a normative sample. Bartels and Merdian (2015) explored child sexual exploitation material (CSEM) users with specific implicit theories (IT) based on an analytic review of existing research. However, as there was minimal information on the possible subtypes of CSEM users, such as the fantasy-driven CSEM users, self-reported or actual users' offline offending behaviors, at this stage of research, little was still known about the

development of implicit theories. However, these authors' underlying assumption was that the online environment, if accessible and anonymous, provided the means for CSEM users. Lastly, Winder et al. (2015) focused specifically on the offender's reasoning and rationalization for their internet activity and how their behaviors progressed into accessing online illegal child sexual material. Winder et al. identified that many offenders minimized their decision-making and provided rationales for how they encountered the material. Other participants verbalized a personal interest by rationalizing their behavior as acquiring the material for purposes other than sexual pleasure.

Understanding the differences in sex offenders is challenging, but Babchishin et al. (2011) provided a quantitative review of the characteristics and demographics concerning child pornography offenders. Babchishin et al. identified typical online offenders as young Caucasian males with no significant differences in education and often self-reported feelings of low self-esteem or loneliness. These offenders were likely to be unemployed and reported being sexually abused themselves. I found a factor of sexual deviant interest in online offenders compared to contact offenders.

McManus et al. provided information regarding typologies resulting from their investigation of contact and noncontact sex offenders and the differences between their online communications. They revealed 26 common themes, one of which, the noncontact online offender theme, indicated that discussions within this group had a sense of normality and a high degree of sexual motivation. McManus et al. further identified conversational themes of detailed sexual acts, sexual behaviors with children, and expressed fantasy plans for child sexual behavior in the future. This research articulated

that contact offenders were less likely to converse about sexual relations with adults as it was not as sexually arousing to them as sexual acts with children, and noncontact offenders would openly discuss sexual concerns with adults but have limited experience of this.

Furthermore, challenges in providing treatment for sex offenders were often exacerbated because many clinicians presented many issues. Adayonfo and Akanni (2019) focused on sex offenders in Nigeria and identified 50% of sexual offenders to be intoxicated at the offense. That said, the results highlighted the prevalence of substance use as 4.41% for sex offenders. However, the sex offenders had a lifetime of alcohol use, at 82.9%, compared to non sex offenders, and effective overall high prevalence rates for alcohol and cannabis use.

In 2015, Statistics Canada reported that the Canadian police force conveyed over 4,200 sexual violations against children, and this rate was amplified from 2012 (para. 2). The Government of Canada also, in 2015, enforced new preventative measures against individuals who committed a sexual offense online, including amendments to the Criminal Code and the Sex Offender Information Registration Act (para. 3). This allowed the criminal justice system to implement maximum and minimum prison sentences for sex offenders and a new database accessible by the public of high-risk child sex offenders within their provincial and territorial jurisdiction (para. 3). Seto and Eke (2015) identified the correcting admissions for pedohebephilic sexual interests with the Child Pornography Offender Risk Tool (CPORT). They used correlating factors from a sample of police case file information, which entailed demographic characteristics, offending behavior,

criminal history, type of child pornography collection, and other sources that indicated the offenders' sexual interests. The results from this investigation specified six variables of significance for admission of sexual interest in accessing and possessing child pornography and potential psychological factors: (a) never married, (b) child pornography content with videos, (c) children sex stories, (d) evidence of sexual interest in children for 2-plus years, (e) been in a volunteer role with access to children, and (f) engaged in online communication with a minor.

Purpose of the Present Study

I aimed to explore the personal experiences felt by mental health clinicians (psychologists, social workers, nurses) when working with noncontact sex offenders in clinical settings. The research design was that of a phenomenological study, the population of interest was mental health clinicians, and the constructs of interest were mental health clinicians and their occupational experiences when treating online sexual offenders. This research design enabled individuals to express their experiences (see Creswell & Creswell, 2018; Patton, 2015) while allowing me to interpret and construct the essence and meaning of their experiences (see Merriam & Tisdell, 2016; Smith, 2011).

Nature of the Study

In this qualitative phenomenological exploration, I analyzed participating mental health clinicians' personal and professional experiences when working with noncontact sex offenders. More specifically, I focused on the participants’ perceptions of treating and assessing noncontact sex offenders and their involvement as professionals in these

individuals' assessments, treatment, and crisis experiences. Participants in this research were mental health professionals in Canada who worked within correctional settings, treating or assessing noncontact sex offenders. As prescribed by this type of research, interviews were conducted using open-ended questions that sought details of the clinicians' professional impact and their treatment experiences during the assessment, therapy, and crisis intervention processes with noncontact sex offenders.

Research Questions

The primary research questions in this study (RQs) were as follows:

RQ1: What experiences do clinicians encounter when assessing and treating noncontact sex offenders?

RQ2: How do clinicians define their personal impacts within the context of treating noncontact sex offenders?

Significance of Study

I focused my research on the unique professional relationship between noncontact sex offenders and their mental health clinicians. This study allowed mental health professionals to describe their own unique experiences that they have had when assessing and treating noncontact sex offenders. Ward and Durrant (2013) described the psychological treatment of individuals who have committed a sexual offense as a vital aspect of prevention and rehabilitation. Supporting professionals who work with individuals who have committed a sexual crime against children is essential (Hardeberg Bach & Demuth, 2019). However, as there is little information about how working with a

sex offender affects a therapist's emotional well-being, it is mostly unknown what this support should entail (Jahnke et al., 2014).

I specifically investigated a mental health clinician's professional experience and inquired about their job's complexity when treating noncontact sex offenders (see Hardeberg Bach & Demuth, 2019; Michalchuk & Martin, 2019). The aim of this research, in allowing mental health clinicians to share their professional, therapeutic experiences from their work with noncontact pornography offenders, was to understand better what clinicians encounter regarding their duties and interventions and their potential for burnout. Existing literature primarily focused on therapists working with contact sex offenders (Baum & Moyal, 2020; Elias & Haj-Yahia, 2019; Harrati et al., 2018); however, I used a qualitative approach to provide a clinician's informed perspective with the inclusive appreciation for the intersection between treatment and noncontact sex offenders.

Theoretical Framework

The theoretical framework of this study was the psychosocial approach of cognitive dissonance and self-perception theory (see Bem, 1967, 1972), which emphasized the development of defined behaviors and thoughts concerning physical and mental health. The psychosocial approach used was a complex perspective of how to conceptualize human ideas, functions, and behavior. Specifically, this approach evaluated an individual by the psychological and social environment and how these impacted an individual's mental and physical ability to function (Bem, 1967, 1972; Christopher, 2004); understanding the relationship between mental and emotional well-being and the

social environment enhanced the ability to understand the changes with self-perception (Christopher, 2004; Melchert, 2015). An individual may experience vicarious trauma on a biological and psychological level, and these exposures could result in an interaction effect that impacts the clinician's cognitive characteristics and change their self-perceptions (Borrell-Carrió et al., 2004; Halevi & Idisis, 2018). Using a psychosocial approach that concentrates on the interaction of these complex systems, a sophisticated perspective for conceptualizing the human impacts of vicarious trauma could be provided (Bem, 1967, 1972). Both theories offer a frame of reference for understanding the density of an individual's occupational experiences when working within a correctional facility with a specific population and how these experiences could create negative symptoms that emulate psychosocial and self-concept effects (Elias & Haj-Yahia, 2019; Bem, 1967, 1972; Tabor, 2011). Thus, applying a psychosocial and self-perception lens to this study allowed me to focus on the individuals' thoughts, beliefs, and attitudes and how they accounted for influences on their behavioral decisions and thought processes.

Sources of Data

Data for the study included interviews with mental health clinicians who had experience working with noncontact sex offenders and were licensed within their field of practice (registered psychologists, social workers, nurses). A purposive sampling strategy was applied, consisting of six mental health clinicians who had worked or were working with noncontact sex offenders. The sample size of six was determined based on the specialized area of expertise for the mental health professionals and when data saturation was achieved. Due to the interest shown in this study, the sample size was increased to

eight participants. Participants in this research were recruited through social media platforms (LinkedIn, Facebook, Twitter) with a flyer and by word of mouth from other participants already involved in the study.

Limitations

The study's limitations were linked to the nature of the study, the number of participants, and research biases. I allowed individuals to express their opinions and share their professional and personal experiences of treating and assessing noncontact sex offenders. I then interpreted and constructed the essence and meaning of these ideas and accounts. Since I used open-ended interviews to collect data, I had to limit the number of participants enrolled in the study; therefore, shaping the range of the research. These issues had implications for the generalizability of the findings.

Nevertheless, due to the lack of research exploring the lived experiences of mental health clinicians working with noncontact sex offenders, my study has provided essential insights into this area and has emphasized the need for additional exploration on the topic. Lastly, as a registered psychologist myself employed within the forensic and correctional field in Canada, specifically in a federal correctional facility, a limitation to this study is my personal bias. My biases remained silent during the research to allow the lived experiences of each participant to unfold naturally, as I was committed to creating a trusting and confidential environment for the participants.

Summary

This chapter has provided a fundamental understanding of mental health clinicians who work with noncontact sex offenders, their professional and personal

experiences of treating and assessing these individuals, and their duties' impact on their mental health. In the following chapter, I present a review of existing literature pertaining to this topic, its current understanding of mental health, and identify the gaps in the literature that need to be addressed to support current research and the mental health professionals in question.

Chapter 2: Literature Review

In this study, I aimed to explore the personal experiences of mental health clinicians (psychologists, social workers, nurses) when working with noncontact sex offenders in a clinical setting. The literature reviewed specified the therapeutic challenges that arise when treating contact sex offenders, but limited published investigations were found on therapists' experiences when treating noncontact sex offenders (Elias & Haj-Yahia, 2019; Hardeberg Bach & Demuth, 2019; Jahnke et al., 2014). This chapter provides an overview of the existing literature, including research on contact sex offenders, noncontact sex offenders, treatment and assessment of sex offenders, and mental health clinicians' experiences when treating these individuals in a clinical and therapeutic setting. Empirical investigations regarding clinicians' personal experiences when working with noncontact sex offenders in clinical settings were limited, thus, implying the need for further research into the well-being of therapists and the difficulties and consequences they face as a result of working with this population (see Elias & Haj-Yahia, 2019). However, the literature did reveal how mental health professionals' worldviews and personal experiences can influence noncontact sex offenders' therapeutic outcomes and noted that clinicians gained from their therapeutic alliances with these individuals (see Hardeberg Bach & Demuth, 2019; Michalchuk & Martin, 2019).

Search Strategies

I searched the electronic databases EBSCOhost, Google Scholar, PsycBooks, PsycINFO, ProQuest, and Sage Journals Online with full text to conduct this literature review. From these primary sources, I gathered relevant peer-reviewed scholarly

literature. The Walden University Online Library was also used to research articles published within 5-10 years. In addition, supplementary journal articles and books were used to strengthen the historical background of this study. The search terms vary based on the specific topic, and the initial search consisted of terms such as *child pornography* and *sex offender*. This broad search provided insight into the themes selected for this literature review. Following the literature searches on *noncontact child pornography sex offenders*, I conducted another general search for *clinicians, treatment,* and *sex offenders*. My search also included the following terms: *Child pornography offender, sex offender, sexual predator, sexual offender, therapy, treatment, intervention, counseling, psychotherapy, therapist, counselor, psychotherapist, psychologist, clinician, nurse, social worker, attitudes, perceptions, experiences, outcomes, cognitive dissonance, self-perception, biopsychosocial model,* and *phenomenological*. Lastly, articles were also found by reviewing reference lists from relevant peer-reviewed scholarly literature.

Review of the Literature

This literature review incorporated current research on mental health clinicians and their personal experiences within therapeutic and clinical settings when treating noncontact sex offenders. Elias and Haj-Yahia (2017) noted that despite the increasing number of interactions and treatment provided to sex offenders, there is a deficiency within the literature on therapists' subjective perceptions of working with this client population. Even fewer accounts are published investigating the specific group of noncontact sex offenders.

According to Elias and Haj-Yahia (2017), in the early 1990s, researchers started to explore the therapist's perception when working with sex offenders. Harper et al. (2016) defined a distinction between positive and negative perceptions toward sex offenders and declared that this opinion could, ultimately, influence the therapist's view and, concurrently, the treatment they provide. Consequently, these authors specified that when a sex offender had a therapeutic relationship with a therapist, the therapist's perception was primarily optimistic.

In such situations, therapists also reported positive perceptions toward their clients (Harper et al., 2016). Conversely, Elias and Haj-Yahia (2017) highlighted that, during the therapeutic process, therapists said their perceptions toward contact sex offenders and their victims changed over time, with some describing their perceptions as positively changing by being more "connected to their functional and positive characteristics," or negatively changing, by stating that certain people "need to go to jail for many years" (pp. 1161–1162). In the following sections, I present an overview of studies investigating contact sex offenders, noncontact sex offenders, treatment, risk assessment, and personal encounters clinicians experienced in a therapeutic and clinical setting.

Contact Sex Offenders

Yates (2013) stated that hands-on (contact) sexual offending was a significant issue within society that impacted the victim and their family. Therefore, the Government of Canada imposed strict monitoring and restricted movement programs in most provinces and territories for individuals with sex offense records when released into the

community; the names and pictures of these individuals were further registered on the National Sex Offender Registry (Statistics Canada, 2015; Thomas et al., 2015). Making a sex offender registry accessible to the public was to reduce the risk of contact offenders reoffending. That said, empirical research and treatment effectiveness demonstrated the need for intervention within a therapeutic setting and its ability to reduce the risk of recidivism (Yates, 2013).

Seto's (2008) study specified that an individual close typically committed most hands-on offending to the victim (e.g., a daughter, a stepson, etc.) and not by a stranger. Also, the recidivism rates for contact offenders were reported to be lower than suspected by society, with most contact sex offenders not committing a sexual offense again (Seto, 2008). Kernsmith et al. (2009) echoed this by stating that registries did not provide empirical evidence of a decline in recidivism by sex offenders after their release. Hanson and Morton-Bourgon (2005) noted that contact sexual offenders tended to reoffend with nonsexual offenses rather than committing another sex offense.

Terry (2006) specified that laws commenced in 1950 regarding the regulation of sexual behavior and, in the 1960s and 1970s, these perpetuated and evolved into a public challenge of deviant sexual behavior. Farkas and Stichman (2002) articulated that many of the laws created for contact sex offenders in the United States of America were intended to remove sex offenders' fundamental civil liberties if there was a perceived risk to the community. The laws' intent was not to rehabilitate an individual convicted of a sexual offense but to protect society by incapacitating a contact sex offender by confinement within a correctional or mental institution (Farkas & Stichman, 2002).

Eventually, the management of sex offenders evolved into a therapeutic process of treatment, which included group psychotherapy and psychoanalysis (Marshall & Serran, 2000). Marshall and Serran (2000) focused on the treatment modalities that provided success to sex offenders; hence, the approach of cognitive-behavioral therapy was identified as beneficial. By the 1990s, treatment programs were habitually used within North America to eliminate the denial and minimization of the offending behavior of an individual while correcting the distorted perceptions and attitudes that allowed for the normalization of their sexual interest (Marshall & Serran, 2000).

Thomas et al. (2015) articulated that many contact sex offenders continued treatment as a condition of their probation or parole once released into the community. Drapeau et al. (2004) reported a struggle between contact sex offenders and their therapists during therapy sessions since the treatment provided needed to be intrinsically driven by the client, and most sex offenders were only engaged in treatment because it was a condition of their release. Conversely, it was also identified that some offenders were using the therapy effectively to process their internal struggles and work through past traumas (Drapeau et al., 2004). Furthermore, clinicians identifying why sex offenders engaged in therapy reduced recidivism and protected the community from future risk (Thomas et al., 2015). Therefore, from the clinician's perspective, therapy and treatment are necessary for this population.

According to Elias and Haj-Yahia (2017), interventions by the Adult Probation Services in Israel began with the clinician conducting a psychosocial assessment, which identified the risk of the sex offender and determined the appropriate strategies to apply

to treat them. Following this, the clinician provided recommendations based on rehabilitation and options regarding the offender's sentencing within the court system. If the recommendations were accepted, the offender would then carry out their legally mandated treatment with the goal of rehabilitation and delinquency prevention (Elias & Haj-Yahia, 2017). The number of sex offenders reported to have engaged in this kind of professional treatment for rehabilitation and behavioral change has increased since the 1990s, as have studies on these individuals and the mental health clinicians that treat them (Elias & Haj-Yahia, 2017).

Elias and Haj-Yahia (2017) further reported that clinicians specified three main categories by which sex offenders were defined as clients: manipulative, involved, or damaged. Within a therapeutic alliance with a sex offender, many therapists were motivated for treatment by a perceived mission to reduce risk, expose sex offenders within the justice system, and protect society from future risk (Elias & Haj-Yahia, 2017). Whether contact and noncontact sex offenders have different or similar qualities has created a considerable debate around the criminal system and within academic research.

Babchishin et al. (2011) illustrated that noncontact offenders, on average, possessed a higher level of education, were younger, typically Caucasian males, and had significantly more sexually deviant interests than contact offenders. Babchishin et al. further hypothesized that noncontact offenders might have lower rates of contact offenses, potentially due to their ability to control their impulses even though they had higher rates of sexual deviancy and demonstrated a desire to view images and videos of physically immature children. In a treatment setting, a therapeutic alliance with a specific

type of sex offender could have a different outcome if the therapist was treating a noncontact sex offender versus a contact sex offender.

The previous literature demonstrated behavioral and therapeutic interventions with contact sex offenders, and they have been extensively examined to understand the types of treatment and interventions needed for behavioral changes. From a societal standpoint, The United States of America and Canada's societal laws were implemented to minimize reoffending rates. They were not intended for rehabilitation and reintegration into the community. There is still a need for further investigation into the specific demographic of a contact sex offender compared to a noncontact sex offender and how this would influence the treatment interventions.

Child Pornography Sex Offender/Noncontact Sex Offender

Seto (2013) highlighted how the internet had created a pathway for the sexual exploitation of children and how the production and circulation of pictures and videos had become more accessible and available for anyone with access to the internet. The term child pornography offender or the noncontact offender has been designated to an individual who has committed an offense by using the internet to download, distribute, access, or produce child pornography. This terminology was argued as being an inaccurate reflection of the offender's behavior. The terms “child abuse material” or “child exploitation material” (Criminal Code Act, 1985) were deemed more accurate definitions of the harm inflicted on the victims used in the material and the individuals creating and viewing the images. Henshaw et al. (2017) described noncontact sex offenders as having exponentially increased over the past 20 years, resulting in

heightened awareness within the criminal system and academic research. It was specified that not all noncontact sex offenders possessed the same characteristics, nor did these offenders collectively have similar criminal histories or motivations for engaging in this type of crime (Henshaw et al., 2017).

McManus et al.'s (2016) investigation of contact and noncontact sex offenders and the differences between these two types of offenders based on their online communications revealed various typologies. For instance, these authors discovered that noncontact online offenders had a sense of normality and a high degree of sexual motivation within their discussions. This research shed light on the conversational themes of detailed sexual acts and sexual behaviors with children and expressed fantasy plans for future child sexual behavior (McManus et al., 2016). It was further articulated that contact offenders were less likely to converse about sexual relations with adults, as this was reported to be not as sexually arousing as sexual acts with children (McManus et al., 2016). Conversely, noncontact offenders openly discussed sexual concerns with adults but had limited actual experiences (McManus et al., 2016). The various typologies have been investigated, but there is no definite answer to the sexual motivation and behavior of a sex offender and the differences between noncontact and contact offenders.

Bartels and Merdian (2015) investigated CSEM users with specific IT based on an analytic review of existing research. As there was minimal information on the possible subtypes of CSEM users, such as the fantasy-driven, self-reported, or actual users offline, it was the expectation that this research would go beyond the existing literature on cognitive distortions and explore underlying implicit theories. Accordingly, Bartels and

Merdian identified five potential ITs: "Unhappy world; children as sexual objects; nature of harm (CSEM variant); self as uncontrollable; and self as a collector" (p. 16). These authors' underlying assumption was that the online environment, if available and anonymous, provided the means for a CSEM user to access said material. The authors concluded that their research contributed to the sex offender field as it facilitated a greater understanding of CSEM offenders (p. 22). Future research could provide more insight into the assessment, intervention, and prevention of CSEM users and current offenders.

Ward and Keenan (1999) speculated that cognitive theories could act as core beliefs for offenders and, thus, they resulted in implicit theories being developed for contact offenders. However, offenders who were convicted of online sexual exploitation material had higher sexual deviance and were less likely to have physical access to children. In addition, fewer noncontact offenders were reported to have a criminal history, and those that did had lower reoffending rates and less victim empathy, emotional awareness, and impact on children (Babchishin et al., 2015). Furthermore, Eke et al. (2011) emphasized that noncontact offenders' criminal histories differentiate from contact sex offenders, and Seto and Eke (2015) elaborated that these offenders demonstrated different levels of education and occupation. Seto and Eke also stated that many sex offenders engaged in dual sex offenses, meaning that they committed a contact and noncontact sex offense. Moreover, these authors specified that, typically, dual offenders that were engaged in hands-on offending were also charged with the production of child pornography, while noncontact sex offenders were less likely to have close

contact with a child and differed in their access to children, whether residing or working close to them (Seto & Eke, 2015).

Seto (2013) created the theory of the motivation-facilitation model that described sexual offending and the elements that aligned with contact and noncontact offending. Focusing on noncontact offenders, Seto declared that viewing child exploitation material was motivated primarily by sexual interest in children, the interaction between sexual deviance and antisociality, sexual preoccupation with problematic online behavior, and perceived sexual opportunities. Merdian et al. (2014) classified the cognitions of contact sex offenders as justification, children as sexual agents, power, and entitlement for contact offenders. However, there was minimal information about the fantasy-driven noncontact sexual offender and if there were possible behavioral changes to facilitate offending contact behavior. Subsequently, Bartels and Merdian (2015, p. 16) underpinned the noncontact offender's implicit theories, as mentioned above. Moreover, Winder et al. (2015) stated that noncontact sex offenders created the perception of being addicted, denied the role of abuse, and or minimized the harm in viewing, collecting, or viewing the items as collectibles. Winder et al. went on to state how these individuals offered explanations for their behavior, such as a lack of positive connection, maladaptive coping, fear of stigmatization, and the negative effect of emotions in early childhood and adolescence; thus, allowing themselves permission to engage in child exploitation material.

Taylor and Quayle (2003) asserted that cognitive distortions were an area of interest for noncontact sex offenders, as fantasy and cognitive distortions often played a

significant role in noncontact offending behavior. These authors speculated that sexual fantasy could be the catalyst for individuals who viewed child pornography images and fulfilled their sexual fantasy and sexual attraction toward children. Thus, if using such material led to sexual arousal, the concern would arise of the potential risk that this could precipitate an individual's desire to make their fantasy a reality and result in contact offending (Carich & Calder, 2003). Concerning a therapeutic setting, understanding a noncontact sex offender's fantasies and cognitive distortions would allow the clinician to facilitate appropriate treatment and intervention for behavior change. From a clinician's perspective, understanding a client's stage of change and their level of awareness of their thoughts, feelings, and behaviors allows for transformational change and progress.

Howitt and Sheldon (2007) defined cognitive distortions as a set of beliefs produced to overcome an individual's internal guilt or shame, as an excuse or justification of their actions to rationalize their crime, or as a set narrative to account for early childhood experiences which the offender believed as being connected to their offending behavior. These authors also noted that cognitive distortions were more in line with internet-only offenders and reported that these individuals experienced sexual thoughts and fantasies about children. The rationalization for these individuals' thoughts was that their behaviors did not harm children and were not as bad as hands-on offenders.

Winder and Gough (2010) identified specific dominant themes for individuals who committed noncontact sexual offenses; these themes were obsession and compulsion, isolation, escapism, and the enjoyment of self-distancing. There was extensive literature on cognitive distortions, minimization, and rationalization for sex

offenders. However, there was no current literature on the nature and functioning of self-distancing from the view of a sex offender who committed a noncontact offense (Howitt & Sheldon, 2007).

The convenience of the internet has allowed individuals to gain access to download, distribute, access, or produce child pornography. The heightened awareness within the criminal system and society has precipitated further investigation within the academic literature into this population. As the research continues to grow and expand, the sexual motivation and sexual behavior of noncontact sex offenders need to grow to explore further into the thoughts and feelings of a noncontact sex offender. The demographic and typology of a noncontact sexual offender have demonstrated the various levels of occupation, age, social-economic status, marital status, and prior criminal history. From this, there is no definitive typology for this population, and additional investigation into noncontact thoughts, feelings, and behaviors would be beneficial concerning the insight into the assessment, intervention, and prevention of future and current offenders.

Treatment

Thomas et al. (2015) highlighted that a sex offender's psychological treatment was controversial, as public opinion supported punishment, not rehabilitation, for individuals convicted of sexual offenses. Nevertheless, sex offending programs have been created to rehabilitate offenders and transform their emotional, cognitive, and behavioral patterns to support a crime-free lifestyle (Beech et al., 2013). Bartels and Merdian (2015) identified the inconsistency between noncontact and contact offenders and specified that

the application of treatment and rehabilitation programs created for contact offenders would not be successful for noncontact offenders. Different modalities of sex offenders' therapy vary in terms of the treatment severity and therapy types (Bartels & Merdian, 2015). Seto (2008) affirmed that treatment severity could range from castration; medication to reduce sexual libido; penile conditioning therapy to masturbatory reconditioning therapy; and more traditional talk therapy, like cognitive behavioral therapy. Initially, sex offender treatment focused solely on aversion condition therapy, but therapy practices have shifted over the decades towards cognitive-behavioral approaches that concentrate on relapse prevention (Thomas et al., 2015).

The American Psychiatric Association (APA, 2013) described pedophilic disorders as being based on the diagnostic criteria of an individual experiencing a sexual interest that caused dysfunction in their life for 6 months. That resulted in their behavioral interests not meeting societal expectations and norms. To meet the criteria, the individual had to be engaging in behaviors that included sexually arousing fantasies and urges to the point that they caused marked distress and personal struggle (APA, 2013). Seto et al. (2010) reported that for males convicted of a noncontact sexual offense, roughly 30-50% of these offenders self-proclaimed a sexual preference for children and acknowledged an interest in child pornography. Nonetheless, child pornography behavior was not a criterion to diagnose a pedophilic disorder, although most individuals convicted of a noncontact offense often accessed child pornographic material for reasons aligned with the pedophilia diagnosis (Ly et al., 2018).

Hanson et al. (2002) argued that cognitive-behavioral therapy (CBT) was the most consistent in its success in treating sex offenders for reducing future risk. It was conceptualized that the cognitive-behavioral model approach would focus on behavioral and cognitive patterns that were associated with contact with sexual offending behaviors; therefore, this would facilitate the understanding and identifying the associated behaviors of sexual deviancy and criminal behaviors and consequently, behaviorally changing these risk factors into pro-social behaviors (Yates, 2013). The simplistic application of CBT was to identify the dynamic risk factors (changeable factors; Hanson & Yates, 2004) and establish self-regulatory skills and coping strategies for managing within society (Yates, 2013).

Specifically, looking at the factors associated with CBT inventions for sexual offenders, the inventions concentrated on intimacy, cognitive distortions, triggers, and developing relapse prevention that focused on offending behaviors (Yates, 2013). Another aspect was the reported cognitive distortions that sex offenders display (Yates, 2013). Yates (2013) questioned how cognitive distortions interacted with a sex offender's cognitive schema and if targeting these during therapy effectively reduced the risk of recidivism. Sex offenders were reported by Ward and Keenan (1999) to exhibit cognitive schemas that projected blame onto the victim in that the child was able to provide consent or held a sexual entitlement view that distorted their sexual offending behavior. Add summary and synthesis throughout the paragraph to balance out the use of information from the literature with your own analysis.

Nonetheless, the CBT model used in treating sex offenders should be decided by the clinician as it was shown that this approach led to positive treatment outcomes (Hanson et al., 2002; Yates et al., 2000). Thus, as Marshall et al. (2003) described when a therapist gained a positive rapport with the offender in therapy, the individual outcome variance was more significant than a negative therapeutic relationship.

Yates (2013) specified that the clinician's characteristics, including warmth, empathy, firmness, investment, and genuine interest in the client, boost treatment and were identified as factors in the sexual offenders' positive achievements. These characteristics were typical, the foundation of a therapist's clinical approach, but clinicians working with sex offenders also had success by being firm and appropriately challenging the individual (Fernandez et al., 2006). Research determined that a specific technique, a positive treatment environment, and specific clinician characteristics must demonstrate treatment engagement and positive progression to achieve success at the termination of therapy (Marshall et al., 1999).

Henshaw et al. (2017) found that it was still unclear whether noncontact sex offenders should engage in the same treatment plans as contact offenders. Seto and Eke (2015) stated that since noncontact sex offenders' treatment was such a novel endeavor, the areas of treatment and assessment were under-researched in the initial stages. Previous research demonstrated that noncontact and contact offenders possessed similar behavioral and psychological problems (Merdian et al., 2011); therefore, both types of offenders could benefit from the same treatment. Subsequently, Merdian et al. (2011) specified that fantasy-driven offenders demonstrated differences from contact sex

offenders. Therefore, future research must be completed to understand the treatment and support required for this selected group.

There were gaps in the literature regarding sex offenders and their personal experiences with treatment (Thomas et al., 2015). Also, the limited research was based on the specific types and techniques of therapy used to treat a noncontact sex offender (Thomas et al., 2015). Rehabilitation and treatment practices were reported to typically use a cognitive-behavioral model that emphasized analyzing the behavior and creating relapse prevention plans, but there was no literature attesting whether this approach was appropriate for noncontact sex offenders (Kernsmith et al., 2009)

Risk Assessment

Bartels and Merdian (2015) specified that the treatment and rehabilitation programs created for contact offenders would not be successful for noncontact offenders. Concerning assessing criminal reoffending, a psychological risk tool was used to determine the likelihood of an individual committing another crime over time (Bartels & Merdian, 2015). Since noncontact sex offenders differed from contact sex offenders, the question arose of the potential risk factors for noncontact sex offenders and how these pertained to the hypothetical risk once the offender was released into the community (Garrington et al., 2018).

The Child Pornography Offender Risk Tool (CPORT) was established to predict sexual recidivism among male offenders convicted of child pornography (Seto et al., 2015). Seto et al. (2015) explained that the CPORT comprised seven significant predictors of sexual recidivism and was used as a structured checklist that explicitly

evaluated sexual recidivism for noncontact sex offenders. Other established sex offender risk assessment measures exist for contact sex offenders (Seto, 2013). Seto and Eke's (2015) specified limitations to the CPORT. They identified some potential risk factors of the tool, such as the motivation of the individual for using child pornography and the inferring sexual interest in downloading, accessing, collecting, or trading for curiosity or sexual interest. These authors elucidated the need for further investigation into the individual's frequency of accessing and using the material to better understand their interests in the content.

As the prevalence of child pornography increases and the amount of child exploitation material available online grows, Ly et al. (2018) determined that future research would be needed to investigate the differences between individuals who viewed child pornography compared to those who continually did so. For that reason, the author declared the amount of child pornography viewed by an individual as another area that would need to be evaluated, as it would provide an understanding of the severity of the individual's viewing behavior (Ly et al., 2018). In terms of treatment, the individual's viewing behavior would allow a clinician to evaluate the individual for any paraphilic disorder or mental health issues and support the individual in any identified underlying influencing factors (Ly et al., 2018).

For centuries, the term sex offender has incited negative connotations and attitudes, as reflected by adverse public opinion and (in modern times) social media and the belief that sex offenders pose a risk to society (Rogers et al., 2011). Based on Seto and Eke's (2015) results, the average recidivism rate was 16% for 286 offenders: 4%

were new contact offenses, and 12% were noncontact sex offenses. Within this cohort, these authors specified that significant predictors for sexual recidivism were the offender's age, their prior criminal history, the occurrence of any contact offending, their failure to adhere to conditional terms of release, their sexual interest in children, and their greater interest in pornography content depicting male children. Eke et al. (2011) highlighted that the gender type of child pornography was critical when assessing risk factors for sexual recidivism. Given the nature of the child content, an atypical sexual interest was revealed, as was the admission or diagnosis of sexual interest in children; thus, a significant association with this risk factor was provided (Eke et al., 2011).

Correctional staff specifically shared those child pornography offenders were prone to committing actionable crimes against minors (Burgess et al., 2012). However, Lawn et al. (2015) articulated a limitation in the available resources that could correctly predict the manifestation of such risks in the future. Therefore, front-line mental health workers with experience in child pornography sexual offenders had to be competent in dealing with and supporting these individuals (Lawn et al., 2015). Drăgan (2018) insisted that the increased availability of child pornographic videos online has resulted in a higher propensity for individuals to view child pornographic material. Moreover, this author attested that an offender could easily use virtual platforms to track and lure gullible minors into engaging in exploitative practices (Drăgan, 2018). In this respect, mental health workers' views would prove essential in determining the triggers that make individuals engage in sexual offenses. It would be easy to decide on the best methods of thwarting child molestation and assault from happening (Yates, 2013). Generally

speaking, specific correctional intervention principles were vital for interventions to reduce recidivism (Yates, 2013).

Andrews and Bonta (2010) acknowledged the principles of risk, need, and responsivity and how these values impacted the treatment. The principle of risk was defined as the value of an offender's level of risk corresponding to the level of treatment and supervision needed (Andrews & Bonta, 2010; Yates, 2013). For example, if an offender were evaluated at a high level of service, there would be a higher risk of reoffending and, therefore, needing more intensive services. Concurrently, low-risk offenders requiring lower levels of treatment may be considered for minimal or no intervention (Andrews & Bonta, 2010; Yates, 2013). Andrews and Bonta highlighted the importance of risk and treatment intensity being matched to the individual's needs because, if done incorrectly, this could lead to increased recidivism.

Andrews and Bonta (2010) further detailed the need principle, the second principle for the treatment and intervention of sexual offenders. The criminogenic needs categorized by Hanson and Yates (2004) included two significant risk factors for higher risk of recidivism: Sexual deviance and antisocial lifestyle. Hanson & Morton-Bourgon (2005) reported that every sexual offender differed in their criminogenic needs; thus, it was critical for the offender to target the strongest predictors within their treatment. In addition to their criminogenic needs, offenders' non-criminogenic needs, including empathy, self-regard, personal suffering, and victim denial, also differed (Hanson & Morton-Bourgon, 2005; Yates, 2013); these aspects were not shown to be significant factors in offenders' treatment or for reducing the risk of recidivism.

Finally, the responsivity principle, the third principle focused on the connection of the individual and their treatment, as defined by Andrews and Bonta (2010) as a therapeutic modality that aligned with the individual's various characteristics and factors to increase their participation, retention, and effectiveness of the therapy received. Characteristics and factors that maximized participation in and effectiveness of therapy were identified as intellectual intelligence, personality traits, anxiety, depression, and learning styles (Andrews & Bonta, 2010). Consequently, as reported by Yates (2013), treatment delivery and engagement were determined by the clinician conducting the treatment; as such, the clinician needed to possess a significant skill set and a degree of therapeutic flexibility.

Clinicians

Elias and Haj-Yahia (2019) and Muntigl (2019) described therapy as a vulnerable and intimate process that allows the client to feel safe, heard, and validated. These authors deemed that clinicians' personal experiences were essential when working with sex offenders. These can significantly differ from public views; thus, these researchers focused on front-line staff and analyzed their responsibilities in understanding and evaluating the mental and psychological challenges presented when working with sex offenders. However, Nelson et al. (2002) advocated the need to investigate the personal and professional experiences associated with treating sex offenders and mentioned that there were variables related to clinicians' attitudes regarding treating sex offenders, which, overall, was a desire to support and help individuals who had committed a sexual crime. Rogers et al. (2011) specified that attitudes toward sex offender rehabilitation were

often perceived as unfavorable by the public. The debate over the sex offender rehabilitation process was generally concerned with its effectiveness and its ability to impact sexual recidivism (Rogers et al., 2011). When treating this population, the clinician's professional and personal experiences significantly affected how they clinically treated these individuals and influenced the outcomes of the treatment (Rogers et al., 2011).

Elias and Haj-Yahia (2019) explored the lived experiences of sex offenders' therapists through their perceptions of intrapersonal and interpersonal consequences and coping patterns. Other scholars have further investigated the therapeutic alliance involving a clinician and a sex offender and the possible repercussions the clinician might experience from treating this population. However, despite the increase in research, Elias and Haj-Yahia, (2019) declared that there was no insight into how clinicians could positively cope with treating this population. Shechory and Ben-David (2005) stated that sex offenders were often portrayed as less aggressive individuals and were typically regarded as nonviolent offenders. Conversely, Elias & Haji-Yahia noted that clinicians had self-reported high degrees of anxiety and experienced hypervigilance when treating this population. This would suggest that Shechory and Ben-David's descriptions of sex offenders understated the severity of the crime committed against a child and caused the manifestation of adverse outcomes for clinicians who treated these individuals.

Baum and Moyal (2020) conducted a systematic review on gender and its role in clinicians' vulnerability when treating a sex offender, focusing on the adverse effects felt and how distress manifested differently in women versus men. These authors theorized

that women were more negatively impacted when working with a sex offender, and the impact on men mainly was in terms of emotional exhaustion, distorted cognition, self-esteem, sexual behavior, and intimacy (Baum and Moyal, 2020). However, these authors cautioned that the literature reviewed for their research was too limited to grasp a better idea of their daily exposure. This was due to sample size and the current understanding of the differences in how male and female clinicians cope when treating a sex offender population and understanding clinicians' caseloads, work duties, and places of employment.

Hardeberg Bach and Demuth (2019) explored therapists' experiences that primarily worked with individuals who had offended children. This research recognized the range of negative impacts on therapists and identified their personal experiences when working with the sex offender population (Hardeberg Bach & Demuth, 2019). In addition, they indicated that therapists experienced various emotional changes in their work that threatened their empathy toward their clients (Hardeberg Bach & Demuth, 2019).

Noncontact sex offenders represent a new type of offender, about which research is lacking for determining how they might differ in terms of character and treatment. Therefore, the alteration of clinical presentation regarding a noncontact sex offender's composition, compared to that of a contact sex offender (e.g., child contact offenders), could potentially change a clinician's experiences, resulting in unknown consequences. Elias and Haji-Yahia (2019) explained that when therapists enter a therapeutic alliance, they also begin a personal experiential process. The therapist's professional relationship

with their client could create responses directly from their immediate and cumulative reactions (Elias & Haji-Yahia, 2019). Elias and Haji-Yahia further demonstrated that when a therapist receives a recent counseling case for a sex offender, the clinician will review the offender's criminal history, potentially containing graphic and detailed sex offenses. After that, the clinician may self-report experiencing psychosomatic reactions. These authors declared that this reaction and response was a perceived intrapersonal consequence. They further reported clinicians experiencing feelings of disgust, a sense of choking, or shakiness in their vocal cords.

At the heart of the therapist's intrapersonal experience, treating a sex offender was described as uncomfortable for clinicians, who reported adverse effects regarding their thoughts, feelings, and behaviors (Moulden & Firestone, 2010). Additional studies echoed the same experiences, with clinicians reporting a moderate to high risk of burnout and symptoms within the clinical range of trauma reactions (Way et al., 2004; Steed & Bicknell, 2001). Bourke and Hernandez (2009) emphasized the many cognitive distortions noncontact sex offenders possessed when being treated by clinicians and described the mental health staff's challenges when distinguishing motivations for the offenders' behaviors between cognitive distortion and thinking errors.

Michalchuk and Martin (2019) acknowledged compassion satisfaction, vicarious resiliency, and vicarious post-traumatic growth as areas that mental health professionals need to maintain when working with traumatized clients and in situations that may also cause them trauma to sustain their lives careers. These authors state how many psychologists throughout their careers experienced adverse biopsychosocial effects when

working with clients with trauma (Michalchuk & Martin, 2019). Moreover, they declared it essential to acknowledge the potential moral impacts they may experience when clinically supporting an offender who committed a crime against a vulnerable population and encompassing cognitive distortions (Michalchuk & Martin, 2019). This then created the question of how a clinician would support an internet offender who conveyed a clinical impression of cognitive distortion and was known to have a greater likelihood to commit a contact offense in addition to their noncontact offense (Bourke & Hernandez, 2009).

Most of Elias and Haj-Yahias's (2019) research was conducted by investigating the therapist's therapeutic experiences of a perpetrator in treatment. Their study analyzed community social workers that worked with sex offenders on parole. These authors indicated that therapists experienced harmful intrapersonal and interpersonal consequences working with sex offenders in a therapeutic setting and identified a limitation in their research's ability to account for additional the variables and resilience of therapists who treated sex offenders (Elias & Haj-Yahia, 2019).

Cognitive distortions were defined by Beck (1963) as the beliefs or thoughts an individual possessed that produced and distorted their view of reality. Cognitive distortions pertained to contact sex offenders and noncontact sex offenders. According to Steel et al. (2020), noncontact sex offenders typically rationalize their actions using explanations built on a cognitive distortion. These researchers emphasized the need to understand a cognitive distortion's extensiveness, which could impact a clinician's ability to assess risk and treatment for a noncontact sex offender. Freeman et al. (2010)

highlighted a valid concern of clinicians and researchers investigating the relationship between sexual offender recidivism and denial regarding treatment, assessment, and release plans. This was that denial may alter this population's offending behavior and pinpoint the offender's rationalization, internalization, and externalization to determine their possible recidivism rates (Freeman et al., 2010).

Adayonfo and Akanni's (2019) cross-sectional comparative study of sex offenders in Benin Prison in Nigeria revealed that up to 50% of the offenders participating in their research were intoxicated at the time of their offense. These authors found that the prevalence rate of substance use was 4.41% in sexual offending; however, they further reported that contact sex offenders had a lifetime of alcohol use at 82.9% compared to non sex offenders (Adayonfo & Akanni, 2019). Adayonfo and Akanni's identified the limitations of this study were the small sample size of the sex offenders interviewed and the fact that the researchers focused on a specific geographic area within Nigeria. Nonetheless, Adayonfo and Akanni identified both prevalence rates for alcohol and cannabis use among sex offenders and the need for treatment for offenders by mental health professionals.

Winder and Gough (2010) reported that internet sex offenders typically received shorter sentences and did not qualify for federally mandated sex offender programming; this created a greater involvement of the mental health department for intervention and support for their correctional release plans. Therefore, being able to explore the lived experiences of the clinicians who work with internet offenders within a federal correctional facility will contribute to the limited literature on therapeutic interactions of

noncontact offenders and mental health staff (Winder & Gough, 2010). Babchishin et al. (2015) theorized that specific psychological factors might be correlated with different types of sexual offenses, but further evaluations would be needed to compare offenders with a normative sample. Furthermore, investigating noncontact sex offenders' sensation-seeking behaviors, particularly those regarding online child pornography and their rationalization of its use, would improve the knowledge of the etiological role and risk factors of these offenders in forensic and clinical fields of study (Babchishin et al., 2015)

Summary

This literature review on sex offenders and clinicians in a therapeutic setting revealed that a unique type of relationship with a diverse set of challenges evolved between those involved in the therapeutic process. Furthermore, therapeutic relationships and occupational outcomes for clinicians treating contact sex offenders were investigated, as were clinicians' experiences stemming from these interactions and how these influenced the intrapersonal and interpersonal aspects of their lives (Elias & Haji-Yahia, 2017; Elias & Haji-Yahia, 2019). Research showed that clinicians were exposed to traumatic events, psychological distress, and possible vicarious trauma when treating sex offenders and examined how clinicians navigated the therapeutic process using coping strategies and resiliency (Borrell-Carrió et al., 2004; Halevi & Idisis, 2018). Also reviewed were studies that emphasized occupational complexity, burnout, psychosocial effects, and the clinician's overall welfare (Parsonson & Alquicira, 2019; Watson et al., 2015). Research regarding the modalities and risk assessment tools used in the treatment process of noncontact sex offenders indicated issues in, and implications for, clinicians'

current practices. However, the consensus of adverse and positive consequences for treating a noncontact sex offender was designated to the specific group that treats these individuals. Thus, a complex and unique relationship between the clinician and the noncontact sex offender was revealed that encompassed how the clinician viewed and responded to the treatment and assessment of the offender.

Research concerning the treatment and assessment of the noncontact sex offender and the therapist's potential for experiencing harmful consequences in the intrapersonal and interpersonal aspects of their life promoted the current gap in the literature regarding the therapeutic alliance, and personal experiences felt by the clinician. There was theoretical support in identifying the trajectory of noncontact sex offenders' sentences and how most offenders did not qualify for mandated sex offender programs. As such, it increased the involvement of mental health staff concerning support, interventions, and correctional release plans. Furthermore, the psychological complexity of noncontact sex offenders demonstrated that noncontact sex offenders typically used cognitive distortions to rationalize their actions and presented with several challenges compared to those of a contact sex offender. The emotional and professional challenges when empathically invested in a therapeutic relationship with a sex offender could include negative experiences, such as burnout, compassion fatigue, and vicarious post-traumatic stress. Research on clinicians' experiences when working with noncontact sex offenders was inconclusive regarding these matters.

The gap in the literature highlighted a specific type of sex offender a mental health clinician assesses and treats in a therapeutic setting. This gap called for the

exploration of noncontact sex offenders' therapeutic relationships with clinicians and how these could be examined through the lens of the clinician's real-world life experiences. A qualitative methodology was necessary to explore the gap in the literature and investigate the clinician's experiences, thoughts, feelings, and professional and personal outcomes of working with noncontact sex offenders. Chapter 3 describes the method, data collection, and analysis techniques I used to explore this phenomenon.

Chapter 3: Research Method

A clinician's professional experience with sex offenders was revealed in the literature to be a multifaceted matter, one of which there was little evidence; therefore, investigating the complexity of working specifically with noncontact sex offenders is an issue that needs to be addressed. As empirical research data exploring this phenomenon were scarce, to obtain a theoretical understanding of a clinician's experiences when working with this cohort in a clinical setting, a phenomenological exploration was applicable. An in-depth exploration of clinicians' personal and professional experiences was performed when treating and assessing noncontact sex offenders. This was used to reveal the psychosocial effects clinicians are exposed to and explore their thoughts, beliefs, attitudes, and self-concepts. This chapter outlines a qualitative method for exploring a clinician's experiences working with noncontact sex offenders.

Research Methodology

For this research inquiry, I applied a qualitative methodology to explore mental health clinicians' perceptions, experiences, and personal and professional involvement (psychologists, social workers, nurses) when treating, assessing, and working with noncontact sex offenders. I selected a qualitative approach in the research design to allow the participants (mental health clinician volunteers) to articulate their complex experiences and perspectives experiences while also enabling me to interpret and construct the essence and meaning of these experiences (see Merriam & Tisdell, 2016; Smith, 2011). Specifically, this approach allowed individuals to describe their psychological and social environment experiences, how they influenced them, and how

they transmitted into their mental and physical functioning (Bem, 1967, 1972; Christopher, 2004).

At the time of this study, the unique professional relationship between noncontact sex offenders and their mental health clinicians was not explored through the clinicians' occupational and personal experiences; however, this topic was widely reviewed within the current literature for contact sex offenders. This gap in the literature allowed these professionals to share their professional life experiences during this current study and, thus, acknowledged the professional duties, interventions, and potential for burnout that clinicians encounter when treating noncontact sex offenders. In the absence of previous insight and methodological investigations into this research topic, this qualitative approach provided clinicians with informed perspectives, including the appreciation for the intersection between treatment and noncontact sex offenders. Creswell and Creswell (2018) defined qualitative studies as a holistic research lens that allows people to express their experiences, thoughts, feelings, and behaviors as individuals. By using a qualitative approach, this current research focused on a small group of participants to analyze the participants' experiences to expose the themes present in the group to understand the human experience of these individuals better. The qualitative approach highlighted the psychosocial areas of the phenomena and contributed to the current knowledge base. This assessment of qualitative research indicated that human phenomena, such as personal and professional experiences, can only be measured through a qualitative approach. Therefore, this research ensured a comprehensive understanding of the complexity involved.

Research Design

Chapters 1 and 2 presented what is already known about clinicians' experiences working with sex offenders. This current research study addressed the gaps in the literature, particularly concerning the unique relationship between mental health clinicians (psychologists, social workers, and nurses) and their noncontact sex offender clients. The clinician's role, perceptions, and professional involvement in supporting clients based on their needs through treatment, assessment, counseling, and crisis support were explored. Using a phenomenological qualitative exploration strategy (Creswell & Creswell, 2018; Patton, 2015), a group of selected participants (mental health clinicians) was asked to share their personal and professional experiences working with noncontact sex offenders. The theoretical framework applied for this research study was a psychosocial approach of cognitive dissonance and self-perception on the part of the clinicians (Bem, 1967, 1972), which emphasized the development of their defined behaviors and thoughts concerning their physical and mental health. The psychosocial approach provided a complex perspective of conceptualizing human ideas, functions, and behaviors.

Contrary to other research designs, this approach evaluated an individual's psychological and social environment and enabled the examination of how these factors influenced the individual's mental and physical functioning (see Bem, 1967, 1972; Christopher, 2004). Specifically, this theory consisted of the dimensions of psychological and sociocultural levels of natural organization that comprise the human organism (Borrell-Carrió et al., 2004). The exploration into mental health clinicians' personal and

professional experiences was performed through open-ended interviews designed to seek details regarding the professional impacts and treatment experiences from the assessment, therapeutic, and crisis intervention process with noncontact sex offenders. Comprehending the emotional, behavioral, and cognitive changes concerning human development is essential for understanding an individual (Lawn et al., 2015). The effects of an individual's occupation and the stress that they encounter during their daily tasks can create negative symptoms that could emulate psychosocial effects exhibiting trauma (Tabor, 2011); thus, expanding knowledge of these concerning mental health clinicians could help the clinicians themselves and, concomitantly, their clients.

An interpretative phenomenological analysis (IPA) was used to identify the themes of categories and concepts from the interviews with the mental health clinicians. The IPA strategy was chosen for the qualitative nature of this approach and its idiographic methodology to ensure that participants constructed their experiences through reporting and reflecting on these experiences (Van Manen, 2017). The idiographic methodology further allowed the participants to provide insight from their experiences and understand the perspective of the phenomena fruitfully and descriptively (Smith, 2011).

Measures

Data collection in this investigation was conducted through in-depth interviews with mental health clinicians who had experience working with noncontact sex offenders and had licensure within their field of practice (i.e., as a registered psychologist, registered social worker, or registered nurse). A purposive sampling strategy was used

with a set sample size of eight participants. The participants were recruited through social media platforms (LinkedIn, Facebook, Twitter) using a research study flyer (see Appendix A), and by word-of-mouth recommendations of those that had already participated in the study. An interview guide and questions were constructed and used to collect data from the participants (see Appendix B). The 37 interview questions used were open-ended and organized into categories. The data were collected using an IPA approach designed to investigate sensitive and personal information about the participants' professional impacts and treatment experiences during the assessment, therapy, and crisis intervention process with noncontact sex offenders. This data collection tool was used to discover the complexity of the participants' occupational and life experiences while allowing participants to provide a wide range of information on the topic (see Lichtman, 2013). The data collection strategy ensured the participants' ability to discuss sensitive subjects confidently to explore and reflect upon their personal experiences and insights.

Research Questions

The primary research questions (RQs) of this study are presented below.

RQ1: What are the experiences clinicians encounter when assessing and treating noncontact sex offenders?

RQ2: How do clinicians define their personal impacts within the context of treating noncontact sex offenders?

Ethical Protections

The participants were provided written consent to acknowledge the nature of the research study and their ability to leave at any point during the study. The consent process addressed the ethical issues that arose during the interview process and the need for confidentiality throughout the study. Each interviewee provided their written consent (via email) to the research agreement, indicating that they understood the purpose and format of the study and that they were aware of the measures set in place to maintain their privacy throughout the study. Their initials were used to label their answers as participants, and their information and data were collected and stored using a secure password-protected and encrypted laptop to maintain and ensure confidentiality. All identifying information reported by the interviewee about their clients or other individuals was anonymized.

Role of the Researcher

Researchers must take a neutral position during the investigation and interviews; however, this can be problematic due to the researcher's connections to the topic in question. Therefore, a researcher must consider the potential for bias in their study. This is an essential aspect of qualitative research studies that involve interviews and the subsequent interpretation of data.

Considering the potential for bias, I must identify myself as an employee and registered psychologist within a federal correctional facility in Canada. I could be considered a colleague of the individuals I interviewed for this study. To address and mostly remove this limitation, I deemed it necessary to recruit mental health

professionals employed at other institutions or facilities than my own. Current colleagues at my place of employment informed other individuals in the correctional and forensic field about my research but did not personally participate in the study. As previously stated, I classified my personal biases and emotions during the interview process, data collection, and analysis as personal limitations. Emotional limitations were my personal feelings on the subject matter, such as anger, sadness, and anxiety; acknowledging and anticipating these, I applied healthy coping techniques and journaling to reduce the risk of bias. Data verification methods were further used to reduce any potential bias, including the use of member checking.

Research Study

This qualitative research study followed the in-depth exploration of a phenomenon with a group of selected participants that allowed them to share their personal and professional experiences on the topic in question (Creswell & Creswell, 2018; Patton, 2015).

Data for the study included those collected from interviews with mental health clinicians who had experience working with noncontact sex offenders and had licensure within their field of practice (as a registered psychologist, a registered social worker, or a registered nurse). Purposive sampling was used with a sample size of six (6) participants (later increased to eight (8)) recruited through social media platforms (LinkedIn, Facebook, Twitter) by way of a research study flyer and by word of mouth from other participants in the study. The exploration of mental health clinicians' perceptions of treating and assessing a noncontact sex offender and their involvement as professionals in

treatment, assessment, and crisis experiences was addressed. I examined mental health clinicians' personal and professional experiences working with noncontact sex offenders. Interviews were conducted using open-ended questions designed to seek details about their professional impacts and treatment experiences during the assessment, therapy, and crisis intervention process of noncontact sex offenders. The in-depth interviews took between 60 to 90 minutes to complete; all interviews were audio-recorded for later transcription. During the interviews, I collected additional notes to identify any specific issues expressed by the participants (who partook via video conferencing) through their body language or facial expressions and highlighted these during the transcription process. The transcription of each interview was completed within 48 hours of its completion.

Data Analysis

The data analysis started with the interview notes being thoroughly read and analyzed. The initial interpretation of the materials enabled me to familiarize myself with the data. Once the data were analyzed, a journal exercise was used as a reflection technique to create a way to identify personal views and reactions to personal biases that might have influenced the interpretations. Once this step was completed, a second interpretation of the information was used to highlight significant statements, identify meanings, and ascribe codes. Once all the interviews were processed and coded, a reflection of the statements and a personal interpretation of the data were completed to gain a deeper meaning of participants' answers. Bracketing was used throughout the journaling process. This allowed my thoughts, feelings, and perceptions to be

externalized during the collection and analysis of the data and ensured that these perceptions of bias were identified and eliminated prior to describing and highlighting the participants' experiences. After the interpretation and transcription of the interviews were completed, the codes were put into an Excel spreadsheet and sorted into groups based on their similarities. The collection of similar codes allowed for themes to emerge and the creation of interconnectedness. NVivo qualitative data analysis software was used to assist in the organizing, coding, and presenting the data. Names were assigned to the collection of codes based on each theme that emerged. Each theme was described and identified by a statement or a quote from an interviewee to highlight the personal experience disclosed (Creswell & Creswell, 2018). There were multiple levels of open coding to ensure that the themes established were based on how the interviewees answered the questions. The final step in the data analysis process was the detailed description of mental health clinicians' lived experiences and perceptions. Quotes from participants were used to capture the fundamental nature of their perceptions, and they described the identified themes.

Trustworthiness

When evaluating a study participant's views and interpreting their experiences, a researcher's credibility is essential to verify their analysis and research findings (Cope, 2014; Polit & Beck, 2012; Lincoln & Guba, 1986). Since my research study was qualitative, I followed the credibility approach, as described in sections 3.2, 3.3, and 3.5. Creditability was, thus, accomplished with specific data collection and analyzing the transparency in recruitment and informed consent (Cope, 2014; Lincoln & Guba, 1986).

In addition, credibility was achieved by demonstrating engagement, observation, and interpretation to identify patterns and themes (Yin, 2013) correctly. As outlined in sections 3.3 and 3.7, the selection of the participants was paramount and a critical component in the credibility of this study, which used a purposive selection to identify clinicians who had professional experience in working with noncontact sexual offenders (Cope, 2014; Lincoln & Guba, 1986; Polit & Beck, 2012).

Transferability refers to recruitment and data collection (Lincoln & Guba, 1986). As this inquiry applied a qualitative methodology approach, the results of this research were based on the related experiences of individuals who participated in the study. It produced detailed descriptions and accurate findings relevant to individuals providing treatment and interventions for noncontact sex offenders within the mental health field of correction (Yin, 2013). Consequently, there were no adjustments made for transferability strategies. In terms of the dependability, I adjusted for the data collection which were not necessary because these were deemed credible as they were collected using interviews with open-ended questions and active listening skills (Cope, 2014). The research process allowed for dependability as this study's findings could be easily replicated if other individuals who worked in mental health in correctional facilities were to participate (Cope, 2014).

A successful qualitative research study depends on the researcher's ability to collect and interpret an interviewee's responses and not interject their own biases or viewpoints (Cope, 2014; Polit & Beck, 2012). To achieve confirmability within the study, member checking and journaling were used, and the interpretation of the data was

managed by researcher bias and interpretation error (Cope, 2014; Yin, 2013). Member checking allowed for the confirmation of accuracy and interpretation of the interviewees' lived experiences (Nastasi & Schensul, 2005). Once the interviews were completed, the data collected were transcribed, the initial member checking was carried out, and the themes were identified and summarized.

A journal was used to document additional thoughts, feelings, and observations made throughout the different stages of the research process (Nastasi & Schensul, 2005). The bracketing technique was used to manage my perceptions and allow the findings to be an accurate reflection of the participants' experiences and perceptions. Journaling was a way for dependability and transferability of the research to build on the trustworthiness of the research study (Lincoln & Guba, 1986).

Summary

Chapter 3 has provided a detailed description of the phenomenological approach used in this study and a comprehensive narrative of the research. Furthermore, the procedural process, data collection, analysis, and verification methods were disclosed. Using a phenomenological approach, the mental health clinician participants were able to express and describe their experiences of working with noncontact sex offenders and provide additional information to the limited amount of research. In-depth interviews allowed the participants to articulate important details about their personal experiences, and the data collection method ensured that their experiences were recorded. For that reason, bracketing was used throughout the research to ensure that this researcher’s personal bias and presumptions did not interfere with the data collection and analysis.

Chapter 4: Results

According to D'Orazio (2013) and Elias and Haji-Yahia (2019), a mental health clinician's therapeutic alliance with the sex offender population could lead to several challenges regarding the intervention's effectiveness, outcomes, and treatment. I aimed to explore mental health clinicians' personal and professional experiences (psychologists, social workers, nurses) when working with noncontact sex offenders in a clinical setting. I sought to provide an in-depth analysis of clinicians' experiences in assessment and therapeutic intervention, the personal influences, and the impacts they experienced from treating noncontact sex offenders. Answers to the following research questions were pursued:

RQ1: What are the experiences clinicians encounter when assessing and treating noncontact sex offenders?

RQ2: How do clinicians define their impacts within the context of treating noncontact sex offenders?

This chapter presents a description of the current research study, followed by the participants' demographics. The participants were eight mental health professionals who worked with noncontact sex offenders. Also presented are summaries of the data collection method, which involved in-depth interviews, data analysis procedures, open coding, and evidence of the study's trustworthiness.

Setting

The setting of this study included community, provincial, and federal agencies operating in mental health. From this setting, participants were found that of

professionals with expertise and experience in assessing and treating noncontact sex offenders. I specifically focused on three groups of mental health clinicians: psychologists, social workers, and nurses.

Demographics

Participants in this study were mental health professionals who worked in correctional facilities with noncontact sex offenders. At the time of this study, the psychologists, social workers, and nurses who agreed to participate were either currently or previously employed in community and government mental health agencies and were involved in the treatment and assessment of noncontact sex offenders. Include some more information on participants- such as how many of each profession were interviewed, years of working with offenders, etcetera. – this helps provide validity to your study.

Data Collection

I collected the data for this psychosocial approach of cognitive dissonance and self-perception theory study through open-ended interviews. Participants were selected by applying a purposive sampling technique that used social media platforms (LinkedIn, Facebook, Twitter) and a research study flyer (see Appendix A). In addition, word-of-mouth promotion by participants already involved in the study was used. Initially, six mental health clinicians were engaged in this study who had worked or were working with noncontact sex offenders. The size of this sample was determined based on the specialized area of expertise for the mental health clinicians and when data saturation was achieved. However, due to the interest shown in this research study, the sample size was increased to eight participants. Before their interviews, I contacted each of the

participants to explain the nature and purpose of the research, ask for their consent in participating in the study, and build rapport. I also inquired about their preferred time(s) for their interviews.

I used the informed consent form to protect the participants' rights and to advise them of the scope and limits of participating. Each participant was informed and aware that the interviews were audio-recorded for data collection and analysis. After the participants had provided their written consent, their interview began by way of replying 'I Consent' to the email in which the consent form was sent and agreed to the audio recording. The interviews comprised 37 open-ended questions, all of which allowed for discussion and the collection of in-depth information. The interviews were all completed through one-on-one interactions and took between 60 to 90 minutes to complete. Following each interview, the discussion recording that arose was transcribed within 48-hours.

Data Analysis

The data analysis procedures involved my use of open coding to describe the emerging themes. These themes were used to develop a theory about what the participating mental health clinicians reported that they experienced during the assessment and treatment with noncontact sex offenders. Once each interview was completed, the dialogue was transcribed, after which it underwent the initial member checking. A copy of the transcript was then emailed to the appropriate participant to verify its accuracy, and upon its return, the open coding stage began.

The data analysis started with the checked and finalized interview transcripts being read in full for me to become familiar with the material gathered. Following this, a journaling exercise was started to engage in reflection to identify my personal views and reactions, which enabled me to account for my bias. After this exercise, a second interpretation of the information began as I started to highlight statements and meanings and ascribe codes. When codes were identified, I looked for similar codes and grouped them into categories. I created as many categories or open codes as necessary during this process until no new information appeared from the data. Every theme had a description; either a statement or a quote from an interviewee was used to highlight personal experiences identified in the themes. Multiple levels of open coding were used, which allowed for the codes and subsequent themes that were established to be based solely on the participants' answers to the questions. Addressing the purpose of the study, the participants verified the themes and the theories relating to these while reflecting on their experiences and perceptions of working with noncontact sex offenders.

Evidence of Trustworthiness

The evidence of the trustworthiness of the data gathered was verified by member checking, reflexivity, and data saturation (Creswell & Creswell, 2018). When no more information emerged from the analysis, the data saturation was considered complete (Creswell & Creswell, 2018). The first participant's interview was used as a guide to developing the codes and themes to assist with comparing the findings from the subsequent interviews. To minimize the bias, I used reflexivity for self-inquiry and

continually questioned myself during the interpretation stage of the data analysis to confirm that the research questions aligned with the purpose of this study.

Results

This section contains the results of this inquiry in the arrangement of themes derived from the data analysis. Description of the themes and quotes from the data are provided. The themes that emerged from the data were as follows:

- Behaviors of Noncontact Sex Offenders.
- Clinicians' Motivation to Work in the Forensic/Correctional Field.
- Clinicians' Work Duties.
- Therapeutic Treatment Modalities.
- External Occupational Factors.
- Personal Impacts and Worldview.
- Lack of Resources for Noncontact Sex Offenders.
- Noncontact Sex Offenders' Motivation for Treatment.

The section concludes with the proposed theory developed through identifying the relationships amongst the themes identified.

Theme 1: Behaviors of Noncontact Sex Offenders

The participants stated that they were made aware that they would be working with an individual who had committed a noncontact sexual offense prior to their interventions or assessments. The participants described their experiences and interactions and provided details about noncontact behaviors and their implicit theories during their clinical interventions. Participant 01 stated the following: "I think the

common theme I find with them is all sex offenders, really, whether they are contact or noncontact, is intimacy, and intimacy and attachment deficits as well as self-esteem problems." Participant 05 also mentioned low self-esteem as an issue:

> It was kind of more low self-esteem, kind of shame, they would be isolated a lot from family at times, kind of would not talk to them. So, they already kind of have some of that kind of self-esteem or lowered self-esteem and there was some guilt and shame.

Participant 07 echoed the loneliness factor: "It is sort of a tendency to see pornography as sort of a refuge and as a bit of a buffer against a more general sense of loneliness and in some cases difficulties with engaging in real world relationships." Equally, Participant 06 described having experienced individuals with low emotional development:

> I have worked with, having really low, like, just presenting, like, not their chronological age, like, really, I do not, I don't want to use the word immature, but like, low, low maturity factor. So, seeing, like, a preteen is actually felt, felt more relatable to them than maybe someone their own age in their 20s or 30s.

Participant 06 went on to state: "As a sweeping generalization, they were, like, younger men in, like, their 20s, or younger, um, antisocial personalities, or, like, shy personalities, didn't have a large social group didn't really fit in with their peers." Add summary/synthesis to fully conclude the paragraph. Avoid ending paragraphs in a direct quote as this reflects a lack of analysis.

As a clinician, Participant 01 elaborated on their specific personal experiences treating noncontact sex offenders and their potential for an increase in their (the offender's) behavioral offending. Participant 01 shared the following:

> I see guys who get caught. So… most typically, they're caught, not super early in their career, but it's hard to say where they might have gotten if they hadn't got caught. I have seen guys, though, who looked at child pornography for 10 or more years, who didn't seem to escalate to hands-on. For example, I saw [a male] who was looking at child pornography, he was also looking at other worrying forms of pornography, such as "snuff pornography," and "mortuary or funeral parlor pornography," and, so that's how he escalated. He became more, he became more and more interested in more intrusive and violent forms of pornography but, as far as they know, they, he'd never actually escalated to a hands-on offense. I have some doubts about that, but nothing that I could confirm in any way, shape, or form.

Participant 02 explained a particular experience relating to an offender's potential increase in behavioral offending:

> In one case, because I worked closely enough, and he was, like, complete child pornography and he had been doing it for years. Actually, when he had been arrested, he had… the bag, the rope, the duct tape, everything in his car, like, the next step. Like he, I mean, of course, denies that any of that was his and whatever. But, I mean, clearly, the next step was a contact offense and he had talked about

> how he didn't. I mean, he did not say in those exact words, that it was not enough. It was not enough, but he was bored with it.

Participant 03 shared their experience of an offender's potentially taking the next step in offending:

> A guy I saw last week, said he wasn't interested in young girls, but he had been looking at so much porn from 13 to age 25, that he was satiated on the normal stuff and so he went through a multiyear period of bestiality. Because he needed something novel and more provocative to stimulate him and then he moved from that to anime, and anime led him to kids sort of thing.

Participant 06 highlighted possible motivations for increased behavioral offending:

> I think it will go both ways…I think it depends on, like…what the goal, like, what their original intent is… If the original intent is for arousal and for stimulation, then I think it can escalate when there is…like, kind of, that satiation has been met right like that, tolerance, maybe, or, like, things aren't, kind of, bringing the same level of risk, maybe. But I also have seen it be related to the males in the videos with, like, the children as well, often…. having there be a fixation on idealizing looking like that, idealizing being that person.

Participant 08 detailed the potential risk of an increase in behavioral offending:

> Yeah, absolutely. There's always that risk, right. Whether or not that it comes to that depends on a lot of factors… I mean, it escalates, right, until you get your primary act of deviance…So it's like the first, it's kind of like that it slowly

> gradually increases and escalates and for some people… they'll, they won't act out.

In addition, Participant 07 also highlighted this potential risk:

> I mean, certainly, some of them do explore… sort of, increasingly perverse images, to, sort of, stimulate themselves and particularly some of the men who are really highly sexual preoccupied. I have had some cases where the guy's masturbated so much that he's developed erectile difficulties in terms of… sex with an actual partner. And so, when that occurs, sometimes for the older guys to where there's erectile difficulties, there's, there's a sense of, well, if I seek out something more "taboo"… that will bring me the stimulation I'm hoping to achieve.

That said, Participant 07 reported their experience with the current research and implied that increase in behavioral offending was unlikely:

> Well, I think the research is pretty clear that, by and large, for the guys who don't have any prior sexual offenses, contact offenses, nor prior criminal history, the research suggests that the chance of a future contact offense is pretty low, all other factors being equal.

Participant 07 reiterated this opinion, specifying:

> They do have a lot of … and I think the data probably supports it… that there are a lot of child porn guys out there who are content to sit in their basements and masturbate to this stuff, *ad infinitum*. I just have never come across a case where

> somebody just got so tired of jerking off in their room that they went out and found the kid.

Participant 03 detailed specific implicit theories about offenders during their interventions:

> Yes, as victims [the offenders], it is never their fault. It is always something technically and practically impossible that they are clinging to. Like, "somebody hacked my phone and put 900 pictures of children on it." I think they all acknowledge the badness of it, and then they distance themselves from it. "I know it is bad, it is awful, but here is why it is not my fault." I do not want to sound cynical across the board of everything they tell me, but their explanation of how it came to be, as often dubious. Because, again, it is in service of that, "I was not even looking for it; it just fell into my lap."

Participant 03 further provided an example of cognitive distortions in offenders they treated:

> I do not think there is a common theme other than the game of unintentional unintentionality. Alternatively, it is one or the other; it is the unintentional, and or some sort of knowable motivation for it is protecting kids. "I was gathering this stuff for the police; [or] I was doing my own research" sort of stuff. But, kind of, one or the other. "I either just fell into it" and "I do not know anything about it" or the, the extension of that is, "I fell into it. I did not know anything about it and now, I felt compelled to continue looking at it, for some reason. That is not

> because I am attracted to children," but rather something for the greater good of, "I'm protecting kids."

Participant 08 provided a similar example of cognitive distortion:

> I had guys who say that they totally believe that it's a sexual orientation. And I had one guy [who had] the audacity to say that he compared himself to, you know, the Black rights movement, saying that, or the gay rights movement, saying that…people of color, or people who are of different sexual orientations, have had to fight for recognition and for rights. Just as he is having to fight for recognition and rights, so that he can, because he feels entitled to act out on his sexual urges towards children.

Participant 04 highlighted the rationalizations of noncontact sex offenders: "So, kind of, looking at, like, the minimizations and justifications in terms of cognitive distortions. Adults, they create these, again, these stories about why they did it, to justify it."

Participant 07 also detailed offenders' rationalizations, stating:

> What I would call permission-giving thoughts, the, it's not uncommon that there's a rash rationalization, like, "I'm just watching," [or] "I'm just looking," […] "I'm not really hurting anybody," [and] "nobody's going to know." In some cases, for some of the guys that get into underage pornography where teens are masturbating online, and posting it… there's a sense of, well…they're kind of into it…so, those sorts of permission-giving thoughts are relatively common.

Participant 03 mentioned curiosity behavior and stated specific rationalizations of how noncontact sex offenders could become involved in their offending:

> Curiosity…It is tough to answer one thing or another, because, I mean, the guys I am thinking of they, it's kind of an a…. rolling trolley of excuses, right? It is like, "I wasn't going looking for it but once I did find it, I was repulsed and wanted to protect these kids, but I was also really very curious." Like, there's, there is a lot of moving parts on the deflection of responsibility.

Participant 01 echoed similar curiosity behavior and stated specific experiences in therapy and assessment:

> The child pornography offenders tend to look at it as "I was just curious, and therefore, I was not actually harming anybody, the material was already there." So…"[it's] not like I created a victim," is how they often describe it. With others… they use somewhat similar rationalizations… in that "I did not touch somebody, so, therefore, it is not as harmful, as if I had actually touch[ed] somebody."

Participant 08 stated how interest in pornographic materials can be perpetuated: "Once they start exploring, then they get more curious and more curious." Participant 04 reported a similar experience of curiosity being a driving factor:

> Curiosity… Like, he had 10,000 images, what they say is there is dumps so basically, somebody will like to send … a ton of porn to you and amongst that, there might be child porn. I had a guy quite recently tell me, you know, what…, he goes, "I was just on normal porn," like normal, "not like 'Hamster X,' or whatever," and [then] there's "a little side thing," and to see it, they click on it and next you got to do another click "and next thing…well, there's girls that are

> looking like 13, 14, and you are, like, okay, is this a trap or what?" But your curiosity's there and he said, he's completed it and he was like, "shit!"

Participant 06 shared a related response regarding continued interest: "I would say curiosity-driven." Conversely, Participant 05 stated: "Yeah, I think it is still, kind of, yeah, that fantasy-based, even though that they're probably doing [a sentence of] at least 30 years for it, they're still, kind of, engaging in the behavior." Participant 07 provided a correlated fantasy response to the rationalization of curiosity:

> I would say a substantial portion [of individuals] who are fantasy-driven offenders, where the viewing is part of a larger pattern of [them] engaging in sexual fantasy to stimulate themselves without necessarily an intent to engage in a contact offense. Particularly for…the guys who are generally prosocial, they do have normative sexual interests and so… that's common, I see that fairly commonly… the challenge is, of course, to try and distinguish between understanding if I got a fantasy-driven guy, or do I have a contact-driven offender?

Participant 04 shared their experience of offenders exhibiting opportunistic behavior:

> Opportunity, opportunistic and just more on it…. like, hey, I was there, and, you know, obviously, he kind of knew it is wrong, but you still did it.

Participant 02 mentioned a rationalization of general exposure to pornographic material:

> Other than just being exposed to it, like, through family members, or, like, exposed to pornographic material, kind of like, [during] "porn nights or whatever." That is, kind of, the most general or the most common answer.

Participant 03, also regarding exposure, stated, “The theme is that there was some third party that introduced them to it one way or the other, sen[t] it to them without their knowledge or wanting or solicited it from them.” Moreover, Participant 06 stated how some individuals were exposed to pornographic material “around the average age (of child pornography in males), being the age of nine years old.”

Participant 06 further reported:

> Especially males, where pornography is starting to be shared as, like, child to child especially through, like, phones and tablets and, like, just the ease of access we have now… Shown by peers or having found, like, an older brother or a father’s, like, kind of, stash, growing up and then seeking it out themselves. Also, just the impacts of that later on in their own sexual performance is just huge.

Participant 08 spoke of excuses made for using pornography, mentioning how, “Some of them will just stumble upon it, or through their internet search searches, because they, they’re going to pornography, and then it just, kind of, develops and then they rationalize it to themselves.”

Participant 08 provided another similar experience of early exposure:

> My sense has been that there’s a lot of these young guys who have early exposure to sexual content. When they’re kids, and they have access to the internet, and it’s unsupervised. And so, they, kind of, get into that and then that, kind of, creates its own monster… So, I find that a lot of them have early exposure to sexual contact when they are not developmentally ready, and they don’t have the supervision or

> the anyone around who can guide them through an understanding of that…It is like, you do not learn how to have an intimate relationship by watching pornography.

Participant 08 continued to elaborate on general exposure to pornography:

> Just access to the internet, I think, I mean, they have access to it, and… it's something they do… It's interesting because I've had guys who say, well, they get on these chat rooms, or they start sharing and then things start getting, this is what they say, "then all of a sudden, people start sharing more younger images," and then, "oh my goodness, how did that happen?" And then they end up developing what they say they're developing arousal to those images…I've got a number of guys say they, they did not, they never saw themselves as having pedophilic tendencies prior, but then they develop them later on and they attribute it to being, you know, [a] repeated exposure type of thing.

Participant 08 then provided a generalization of pornography:

> Pornography is such a huge industry … when you look at, I think, how many people are accessing it, it blows you away. I think it's people of all areas. I mean, so many people who have all these little hidden… they hide, they hide what… they call these little secret things that are going on, that nobody else knows about. So…what they watch on their computer when nobody is looking, and it's CEOs, it's religious leaders.

Participant 07 mentioned sexual preoccupation as a reason for pornography exposure:

> It is not uniform, but certainly a long-standing pattern of sexual preoccupation is often part of the clinical picture and…in some cases, that includes a long-standing pattern of legal pornography use, sometimes, since their teens.

Participant 02 mentioned behavioral presentation of individuals with a disordered sense of self:

> Well, I mean, other than the normal angry because they are in jail, and they are told they did something wrong…and they do not get why it is wrong. I think maybe more reserved, more quiet. I have not had anybody, like, you know, break down… I would not say defensive… they are usually just, like I said, more reserved. Any of the ones that I have worked with that, like, the pedophiles? They do not believe what they did was wrong… So, it's really just a matter of trying to convince them the law says, you know, it is wrong.

Participant 06 identified behavioral responsibility in treatment:

> I was offering treatment as a prosocial choice… It's showing that they were taking some ownership and responsibility to unpack some of those behaviors often them not seeing it as problematic as, like, "I will, I can stop whenever I want," …. like, "well, now I don't have access to the internet, so, like, [I] can't do it anyway." … felt like more of a "buzzkill," then, maybe, regret for harm of the of the children or harm of the subject, the victims.

Participant 06 also highlighted a specific experience toward behavioral presentation:

> It is maybe, it is bizarre… a lot of video game use…a lot of, like, living in the basement to a parent or grandparents' house. And so, like, kind of, a space where

> maybe other people aren't seeing what they're doing or interacting with them, like, being, kind of like, involved in what's going on or what their what, kind of, content they're taking in but yeah, I would say, like, not a large social group, not really connected with peers of their own age, often connect with peers of younger ages.

Theme 2: Clinicians' Motivation to Work in the Forensic/Correctional Field

Most participants articulated their motivation, their opportunity, and a desire to work within the field. Participant 01 shared their interest in working with sex offenders:

> I mean, I like all of it, to be honest with you…I have never yet had a patient that I could not find, or [a] client…I couldn't find something to like about them and to enjoy working with them. I suppose I like the more complicated cases. Now, when I first started, I did like the easier cases. But now I chose to go to a high maximum secure unit for guys with serious mental disorders. So, clearly, I like the challenging cases, I like working with people who have borderline personality disorders, for example, because they are phenomenally challenging…to be able to be successful with and…I mean, that's one thing I like about working with sex offenders in general… I [have] had to deal with almost every mental health issue, and that I have to go away and learn more about each specific mental health issue and how it would impact their response to treatment and their risk for reoffending. So, I just found that enormously rewarding and interesting.

Participant 02 perceived this field of mental health as difficult but rewarding, describing their experience as "Challenging, but good…A lot of self-development, a lot of self-realization, a lot of learning… a lot of improvement, but definitely hard."

Some participants shared their fascination for human deviant behavior. Participant 03 shared, "Oh, I love of all things dark. Just a fascination with human behavior in general, and how and why people do the worst things…the things that our society frowns most upon, but we all seem to be capable of." Participant 04, talking about this same topic, stated, "I don't really know why, I think, it was always an interest in understanding human behavior and an interest in crime." Participant 08 declared their interest in the work: "I was very intrigued with the offender population, what makes people tick. What makes people choose bad lifestyles [and] that kind of things. So, I always, kind of, wanted to work in a, in the prison setting."

Participant 04, likewise, stated, "I love working with this client group, Yeah, I don't seem to get out of it anytime soon." Participant 07 similarly reported, "I would say it has been very satisfying. It has been intellectually stimulating, it has provided all kinds of professional opportunities."

Participant 07 detailed how they entered the field of mental healthcare at a correction facility:

> It was a combination of… I needed a job and [a correctional agency] was offering, and also it was, sort of, an interesting area of work. I …did some work

> with men who had committed sexually motivated offenses and forensic work was interesting and, so, it was a combination needing a job and interesting work.

Participant 05 shared their reasoning behind taking the opportunity to work with offenders:

> Well, during [my] internship, I very [much] enjoyed it. [Then,] I was at a correctional facility, but even in grad school, I've always, kind of, felt I wanted to go into corrections, just [because of] the experiences and opportunities.

Participant 06 had a similar experience:

> I did a nine (9) months internship rotation…and I… loved it, there was something I do not really know why… I have always… I have always been interested in it. It is a really underserved population and, I think, bringing clinicians to care about the whole person.

Theme 3: Clinicians' Work Duties

Some participants described their multiple work duties as clinicians, whereas others spoke of their specific roles and occupational responsibilities.

Participant 03 stated about their work, "It is all assessment," while Participant 01 said, "I do a lot of psychological risk assessments for the parole board…I do counseling…I do crisis, I do training…I do training for staff on identifying risk for suicide and self-injury."

Participant 02 specified the multiple duties that they had at their correction facility:

> We could do everything, we do everything. From, like, facilitating regular activities like morning walk and gym time and then we can do crafts: I run a garden group. We do individual, one-to-one programming; we do programming,

> like, for emotions management, behavior control emotion, or, well, then there's the healthy relationships [group therapy]…general wellness [group therapy].

Participant 04 also reported that they had several obligations:

> Typically, [I] have two (2) to three (3) [assessments] on the go. A lot of counseling …a lot of consultation… But yeah, I would say, if you were looking at it really, it's probably like 50% counseling, 25% assessment times.

Participant 05 shared a similar experience, stating, "To many things. I'm chief psychologist, so, a lot of administrative duties, but still doing intakes, group therapy, suicide risk assessments, drug interview[s], assessment interviews, things like that."

Participant 06 spoke of their busy schedule:

> We have 200 clients on our team and, so, we try and touch base with each of them once a week. And, so, there's a lot of crisis work…We do a lot of… I do a lot of counseling…outreach home visits, crisis.

Participant 07 described their diverse caseload:

> I have general clinical clients who present with anxiety, depression, what have you, non-forensic population trauma. And then I have a fair number of forensic clients, who are referred to me, generally, by defense attorneys who may want their client to get some therapy, pre-sentence… A number of those men are CSEM [Child Sexual Exploitation Materials] clients, because I am, sort of, known to work with those folks and there is not a lot of general psychologists who do.

Participant 01 shared their experience of how their duties have changed:

> So, primarily, I see patients, not many these days, because I mostly provide supervision to therapists, psychotherapists, or others, and then [I partake in] research activities. My role is halftime research, halftime clinical. Prior to that…I spent the first…11 years as, essentially, almost exclusively, a therapist.

Theme 4: Therapeutic Treatment Modalities

During the treatment of sex offenders, most participants stated that they used a specific modality technique for their therapeutic interventions. Participant 01 shared that their approach was to build a good therapeutic alliance. Participant 01 stated, "I don't really change my approach with them;" this clinician identified using Cognitive Behavioral Therapy (CBT) primarily with Psychodynamics and Dialectical Behavior Therapy (DBT). Participant 02 stated, "CBT for sure…[and] flashes of DBT in there just for, like, distress tolerance and emotions management stuff… But yeah, pretty much everything is CBT." Participant 04 mentioned that their technique involved, "Using some CBT, some DBT…those are, kind of, the main modalities that I do use, because, again, I'm looking at, kind of like, distorted thoughts, self-talk, and unhealthy coping skills." Participant 04 further explained how they deal with individual offenders:

> So, with every offender, I also do… [I think,] what are the risky emotions or the risky thoughts or the risky situations…like, the risk management plan part and, equally,… what are these distorted thoughts we have about this? Let's do some kind of reality testing here. Let's look at what are you telling yourself throughout

> challenging that piece…with these guys that have…these real stories about why they did it… you got to chip away at it.

Participant 05 declared, "CBT is kind of the main kind of go-to for me," and Participant 07, likewise, specified, "Primarily, I've used a CBT approach."

Participant 06 shared their take on therapy:

> My goal is always to look at, like, why, like, what happened to this, to this person that, kind of, led them to this…what need wasn't being met?... From an attachment perspective, what wasn't going on? Or from a relational perspective, which is attachment, like, what wasn't happening or what was broken there? As opposed to… being in the room to know that someone has harmed someone.

Participant 01 also talked about looking at the bigger picture, stating, "In particular, doing, looking at life history and attachment issues," further explaining:

> Primary treatment procedures where we actually address the issues that lead to these problems, and then sort of future life strategies would be the wrap up of the program. That would probably be about a third to a half of the program is how you're going to live your life without having, putting yourself at risk to get, have this problem again.

Participant 02 mentioned their strategy of examining offenders' psychosocial backgrounds and reported:

> We first…look at…their family history, family roles…what are the things you have learned…How to treat people; how to treat them normally; how to treat your friends; how to treat them sexually…more education around that, we look at

> attachment styles. Getting them to look at themselves and why they act the way they do….so they can understand themselves better.

Participant 04 expressed their use of motivational interviewing:

> I love motivational interviewing…I love the role values play at the beginning stages of, like, what's important to you? What are your values? And how's this behavior impacting your ability to live that value out? So, to me, that's a real big, kind of, like, measurement at the beginning.

Participant 05 explained their personal approach:

> I tried to take… as non-judgmental approaches as possible, as Rogerian [based on client–centered therapy] as I can be with them, when, kind of, interacting with them… I'm not there to judge them. We can't change the past of their crime but, hopefully, in the future, either they can change some of these behaviors, or get better relationship[s]. While they are in prison, a lot of the people that I would interact with, these charges would have 30 plus years [of sentence to serve]; some of them, [this would be] enough for life sentences, so they would not be getting out. So, just trying to make their prison stay, as best as it can be.

Participant 02 mentioned sexual education for offenders and specified:

> They have never had any sort of education on sexual health, sexual appropriateness, and sexual behavior, like, there is just really a lack of education there. Coming from…their background… their parents, their grandparents, or whoever, or foster care, and then being sexually abused and… of course, not educated about anything. For group [therapy], even when we get talking about the

> pieces on puberty, even things like… wet dreams and stuff like that… they have no clue…They have no idea how the female body works. They, you know, other than putting the penis in the vagina, that is it. It is as far as it goes, that is how babies are made, right.

Participant 06 explained their holistic approach to therapy:

> I use a lot of art and a lot of movement… this is a no contact [approach], like, we are specifically talking about no contact charges. But often it is because there's a disconnect to your body… So, I think that can be really valuable and important sometimes, because there is so much shame and, kind of, self-loathing related to, to this, to this use of pornography and child pornography. There is also, like, trauma protocols… because… for shame, resilience, and…access, and then using art is a way, because sometimes, it's hard to just talk about those things.

Participant 08 highlighted their experience with their broad scope of practice:

> We're looking at more things like anxiety, depression, PTSD [post-traumatic stress disorder] – PTSD is huge. Everybody wants treatment for PTSD, and so, we are looking more at that, because the programming is directed towards their criminal genic factors.

Participant 04 talking about looking for reasons for an offender's behavior, stated, "But really, to me, it's, kind of like, just, really, why did this person do this? What was lacking? How can we, kind of like, replace it with something better?"

Participant 06 shared their experiences on this same topic:

> My goal is always to look at, like, why, like, what happened to this to this person that kind of led them to this…what need wasn't being met?... From an attachment perspective, what wasn't going on? Or from a relational perspective, which is attachment, like, what wasn't happening or what was broken there? As opposed to… being in the room to know that someone has harmed someone. As a parent …it might feel equally as awful and I think that there was always, kind of, [it was] hard to be a woman in the room with a sexual offender, [this] is always a little bit unnerving. But, I think, I would always try and go back to the attachment piece… what happened to this person… instead of focusing on what they did.

Participant 07 further shared their view of possible reasons for offenders' behavior:

> The piece that's unique to this population, besides, sort of, the standard dynamic risk factors that we see in men [who] have committed sexually motivated offenses, like sexual preoccupation sex, is coping… in addition to those things…. in this population [it] is also needing to address general internet health. For a portion of these guys, it is not just using sex to cope, it's using the internet to cope and immersing themselves in, sort of, online fantasy. The other piece that often requires some attention is general internet health, what is…healthy internet?

Theme 5: External Occupational Factors

One of the struggles within the correctional and forensic field is clinicians working within multiple organizations and bureaucracies. Most participants highlighted the struggles and dilemmas they encountered when working in a multiple-level system. Participant 02 believed that the clients were the easy part and reported that the hardest

part of the job was "total operational and management." Participant 06 stated, "The clients are never the hardest part for me, [it is] always the system." This clinician went on to say that "There is the legal dynamics, there is those implications, there is the relationship to a justice system." Participant 04 also pointed toward the trying matter of bureaucracy and said, "there's things that you learn to, you don't like in any job, I guess, like, I, kind of, sometimes working with other organizations or other professionals can be frustrating and see how slow the system moves." Participant 05 reiterated this issue, stating, "I felt burnt out, but I don't think it has to do with this population. Corrections, at times, we were understaffed a lot of the time, so I think that has to do with it [the environment], more so than the working with the [noncontact sex offenders]." Participant 08 stated their grievance with bureaucracy: "My biggest frustration is the federal government, because… the federal government is not staff[ed] enough … because they can't hire enough psychologists."

Participant 04 echoed this view, expressing how this can negatively affect them as a clinician, and their noncontact sex offender clients:

> So, again, I think it's not the offender, the offender doesn't…bring any stress to me already… it's…more everything else. It's the professionals. It's…these parole officers…seeing how sometimes that they go into a place like [a federal prison], they get assessed [using the psychological risk assessment tool,] Static 99, they get a low risk…they get released…[the parole officers (POs)] are like, "Oh my God, you're a sex offender. You're such a high risk" …I get [that] a PO's going to

> be risk-averse, but sometimes, again…. where are these decisions coming from? They're [parole officers]…being risk-averse and making decisions through fear rather than based on what the reality is. These guys [noncontact sex offenders,] they're at the mercy of the POs because they will be considered unmanageable in the community and sent back [to prison]. I think these guys, once they have a PO they have to deal with the parole board…they're pretty much at the will mercy of that system.

Participant 01 mentioned that structural issues were at the root of the cause of therapists' burn-out:

> Usually, the thing that most impacts my feelings of burnout are structural issues. The people who oversee the managers, the, the system, the organization, you know. While recognizing that organizations are doing, often, the best they can, they often impose circumstances that burn people out. For example…expecting that a therapist will be delivering therapy all the time, or they are not doing their job, and that is ridiculous, because therapy is exhausting. When I delivered group therapy, [I work] in a morning and an afternoon to different groups [and,] by the end of the day, I am pretty wiped out. So, we only require our therapists to do, to do a maximum of four sessions a week of group therapy, because if you did more than that, we noticed that people would start to get burned out.

Participant 02 highlighted problems with structure space and staff shortages:

> Well, we need more program rooms, or interview rooms. We have to meet with guys who … require to have two CXs [correctional officers]…but then there's no

> staff …they're just not available to escort them. So, then we can't meet with them being locked down all the time.

Participant 05 explained that inmates were the easiest part of their work and that it was the correctional staff that caused the difficulties, detailing:

> The inmates are the easiest part. They're…only coming to you because they want something; they want some help or something like that, or they're interested in some kind of programming, or things like that. The hardest part is dealing with all the other staff; the staff members make it harder on the inmates. No one will argue with that. Especially with this charge [noncontact sex offense], it goes throughout the Correctional Institution, everyone knows they have some kind of snide…they might single out this person for whatever reason… makes it more difficult. But then everything else dealing with Wardens… and things like that. I think the setting is not an ideal one for psychology, but if we're not there, then they're not going to get any help.

Participant 7 mentioned that they have struggled in their workplace: "When you're in an organization where there are, in some cases, high work demands [and] limited control over the work, that was challenging, and times would…you just try and keep your head above water and that was stressful."

Participant 07 further detailed their unease regarding the correction environment and its affect on them, the offenders, and the therapeutic relationship:

> I think more the, the mentality that the system facilitates in the man [offender] you're working with, because in that sort of setting, there's greater potential for

> mistrust between the client and the therapist. There's concerns about being identified as someone who's committed a sexually motivated offense when you're in an incarcerated federal setting, and so there is no greater guardedness. So, I think that that interferes with the therapeutic rapport. So, the very nature of the setting, not always, but certainly more so than is otherwise the case.

Conversely, Participant 03 reported the client to be their main stressor, not the system:

> No, it's the client. Doesn't mean [that] the system is perfect or anything. It's just that's not where the grief comes from in working with child porn offenders. I mean, the system is, I don't know, I'm not sure what is really right or wrong with the system. As far as child pornography offenders go, they want to put them in jail for two years, you know, as a starting point, which I think is not a good use of resources. But no, no, the system is just doing what they can with these with these guys.

Participant 03 highlighted the low risk of noncontact offenders and the external factors explaining:

> I find [that] this is the, this is, the real catch 22 of these guys is that, empirically, they are usually low risk individuals and consistent with our understanding of the risk-need-responsivity model, [the] right correctional rehabilitation. You should not waste treatment, treatment resources on a lot of these guys, are most of these guys, despite the courts wanting to throw them in jail for long periods of time… The research says that if you're looking at child pornography, you're probably a pedophile; you probably are attracted to children, because you can look at

> whatever you want on the internet, and you've chosen this… The data shows, if we hooked them up to a plasma graph, they will get erections to children…So, they are pedophilic, but low risk pedophilic, and that is what makes it "dicey." For courts, it is like you are saying he's a pedophile, but you're saying not to do much about it...So, recommendations are usually around low risk, but some sort of treatment, which is kind of paradoxical and is admittedly a bit of a "cover my own ass" [strategy].

Theme 6: Personal Impacts and Worldview

The majority of the participants confirmed that they had been practicing in the field for multiple years in the treatment and assessment of noncontact sex offenders. Many participants highlighted personal impacts and changes in their worldview in relation to their professional and personal lives. Participant 01 stated how, sometimes, they struggled with the nature of their job: "Every now and then, once every blue moon, you do read a case that maybe is a little hard to take, for whatever reason." Participant 03 stated how their job caused them to feel exhausted: "I can certainly think of times when I've been really burned out." Participant 04 reported that, sometimes, they felt a certain sense of moral detachment: "Well, I'd be lying if I said sometimes you do[n't] become a little desensitized to stuff that you hear and if they're not in the field, they're not going to get it." Alike to Participant 03, Participant 06 spoke of their exhaustion: "I mean, yes, anytime working with all trauma and all offenders can, I have experienced burnout at various points in my career." Participant 07 mentioned that working with sex offenders

had made them more cautious: “Earlier in my career, when I worked in the federal service….it’s certainly…led me to be a bit more conscious or careful.”

Participant 01 discussed their changed views as a parent:

> One of the things that really helped me by doing this work was a better understanding of how to keep my kids safe. I knew what the issues were; I knew how contact offenders would select children for offending. So, I very quickly understood that the stranger-danger myth was just that, [and children were] much more likely to be offended against by somebody [they knew]. [I] also understood how the internet can lead somebody down this path to problematic behavior.

Participant 02 declared how their experience working with this population negatively impacted their life as a parent:

> Swimming pools are ruined for me; they are 100% ruined. They [Participant 02’s children] were never allowed to go into the bathroom by themselves, you got to go you watch your brother, you know, like, at least go in twos because I couldn’t go in with them.

Participant 03 shared one of their parenting experiences regarding their heightened personal connection with the victims of sex offenders which changed their perspective on the offenders themselves:

> I had recently become a father for the first time, which really changed my perspective on all files involving children for a little while. I think it took a little while for me to find my, sort of, optimal way of engaging with those things where you can be connected to them and, and be empathetic, and connect with the

victims and the perpetrators in that sense, without being overwhelmed by it. I think that's an adjustment…and then it was the nature of the work.

Well, because I was now acutely aware of [the situation], I was very sensitive to the notion of children living in fear in their own homes and I'd always been academically aware of that, but it was just, it was front and center for me…I could see how all of my own behavior affected my own child at home. But now, I could connect to it in a very different way…. the burden to protect and the inability to maintain boundaries, I don't think there are boundaries about objectivity. It wasn't "let's go get this guy," so much as it was, like, just punch the clock at five o'clock and leave this on my desk and go home. Because now, the stakes are very, very real.

[For example] I got a file dropped on my desk on Thursday at 3:30… [due to the nature of the file] [the] dad was being investigated for sexually abusing his kids and putting pictures of them on the internet. So, I feel compelled on that Thursday night, even though I want to have good work life boundaries, that I need to dive into this file. It's been my whole lifetime, looking at this on Thursday night, because on Friday morning, we're gonna have a meeting deciding what to do about this guy and whether they're going to act or not act before the kids go to him on the weekend. There was a real sense of imminence, and the potential to protect or to be responsible for not protecting, and it really shifted the perspective of the burden out.

Participant 04 spoke about parenting impacts and how their work causes them to distrust others around their own children:

> Terms of parenting, I've always, like, [been] aware…I don't trust teenage boys whatsoever because of my work. I really don't, like, it's, kind of…. I'd always be assessing like… no one thinks it's going to happen to them till it happens to them. I have a hyper vigilance towards…teenage boys being around my kids, so I try to, like, risk managing that myself.

Participant 05 reported parental impacts from colleagues:

> [They are] being little bit more precautious, especially if you're cautious, I should say, with, you know, younger kids or colleagues that do have kids…hey, these things are real, that there's a possibility for that. So, again, reading some of these things or learning some of these things…so, I think it [my worldview] has kind of changed…a little bit of my worldview, [it] hasn't shattered it or anything like that, but I think it's, kind of, opened my eyes to some things that I probably wouldn't have been privy to before.

Participant 08 reported parental impressions and how they are extra cautious:

> I've said to my kids, my husband … we live in a small community, and [Participant 08's husband] wanted to let our daughter go play in the school ground after school by herself, and I'm like, "No!" Why? "because [of] Mr. So-and-So," you know, [and stories of kids being] lured from the playground, and so, we're not… that's not happening. And the way I teach them [Participant 08's children] about strangers is very different.

Participant 05 shared some professional impacts that working with this population has brought:

> I think it's impacted me in that having to educate other staff that we have to, yes, this is probably one that brings up a lot of emotion…within [the] psychology or treatment staff, there was always a split that people wouldn't interact with this [noncontact sex offenders] because if we don't [provide service], then they're not going to get better or anything like that, and we're there to help if they ever get released, or help society in general if they ever get out. Me, personally, working with them, I don't think I was necessarily affected by it…I was probably the one provider that would, kind of, interact with them on some level.

Participant 06 specified professional impressions, and spoke of enabling their colleagues with children to minimize their contact with sex offender clients:

> I purposely would take these on [noncontact sex offenders], so that my colleagues who had little kids at home don't have to sit and, kind of, listen to, like, predators in our community, talk about things. Even just to hear about it and to hear the stories, and to hear about the ways that it was benefiting them can just be upsetting when you think about what the victims had to go through. So, yeah, like, purposely, I will take them so that people who have children didn't have to.

Participant 02 detailed the personal impacts working with sex offenders had on them and how their job, and keeping their experiences from their partner to protect them (the partner) and themselves (Participant 02), was difficult and draining:

> I guess there was a big difference in the understanding, because my ex-husband didn't work in the environment…whereas my common law partner now, he's been in the environment for over 20 years… I mean…he's seen it all from that side, kind of, thing. And there's so, there's definitely a difference now. I would try to hide it from, like, from my ex, I would try to hide, maybe some of the… I would minimize everything. I would minimize, you know, incidents, I would minimize, you know, just anything, like, being called a "two-faced fucking cunt" for months on end. So, I would minimize how much that was, kind of, impacting me, because I didn't want him to know, right, like, or to worry, or to whatever. Whereas now, I don't have to minimize that stuff. Well, I can't because he'll notice it's "bullshit" if I do, right, so. So that did wear on me.

Participant 03 mentioned the personal impact of not being able to share their day with others:

> I find it's, it's a tough thing to talk about your day with people about, right. If you're just talking about what happened at the office today, and your day is "I had to assess this guy and here's what was going on for him…" Just the processing of the usual daily stuff. As people do not want to hear about child pornography offenders.

Participant 08 also reported the personal impacts of having to be quiet about their work when it came to their family:

> I can't come home from work and talk about my day. My husband does, but I just, it's not, it's not conversation for the dinner table. So, a lot is kept, you know, I have a very different life in the office where we talk, and its dark humor…sex crimes against children would be horrifying. My husband overheard me one time talking to one of my colleagues about a case, and he was traumatized… he was like, "that, that image is not leaving my head and I wish I wouldn't have heard that."

Participant 01 mentioned the positive impacts in their practice and their family life, because of a change in attitude and, thus, therapeutic modality:

> Then secondly, I think the one of the most significant changes I made in my practice, which we did in our whole practice as a team, was to move towards a more strength-based positive psychology kind of approach to treatment. Where, when I first started, the goal of therapy, at the time, was to take the official version of the offense, and then, sort of, tried to bully the guy into agreeing with the official version of the offense. Once the research came out, that denial did not predict recidivism, that, kind of, rid us of that idea. And, and as I became more positive in my therapy with, with my clients, that translated into, I think, being more positive with both my colleagues, as well as my family and friends. So, I think it actually significantly improved my life as a result of taking that kind of approach.

Participant 01 further mentioned the importance of attitude and, thus, perspective:

> If people are trained to see their patients or the clients as a puzzle to be solved, rather than that they have ultimate responsibility about whether this person reoffends or not, you have to put your role in perspective, because you can't make people change, and you can't control all the external factors that could lead them to reoffending. So, it is disappointing when a client reoffends, but you have to put it in perspective.

Participant 01 also spoke of how looking at the clients (the offenders) as examples of what not to do has had a positive impact on them, personally:

> I often say this when I do trainings for therapists is that the guys in our groups are often very good recipes of how not to have a relationship in your life. I'd like to think that it improved my relationship with my partner enormously, because I had to learn about intimacy and attachment…[and] jealousy, [and] those kinds of issues and hopefully that translated into me responding to my partner in a in a better way.

Participant 07 mentioned the professional impacts of learning how it is important not to take anything at face value, but realizing that the offenders are just people:

> I think one of the things I've certainly taken away from working in this field is that how someone appears is, is often a limited part of the[ir] story. I used to say, I've met some of the nicest rapists and murderers you'd want to meet, because there's some guys I [have] met…[where I would think,] I'd go for coffee with him…but…there was also this history there.

Participant 03 shared their experience of feeling pity for some offenders:

> But, so I, yeah, that's all I feel, I feel bad for them. There is not very many people you can say "I feel bad for the child porn guy" to either, right, which is why it's important to have the support system. Like, we revile child sex offenders more than anything in the world and I am not saying it anytime… for John Q. Public, so, it's just…it's a real radioactive charge. I can think of a few things you would rather be charged with less, you know, you would rather be charged with first-degree murder than your child pornography.

Participant 06 shared their experience of treating their client as an individual and not sole as an offender:

> As a parent …it might feel equally as awful and I think that there was always, kind of, [it was] hard to be a woman in the room with a sexual offender, [this] is always a little bit unnerving. But, I think I would always try and go back to the attachment piece… what happened to this person… instead of focusing on what they did.

Theme 7: Lack of Resources for Noncontact Sex Offenders

One of the professional struggles experienced by the participants involved in this study was the lack of therapeutic resources in the community that were available for noncontact sex offenders. Most of the participants identified themselves as one of few mental health clinicians who were willing to work with this population. The perception of Participant 01 and Participant 03 was that there were not many therapists that were willing to deal with noncontact offenders. Concerning this, Participant 03 stated, "I think people hate sex offenders, and they hate pedophiles in particular."

Regarding therapist that could work with this population, Participant 03 further mentioned how they may be will, but they may not be qualified:

> If I had to refer somebody for treatment, because they've been convicted of child pornography, I can think of maybe two people that I would send them to, there's probably a wider circle…who would accept the referral, but they don't know what the "hell" they're doing. So, yeah, it's a very small strike zone.

Participant 05 suggested a possible reason for therapists being reluctant to take on client sex offenders: "Obviously, I think having children was a big deterrent for people, I don't have any children, so I don't, maybe, it didn't hit home as [it] maybe [for] some of my other staff members that had children, things like that."

Participant 01 reiterated this reluctance, explaining,

> I don't know that to be categorically true, but it certainly seems to be the case. Because so many of the guys that I see tell me they've contacted a whole bunch of people [therapists] and they've all said no, they don't deal with noncontact [sex] offenders.

Participant 03 offered their insights into the lack of resources:

> I wish I could say it was, I think, there are some really legitimate reasons [why a lot of therapists do] not to want to work with them…I think … most psychologists don't want to work with them because…all psychologists, obvious[ly,] are just regular people and society in general seems to view this as one of the most egregious offenses you could possibly participate in. So, I think it's got a real stomach-churning aspect to it. I've got some understudies that work with me who

> are really interested in forensics in general… but [the individual] does not want to see any of these files… I think it just really pushes a [few too many] button[s]… sex offenders, in general, really push a button with John Q. Public. I think that's the biggest thing, they just find them as revolting as the general public does.

Participant 03 highlighted their concern for the lack of resources and stated, "I think there are clinical concerns to it, but what do we do about this? I don't want or [know] how do I manage this?"

Participant 04 provided their perspective on the lack of clinicians:

> I think it's, it can be a very emotive for people to, kind of, [it (working with sex offenders)] arouses feelings sometimes of whether people have their own trauma, whether they know someone who's been traumatized, whether … as a psychologist, right, try to place your own values and your beliefs and all the other stuff, and put it to the side and work with that person. Everyone's going to have areas that they don't feel comfortable with. Or maybe it's not their thing. And I get a lot of people [that have] said to me, Oh, how could I work sex offenders? Like, well, you know, I could not work with couples… everyone's going have their biases and, kind of, preferences

Participant 05 mentioned the possibility of the correctional environment being a deterrent:

> I don't think a lot of people, when they go into psychology, go, like, oh, I want to go into corrections. Maybe they might be thinking of going to, like, a hospital, or a private practice or something like that, and corrections, being locked behind a

> wall where you can't leave, and things like that. I think it might also just be the stresses of the job and you might have, like, two or three psychologists for, like, 1,000 inmates and that's, kind of, a lot to, to have on your plate.

Participant 07 provided a rationale for the limited number of clinicians willing and able to take on clients from this population:

> Well, I think…the percent[age] of forensic psychologist[s] within the broader clinical realm is somewhat limited, and then within that group…there's perhaps a smaller number, again, who has specific training and expertise and working with men who committed sexually motivated offenses. So, a general clinician, if they know someone's facing a charge for sexual offense, generally, I think they would not feel they have the background of the training to take on a client like that and, so, I think that's, that's largely the reason why.

Participant 08 mentioned the limited resources for a noncontact sex offender but specified the conditions by which an offender needs to abide:

> Basically, we're just [only] putting conditions on them. You can't be on a computer, you can't be around children, you know, those types of things. You have to continue [like that], well, as long as you're on statuary release…you have to continue working with your, in your maintenance program and the community, a community-based maintenance program.

Theme 8: Noncontact Sex Offenders' Motivation for Treatment

Participants mentioned the modalities and framework they followed in treating noncontact sex offenders; however, many participants shared noncontact sex offenders'

motivation, or lack thereof, to engage in treatment and their internal motivation while in treatment. Participant 02 specified, “They don’t, or they haven’t [any motivation] …there was no desire to change.” Participant 03 shared a similar experience, stating, “they’re clinging vigorously to an excuse that they’re just regular dudes who have [committed an offense through] no fault of their own, but they [just] stumbled into something.” Participant 04 shared their experience of noncontact sex offenders beginning treatment because they were driven by external motivation, explaining, “typically, my clients are mandated.” Participant 06 told of a similar experience: “Everyone I worked with was mandated at that time.”

Participant 05 participant provided a reason as to why a noncontact sex offender would be in therapy with a clinician:

> I still think [they came to me because they were] not accepting that they’re in prison for such a long time and I think it was more, kind of, the adjustment [and] trying to make their prison stay a little bit easier, I would say, whether it would be maybe getting on an antidepressant, or something like that.

Participant 01 also spoke of external influences, “Typically, it’s either their partner says…“either you do something about this, or I’m gone,” or the courts saying to them, “you clearly need therapy.”” Participant 3 provided an example of the lack of motivation:

> So, on the one hand, they’re paying lip service to “I’ll do whatever you and or the courts want me to do to make this go away, so I don’t go to jail.” But there’s,

> never any, sort of, claim that "I'm a broken person, and I have problems that I need to deal with."

Participant 01 declared that, in their opinion, offenders don't come to therapy by their own choice, something (or someone) often pushes them to this: "I would say the primary motivation for seeking therapy, for most of them [noncontact sex offenders] is external, rather than internal." Conversely, Participant 01 also mentioned that, for those that do seek out therapy by choice, it is because there are positive motivations behind their actions, motivations of them looking to heal:

> I would say the majority do want to deal with the problem and not getting themselves in trouble for this type of behavior again…there are some who it's very clearly external pressures that are sending them to therapy. But for others…it's quite often… a desire to, to stop this behavior. They know it's a problem… it's usually caused some problems in other ways in their life, too.

Participant 08 shared their experience of positive internal motivation for therapy of offenders feeling severe regret and remorse:

> You have a lot of guys who realize, you know, what they've done, and they're absolutely horrified that they did that. I have a guy in his 50s… and he's absolutely horrified about what he did… he has huge remorse and struggles to really live with himself…you get lots of guys like that, who [think that] what they did is horrible.

Participant 04 shared affirmative motivation of offenders wanting to change:

"I would say most of those guys…there is a recognition that they need to change. They're not happy…if they were happy and they would have good tools and healthy coping skills, they wouldn't be relying on…living this lifestyle."

Participant 02 shared noncontact sex offenders' motivation in therapy:

> Some of them do…some of them don't, some of them are simply there because it'll look good on their plan. Any of the ones that I've worked with that [are], like, the pedophiles, they don't believe what they did was wrong. So, it's really just a matter of trying to convince them the law says, you know, it is wrong [what they did], kind of thing.

Participant 06 mentioned that some offenders had both internal and external motivation to seek therapy:

> I would say, I would say that there was definitely external motivators… internally, I think the lack of motivation also was related to the level [and] the degree of consequence. It's hard to be hopeful when you don't really know your outcome. When you don't really know what you're going to be sentenced to. So, I think maybe…just the stage of where I was at in the intervention.

Participant 07 spoke of therapy motivation for offenders on probation and in private practice:

> When I was working with guys on probation, as well as guys in clinical practice, the CSEM [Child Sexual Exploitation Materials] guys, generally, had a sense where their motivated….often at a deep shame about what they'd done and their interested in not going down that path again.

Participant 01 shared their uncertainty as to how to deal with some of their clients, because of their (the clients') belief that all has been well in their lives:

> Sex offenders, it's more the intellectualizers, the guys who will tell you that they have never had a problem in their life; that their life the childhood was perfect. Their parents were wonderful, and, I think, it's not that it's been difficult to work with them, it's more that they, you often wonder, or at least I do, whether I should topple that house of cards for them. It seems like it's the only thing that's keeping them, kind of, somewhat together. If they actually really did face their life, realistically, they might, it might be devastating for them. So, it's always been a bit of a challenge to try to figure out what's the appropriate strategy under those circumstances.

Participant 03 shared their personal experience and view of pity for some offenders:

> I would emphasize that I feel very compassionate towards these guys, I really do feel for them. Most of them are, like, 40-year-old dudes who have never been in trouble with the law for a minute in their entire lives. They have wives and they have kids that they, very often, are not allowed to see since they have been arrested. Their heads are spinning…it is their entire identity, their entire world hinges upon this thing….and if I did this, then I am one of these people and if I'm one of these people, the world hates me. That is a huge burden to take on and a tough thing… to encourage anybody to accept…so, I guess that's a lot of my frustration with them, as well as that I feel for them quite deeply. But they also can't seem to get out of their own way. They are not helping themselves. I

> understand why they are not helping themselves. They [have] never been in this position before and the stakes are so crazy high.

Participant 08 explained about some of their clients who struggled to come to terms with their offenses:

> You can have an orientation to whatever you want. You can feel a sexual orientation to, to animals, and you cannot go out and have sex with them. Same thing with this, if you feel attracted to them [to children], that's one thing, but you don't have to act on it and it's not your right to act on it, because they [the offenders] don't have the ability [to stop using pornographic material], and so that would be part of the therapeutic process. You get people some people like that… other people are just extremely embarrassed. That…they have done that, and they got caught…because it was hidden.

Participant 06 spoke of clients with long sentences and mentioned that, as a consequence of their longevity, they had given up, and claimed that they don't want help; however, this was not always the reason for their despondency:

> The severity of the charges, lots of [individuals say] like, well, why bother? I am going to be in jail for the next 25 years anyway, so why bother doing something, like, my life is over? So, yeah, not a lot, like, motivation, but underneath that…lots of shame.

Summary

This chapter presented the results of the current study examining mental health clinicians' personal and professional experiences of working with noncontact sex offenders. As such, these results addressed the following research questions:

RQ 1: What are the experiences clinicians encounter when assessing and treating noncontact sex offenders?

RQ 2: How do clinicians define their personal impacts within the context of treating noncontact sex offenders?

They studied the personal experiences and impacts of clinicians working with noncontact sex offenders in clinical interventions and assessments involved examining how clinicians were exposed to and dealt with unique behaviors of noncontact sex offenders. It also involved identifying their motivation and desire to work within the correctional and forensic field. Although the participants identified demanding work duties, personal impacts, and changes to their worldview, they also highlighted the therapeutic approaches and psychological assessment interventions they had experienced that made their work satisfying, even with the challenges of the lack of community and professional resources being available and the additional stress of external occupation factors.

Most of the participants claimed that the treatment of noncontact sex offenders did not differ drastically from the treatment of other clients; however, the clinicians identified specific modalities and techniques that they engaged in when treating noncontact offenders due to their (the clients') lack of motivation to partake in therapy

and their sometimes distorted thinking. Most of the participants started working and continue working within the forensic and correctional area because of their personal and professional interests in this field. The participants described their experiences working with the noncontact sex offender population as fascinating, exciting, and challenging but rewarding. Many participants expressed that they experienced challenging, complex cases, but they learned to view these cases as puzzles to be solved rather than viewing these clients as someone who could not be helped. These presented difficulties and obstacles in terms of personal impacts in parenting, personal relationships, professional struggles, feelings of burnout, and frustration.

The personal impacts that these professionals experienced when providing treatment to noncontact sex offenders were both positive and negative. The majority of the participants declared that they empathized with their clients, while they also highlighted specific events during their careers that changed their outlook on how they parent their children. Some participants spoke about struggling with not being able to talk about their day with their spouses, friends, and family because of their specific area of work. Participants highlighted the lack of resources for noncontact sex offenders in the community and correctional centers. One participant emphasized that sex offenders were viewed as revolting by the general public. Others stated that this viewpoint could potentially be a reason for the small number of registered professionals who want to specialize in the forensic and correctional field and work with noncontact sex offenders. That said, the participants described that they had an intrinsic fascination for understanding human behavior and, as such, they were intrigued about the offender

population. Furthermore, most remarked on their aspirations for taking on challenging cases as these would bring with them the benefit of self-development and lead to the prospect of professional opportunities and growth.

The participants reported that they were very much focused on their jobs and their professional responsibilities in working with this population. However, they disclosed that external factors hindered their ability to engage in everyday professional duties. Many participants mentioned the external impacts of multilevel organizations, other agencies, the judicial system, the courts, lawyers, psychological risk assessment tool outcomes, and other professionals working with their noncontact sex offender clients. The participants used standard therapeutic approaches to treat their clients, but the participants clarified that they have also adapted their therapeutic approaches to support their clients to facilitate positive change within their interventions. However, this did not necessarily motivate the noncontact sex offenders to engage in the treatment process with them or remove the feeling of external pressure on them from other areas. Nonetheless, the participants emphasized that it was because they were able to navigate the limitations and external impacts of the work and the system and that they had the necessary resilience to process their struggles that they could continue to work within the correctional and forensic field. The results showed how the unique experiences that the clinicians encountered when assessing and treating noncontact sex offenders defined the impact of these interactions on them, both personally and professionally.

The themes and the framework revealed, as presented in Chapter 4, are discussed in the following chapter, Chapter 5. When writing the discussion, this author drew upon

the existing literature and considered the bias of the theoretical framework. The next chapter ends by acknowledging and describing the limitations of this study, suggests recommendations of strategies to bring positive change to clinicians working with noncontact sex offenders, and presents the implications and the conclusion of this research study.

Chapter 5: Discussion, Conclusions, and Recommendations

Elias and Haj-Yahia (2019) conveyed that experiences during clinical interventions varied between therapists and increased awareness of how these experiences can influence individuals' intrapersonal and interpersonal aspects of their lives. Since minimal empirical research has been completed on noncontact sex offender treatment and recidivism rates (Duggan & Dennis, 2014), these reported impacts would likely increase the difficulty for clinicians in mental health to provide appropriate clinical interventions and precise psychological risk recommendations for their clients. Thomas et al. (2015) postulated that as sex offenders were a controversial topic and society continued to view this population with opposing views and attitudes, clinicians may struggle to provide psychological treatment to these individuals because of societal pressure and their own opinion on this matter. Thus, as evidenced by Church et al. (2011), clinicians within the forensic and clinical field are tasked with managing the negative public opinions concerning this population; however, they may also need to exhibit more complex and diverse outlooks toward clinical interventions and assessments of their sex offender clients. Bartels and Merdian (2015) identified the inconsistency between the noncontact and contact offenders. These authors specified that the application of treatment and rehabilitation programs created for contact offenders would not be appropriate or, therefore, successful for noncontact offenders. Mental health clinicians working comprehensively with noncontact sex offenders might have a deeper understanding and insight into the population through their meaningful experiences and personal impacts of treating these individuals (Bartels & Merdian, 2015). These

experiences may affect their personal and professional lives and their ability to continue working with noncontact sex offenders. Additionally, mental health clinicians working within the forensic and correctional field must also navigate working within multiple organizations and bureaucracies. These circumstances can create further professional challenges for therapists in providing appropriate treatment and interventions to their sex offender clients in unrealistic therapeutic settings, such as understaffed and under-resourced.

I aimed to explore the personal experiences felt by mental health clinicians (psychologists, social workers, nurses) when working with noncontact sex offenders in a clinical setting. The following research questions were created to achieve this purpose:

RQ1: What are the experiences clinicians encounter when assessing and treating noncontact sex offenders?

RQ2: How do clinicians define their personal impacts within the context of treating noncontact sex offenders?

I conducted in-depth interviews using open-ended questions with eight mental health clinicians who worked with noncontact sex offenders in the community and correctional settings to address the research questions. Using an IPA approach, I revealed my lived experiences (see Creswell & Creswell, 2018). The participating clinicians encountered clinical intervention, treatment, and assessment of noncontact sex offenders and the personal and professional impacts of treating this population. Due to the increased numbers of noncontact sex offenders, great emphasis was required on investigating this specific population and the clinicians who work directly with them.

Knowledge of the essence of a clinician's lived professional experiences has potential for social change in professional support, psychological interventions, clinical expectation, and potential growth within psychology's forensic and correctional field.

If mental health clinicians within the correctional and forensic arena share knowledge of the complexities, the advantages of the specific therapeutic modalities that they apply, and their abilities to navigate multifaceted clinical cases, positive change in terms of clinician satisfaction and staff retention in correction settings could occur. A clinician's theoretical framework and personal philosophy of change set the foundation for a balanced approach to their clinical responsibilities. The findings from this study could work to catalyze change in the forensic and correctional field in treating noncontact sex offenders. By understanding the external challenges involved in the work, investigating specific noncontact sex offender behaviors, creating motivation to work in the field, and establishing treatment modalities, opportunities could be initiated to encourage and support current and future individuals working in this field.

The following section presents the interpretation and discussion of the results from the interviews with eight mental health clinicians working with noncontact sex offenders in the community and correctional settings. Following this, the limitations of this research are acknowledged, and the recommendations and implications for positive social change of the inquiry are defined. Finally, the conclusions of this study are presented.

Interpretation of the Findings

This section includes the themes that emerged from the current study. Using an IPA approach was to gain deeper insight into this phenomenon. The findings from this research inquiry showed evidence of how the experiences that clinicians encounter when assessing and treating noncontact sex offenders can impact their personal and professional lives.

Theme 1: Behaviors of Noncontact Sex Offenders

The term child pornography offender, or noncontact sex offender, has been designated to individuals who commit offenses by using the internet to download, distribute, access, or produce child pornography (Criminal Code, RSC 1985, c C-46, s 163.1(1)(a)). Seto (2013) emphasized that the advent and rise of the internet created a new pathway for the sexual exploitation of children, with the material being available for anyone who has internet access. Concerning the ease of access to material online, one participant (P08) stated, “Once they start exploring, they get more curious.” This same participant further declared, “Some of them will just stumble upon it, or through their internet searches.” McManus et al. (2016) investigated contact and noncontact sex offenders’ online communications to understand the differences between these two types of offenders. These authors discovered that common noncontact offenders’ online conversation themes had a sense of normality and a high degree of sexual motivation within the discussions. In my study, the participants mentioned that the noncontact sex offenders they treated exhibited a general sense of intimacy and attachment deficits and low emotional development, and they also struggled to fit in with their peers. The participants further

reported that this cohort would openly discuss their sexual concerns with adults, but they had limited sexual experiences personally (see McManus et al., 2016). Henshaw et al. (2017) stated that the number of noncontact sex offenders had exponentially increased over the past 20 years, resulting in heightened awareness within the criminal system and academic literature. These findings, along with my findings, describe displays of problematic behavior that included isolation, lack of meaningful connections, intimacy issues, and attachment deficits that might lead to behavioral escalation. Henshaw et al. (2017) further identified that not all noncontact sex offenders possess the same characteristics, but there could be potential for behavioral similarities to arise from the present study.

Bartels and Merdian's (2015) investigation of CSEM users with specific IT was based on an analytic review of existing research, as there was minimal information based on the possible subtypes of CSEM users, such as fantasy-driven CSEM users, for example. However, most of the participants in my study identified noncontact sex offenders as curiosity-driven offenders because they were exposed to pornography at an early age and became interested in more intrusive and increasingly perverse images with time. One participant (P08) stated, "Once they start exploring, then they get more curious and more curious." Conversely, a few participants described noncontact sex offenders as fantasy-driven, engaging in sexual fantasy to stimulate themselves. The same participant (P08) also reported working with several males who did not believe they had pedophilic tendencies but developed them due to repeated exposure. P05 and P06 mentioned

experiences where noncontact sex offenders fixated on idealizing the males in the videos and continued to engage in fantasy-driven behavior, even when incarcerated.

At this stage, there was limited information on the development of implicit theories, but the underlying assumption was that the online environment, if accessible and anonymous, would provide the means for a CSEM user (Bartels & Merdian, 2015). P08 stated, “Pornography is such a huge industry… when you look at, I think how many people are accessing it, it blows you away.” Another participant (P06) stated, “The ease of access we have now,” referring to pornographic material being accessed online through smartphones and tablets, etcetera. My study’s findings aligned with the idea that the internet has created the means for users with a foundation for curiosity and for those who are fantasy-driven CSEM users to quickly and anonymously access pornographic material.

Ward and Keenan (1999) speculated that cognitive theories acted as core beliefs for an offender, and these could result in implicit theories for contact offenders; however, these authors also stated that offenders who were convicted of online sexual exploitation material had higher sexual deviance and were less likely to have access to children. Most participants in the present study specified that their noncontact sex offender clients had long-standing patterns of sexual preoccupation. As P07 stated, “It is using the interest to cope and immersing them themselves in sort of online fantasy.” Another participant (P08) stated, “It escalates, right until you get your primary act of deviance.” In addition, noncontact offenders were reported to have a less criminal history than contact offenders, lower reoffending rates, and less victim empathy, emotional awareness, and impact on

children (Babchishin et al., 2015). Add summary and synthesis throughout the paragraph to balance out the use of information from the literature with your own analysis.

Most of the participants confirmed that noncontact offenders verbalized the minimization and justification of their sexual offenses. The participants provided rationalizations they had heard, such as “it was never their fault” (P03), “it is not as if I created a victim” (P01), “I did not touch somebody” (P#01), “what they did was not wrong” (P02), and “I just fell into it” (P03). Most participants reported that noncontact sex offenders would create stories to justify their actions and, according to P07, allowed themselves “permission-giving thoughts” to use underage pornography. Several participants mentioned the rationales that the offenders provided, such as “I’m protecting kids” and “gathering this stuff for the police” (P03). On the other hand, some participants mentioned that noncontact offenders had cognitive distortions regarding their offenses, such as one offender believing that they had a sexual orientation towards children and felt entitled to act out on their sexual urges (P08). Howitt and Sheldon (2007) defined cognitive distortions as beliefs produced to overcome the internal guilt or shame to justify their actions and rationalize their crime. My research findings also supported the idea that cognitive distortions were specified for internet-only offenders and their ability to self-distance themselves and minimize the harm in viewing or collecting.

Theme 2: Clinicians’ Motivation to Work in the Forensic/Correctional Field

My study’s participants mostly articulated their desire to work within the correctional field and provide treatment and assessment for noncontact sex offenders. They further emphasized how their experiences were challenging but satisfying, as they

provided learning opportunities and self-development (P02). Therapy has been described as a vulnerable and intimate process, with the clinician's responsibilities when working with noncontact sex offenders being to understand and evaluate the mental and psychological challenges that are involved in these alliances and to have their clients feeling safe, heard, and validated (Elias & Haj-Yahia, 2019; Muntigl, 2019).

Nelson et al. (2002) mentioned variables related to clinicians' attitudes regarding treating sex offenders; the consensus here was the desire to support and help individuals who had committed a sexual crime. Most of the participants in my study verbalized their aspiration to work within the forensic and correctional field because they were fascinated with human deviant behavior and to understand better why people do the worst things (P03, P04, P08). A few participants detailed that they entered the field by internships (P05, P06) or needed employment, and a correctional agency was hiring (P07). Previous research indicated that a therapist would experience various emotional changes when working with this population, threatening therapists' empathy toward their clients (Hardeberg Bach & Demuth, 2019). Participants in my study believed the correctional and forensic field to be an intellectually stimulating and underserved population that provided a positive outlook on sex offender treatment and assessment (P01, P06, P07, P08) even though the effectiveness of the sex offender rehabilitation process is debated over about its ability to impact sexual recidivism (see Rogers et al., 2011). In my study, all participants that were presently employed within the correctional and forensic field and had no desire to change their area of specialization.

Theme 3: Clinicians' Work Duties

Previous research focused on front-line staff and analyzed their responsibilities in understanding and evaluating the mental and psychological challenges presented when treating sex offenders (see Nelson et al., 2002). Given this situation, there was a need to investigate the professional experiences associated with the clinical intervention of sex offenders within the context of a clinician's job-related responsibilities. In my research study, most participants (all but P03 and P08) specified that their occupational responsibilities encompassed a variety of roles, while few participants specified having one specific role. The participants reported that a mental health clinician's role varies based on their place of employment. Some clinicians will only provide psychological risk assessments (P03). Other clinicians will provide a variety of clinical interventions and services such as group therapy, crisis intervention, individual counseling, psychological intakes, and general clinical clients in the community, providing staff training and clinical supervision and research (P02). Add summary to fully conclude the paragraph.

The gap within the literature meant that there was limited information regarding clinicians' exposure to sex offenders and clinicians' caseload, work duties, and place of employment to grasp a better idea of their daily exposure (Baum & Moyal, 2020). The findings of this and previous studies indicated a need for further investigation into clinicians' occupational obligations, as this would afford some insight into their daily exposure to noncontact sex offenders. My findings indicated inconsistencies in a clinician's work responsibilities. For this reason, it is suggested that mental health

clinicians will experience different professional experiences due to the nature of diverse caseloads, place of employment, and occupational duties.

Theme 4: Therapeutic Treatment Modalities

Previous research deemed a sex offender's psychological treatment as a controversial topic in the eyes of the public and not necessarily as a rehabilitation process (Thomas et al., 2015). The different modalities of sex offender therapy were reported to vary in terms of the treatment severity and therapy types, incorporating medication and cognitive-behavioral approaches that concentrated on relapse prevention (Seto, 2008; Thomas et al., 2015). The therapeutic approaches of the participants in my study did not differ concerning each other's modality, nor when it came to them treating different sex offenders, despite them being contact or noncontact offenders. One participant stated, "I do not change my approach with them" (P01).

Hanson et al. (2002) recognized that (CBT was the most consistent and effective technique used in treating sex offenders for reducing future risk. In my study, several participants confirmed using CBT as their primary modality (P02, P04, P05). Many participants detailed that they combined CBT with other approaches such as dialectical behavioral therapy (DBT; P01), psychodynamics (P02), and motivational interviewing (P04).

Previous research explained that CBT inventions with sex offenders allowed therapy to focus on intimacy, cognitive distortions, triggers, and developing relapse prevention centered on offending behaviors (see Yates, 2013). The participants in my study mentioned that through their therapeutic approaches; they also looked at factors of

distorted thinking, self-talk, unhealthy coping skills, and evaluating risk emotions. Nonetheless, previous research identified that the individual clinicians should decide on the model used in treating their sex offender clients as this has a positive outcome in treatment (see Hanson et al.; Yates et al., 2000). In my study, participants highlighted the importance of building an excellent therapeutic alliance (P01) and engaging in a psychosocial history with the client to understand their family history (P02), roles, attachment style (P01), sexual health education (P02), past trauma (P06), healthy coping (P04), and current mental health diagnosis (P08). Current and past research acknowledged the importance of demonstrating empathy and genuine interest in the client and taking a nonjudgmental approach (P01) as these enhanced the treatment outcomes (see Yates, 2013).

It was still unclear whether therapists should engage their noncontact sex offender clients in the same treatment plans for contact offenders (Henshaw et al., 2017). In my research, none of the participants changed their approach or modality when treating a noncontact or contact sex offender. In the current and previous research, it was further demonstrated that noncontact offenders and contact offenders possessed similar behavioral and psychological problems (see Merdian et al., 2011); therefore, they would benefit from the same treatment type.

Theme 5: External Occupational Factors

The current study identified a theme of mental health clinicians struggling with working in multiple organizations and bureaucracies. Not only did the clinician have to battle against the public's views about working with sex offenders, "society, in general,

seems to view this [committing a sexual offense] as one of the most egregious offenses you could participate in" (P#03), as Thomas et al. (2015) highlighted, a sex offender's psychological treatment is a controversial topic with punishment, not rehabilitation being at the forefront of the public's mind. The participants also mentioned that the most challenging part of their job was working within a system that has legal dynamics (P#06). Most participants reported their occupational hardship to the correctional system, the federal prison system, and other organizations and professionals within the field (P#04).

Several participants stated, "The inmates are the easiest part" (P#05). The majority of the participants emphasized the lack of staffing in their department (P#02, P#05, P#08), the inability to hire and retain psychologists (P#03, P#05, P#08), experiencing large caseloads (P#01, P#02, P#05, P#06, P#07), limited control over their work (P#07), and unrealistic expectations to deliver therapy all the time (P#01). Many participants verbalized that their departments were understaffed (P#05), which led to individual burnout (P#01, P#03, P#06). One participant (P#07) specified that the correctional system did not facilitate positive personal growth and an environment that allows for change. They further detailed that the system created a guardedness and mistrust between therapists and clients, interfering with the therapeutic rapport.

In addition, sex offender programs were created to rehabilitate the individual and transform the offender's emotional, cognitive, and behavioral patterns to support a crime-free lifestyle (Beech et al., 2013). That said, previous research reported that offenders would be assessed based on their risk level and the value of risk, corresponding to the level of treatment and supervision they needed (Andrews & Bonta, 2010; Yates, 2013).

Therefore, as these authors declared, if an offender were evaluated at a high level of service, they would be deemed at a higher risk of reoffending, and more intensive services would be required. Accordingly, lower-risk offenders with lower interventions may be considered to have a minimal intervention or no intervention (Andrews & Bonta, 2010; Yates, 2013). Ly et al. (2018) reported that child pornography behavior was not a criteria measure to diagnose a pedophilic disorder, although most individuals who access child pornographic material did so for reasons aligned with the pedophilia diagnosis. In the current research, a participant (P#03) stated that this is a "real catch 22 as for courts, it is as if you are saying he is a pedophile, but you are saying not to do much about it." Consequently, the recommendations were typically low risk, but the courts and justice systems required some treatment, which this same participant declared "paradoxical." Previous research illustrated that noncontact offenders, on average, had significantly more sexually deviant interests than contact offenders, and they typically received shorter sentences than contact sex offenders; therefore, they did not qualify for federally mandated programming (Babchishin et al., 2011; Krone, 2004; Ly et al., 2018; Winder et al., 2015).

For this reason, mental health clinicians working within the forensic and correctional field were faced with treating and assessing challenging clients and navigating a system that provided additional stress and burden within their occupation.

Theme 6: Personal Impacts and Worldview

In previous research, Elias and Haj-Yahia, (2019) explored the lived experiences of sex offenders' therapists through their perceptions of intrapersonal and interpersonal

consequences and coping patterns. For instance, Shechory and Ben-David (2005) mentioned that sex offenders were often portrayed as less aggressive individuals and, typically, nonviolent offenders. However, in Elias & Haji-Yahia's (2019) study, clinicians self-reported high degrees of anxiety and experienced hypervigilance when treating this population. In the current research, the majority of the participants were practicing within the field for multiple years and highlighted their impacts and changed worldviews concerning their professional and personal lives. Many participants described becoming desensitized to the client files (P#03, P#04, P#07) or reading a case that was a little hard for them to take (P#02, P#04). This result aligned with the previous research that when a therapist receives a recent counseling case for a sex offender, the clinician may self-report experiencing psychosomatic reactions (Elias & Haji-Yahia, 2019). A few participants mentioned experiencing vicarious trauma and being more conscious and careful in their personal lives (P#07).

Previous research identified that gender had vulnerable and adverse effects when treating sex offenders. Baum and Moyal (2020) research theorized that females were more adversely impacted when working with sex offenders, but it was reported that males had more of an adverse impact in terms of emotional exhaustion, distorted cognition, self-esteem, sexual behavior, and intimacy. In the current research, most parent participants identified changes in their parenting (P#01, P#02, P#03, P#04, P#08). The participants reported becoming acutely aware of the potential impacts on their child(ren) and having established negative feelings towards places or specific individuals around their children (P#04). An overall consensus was that of becoming more precautions

around places the participants would allow their child to go to, for example, swimming pools and playgrounds (P#02). One participant (P#01) detailed that this type of work allowed them to understand better how to keep their kid safe and how the internet could lead to problematic behavior. It was echoed by the participants in the current research that this type of work "opened my eyes" (P#05) to the things that they were not privy to before; therefore, it has created a hyper-vigilance and risk management behavior in their parenting (P#04). The participants who did not have children reported that they purposely took on the sex offender cases, so their colleagues who did have children at home did not have to do so (P#06).

Earlier research acknowledged compassion satisfaction, vicarious resiliency, and vicarious post-traumatic growth as areas mental health professionals needed to maintain when working with trauma and sustaining their careers (Michalchuk & Martin, 2019). In this current research, the participants echoed similar acknowledgments but identified personal and professional support as an area of need. Many participants spoke about not talking about their job with their spouses, friends, and family (P#08) and identified their colleagues and other professionals in the field as outlets and support systems or as an outlet for their colleges (P#05, P#06). From other studies, numerous professionals who worked with sex offenders reported how colleagues and peers helped them deal with work-related stress (Parsonson & Alquicira, 2019).

Prior research reported that many psychologists throughout their career would experience adverse effects when clinically supporting an offender who committed a sex offense and their encompassed cognitive distortions (Michalchuk & Martin, 2019). Even

though participants articulated adverse effects on their personal lives in the current study, many participants mentioned positive impacts in their professional practice (P#01). Participants stated to have shifted their practice into a strength-based approach, viewing their clients as puzzles to be solved rather than just taking on the ultimate responsibility for their clients' change (P#01). A participant (P#06) reported focusing on "what happened to this person, instead of what they did." Other participants mentioned feeling greater empathy and unconditional positive regard toward some of their noncontact sex offender clients. One participant (P#03) stated, "I feel bad for them." However, the participants differed in how their professional experiences impacted their personal and professional lives and, subsequently, how they learned to deal with and learn from their experiences. Therefore, clinicians sought to find optimal ways to cope and learn from their experiences to gain resiliency and reduce burnout.

Theme 7: Lack of Resources for Noncontact Sex Offenders

Nelson et al. (2002) mentioned that there were variables related to clinicians' attitudes toward treating sex offenders, and the overall consensus was the desire to support and help individuals who had committed a sexual crime. In the current research, the majority of the participants identified a lack of therapeutic resources available in the community for noncontact sex offenders (P#02, P#03). The participants detailed that it is their perception that clinicians are not willing to work with noncontact sex offenders (P#03). One participant (P#05) speculated that the deterrent for clinicians working with this population was clinicians who had children. They theorized it would be difficult therapeutically support a client that has harmed a child.

Sexual offending has been seen as a significant issue within society as it affects children and families, creating a negative societal view of sex offenders in general (Yates, 2013). In the current study, one participant (P#03) stated, "I think people hate sex offenders, and they hate pedophiles in particular." With such strong negative connotations towards sex offenders, the percentage of mental health clinicians being motivated to specialize within the forensic and correctional field was low. Some participants reported difficulties in providing referrals for noncontact sex offenders for therapy as there were a minimal number of therapists trained and willing to treat individuals from this cohort (P#03).

One participant (P#03) theorized that "all psychologists, obvious[ly,] are just regular people" and also that as society views sex offenders as committing "one of the most egregious offenses you could possibly participate in," this is what made it difficult for psychologists to enter the correctional field. Harper et al. (2016) defined a distinction between positive and negative perceptions towards sex offenders; therefore, this opinion could ultimately influence the therapist's view and, thus, the treatment they provide. The previous and current research shows that the differences in therapists' perspectives may be attributed to the differences between the professionals themselves (Elias & Haj-Yahia, 2019). Therefore, some clinicians may not find it as easy to work in the forensic and correctional field or find the job's positive sides. Participants in the present study shared their motivation and aspirations to work with noncontact sex offenders and identified removing the label of a sexual offense to see the clients as whole human beings (P#03, P#04, P#06, P#08). As a result, the participants treated sex offenders as regular human

beings, which allowed for a positive therapeutic alliance (P#01). In terms of recruitment, retention, and lack of therapeutic interventions and resources for noncontact sex offenders, this continued to be a question of concern within the field (P#02, P#03, P#05, P#08).

Theme 8: Noncontact Sex Offenders Motivation for Treatment

Prior research reported a struggle between offenders and clinicians within a therapy setting since most sex offenders engaged in treatment because it was part of their conditions on release (Drapeau et al., 2004). In the current research, most participants echoed similar experiences of their clients being mandated by the courts, their correctional plan, or another external motivation (P#04, P#06). Participants detailed the external motivators to be the client's partner (P#01), avoiding possible "jail time," probation conditions, and parole conditions (P#03). In addition, a few participants mentioned cases where the clients presented with cognitive distortions and had a sexual orientation towards children (P#08) or individuals who believed they did not have a problem (P#01, P#02, P#03).

Conversely, participants also mentioned working with offenders who were internally motivated in therapy and desire to change (P#07). Previous research detailed similar findings that some offenders effectively used the therapy to process their internal struggles and work through past trauma (Drapeau et al., 2004). In the current study, participants identified noncontact sex offenders as individuals who had never been in contact with the law before they were charged with a sexual offense (P#03). Therefore, many individuals realized what they did was wrong, and they were clinging vigorously to

an excuse as they were “just regular dudes” (P#03) who happened to “just stumble upon it” (P#08).

From the current and previous research, clinicians identified the purpose of sex offenders engaging in therapy: it supports the reduction of recidivism and protects the community from future risk (Thomas et al., 2015). Having the client acknowledge a problem would be the first step in the change process, as the client must affirm a desire to change. The current and previous research reported that working with individuals who were mandated to engage in therapeutic interventions was challenging as these offenders could be the type to exhibit cognitive schemas that projected blame onto their victims and, therefore, lacked internal responsibility and motivation (Ward & Keenan, 1999). Other research studies emphasized the dynamism of therapy, stating that treatment success relied on the cooperation of both parties (Watson et al., 2015). With these insights, clinicians could focus on building a solid therapeutic alliance with their clients.

Limitation of the Study

As detailed in Chapter 1, the nature of this qualitative study stood as a limitation due to the low number of mental health professionals working with noncontact sex offenders in clinical settings. However, the sampling size of eight (8) participants did not impede the ability to utilize this phenomenological research strategy to understand clinicians’ professional and personal experiences in better treating and assessing this population. The main goal of this inquiry was to enable participants to express their opinions and share their experiences while I interpreted and constructed the essence and meaning of these ideas and accounts (Merriam & Tisdell, 2016; Smith, 2011). Thus, the

number of participants represented in the study allowed for depth in the subject matter, but the findings could not be generalized. For this reason, not all mental health professionals who work in correctional and forensic fields with noncontact sex offenders may share or encounter the same experiences during assessment and treatment.

Other limitations included researcher bias and the sampling method. As a psychologist employed within the forensic and correctional field, my biases remained in the research to allow the lived experiences of each of the eight (8) participants to unfold naturally. Participant recruitment started through social media platforms (LinkedIn, Facebook, Twitter) utilizing a research study flyer, and other participants were recruited by word of mouth from participants who were already involved in the study. Another possible limitation to this study was the mental health clinicians who did not use social media or claimed connections to other clinicians who partook in the research. Nonetheless, each participant's individual lived experiences were personal, unique, and diverse.

As a researcher, I was committed to creating trustworthiness and confidentiality for the participants. The purposive sampling strategy applied in this study contributed to the limitation on generalizability, as the sample selected could not represent the entire population of mental health clinicians working in the forensic and correctional field with noncontact sex offenders. In addition, the capacity of the mental health clinicians that participated in this research study to answer the questions honestly and openly was not specific.

Recommendations

The findings could be a catalyst for future research regarding gathering different lived experiences of mental health clinicians working with noncontact sex offenders in the correctional and forensic fields. The perceptions and experiences related by the participants represented vital data that could be especially important and useful for other individuals working with noncontact sex offenders in treatment and assessment (Hanson et al., 2002; Henshaw et al., 2017; Thomas et al., 2015; Yates, 2013).

Based on the research findings, I found that due to the increased number of noncontact sex offenders (Ly et al., 2018) and the lack of therapeutic and assessment resources, it would be advisable for greater emphasis to be placed on the need for further investigations on this specific population and on the clinicians who work directly with them. Sex offenders have incited negative connotations and attitudes for centuries, creating an adverse view of sexual offenders in society (Rogers et al., 2011). Therefore, further research into clinicians' experiences could create social change regarding professional support, psychological interventions, clinical expectations, and future growth within the forensic and correctional field.

Consequently, it is recommended that this framework undergo advanced examination using a quantitative method to increase the empirical rate and larger sample size to facilitate its generalizability for future research. For example, an experimental study using specific modalities to treat noncontact sex offenders and evaluating the effectiveness of a large-scale quantitative survey on the external struggles that clinicians have faced within the correctional and forensic field and which strategies or solutions

have worked to overcome their professional dilemmas. If mental health clinicians within the field share knowledge of the complexities, the disadvantages, and advantages of specific therapeutic modalities and their abilities to navigate multifaceted clinical cases, positive change in terms of clinician satisfaction and retention could occur.

Implications

The knowledge of the personal experiences of mental health clinicians working with noncontact sex offenders in a clinical setting and how this promotes positive social change by initiating occupational experiences encourages and incites conversations within the forensic and correctional field to build a sense of engagement for the current and future clinicians. Not only does the examination of mental health clinicians permit an opportunity for clinicians to develop a deeper understanding of how other clinicians treat and assess noncontact offenders, but the examination of the lived experiences of clinicians to dig deeper into their own beliefs about noncontact sex offenders treatment modalities can foster a reflective learning experience that supports the building of a solid foundation for clinical practice with this population.

The insights revealed in this study provided by the participating mental health clinicians showed positive perspectives on noncontact sex offenders by therapists alongside the complexity of negative societal views, as influenced by numerous external occupational factors and the lack of resources. The findings further indicated a disconnect between the general public's views on noncontact sex offenders and clinicians' experiences of treating and assessing individuals from this cohort. Current and future mental health clinicians may reflect on the findings regarding their current personal and

professional impacts. The present study found that the participants had their internal motivations and obligations to treat noncontact sex offenders because there were limited clinicians within the correctional field and because there were few clinicians that held the proper perspective to enable them to see the offenders as human beings and that possessed the professional ability to support and provide interventions for this population. The participants were able to engage in supervision, collaborate with colleagues, create a support system, and find personal strategies to alleviate their job's burden and occupation stress.

The findings indicated that society and the general public impacted how noncontact sex offenders were viewed; this was reflected in sex offender treatment, and assessment perspectives as participants stated that they were focusing on viewing noncontact sex offenders as "human beings" and providing them with treatment as if they were any other type of client, society and other clinicians should strive to become supportive of the process of noncontact offender treatment and rehabilitation and also to the clinicians to whom this responsibility is assigned. Moreover, external occupational factors within the forensics and correctional field should understand how mental health clinicians can streamline services, reduce clinician burnout, increase community services, and expand reintegration programs. Guidelines on mental health clinicians' professional wellness should be required, in terms of frequency of therapy, streamlining work duties, reducing occupational expectations, and supporting healthy work environments. The findings of this study implied several insights into the profession that will be helpful for clinicians who are unaware of the forensic and correctional field.

A methodological implication for this study was the phenomenological exploration, as this allowed for a more significant investigation into the perceptions and experiences of mental health clinicians working with noncontact sex offenders. The nature of the study allowed for themes to emerge from the research; the results produced could apply to future researchers in the field wanting to extend the exploration of the phenomenon.

Conclusion

Sexual offending has been seen as a significant issue within society for centuries, with sex offenders being viewed negatively by the majority of the public (Yates, 2013). Empirical research and treatment effectiveness has demonstrated the need for intervention and the capacity of therapy to reduce the risk for this type of offender within a clinical setting (Yates, 2013). Mental health clinicians who have worked with noncontact sex offenders may have shared similar views to general society, but these clinicians had perspectives and clinical attitudes to support and provide therapeutic intervention to assist in a level of change. The findings from this study indicated that clinicians shared similar perspectives and professional and personal experiences with each other when treating and assessing noncontact sex offenders.

The nature of the Interpretative Phenomenological Analysis (IPA) enabled the identification of the themes of categories and concepts that emerged from the interviews with the mental health clinicians allowing this researcher to gain insight into the lived experiences of other clinicians in similar settings. Although I interpreted the data, I avoided my personal biases from manipulating the findings by ensuring that all eight (8)

participants vocalized their lived experiences, which were transcribed verbatim, and then checked and verified for their accuracy. The eight (8) themes that emerged were: Behaviors of Noncontact Sex Offenders; Clinicians Motivation to Work in the Forensic/Correctional Field; Clinician's Work Duties; Therapeutic Treatment Modalities; External Occupational Factors; Personal Impacts and Worldview; Lack of Resources for Noncontact Sex Offenders; and Noncontact Sex Offenders' Motivation for Treatment. These themes serve in correctional and forensic treatment and intervention, providing insight into mental health clinicians dealing with noncontact sex offenders and how multiple factors influence their professional occupations and personal lives. Advocacy was exhibited for mental health clinicians within the forensic and correctional field and professionals who currently work with noncontact sex offenders in treatment and assessment.

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Appendix A: Participant Recruitment Flyer

PARTICIPANTS NEEDED FOR RESEARCH STUDY INVESTIGATING CLINICIANS WORKING IN CORRECTIONAL/FORENSIC PSYCHOLOGY

What is this study about?
The purpose of the study is to explore the personal experiences of mental health clinicians (registered psychologists, social workers and nurses) when working with noncontact sex offenders in a clinical setting.

Why Participate?

- You can describe experiences of noncontact sex offenders while assessing and treating them.
- You may contribute valuable information to support future and current clinicians working with individuals who have committed a noncontact sexual crime.

Who Can Participate?

- Participants who are 19 years or older
- Speak English as your first language
- Have specific experience working with noncontact sex offenders

Compensation?

- There is no compensation for participating

Please email:

. . . Appendix B: Guiding Interview Questions

1. How long have you worked within the correctional/ forensic setting?
2. Did you work at another place of employment before working in corrections/forensic?
3. What was your aspiration/decision to work in a correctional setting?
4. How would you describe your career within corrections?
5. With your current job, what population do you work with the most?
6. What are your typical duties within a workday?
7. What population/offender is the most difficult to work with?
8. What population/offender are you most avid to work with?
9. What do male offenders with a noncontact sex offense think about themselves?
10. What are their rationales about themselves and their noncontact offense?
11. What do you think a noncontact offender believes/internal narrative about what child pornography is all about?
12. What do they find good/bad about their offense?
13. How does someone become involved in a noncontact sexual offense and what do they need to do to become interested?
14. What are they looking for online before they come in contact with child pornography?
15. Do you feel a child pornography offender's behavior will increase to contact offending?
16. What emotions are evoked during therapy/assessment of treatment of a noncontact offender?
17. What does a noncontact sex offense know about their cognitive processes about their offense (fantasy-driven, curiosity) and their own cognitive abilities and limitations?

18. Do they get frustrated when they talk about their offense? Or what types or emotions come up in therapy?

19. What types of approaches do you use when treating a noncontact sex offender?

20. Do they often talk about trauma?

21. Is there a common theme in therapy?

22. What other emotions may be involved when they talk about their offense?

23. Does believing they can be rehabilitated/changed help them change their behavior?

24. In what ways do they feel they need to rehabilitate/change?

25. In what ways do you feel they need to change or rehabilitate?

26. Is there a common mental health diagnosis with noncontact sex offenders?

27. From your experience, are noncontact sex offenders accessing psychopharmacology treatment?

28. Do many of the individual seek individual counseling? Or is it a mental health referral?

29. Is there a difference between treatment between noncontact and contact offenders?

30. How would you describe a noncontact offender intellectual ability?

31. What are the inter/intrapersonal impact the clinician feels from working with sex offenders?

32. How would you describe working with a noncontact offender?

33. How do you feel it affects your mental health?

34. How do you feel this type of work has impacted your personal life? Your family? Your parenting?

35. What do you think this work has changed about you?

36. Can you think of a time where you felt burned out from working from this population? Or experienced a mental or physical impact from working with this population?

37. What types of things do you do for self-care?