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Janel Nicole Harper

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Walden University
2024

Abstract

Perceptions of Clinicians Towards Offenders Who Utilize the Good Lives Model for Sex Offender Treatment

by

Janel Nicole Harper

BS, University of Massachusetts, 2020

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

November 2024

Abstract

Understanding how clinicians perceive offenders who utilize the strength-based good lives model (GLM) in treatment may help facilitate more acceptance among clinicians to incorporate strength-based alternatives as well as provide better therapeutic outcomes in treatment. The purpose of this qualitative grounded theory study was to examine the perceptions of clinicians who utilize the GLM for sex offender treatment. Grounded theory was utilized to formulate a theory regarding clinician perceptions towards offenders and its social change implications. The sample comprised of 11 clinical health professionals from mental health agencies who currently work or have worked with sex offenders within the past 5 years utilizing the GLM for sex offender treatment. Data were collected utilizing semistructured interviews. Data were open and axial coded to generate themes. Findings indicated that the perceptions of clinicians towards offenders in sex offender treatment were found to be overall positive, and many described the experience as fulfilling and rewarding. The findings showed that clinicians focus on treating the offender like human beings and collaborate with colleagues and other clinicians if difficult emotions arise to ensure no impact to the client’s treatment. Participants continue to utilize the GLM due to the strengths-based approach. Participants also emphasized the importance of rapport between the clinician and client and the willingness of the client to participate for successful treatment outcomes.

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Dedication

This dissertation is dedicated to my daughter Jasmyn who I hope will always remember that anything you set your mind to can be accomplished.

Acknowledgments

I am forever grateful to my husband Kevin Harper for carrying me through this process. Dr. Page, this would not have been possible without the unwavering support and guidance during this process from you. I am forever grateful to my mentor Dr. Katrina Buwalda whose knowledge and support was unwavering. Lastly, to my dear friend Erica Howard who never let the demands of this dissertation affect our friendship who I now refer to as my “soul sister”.

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Chapter 1: Introduction to the Study

Introduction

Reduction in recidivism risk is a main goal associated with sex offender treatment (Harrison et al, 2020). The perceptions of professionals who provide treatment to sexual offenders has been shown to be an important factor in influencing positive treatment outcomes and reducing the risk of recidivism among sexual offenders (Harper & Hicks, 2022). Treatment interventions for the rehabilitation of sex offenders has primarily focused on clinicians utilizing reintegrative shaming theory (RST) and risk needs responsivity (RNR). RST does not make the distinction between behavior and self, and utilizes stigmatization with the goal of isolating, humiliating, and punishing the offender to change their behavior (Tangney et al., 2011). The RNR approach is the prominent model of sex offender rehabilitation and treatment, which focuses on the theory that criminal behavior develops due to personality predisposition and is influenced by the individual's expectations and consequences of criminal behavior (Lutz et al., 2022). Evidence has suggested that instilling the feeling of shame has been associated with higher rates of recidivism among sex offenders and is a component of prominently utilized sex offender treatment methods (Hosser et al., 2008). Strength based treatment alternatives such as the good lives model (GLM), are focused primarily on enhancing the well-being, awareness of core values, and applying the awareness into concrete intervention plans for the individual to reduce risk and enhance management (Ward & Fortune, 2013). The perceptions of clinicians towards offenders who utilize the GLM was explored in this qualitative study.

This chapter will introduce the study describing the research problem and the purpose for the research. Next the research question and conceptual framework will be addressed. Following the framework is a discussion on the nature of the study, then definitions of key terms. Following the definitions of key terms are the assumptions, limitations of the study and the significance. Chapter 1 will conclude with a summary.

Background

Most individuals charged with a sexual offense are required to participate in some form of sex offender treatment (Barros et al., 2022). Sex offender treatment is often a requirement while serving a sentence while incarcerated or included as a condition of probation. The goal of sex offender treatment is to reduce the risk of recidivism as most sex offenders will be re-introduced to or remain within a community. However, research emphasizing the type of sex offender treatment with the most positive outcomes has been limited. There are inconsistencies found within the current literature regarding the reduction of risk among the different types of treatment offered as well as clinician perceptions and their potential influence on treatment outcomes. Longitudinal studies focusing on strength-based methods such as the GLM are even more lacking.

According to Tyler et al. (2021), rehabilitation from sex offender treatment programs is as effective as the clinician providing treatment. Tyler et al. suggested that clinicians are most effective when providing treatment when they are "warm, tolerant, and flexible, yet sensitive to conventional rules and procedures" (pp. 36-37). Furthermore, positive treatment outcomes are influenced by the attitude of the offender towards their offense. Dealey (2018) explored the impact the denial of sexual offending

may have on the offender's ability to create a new nonoffending life. Different treatment models were also analyzed within the study. It was found the GLM may be beneficial in enabling offenders to take accountability for their behavior. The accountability of behaviors included what led to the offender committing the offense and reducing recidivism.

Sexual offenses often incite a negative visceral reaction among individuals, and this initial reaction may be experienced among clinicians who work with offenders. The attitude among clinicians is not widely known, and the influence attitudes among clinicians working with sex offenders and how that may influence treatment outcomes has not been widely explored (Harper & Hicks, 2022). This is even more evident when exploring the attitudes among clinicians who utilize the GLM. According to Harper and Hicks (2022), attitudes among professionals working within the forensic population is more positive overall than the general population, but still has implications of potential bias and negative attitudes towards offenders within their treatment programs. These biases or judgements may influence treatment outcomes, legislation, and policies and may underperform risk when predicting future offending. The study highlights the importance of clinician attitudes in relation to the interpretation of sexual crimes and how those influence treatment outcomes and social change through legislation and policies.

In a study conducted by Hancock (2019), the attitudes of clinicians who work with sex offenders utilizing standard treatment methods were explored to gain an understanding of what influenced professional behaviors and client interactions. Grounded theory was utilized to formulate a theory regarding clinicians' perceptions who

work with sex offenders and the implications these perceptions have on treatment outcomes. The study utilized a sample of 10 clinical professionals from mental health agencies who specifically worked with sex offenders utilizing standard treatment methods. The results indicated that the clinicians in the study were primarily concerned for the behavior of the sex offenders but were still willing to work with the sex offenders despite having feelings of “fear” and “disgust” (Hancock, 2019, p.13). The study further indicated that clinicians were also genuinely curious about the possibility of treatment but struggled with their own bias due to the nature of the crimes (Hancock, 2019). The results suggested that clinicians are still able to offer treatment utilizing widely used methods for treatment regardless of their own personal bias, but they struggle with feelings of anger and disgust which may impact treatment outcomes.

In a study completed by Pryboda (2015), desistance and the theoretical underpinnings of strength-based approaches were explored to see how these can inform forensic clinicians in applied settings. The study found contradictions in the literature regarding the relationship between denial and recidivism risk, implying that accountability among clinicians is just as important as accountability among offenders during treatment. Bias among clinicians when working with offenders may influence treatment outcomes. This is important in relation to my study as it addresses the need for further research to help reduce the risk of bias among clinicians and individuals in treatment and highlights the need for training for clinicians and staff to understand the influence their beliefs about sex offenders may have on recidivism risk and overall treatment outcomes.

Risk reduction and the alignment of promotion of an offenders' personal goals were explored regarding the foundation of the GLM. The journal article by Pryboda (2015) focuses on the significance of the 10 common life goals in this treatment modality. The GLM focuses on developing core values and awareness among the individual in order to reduce risk by building competencies needed to achieve a more fulfilling life. Ward and Fortune (2013) indicated that well-being enhancement is the focus of this treatment modality to reduce risk and enhance management of arousal and maladaptive behaviors to achieve the goal of risk reduction.

Analyzing the results from each study referenced, there is evidence to suggest that clinician attitudes towards offenders as well as the offenders' own attitudes towards themselves and the treatment concept may influence outcomes and risk for recidivism. Focusing on processing through feelings of guilt rather than shame seemed to correlate with a reduction in risk (Hosser et al., 2008). Self-perceived views of rehabilitation among offenders also influenced risk reduction and treatment outcomes as well as their overall well-being and meeting of needs (Serie et al., 2023). Risk reduction seems to be aligned with both clinician attitudes and perceptions of offenders. There is lacking research regarding the perceptions of clinicians when strength-based treatment methods such as the GLM are utilized. This study explored the perceptions of clinicians who utilized the GLM as clinician perceptions may influence treatment outcomes and risk reduction.

Problem Statement

Perceptions of sexual offenders can influence professional judgements and attitudes. Research is lacking in how influential these perceptions can be on interpretations of the sexual crimes themselves as well as how those perceptions can influence bias among treatment providers (Harper & Hicks, 2022). Perceptions among treatment providers regarding the sexual crimes committed by the offender may influence the clinicians' decision making and therefore influence treatment outcomes for the offender. Research studies have focused primarily on shame-based, risk management methods and the attitudes of clinicians utilizing these methods who work with sex offenders. However, it is not widely known how clinicians utilizing the GLM perceive the strength-based method of sex offender treatment. Thus, in this study, I investigated clinical perceptions towards offenders who utilize the GLM in one Southern state.

Purpose of the Study

The purpose of this qualitative study was to explore the perceptions of clinicians towards offenders who utilize the strength based GLM for sex offender treatment. My specific research explored the perceptions of clinicians in one Southern state who primarily utilize the GLM in their work with facilitating sex offender treatment. There was a need for this research due to the lack of information exploring strength-based treatments for reducing recidivism risk and the experiences and perceptions of clinicians who utilize these methods.

Research Questions

Research question (RQ)1: What are the perceptions of clinicians towards offenders who utilize the GLM for sex offender treatment?

RQ2: What influences the clinician to utilize the GLM to provide treatment to sex offenders?

RQ3: How much of an influence do clinicians think their own perceptions towards offenders have on treatment outcomes?

Theoretical Framework for the Study

The type of framework I utilized for this study was theoretical. I utilized grounded theory to explore the experiences and perceptions of clinicians who utilize the GLM for sex offender treatment. I coded, analyzed, and summarized the data collected, which allowed me to process and discover new information. Information was based off the analysis of the real-world data collected. A grounded theory framework allowed for the exploration of how clinicians perceive offenders, and how their interactions and experiences influence the treatment they provide to sex offenders while utilizing the GLM.

Nature of the Study

For this qualitative study, a phenomenological method was utilized. The phenomenological method aims to describe, understand, and interpret the meanings of experiences of human life which would be relevant to understanding the perceptions of clinicians who utilize the GLM for sex offender treatment (Burkholder et al., 2016). Grounded theory allows for exploration of the results of the data collected to determine a

theory that will describe in depth the perceptions of clinicians towards offenders who utilize the GLM in sex offender treatment (Razali & Baker, 2023). By combining a phenomenological method with grounded theory, I aimed to understand the experience of clinicians who utilize the GLM and how those experiences influence their perceptions towards offenders.

Definitions

The following definitions were used operationally within the current study:

Clinician: Psychiatrist, psychologist, therapist, or authorized treatment provider having direct contact with and responsibility for providing sex offender treatment to individuals.

Sex-offender: An individual charged and convicted of a sexual offense.

Shame based treatment: Treatment focusing on shaming and instilling guilt in an individual for their offenses.

Strengths based treatment: Treatment focusing on building up an individual's unique strengths and attributes.

Recidivism: The act of an offender committing another offense during or after completing their sentencing requirements.

Assumptions

The assumptions of this research were grounded in the belief that clinical professionals utilizing the GLM would have a more positive outlook towards sex offenders and the treatment they provided due to the strength-based nature of the program. Widely utilized treatment programs focus on more shame-based approaches,

and these would influence clinicians utilizing those methods to have a more negative perception of offenders, therefore influencing my belief that clinicians using a strength-based method would have more positive perceptions. Sexual offenses often incite a negative visceral reaction among individuals and professionals, which influences negative bias, judgement, attitudes, and perceptions towards the sex offender. Clinician perceptions may influence overall treatment outcomes. These positive attitudes would have a positive influence on the focused behavior changes and would be articulated and observed by the professionals providing treatment utilizing the GLM.

Scope and Delimitations

The study is limited by the number of participants who can participate due to the limited utilization of the GLM among clinicians as well as the type of research being conducted. I examined the perceptions of clinical professionals towards offenders who utilize the GLM exclusively. I utilized audio recorded interviews to collect data. Limitations were further evidenced by the limited research exploring clinician perceptions and attitudes towards sex offenders in general coupled by the even more limited research focused on the GLM. Relevant information will be provided by my research to explore the implications perceptions of clinicians can have on treatment outcomes among clinicians who utilize the GLM.

Limitations

Limitations of this study included the limited number of available participants due to the GLM being the less utilized treatment method among clinicians in one Southern state. A barrier to the study was the overall lack of research concerning the experiences of

clinicians who utilize the GLM. The challenge was developing relevant questions to include in the interview to ensure the perceptions of clinicians utilizing this treatment modality toward offenders are adequately captured. Limits in scope were due to the experiences of the clinical professionals interviewed and are unique to the clinicians themselves. Lastly, highlighting the importance of these findings and tying them into the positive impact for social change was challenging due to the limited number of participants and research.

Significance

Understanding the perceptions of clinicians towards offenders who facilitate sex offender treatment utilizing the GLM may help in promoting better future outcomes for those in sex offender treatment. Understanding how clinicians perceive offenders who utilize the strength-based treatment process may help facilitate more acceptance among clinicians to incorporate strength-based alternatives as well as provide better therapeutic outcomes in treatment.

The GLM focuses on a dual treatment approach (Harris et al., 2019). The model emphasizes the importance of reducing the risk of recidivism while increasing the motivation for treatment by increasing the offender's wellbeing and overall quality of life (Willis et al., 2013). The treatment model focuses on risk factors as well as strengthening the offender's sense of self to improve resilience by allowing the offender to explore their individual needs that were not being met at the time of the offense. Referenced as the offense chain, offenders participating in this form of treatment analyze their choices that lead to the offense by exploring the seemingly unimportant decisions that allowed the

offense to occur and then further explore their cognitive schemas and unmet needs that influenced the urge to offend. The GLM emphasizes the relevant needs that were not being met for the offender both externally and internally, influenced the offender to commit the crime. The GLM emphasizes the importance of finding positive ways to fulfill a personal relevant need that improves well-being and quality of life (Willis et al., 2013). The GLM utilizes a foundation of cognitive behavioral therapy techniques and concepts, which explore individual core beliefs, schemas, and automatic thoughts that influence offending behaviors.

Summary

The treatment of sex offenders with the goal of reducing the risk of recidivism can be a challenging endeavor among clinicians. Treatment outcomes and explorations of different methods that contribute to reduction in recidivism risks have been well reviewed in the literature; however, perceptions among clinicians, especially those who utilize strength-based methods such as the GLM, have not been well researched. By exploring the perceptions of clinicians towards offender who utilize the GLM in the treatment of sex offenders, knowledge was gained into how the experiences influence the perceptions of clinicians and how those perceptions influence clinicians providing treatment to offenders. By further understanding these perceptions and how they influence treatment outcomes, it may be possible to further explore implementing strength-based treatment methods into mainstream rehabilitation and treatment programs, with an overall goal of reduction of recidivism with an increase in well-being among offenders who are

reintegrated into society with the newly developed strength-based skillset to overcome challenges in a proadaptive way.

Chapter 2: Literature Review

Introduction

In this study, I aimed to understand the perceptions of clinicians towards sex offenders who utilize the GLM in treatment. A review of the current research has suggested that information regarding clinician perceptions towards offenders who facilitate sex offender treatment is limited, and research is further lacking when focusing on strength-based methods such as the GLM. Perceptions and attitudes of clinicians has been explored in limited capacity focusing on bias and judgement surrounding the stigma of sexual offenses as well as how clinicians view themselves when working with the sex offender population. Research has focused and explored more of the implications concerning utilizing different treatment methods and the self-perceptions of offenders themselves rather than the influence clinician perceptions may have on the outcome of treatment. The research has suggested there is an overall negative public opinion of sex offenders due to the stigma and fear surrounding the offenses as well as perceived higher recidivism rates (Rosselli & Jeglic., 2017). Clinician perceptions of sexual offenders may influence professional judgements and attitudes and may impact treatment outcomes as well as legislation and policies. However, research is lacking in how influential these perceptions can be on interpretations of the sexual crimes themselves as well as how those perceptions can influence bias among treatment providers (Harper & Hicks, 2022). Research is even further lacking regarding the perceptions of clinicians utilizing strength-based methods such as the GLM and if there is a more positive perception among clinicians who utilize these methods.

Literature Search Strategy

To conduct this literature review, I searched electronic databases within the Walden University Library, ProQuest, Google scholar, Sage journals, EBSCOhost, and Walden Dissertations. Databases used for this investigation included E-Journals, ResearchGate, APA PsycARTICLES, APA PsycBOOKS, APA PsychInfo, The Journal of Forensic Psychiatry & Psychology, Psychotherapy Research, The National Library of Medicine, Psychiatry and Psychology and the Law, and Science Direct. To narrow down the investigation to current literature, I set limits on the initial searches conducted that included full-text articles published in scholarly peer-reviewed journals within the last 10 years (2015-2024). Due to the lack of current research within the past 10 years, limits were modified to cover a wider range of 15 years (2010-2024). Older articles with relevant information appeared within the search due to the lack of current research fitting the limited parameters and were included when relevant.

Search terms utilized varied based on the specific topic identified for research. The initial search consisted of the following terms: *the good lives model in sex offender treatment, recidivism risk of sex offenders, recidivism risks in Arizona, standard sex offender treatment methods*, and *clinician perceptions and outcomes on sex offender treatment*. The initial search revealed further topics to explore for this investigation. A more specific search was conducted utilizing the following terms: *strength-based sex offender treatment methods and outcomes, what determines successful sex offender treatment outcomes, standard sex offender treatment and outcomes, attitudes of clinicians who treat sex offenders, grounded theory in clinician perceptions when working with sex*

offenders, sex offender treatment outcome statistics, and *public attitudes towards sex offenders and treatment*. For all searches, I completed a review of the abstracts of each full-text article to see if the information was truly relevant to the topic. Once concluded to be relevant for this investigation, I saved the full text article to be reviewed, summarized, and included in the research review.

Theoretical Foundation

I used a theoretical framework utilizing grounded theory, which allowed me to explore how clinicians perceive offenders and how their interactions and experiences influence the treatment they provide to sex offenders while utilizing the GLM. Grounded theory originated by Barney Glaser and Anselm Strauss while they were working on a qualitative study titled "The Awareness of Dying" in 1965. The development of grounded theory began due to the need for qualitative research to have more social theories to develop further qualitative research (Chun Tie et al., 2019). Grounded theory is flexible, and the nature of the construct allowed me to discover new theories based on the data I collected from interviewing clinicians (see Chun Tie et al., 2019). The basis of grounded theory is the ability to construct new theories from data to better understand the phenomenon that is lacking in information. According to Turner and Astin (2021), grounded theory as a methodology is appropriate when there is little known about what wants to be further explored and the aim of conducting the research is being able to produce or construct an explanatory theory that further explains what is wanting to be researched or further explored. Most appropriately for this study, ground theory is "grounded" in the data collected from the research being conducted which fits with my

aim to understand the perceptions of clinicians towards offenders who utilize the GLM in sex offender treatment.

Literature Review Related to Key Variables and/or Concepts

Public Perceptions and Attitudes Towards Sex Offenders

The term "sex offender" often produces a negative visceral reaction among individuals, according to Harper and Hicks (2022). Sex offenders are notably perceived as the most despised offender type due to the moral outrage and disgust associated with the offenses committed. These offenses such as rape and molestation are often associated with pedophilia, which contributes to an added layer of public distain. Due to the intense emotional response these offenses often have within individuals, public perceptions of sex offenders often play a crucial role in shaping policies and interventions aimed at managing and rehabilitating this population. Understanding public attitudes toward sex offenders is important for the effective implementation of social control measures and the design of intervention programs. According to Rosselli et al. (2017), sexual offenses are often associated with a perceived negative outcry of the public, which seems to assume sex offenders have higher rates of recidivism than actually occurring.

The risk of recidivism and the fear of higher rates of reoffending influence legislation and contribute to continued negative assumptions and stigma towards sexual offenders (Willis et al, 2010). However, outside of public perceptions, Rosselli et al. (2017) noted that sex offenders have the lowest rate of recidivism among offenders. In the study, the conservative belief systems of a sample of 559 undergraduate students were examined to explore the relationship between conservative belief systems and attitudes

towards sex offenders along with overall knowledge of sexual offenses. The results indicated individuals with more conservative beliefs and more knowledge about sexual offenses had less negative views than those with more conservative beliefs and less knowledge about sex offenders. According to Rosselli et al.(2017), there are over 750,000 registered sex offenders in the United States with over 265,000 under the supervision of a correctional agency. Negative public attitudes and perceptions towards sex offenders influence laws and restrictions, but evidence is lacking in how effective either are in preventing the very thing they are in place to prevent. The study seems to suggest that knowledge about sexual offending seems to reduce negative perceptions of the public even when the individuals have a higher conservative belief system. This seems to suggest that education may play a role in reducing the stigma and fear within the public perceptions and attitudes towards sex offenders in general.

The type of sexual offense may also play a role in public perception as well. Rothwell et al. (2021) noted sexual offenses with varying demographics such as the age of the victim, the age of the offender, level of violence, etc., played a role in the perception of offender. The study results indicated there were no differences found in perceptions relative to the characteristics of the offender themselves. When compared to forensic students, public perceptions were harsher and more punitive. According to Levenson and Ward (2010), negative public perceptions towards sexual offenders are influenced by the anxiety and fear provoked by the type of crimes associated with sexual offenses. These anxieties and fears contribute to inaccurate assumptions regarding the risk associated with sex offenders, even those who have committed lesser sexual

offenses. The assumptions highlight the prevalence among the general public of the perception there is a higher level of risk for recidivism regardless of the type or level of sexual offense committed by the offender. The public perception of a sex offender is noted then as an offender being someone who needs to be punished, perhaps for the remainder of their lifetime, rather than helped or rehabilitated (Rosselli & Jeglic., 2017). The literature further indicated that overall public perception seems to be based on the assumption a stranger is most likely to commit a sexual offense, when statistics indicate that most victims of sexual offenses knew their perpetrator (Rosselli & Jeglic., 2017).

According to Harper et al. (2017), there are implications associated with the negative public perceptions of sex offenders, such as limited access to stable housing, employment, and the ability to be reintroduced into society after incarceration. This is largely due to the stigmatization of this population. In a study conducted by Harper et al. the Attitudes to Sexual Offenders (ATS) scale, the Community Attitudes Towards Sex Offenders (CATSO) scale, the Perceptions of Sex Offenders (PSO) scale, and nonstandardized methods were utilized to analyze public attitudes towards sex offenders. Demographics were found to play a large role in influencing attitudes towards sex offenders. The results showed that individuals with higher levels of education expressed more positive attitudes when compared to individuals with less qualifications. Other factors such as victimization and the type of offense were analyzed. The results showed that attitudes towards sex offenders are highly skewed by the stereotypes concerning this population. According to Harper et al., these stereotypes are termed as the sexual offender schemas and influence the judgement of a person based on the image perceived

by the schemas. Understanding these schemas is important as these cognitive belief systems among the public and clinicians influence legislation, policies, and rehabilitation efforts for sex offenders and can directly impact sex offender treatment outcomes.

Clinician Perceptions and Attitudes Toward Sex Offenders

Clinician perceptions toward sex offenders may play a crucial role in shaping the treatment process and outcomes for sexual offenders. The need to have an understanding of just how crucial this role continues to increase as the number of individuals who are charged and incarcerated due to committing a sexual offense continues to increase. According to Mivshek and Schriver (2022), clinicians who provide sex offender treatment to individuals face unique risks and challenges due to the type of work it requires. The study conducted by Mivshek and Schriver explored whether the attitudes towards treatment among clinicians working with sex offenders related to levels of empathy and burnout. Ninety-two sex offender treatment providers participated in the study. Results indicated that lower levels of empathy were associated with higher levels of burnout among participants. These findings highlight the importance of self-care among clinicians, as empathy among clinicians providing treatment to offenders was also found to influence treatment outcomes (Mivshek & Schriver, 2022). A number of other factors have been identified in the literature that may influence clinician perceptions toward sex offenders.

One potential key factor may be the nature of the offense committed by the individual. Research has shown that clinicians tend to have more negative attitudes toward individuals who have committed more violent or deviant sexual offenses, such as

rape or child molestation, compared to those who have committed less severe offenses (Mann & Hollin, 2010). These negative attitudes can impact treatment outcomes for sex offenders, as clinicians may be less motivated to provide effective interventions or support for their clients. On the other hand, research has also shown that clinicians who hold more positive attitudes toward sex offenders are more likely to provide effective treatment interventions and support for these individuals (Fortune et al, 2015). Clinicians who facilitate treatment to sex offenders may view offending behavior as complex and multifaceted, recognizing the need for comprehensive assessment and intervention strategies tailored to everyone's unique needs while simultaneously experiencing an internal moral struggle.

According to Harper et al. (2017), attitudes and perceptions of clinicians who work with sex offenders are malleable. Harper et al. explored attitudes, which were measured in both before and after a 3-week training program in a study by Hogue (1994). The training program consisted of modules that explored different modalities, theories, practical skills needed and treatment outcome goals. Results indicated that professionals had significantly more positive attitudes towards sex offenders after they completed the training, and those attitudes were even more improved when a 6-month follow up was conducted. Harper et al. concluded that clinicians who felt more competent working with sex offenders had more positive attitudes towards working with sex offenders.

Comparisons to Public Perceptions

Similar to general public perceptions and concerns, another important factor influencing clinician perceptions is the level of risk posed by the offender (Holliday et al,

2013). Clinicians are more likely to view high-risk offenders such as those who have violently raped young children as dangerous and untreatable, leading to negative attitudes and potentially impacting treatment outcomes and increasing risk of recidivism. Additionally, clinician characteristics such as gender, age, and years of experience have also been found to influence perceptions toward sex offenders (Hancock, 2019). According to Stapleton et al. (2022), the lack of resources and support available to sex offenders may influence the attitudes of clinicians who work with noncontact sexual offenders and contribute to a more positive outlook as the clinician may sympathize more with the offender.

According to Diciro et al. (2023), working with the sex offender population may be referred to as "dirty work." Dirty work is referenced in the article as employment that is "distanced from mainstream society" (Diciro et al., 2023, p.1; Hughes, 1951). Clinicians who provide treatment to those who commit sex offenses can negatively impact the clinician, even more so if the treatment provided by the clinician is involuntarily. This means that the clinician did not specifically seek out working with sex offenders, rather they are providing inpatient or outpatient treatment and so happen to treat a sex offender. Clinicians may be impacted by what is coined as the term "moral injury." The clinician who works with the sex offender may themselves be stigmatized contributing to an increased negative perception towards the offender. Moral injury is defined in the study as painful dissonance the clinician experiences when they act in a way that "transgress deeply held morals and beliefs" (DiCiro et al., 2023, p. 2). This "moral injury" can occur among clinicians when the clinician providing the treatment

holds a negative perception toward their clients, that is in "direct conflict with professional values to have regard for and not harm their clients" (Diciro et al., 2013, p. 2-3). According to Diciro et al., this moral injury can also arise from helping individuals in general.

Recidivism Risk Among Sexual Offenders

Public perceptions of sex offenders seem to be associated with a perceived threat of a risk of recidivism that propels public fear of sexual offenders. Standard sex offender treatment statistics according to Gualco et al. (2021) indicated a reduced percentage of recidivism risk from 17.3% to 9.9% for sex offenders who have completed treatment in central Italy. Gualco et al. explored whether it was possible to measure the risk of recidivism through specific tools. The results indicated that risk of recidivism among the sample were reliant on other factors such as early school dropout, substance abuse, traumatic childhood experiences, criminal histories, and the influence these factors had on the offender's likelihood of developing psychopathy. The higher the likelihood for psychopathic characteristics, the higher the risk for recidivism. These results suggest personality traits may play a larger role in recidivism risk rather than the type of sexual offense itself.

Predictors of recidivism were explored in a longitudinal study by Hosser et al. (2008), utilizing data collected from young prisoners. The relationship between feelings of "guilt" and "shame" in sex offender treatment and the risk of recidivism among sex offenders was indicative of having an influence on recidivism rates. According to Hosser et al., feelings of guilt were associated with lower recidivism rates among sex offenders

while feelings of shame were associated with higher rates of recidivism among sex offenders. Tangney et al. (2011) conducted a study that focused on further exploring the distinctions between shame, guilt, and remorse as utilized in RST and how that influenced treatment outcomes. The study found that feelings of guilt become a protective factor and seemed to influence positive outcomes in treatment. Feelings of shame appeared to become maladaptive during treatment and hosted psychological problems that contributed to an increased risk for recidivism. Results highlight the implications shame-based treatment models produce in relation to increasing recidivism risk.

Smith (2020) explored recidivism rates post participation in rehabilitation and treatment programs. Many offenders were found to be ill equipped to reenter society after being released from incarceration utilizing standard sex offender treatment methods. It was found that without rehabilitation and treatment programs that support their basic needs being met, there may be an increase in recidivism risk, further indicating participation in a program is not enough to reduce risk. Results also indicated that programs must be completed and that not completing treatment or fully participating in rehabilitation programs also leads to an increase of risk for recidivism.

How sexual offenders perceive themselves in relation to recidivism risk was explored in one study conducted by Serie et al. (2023). The self-perceived views of rehabilitation of 20 adolescent males between the ages of 14 and 17 years old were specifically explored. The study utilized a semistructured interview focusing on well-being, goals in treatment, needs, goals during rehabilitation, motivation during treatment,

and individual views on recidivism. The results indicated that the dual focus of reducing recidivism and enhancing offender's well-being was in tandem with the self-perceived views of the participants. The results of the study conducted by Serie et al. indicated that there was a match between the "well-being needs being met" and treatment goals that seemed to improve motivation and rehabilitation efforts.

Misperceptions of recidivism rates in the state of Arizona were explored in a study by Lave (2020). Current misperceptions of recidivism rates seemed to influence current Arizona sex offender registry laws. Misperceptions among individuals in Arizona who participated in the study indicated individuals tend to believe an offender is likely to reoffend once they have completed their sentencing or probation. However, the results indicate actual rates of recidivism are much less then assumed. The study offered recommendations to change registry laws in Arizona has the results indicated there was a reduction in recidivism risk associated with a stable residence and basic needs being met. According to Lave, registry and other restrictions were found to possibly aggravate risk for recidivism instead of reduce risk, the opposite of the intended outcome from public perceptions and influence.

Media seems to negatively influence public perceptions of sexual offenders and recycles the same misinformation regarding the risk of recidivism among sexual offenders. In a meta-analysis conducted by Zatkins et al. (2022), a total of 37 articles spanning from 2007-2017 were analyzed to explore the role media plays in public perception and the continued misinformation regarding true recidivism risk among sexual offenders. The results indicated a cyclical relationship between the media, institutional

myths, policy driven myths, and thus the policy then leads again to media reporting. The cycle perpetuates misinformation regarding the risk of recidivism, which is then reciprocated through media outlets. These media outlets than drive negative public perceptions regarding sexual offenders which than influences policy and law makers. These results seem to indicate a lack of accurate information influencing negative stigmas and perceptions, which then lead to policy and legislative decision making.

Rates of reoffending were found to be higher among sex offenders who did not complete treatment. According to Frank et al. (2021), outpatient psychotherapeutic treatment for sex offered was proven to have a preventative effect on criminal behavior. The results, however, were not significant as individuals who participated in treatment did not significantly reoffend less than those who did not complete treatment. In the study, the type of treatment was not specifically explored and did not seem to make a difference on the risk of recidivism among the participants. When compared with previous studies indicating the influence clinician perceptions and attitudes have on treatment outcomes, the next topic to further explore highlights the influence clinicians may have on sex offender treatment outcomes.

Clinician Influence on Sex Offender Treatment Outcomes

The therapeutic alliance is evidenced in the literature to be the main factor contributing to overall successful treatment outcomes regardless of the reason for treatment. Sandell et al. (2007) emphasized the relationship between the therapist and the patient is influenced by the attitude of the therapist. This was further evidenced in a study conducted by Safran et al. (2012), which explored the correlation between the

mindfulness of the therapist and the effect on treatment outcomes for the client. Results indicated mindfulness of the therapist was associated with therapist self-affiliation which positively correlated with therapeutic alliances. Heinonen et al. (2020) emphasized the attachment history of the therapist, the coping skills, professional characteristics, and attitudes towards therapeutic work the therapists contained influenced their effectiveness more than their self-perceptions.

In a study conducted by Raymond et al. (2023), the impact of sex offenders reoffending on the therapist was explored. The study consisted of 59 participants who participated in a self-report questionnaire, which emphasized on their reactions to sex offenders participating in treatment who reoffended. The results indicated that therapists working with sex offenders are managing both societal expectations and the expectations of treating the offenders. Participant responses to their patient's recidivism were varied. The way the clinician learned of the recidivism also seemed to impact how the clinician processed the information. If the offender offered the information directly to the therapist outright, there was more empathy from the therapist. If the therapist learned of the act of recidivism by other means, there was more anger/disappointment involved. The results indicated the most common cognitions among the therapists were regarding the impact the act of recidivism had on the victim as well as thinking about the consequences towards the offender concerning further judicialization as well as those close to them. The most common emotions reported among participants were again the sadness for the victim and a fear that the offender would reoffend again. The results indicated common intervention strategies were being both sensitive to the experience of the offender and

working towards understanding what drove them to reoffend. The results further indicated female clinicians are more likely than males to feel guilty, discouraged, and disappointed regarding the act of the individual in treatment reoffending. The direct emotional impact the recidivism seemed to have on participants were feelings of incompetency and self-blame for the offender committing the act. The article further indicated reduced hope and expectations, anger, frustration, and increased pessimism seemed to impact the clinician creating a more confrontational intervention style towards offenders in treatment. The article further emphasized recidivism during treatment is something clinicians working with offenders should be prepared to face as it is often a reality of this type of work.

Environments where clinicians work also plays a role in the influence their attitudes and perceptions may have on treatment outcomes. According to a study conducted by Blagden et al. (2016) using a mixed methods approach, the experiences of both staff working at prisons and the offenders were explored. Staff participants with a total of $N = 48$ were interviewed and asked specific questions regarding sex offenders in prison. Results indicated staff believed that offenders could change and had a positive outlook on the "therapeutically oriented sex offenders" (Blagden et al., 2016, p. 391). Sex offender participants of $N = 112$ were also interviewed. Results indicated the sex offender participants had a positive outlook towards staff, felt safe, and felt they had a place where they could process therapeutically. This was referenced in the study as the processing of the complex emotions and problems which lead to their offending, which also allowed for contemplation to change. A theme throughout the study was prisoners

felt like “they treated us like human beings” (Blagden et al., 2016, p. 384). This suggests the importance of the therapeutic alliance and the impact perceptions and attitudes clinicians may have on treatment outcomes.

In a study conducted by Springer et al. (2005), although dated, seems to emphasize the same general theme. The relationship between the therapeutic climate and the outcome in group-based sex offender treatment programs was explored. A total of 12 groups participated. The overall treatment impact was assessed by looking at significant attitude changes among sex offender participants. Results indicated clinician leadership had a direct impact on the engagement of group members. Increased engagement was influenced by feeling free to act and express genuine feelings, which lead to friendships among group members. The overall cohesion and effectiveness of the successful groups was directly linked to the therapist leading the group. Results indicated therapists who facilitated the groups where the emotional expression was allowed by group members and the therapists were the most effective. Making the impact less about the training of the therapist and more about the openness of the therapist (Springer et al., 2005). This seemed to align with previous literature which evidenced the influence the mindset of therapist had on treatment outcomes.

Clinician Perceptions of the GLM

When conducting a review of the literature, perceptions of clinicians who utilize the GLM was difficult to find. Research is significantly lacking when specifically analyzing the use of the GLM. Due to the lack of research regarding clinician perceptions of the GLMs other studies that focus on participant and clinician opinions of the model

are included here. A study conducted by Barnoa et al. (2016) explored the GLM when utilized in rehabilitation and therapeutic programs by analyzing the responses from both participants in the program as well as the facilitating clinicians. A total of 10 clinicians and eight forensic patients participated and upon completion received a $40 gift card. The GLM was utilized in a 15-week program in week a mixed method approach was utilized to gauge an understanding of the participant's mindsets before and after treatment. Semistructured interviews were utilized to explore each participant's perceptions of the 15-week program geared towards rehabilitation. The results showed four influenced responses: exposure to GLM, previous clinician experience, readiness to change, and the manner in which the program was delivered to participants. The results showed three categories of change among participants: no change, subtle change, and definite change. The results further indicated that participants with longer exposure to the program as well as working with a clinician who utilized the GLMs previously had more of an influence in the "definite change" category among participants. In other words, participants who completed the entire 15-week program with a clinician who had experience utilizing the GLM in treatment had more definite change among participants when compared to other responses in the study (Barnao et al., 2016). This seems to suggest clinician exposure to the GLM may impact the positive change among participants in the program.

Research is limited regarding the perceptions of clinicians utilizing the GLM in sex offender treatment in urban areas and even further limited when exploring treatment in remote areas. One study sought to investigate the use of the GLM in remote communities. In a study conducted by Johnson et al. (2023), the reflections of

clinicians/practitioners who utilize the GLM was explored in a remote community. The results indicated several ethical factors emerged from working in remote areas such as the risk of dual relationships forming due to the remote locations as a result of access to more clinicians. However, the results indicated that not all the reflections were negative. In fact, there seemed to be positive reflections regarding the ability of the clinician/practitioner to form meaningful relationships and community support among offenders, which is a foundation associated with success within the GLM application.

GLM Treatment Outcomes

The GLM was developed based on the notion that in order to reduce the risk of reoffending among sex offenders, it is first necessary to focus on building the capabilities and strengths within the offenders themselves. The foundation of the GLM is based on the belief every individual should have access to basic human dignity, universal human rights, and places emphasis on the individual offenders' self-evaluation and self-worth (Marshall et al., 2017). According to Marshall et al. (2017), the GLM aims to offer that offenders also value the same things all humans value such as creativity, spirituality, relationships, peace of mind, etc. The GLM proposes that due to the lack of ability or circumstances bestowed upon the offender, they are unable to meet basic human needs without resorting to offending. The overall goal of the GLM being utilized in treatment is to help the offender shift their mindset and allow them to regain the capacity where these basic needs can be met in positive ways. According to the GLM, these needs can be met by building strengths rather than the traditional approach of eliminating deficits utilized in traditional sex offender treatment models.

According to a study conducted by Harris et al. (2019) the GLM is a treatment model that "promotes a dual focus: risk reduction (through identifying and modifying criminogenic needs) and promoting prosocial attainment of PHGs" (p.198). The study is noted as being the first of its kind in exploring the experiences of offenders who have participated in treatment where the GLM was utilized. PHGs are defined in the study as primary human goods. The GLM emphasizes that all humans are fundamentally goal-directed and will "seek out" specific outcomes in life based off the goals to have the specific PHG met. The study further emphasizes that the GLM indicates the actual human behavior of offending can be identified as a way to secure one of the 10 primary basic needs.

These basic needs include living and surviving, learning and knowing, being good at work and play, personal choice and independence, peace of mind, relationships and friendships, community, spirituality, happiness and creativity. The study consisted of 42 male participants all who had committed a contact sexual offense, served a custodial sentence, and were participating in treatment at the time of the study. Each participant was privately interviewed at an office for approximately 90 minutes and were given a $25 gift card to a grocery store for participation. The results indicated there were specific trends found among the primary human goods hoped to be obtained by participants. The PHGs of relationships and friendships, life and survival, and knowledge were the most noted among participants. One participant mentioned that the loss of friendships and family members due to their offense was impactful and noted feeling rejected by family and friends. The ability to repair the broken relationships was also noted as some

participants felt lost at knowing where to start to rebuild those connections with old friends (Harris et al., 2019). There was positivity noted among participants concerning personal relationships and that generated a more positive outlook regarding the ability to create meaningful relationships in their lives, especially after completing treatment. Living and surviving was another frequently mentioned PHG among participants. One participant responded, "I just need enough money to survive today, and to have my place where I can lay my head and live at peace, a place to call my home, and I'm ok today" when asked what his hopes were for the future (Harris et al., p. 212). The results indicated that two thirds of participants reported barriers when achieving the ability to live and survive as finding stable employment and housing were difficult. Gaining employment was a significant barrier noted among participants along with the lack of a livable wage. Knowledge was identified as an empowering PHG among several participants who were able to identify triggers, risky emotional states, seemingly unimportant decisions, and core beliefs that influenced offending behaviors. Independence and peace of mind were noted as having the most barriers to achievement by participants as the ability to have independence and peace of mind were also linked to the ability to achieve goals related to the other PHGs. Peace of mind barriers were also identified as being a registered sex offender and the stigma surrounding the term. The results indicated the importance of the PHGs within the GLM to participants and seem to highlight the difficulty of obtaining these 10 primary human goods. Furthermore, only three of the PHGS were noted to be obtained by a majority of participants, which included community, knowledge, and spirituality. These results further highlighted the

importance of these primary human goods and the difficulty for them to be achieved even through strength-based treatment programs. The study highlighted the reality of the difficulty of obtaining employment and finding stable housing among sex offenders, which further impacts their ability to achieve other PHGs and further impacts the risk of recidivism.

The GLM further recognizes the complexity of human behavior and the many facets that may lead to an offender committing a crime. Jaimee (2021) explored the GLM in relation to treatment outcomes in preventing recidivism among violent offenders. The article emphasized the theory behind the GLM and how an individual participating in GLM treatment may build of strength and the capability to overcome the risk for committing future violent offences. This is done by focusing on the strength of the individual, goals and learning to achieve basic needs being met in positive ways, which reduces the unwanted violent behavior. Jaimee also emphasized the ability for the GLM to have supplemental treatment components added which would continue to support the evidence-based model. Cognitive behavioral therapy for example can be added to support the GLM. Lastly, according to Jaimee, the GLM "proposes the risk of offending lessens when an individual has sufficient level of capabilities and strengths to achieve their personal goals" (p. 3). This seems to suggest that the GLM may have positive treatment outcomes within a wider array of offenses than just solely sexual offenses due to the strengths-based foundation of the program.

In a meta-analysis conducted by Prescott and Willis (2022), the success of the GLM in treatment was explored. The results indicated that much of the success when

implementing the GLM was influenced by both the mindset of the practitioner and their understanding of the context of the GLM in treatment along with the understanding of their client's lives. Utilizing a practice framework during implementation of the GLM weas further explored which resulted in more promising treatment outcomes. According to Prescott and Willis, a practice framework consists of three interconnected levels that include core values and principles, knowledge rated assumptions, and intervention guidelines. The results indicated that when practitioners utilize the GLM as a practice framework and utilize the three interconnected levels by fully embracing the context of the treatment, there is a positive influence in treatment outcomes.

Summary and Conclusions

While reviewing available research, common themes emerged concerning the perceptions of clinicians and the public towards sex offenders. Negative opinions seem to be generalized among both the public and clinicians who work with the sex offender population. These opinions seemed to be based off the fear of sex offenders reoffending. Media outlets also seem to perpetuate negative stigmas which impact local and federal laws, regulations, and policies (Harper et al., 2017). The fear of recidivism appears to be unwarranted. When reviewing the statistics concerning actual rates of recidivism and perceived public risk of recidivism, there is a disconnect between reality of recidivism and the actual rate of reoffending among sex offenders.

Numerous articles have highlighted the importance of the therapeutic alliance in successful treatment outcomes regardless of the reason for treatment. When exploring the impact the therapeutic alliance can have on sex offender treatment in particular, the

literature is lacking. Among the research available, perceptions and attitudes of clinicians towards the sex offender population they work with can impact treatment outcomes in both inpatient and outpatient treatment programs (Barabas, 2007). This seems to highlight the importance of the relationship between the facilitator of treatment and the participants of treatment.

Research is significantly lacking regarding clinicians' perceptions towards the GLM in sex offender treatment. The GLM when utilized in treatment appears to have potentially positive outcomes but literature is scant when reviewing the actual outcomes of treatment when the GLM is implemented. This further highlights the gaps in the literature and the need for continued research exploring the GLM in sex offender treatment and the influence clinicians may have on treatment outcomes when the GLM is utilized.

Chapter 3: Research Method

Introduction

Successful completion of sex offender treatment is associated with the main goal of a reduction in recidivism risk (Tyler & Olver, 2021). The fear of recidivism from sex offenders is associated with negative public and clinician perceptions and attitudes, which has been shown in the literature to influence legislation and policies. The perceptions and attitudes of professionals who provide treatment to individuals charged with a sexual offense has been shown in the literature to be an important factor in influencing positive treatment outcomes and reducing the risk of recidivism among sexual offenders (Harper & Hicks, 2022). Traditional treatment for the rehabilitation of sex offenders has primarily focused on clinicians utilizing RST and RNR, both models which focus on more of a shame-based approach. There are several alternatives to the traditional treatment models such as the GLM, which focus primarily on enhancing the well-being, awareness of core values, and applying the awareness into concrete intervention plans for the individual in treatment to reduce risk and enhance management (Ward & Fortune, 2013). This study aimed to explore the perceptions of clinicians towards offenders who utilize the GLM for sex offender treatment.

The perceptions of clinicians towards offenders who utilize the GLM was explored in this qualitative study, as there is limited research regarding clinician perceptions of offenders who facilitate sex offender treatment and even less research exploring the perceptions of clinicians who specifically utilize the GLM. To obtain a theoretical understanding of how clinicians who utilize the GLM perceive sex offenders

and the influence these perceptions may have on treatment outcomes, including reduced recidivism risk, empirical research exploring this phenomenon is nonexistent. Understanding clinician perceptions towards sex offenders requires a comprehensive and systemic review of the topic to generate deeper understanding and to apply the information obtained to positively influence the development of sex offender rehabilitation treatment. This chapter outlines a qualitative method for exploring clinician perceptions towards offenders who utilize the GLM in sex offender treatment.

Research Design and Rationale

The RQs for this study included the following:

RQ1: What are the perceptions of clinicians towards offenders who utilize the GLM for sex offender treatment?

RQ2: What influences the clinician to utilize the GLM to provide treatment to sex offenders?

RQ3: How much of an influence do clinicians think their own perceptions towards offenders have on treatment outcomes?

For this study, I selected a theoretical framework utilizing grounded theory. According to Merriam et al (2016), "Data utilizing grounded theory can come from interviews, observations and a wide variety of documentary materials" (p. 31). The lack of information available regarding the perceptions of clinicians towards offenders who utilize the GLM in sex offender treatment creates a usefulness for grounded theory as there is lacking information concerning this phenomenon. Utilizing grounded theory enabled me to explore the experiences and perceptions of clinicians who utilize the GLM

for sex offender treatment. Data collected provided insight and will hopefully allow for positive social in change in encouraging implementation of the GLM in sex offender treatment.

Role of the Researcher

The role of the researcher in this study was "to attempt to access the thoughts and feelings of study participants" (see Sutton & Austin, 2015, p. 227). The ability to reflect both before and during the research process was also part of my role as researcher. According to Sutton and Austin (2015), the researcher in qualitative work must remain reflexive, neutral, and allow themselves to view their own positions and subjectivities without allowing that to influence the work. As the researcher I explored my own bias before, during, and after the data collection process in order to be aware of it. According to Sutton and Austin, when a researcher is aware of their own bias and subjectivity, it is best to be articulated up front in order to be "clear and coherent" for readers (p. 227). Finally, my role as researcher was to objectively analyze the data to explore themes that are found among the data collected to explore the perceptions of clinicians towards offenders who utilize the GLM in sex offender treatment.

Methodology

For this study, I selected a qualitative methodology. A qualitative approach lets the researcher delve right into the ability to understand how individuals interpret their experiences, how those experiences influence their perspectives, and how those perspectives shape their world (Merriam & Tisdell, 2016). Upon initiation of this study, the perceptions of clinicians towards sex offenders who utilize the GLM in sex offender

treatment had not been explored. Previous studies attempted to provide insight into how the attitudes of clinicians may influence treatment outcomes of sex offender treatment, but the information was minimal and did not focus specifically on clinicians who utilize the GLM. Numerous articles highlighted the importance of sex offender treatment completion, but research was lacking in what successful treatment was defined as. Due to the lack of information regarding this specific study topic, a qualitative methodology appeared to be the rational choice to gain an understanding of how clinicians perceive sex offenders utilizing the GLM in treatment.

A qualitative methodology for this study was selected based on the current gaps in the literature. These gaps indicated a need for researchers to focus on the experiences of clinicians who work directly with the sex offender population. Exploring the experiences of these clinicians provided insight into how the perceptions of clinicians who utilize strength-based methods may vary from the current (although minimal) research regarding attitudes clinicians have towards sex offender treatment in general. The research indicated the importance of the therapeutic alliance between the clinician facilitating treatment and the offender participating in treatment. However, there was lacking information regarding the specific phenomenon that I explored in this study. Rationally, a qualitative methodology appeared to be the most logical approach to gaining insight into the experiences of clinicians who work with the sex offender population.

Participant Selection Logic

For this study, I specifically wished to interview a total of 11 clinicians who either currently worked with sex offenders or who had worked with sex offenders within the

last 5 years utilizing the GLM in treatment specifically. The rationale for this was ensuring that the experiences of clinicians was still within the forefront of their minds, and they were able to provide an accurate explanation of their experiences as they were either currently providing treatment to sex offenders or had done so within the past 5 years. It also appeared rational to only include clinicians who specifically worked with sex offenders and who utilized the strength based GLM approach to treatment as those are the specific perceptions this study intended to explore.

Instrumentation

For this study, an audio recorded interview was conducted via the Zoom platform between the researcher and participants individually, which aimed to understand the phenomenon of the perceptions of clinicians towards offenders who utilize the GLM in sex offender treatment. The interview questions were peer and expertly reviewed, and I practiced conducting interviews with participants in a pilot study to receive feedback and further develop interviewing skills prior to conducting the research interviews.

Procedures for Pilot Study

Convenience sampling was utilized to recruit a total of six participants in a pilot study. The participants were conveniently recruited from a clinic I worked at and fellow cohort members who had no experience working with sex offenders. I interviewed these participants individually via audio recorded interviews conducted over the Zoom platform. The interviews were timed to gain insight into how long participants should be aware interviews may take, and feedback was given by participants to aid me in further development to prepare for and conduct the research interviews.

Procedures for Recruitment, Participation, and Data Collection

A total of 11 clinicians were recruited to participate in the study in Arizona. Recruitment was completed first by identifying clinics who offer treatment for sex offenders utilizing the GLM. One clinic agreed to allow for data collection among their clinicians who specifically utilize the GLM for sex offender treatment. The site director shared the research study flyer information with other clinic directors in Arizona as well. Contact was also made by directly contacting clinicians by email, who provide sex offender treatment utilizing the GLM in multiple clinics throughout Arizona. Further recruitment was made by network sampling from participants who were passionate about the study subject matter and who volunteered to share the study with other clinicians they knew who also utilized the GLM in treatment. According to Mirriam and Tisdale (2016), snowball or network sampling involves asking recruited participants for referrals to recruit more participants. Due to the limited use of the GLM among clinicians, there was difficulty in obtaining a larger sample size.

Data Analysis Plan

Data analysis for this study had the goal of developing a theory based off the data collected regarding the perceptions of clinicians towards offenders who utilize the GLM in sex offender treatment. Data analysis started with verifying the information obtained during the interviews utilizing respondent validation, which is defined as “soliciting feedback on your preliminary or emerging findings from the people you interviewed” (Mirriam & Tisdale, 2016, p. 246). In order to obtain respondent validation, transcription was completed for each interview, and the transcripts were sent to each individual

participant to confirm the information provided in the transcript was correct. If any inconsistencies were noted by participants, each inconsistency was addressed and corrected to ensure accuracy. Additionally, analysis of the transcripts was provided to all participants if requested, which was an option provided on the consent forms they verbally agreed to via audio recording prior to participation.

After each interview was conducted, the data provided were analyzed utilizing open and axial coding procedures. First, the data collected were examined and coded utilizing the excel application. Once coded, categories noted among the data were identified. Categories found among the data are defined in qualitative data analysis as open coding (Vollstedt & Rezat, 2019). Once categories had been identified utilizing Open coding, Axial coding was utilized to further explore themes among the noted categories. When utilizing grounded theory research, Axial and Open coding are fundamental in linking the categories, themes or properties and hypotheses that may be "conceptual links between the categories and properties" (Mirriam & Tisdale, 2016, p. 228). According to Vollstedt snf Rezat (2019), open coding allows the researcher to identify general concepts in the data by assigning general concepts, which can further link singular components of the data to better understand the thoughts, ideas, and meaning of the information being explored.

After open coding of the data was completed, axial coding was utilized to further identify "findings within the categories," which helped me answer the RQs aimed explored in the study (see Mirriam & Tisdale, 2016, p. 217). According to Vollstedt and Rezat (2019), axial coding is needed to "investigate the relationships between concepts

and categories that have been developed in the open coding process" (p. 87). Once axial coding was completed from the data from each of the interviews, comparison of the results was conducted to explore individual clinician responses to develop the foundation for grounded theory in understanding the perceptions of clinicians towards offenders who utilize the GLM in sex offender treatment.

Issues of Trustworthiness

Due to the lack of research regarding the phenomenon being explored in this study, the ability to replicate the study is of utmost importance. Furthermore, ethical considerations and trustworthiness of the study needed to be upheld to the highest of standards to ensure the legitimacy and ability to continue to further research the phenomenon explored in this study. According to Mirriam and Tisdale (2016), each participant in a study should be provided with information regarding the purpose of the inquiry and the specific methods that are used in the study. This was done when initiating contact via email, and then I briefly outlined the information again on the provided informed consent form reviewed via audio prior to participation by each individual. Mirriam and Tisdale (2016) defined reciprocity as "what's in it for the interviewee" (p. 264). I was sure to inform each participant via the initial contact email as well as within the IRB informed consent form of the acknowledgment that participation was used for research purposes only, and no compensation of any kind was going to be provided. The issue of anonymity was also addressed as participants were reminded of the importance to uphold confidentiality in case they chose to discuss clients as well as the fact their own names were going to be withheld from the study.

Internal validity and credibility were maintained by utilizing respondent validation or member checking (Mirriam & Tisdale, 2016). This ensured transparency and the ability for me to receive feedback regarding the information transcribed during the interview process. Any inconsistencies were addressed, corrected, and then once more validated by the respondent prior to finalization. Including participants in the validation process ensured accuracy of information and results obtained from the interview process.

Ethical Procedures

The IRB approval number for this study is 09-03-24-1046600. To ensure the study had a focus of following ethical procedures and guidelines after a participant had agreed to participate in the study, a verbal consent form was reviewed via audio recording, which again highlighted their ability to change their mind, noting they could also choose to not respond to interview questions. The consent form was reviewed, and participants were verbally required to agree prior to participating in the interview process. The consent form was also sent via email. The consent form also included an option for the participant to receive a copy of their interview transcript as well as information regarding the respondent validation to ensure internal validity and credibility.

Confidentiality was also addressed as participants remained anonymous. Participants were also be reminded of the importance not to disclose any confidential client information during the interview process as all interviews will be audio recorded via the Zoom platform. If participants wished to discuss specific clients, they were asked to utilize safeguards to ensure they do not accidentality disclose the client's name or other identifying information.

Summary

A qualitative methodology approach was utilized for an in-depth exploration of the topic. This in-depth exploration facilitated the ability to gain insights and a further understanding of the perceptions of clinicians towards offenders who utilize the GLM in sex offender treatment. Specific measures were utilized, such as pilot-testing to ensure accuracy of the interview instrument and respondent validation. Due to the importance of trustworthiness, respondent validation was utilized to ensure internal validity and credibility. Feedback from participants is also, if received, included in the study for transparency. Grounded theory was utilized in the study to build a foundation upon the data collected from individual interviews conducted.

The following chapter will include an overview of the data collected. This will include results from interviews with participants, detailed demographics of the population participating in the study, and the categories and the themes identified among the data collected.

Chapter 4: Results

Introduction

Clinician attitudes and perceptions have been evidenced in the literature to have an influence on overall treatment outcomes for individuals (Stone et al., 2019). The goal in sex offender treatment is to reduce the risk for recidivism among offenders (Gualco et al., 2021). The GLM is a strength-based alternative to mainstream treatment models that focuses on building up the esteem of the offender by providing them the tools to have their needs met in a positive way to change behaviors that lead to the offense being committed (Barnao et al., 2016). The purpose of this study was to examine the perceptions of clinicians towards offenders who utilize the GLM in sex offender treatment. The aim of this study was to explore in depth the perceptions, emotions, and influence of clinicians who utilize the GLM to attempt to understand the impact on sex offender treatment outcomes. To investigate the aim of this study the following RQs were utilized:

RQ1: What are the perceptions of clinicians towards offenders who utilize the GLM for sex offender treatment?

RQ2: What influences the clinician to utilize the GLM to provide treatment to sex offenders?

RQ3: How much of an influence do clinicians think their own perceptions towards offenders have on treatment outcomes?

This chapter provides a summary of the pilot study conducted, setting, demographics, data analysis, and evidence of trustworthiness utilized for this study.

Participants of the study consisted of 11 mental health clinical professionals who work or have worked specifically with sex offenders within the past 5 years who utilize the GLM for sex offender treatment.

Pilot Study

A pilot study was conducted which sought to establish a time frame for which to inform participants of how long the interviews would approximately take. Participants in the pilot study were also asked to provide feedback regarding the amount of interview questions, subject matter, overall utilization of the Zoom platform, consent form, and member checking process. A total of six participants were interviewed for the pilot study and conveniently recruited from a clinic I worked at and fellow cohort members who had no experience working with sex offenders. Feedback was positive and suggested the interview questions, number of questions, utilization of the Zoom platform, and time frame were appropriate for research purposes.

Setting

The interviews were conducted via the Zoom platform. Due to the flexibility of the platform, participants were able to choose where they felt comfortable to complete the interviews. I conducted the interviews via the Zoom platform from the privacy of my home office, which has a separate entrance and a door that locks. The door remained locked during interviews as an extra precaution to protect privacy. Participants were audio recorded only and were permitted to turn their cameras on only if they chose to after audio recording had been completed. This was to ensure protection of the identities of interviewees. Data were stored utilizing an encrypted password application.

Demographics

The sample of participants for this study consisted of 11 mental health clinical professionals who currently work or who have worked with sex offenders within the past 5 years by facilitating sex offender treatment utilizing the GLM. Participants were recruited through convenience sampling supported by a site participation agreement by an agency who agreed to allow me to recruit directly from within their agency. Participants were further recruited by snowball sampling from participants who shared the study with clinicians from other agencies. Participants included psychologists and licensed therapists who either currently work or have worked by facilitating sex offender treatment utilizing the GLM within the past 5 years in Arizona.

Data Collection

Semistructured interviews were utilized to collect data for this study utilizing a grounded theory framework. Participants were recruited by both convenience and snowball sampling. A private practice mental health agency where I had a professional relationship allowed recruitment on site. Participants were also recruited by snowball sampling from clinicians from the mental health agency who shared the information for the study with other professionals in their network who fit the criteria. Participants consisted of a sample of 11 mental health clinicians who either currently work or have worked by facilitating sex offender treatment utilizing the GLM within the past 5 years in Arizona. A sample size of 11 participants was determined from saturation from the data being achieved. Contact was made with participants via email prior to the interview being conducted to provide insights into what to expect, time frame expected for the interview

to be conducted, scheduling options, informed consent review as well as to establish rapport prior to interview.

Prior to the interview being conducted, all 11 participants were read aloud the informed consent information and were audio recorded agreeing to participate in the interview. This was to provide informed consent, highlight participant rights, how the data obtained would be utilized and stored, and to emphasize participant identities would be protected. After audio consent was obtained by participants and the recording was agreed upon, the interview began, which consisted of a total of 12 open ended questions. All interviews were conducted one on one via the Zoom platform, audio recorded only, and lasted approximately 30-45 minutes. After the interview, transcription occurred within 24 hours and a copy of the transcription was emailed directly to the participant for member checking.

Data Analysis

The procedure utilized for data analysis for this study included open and axial coding to generate categories and then to derive themes from the categories generated. The themes derived from the categories were then utilized to develop a theory about how clinicians perceive offenders who utilize the GLM for sex offender treatment. The specific data analysis for this study are explained in this section.

After data analysis was completed, the interpretations derived from the data collected via interviews was confirmed by utilizing member checking. Each participant first confirmed receipt and accuracy of the transcription of the interview conducted, which was sent via email within 24 hours of interview completion. Interviews were

transcribed via the Zoom platform and reviewed for errors prior to emailing participant. Once the participant verified accuracy of the transcription, the transcript was open coded. Each code was highlighted and then color coded for easy cross reference. Each code was then grouped to a specific RQ. Duplicate or similar codes were combined. Further analysis was conducted by then comparing each code obtained and further condensing the codes with similarities. Codes with similarities were then placed into categories that summarized the information. Once no new information or codes were obtained from the data, interviewing commenced as saturation or no new data emerging had occurred (see Merriam & Tisdale, 2016). After the data were further analyzed, groups were formed from similar codes and then categorized, and themes were then generated from the categories. Once formed, the themes were confirmed via email by participants who confirmed the interpretations were correct. Once confirmed, the themes were further analyzed to determine relationships which than formulated a theory based off the RQs. The purpose for this study to be conducted was to examine perceptions of clinicians towards offenders who utilize the GLM for sex offender treatment.

Evidence of Trustworthiness

According to Merriam and Tisdale (2016) internal validity “deals with the question of how the research matches reality” (p.242). Member checking was utilized in this study to address the evidence of trustworthiness. Engagement directly from participants helped ensure that the researcher was getting as close as possible to participant’s understanding of the phenomenon and immediate feedback helped the researcher navigate their own potential bias through reflexivity (Merriam & Tisdale,

2015). Participants were emailed a copy of their interview transcript within 24 hours of the interview being conducted to ensure the interview was in the forefront of participants memory for easier recollection of topics discussed. Once data were analyzed, a hierarchy chart summarizing the findings was emailed to participants to ensure accuracy of interpretations and findings. Throughout data analysis, special attention was paid by researcher to ensure that each code was categorized in relation to the RQ it addressed and analyzed further to ensure accuracy of themes derived.

Results

Results from the data collected will be presented in this section in the form of themes, which were generated from the data analysis conducted. Each theme will be described, and an excerpt from the data collected will also be provided in relation to the specific theme it references. The theory developed through identifying the relationships among the themes as intended by the utilization of grounded theory for this study will be provided at the conclusion of this section.

Theme 1: Treat the Offender Like a Human Being

Each participant shared similar experiences pertaining to how they perceive a new client admitted to sex offender treatment, which seemed to focus on the offender as being a human being and not on their offense. Many participants emphasized how sex offenders are often not treated like an individual and negatively stigmatized in society. Many participants reported feeling like treatment should be a different space for offenders where they felt welcomed and engaged. Some participants indicated they do not look at

the offender’s file until after they meet them a few times to ensure rapport is established first and to help eliminate developing a judgement towards the offender.

Some participants reported trying to forget the offender’s offense to focus on who the offender is today. Participant 004 reported,

> Actually, after a few sessions with the guys in my group, I forget what they're there for. Anyways, I see them as human beings and that’s really important. So you end up, you end forgetting what their offense is after a while. Yeah, I do try to forget their offense. I do because it doesn't matter anymore. Yeah, they're there for a reason but I don't need to know the specific reason in order to help them. I want to focus on who they are now and helping them now not shaming them for what they did in the past and just focus on them as a human being not an offender.

Participant 06 mentioned that they focused on the mindset that everyone is equal and that no one is better or worse than another person, especially during intakes of new clients for sex offender treatment:

> Yeah umm I mention this in probably half of the intakes that I do with new clients and I organically view us all as equals, so I don't view myself as any better or worse than any clients that I'm doing an intake with regardless of what they've done because I believe that for any of us that if our worth is determined by our worst behavior then we're all doomed.

Participant 06 further shared they perceived the ability to view all clients as equals regardless of their offense as a strength and credits this strength for being able to do the work for as long as they have:

> I think one of my strengths one of the reasons I've been able to do the work for such a long period of time and be so fulfilled doing it is because of that foundational view that we are all equals, all people, regardless of the behaviors we've done and then it boils down to how seriously do you take that? How motivated are you to make changes, and be a positive loving, giving, compassionate force in the world versus any of the negative impact that you may have had as a result of the offense history.

Another participant mentioned there is importance in reviewing a new client's file for sex treatment, so they have an understanding of why there are there but highlighted the importance of building rapport with the client first. Participant 08 shared the following:

> I try to just look at the facts essentially and kind of put aside any sort of like you know what's the word I'm looking for ….like… judgement. I try not to analyze too much ahead of time. I wait until like I've met them and we've kind of gone through assessments and also built that rapport. I think the rapport is really important.

Participant 05 mentioned the importance of viewing the offender like a whole person and not focusing on their offense at first. They highlighted the importance of getting to the root cause of behaviors but only after rapport has been built:

> So, to be honest with you, I stopped reading the client's offense report right away. I actually wait to meet with them first and try to see them as a human being first, and then once I feel I have started to build some rapport with them I will go back and see what their offense was. But, I think I got that from my supervisor because

> she kind of instilled in me to really see the whole person first and then once that is established I can go back in and see why they are a client and then get to the root cause of their offense behaviors.

Participant 07 reported having difficulty at first when first beginning to facilitate sex offender treatment and how seeing offenders as an individual took time but that her experience working at other agencies helped develop skills to overcome those difficulties. Participant 07 stated,

> I think some of my background and experience helped me because I worked in child welfare and so I had seen some pretty heinous stuff but had to still work with the person and so when I work with sex crime people or those that are labeled as sex offenders, um I think I use a similar kind of compartmentalization. I think, to separate them from their background and their history and focus on where they are currently and where they want to go as individuals. It helps me see them as human beings instead of the mayhem they caused.

Participants 09 reported communication with probation officers and other members of the treatment team are important in making sure that offenders are set up for success. Participant 11 shared similarities in emphasizing the importance of collaboration with the offender's probation officer as well as building rapport. Participant 11 stated,

> I think I take the same approach as I do with any client. I think my um my biggest agenda is really to build that rapport as quickly as I can and to show them that there's this genuineness, this authenticity in that I want to help them progress, so I

> really take a more umm I take an approach that is more collaborative and includes the probation officer as well.

Participant 03 shared that sometimes it is difficult navigating a client who has been admitted for sex offender treatment because they might not be ready to face the reality that they committed a crime yet. Participant 03 shared, “No sin outweighs the other. In some instances, no offense is greater than the other especially when it comes to sex offending because that's not that great of an offense to begin with.” When asked to elaborate a little more on what was meant by that statement Participant 03 stated,

> I don't discriminate based on offense because like sex offending, they are sex offending whether it's raping an adult or molesting a child. Both of those things to me equally hold the same amount of weight in being wrong. I treat all of the clients the same regardless of how long they've been there if they're new to treatment, or if it's their first day or their last day I still treat them the same. I just went from now being in the trenches a little longer than I was in previously when I was still new, I see how the new guys are not ready to face their realities… so you, you kind of have to like to walk them through that process.

Participant 02 mentioned that they view the offender starting sex offender treatment as a fresh start and admitted they would like to believe that they perceive offenders the same as any client. Participant 02 and Participant 04 both mentioned feeling honored to be a part of the treatment journey for offenders. Participant 02 stated,

> I would like to believe I perceive a new client for sex offender treatment the same way I perceive all clients. I think I view it as a fresh start for the client and in

> some ways, I feel honored right? In a way, to be able to help them through that new chapter, I am playing a large role in that new chapter and hopefully by using the good lives model I set them up for success in doing so.

Theme 2: Focus on Therapeutic Alliance Not the Offense Committed

Similarities emerged in responses from participants regarding the importance to focus on building rapport and a strong therapeutic alliance and not on the offense committed. Many participants reported this was also a component in helping them eliminate negative judgement or bias towards an offender. Viewing the offender like a human being helped with the ability to focus on building the therapeutic alliance. Many participants highlighted how important the therapeutic alliance was to the client being able to view themselves in a more positive light and to then be willing to participate in treatment. Participant 11 reported difficulties they noticed if rapport was not established and how that contributed to a lack of a strong therapeutic alliance and willingness of participation by offenders:

> I look back on some of my clients that I had initially where there was not the rapport and again there's that guardedness there's that unwillingness to whether it's participate, whether it's to share information whether it's to be like hey you know this is what I was thinking at the time. If you don't have that therapeutic alliance it's gonna be hard to move forward as far as looking at your offense cycle and getting down to the nitty gritty of like what you thought about yourself, the world and others at that time.

Participant 08 stated that an offender can feel if a clinician feels negatively towards them and that can affect the willingness of the offender to participate in treatment:

> I mean I think everybody has a little bit of a sixth sense right, hmm so now I will say well it's much easier now in private practice because I can like, I can choose right who I want to work with, but you know if I don't want to really work with a client I shouldn't right. But you know I mean that like effects treatment and if I don't want to be meeting with them well, I mean that's really unethical to me I think it and goes both ways. So, if a client doesn't want to meet with me how effective is it going to be really and on top of that if I don't want to meet with a client it's not going to be super effective either.

Participant 04 reported feeling they build rapport with all clients they have in sex offender treatment, but emphasized how important it is for the client to be in a place where they are open to treatment stating,

> I think I build a good rapport with all of them. I mean OK a couple have been nasty because they were not open. They weren't in a place yet where they were open to any of it. And there have been circumstances where we've had to send them back because they weren't open to participating, but for the most part they've been really responsive to treatment and group.

Participant 08 further elaborated on the importance of building rapport and the therapeutic alliance by stating,

> I don't care what kind of therapy you're doing 95% of therapy is your relationship with the client, that therapeutic alliance. I mean it's not the interventions like

> anybody can do these interventions, it's so much more about the relationship. The relationship is so important for successful therapy outcomes.

Participant 04 shared they view rapport building and establishment of strong therapeutic alliances as a strength of theirs but also highlighted how that can only go so far and reported how a client views them is just as important to that establishment of rapport. Participant 04 stated,

> I think that I come with the same perspective for each client. I think it's important to be open as a clinician. I think outcomes are more dependent on their reaction to me and their reaction to me trying to build rapport because I think I set out with the same mindset of you know let's help this person regardless of what he's done and some of them back off to that significantly, you know not focusing on the offense. But then the ones that let me in and let me build rapport I think it goes positively. I don't know if I'm answering your question correctly, but I try to treat everyone the same, but it isn’t up to me how they perceive me so sometimes it’s more about their reaction to me then my perception of them.

Theme 3: Recognize Bias Without Impacting Client

Participants shared similarities in responses regarding the importance of recognizing potential bias and judgement and how that can impact a clinician’s perceptions of a client in sex offender treatment. The ability for the clinician to be able to do this was described as being the job of a good clinician and that it is something that should be a given in the profession. Many participants reported conducting self-checks to prevent bias from impacting interactions with clients. Others mentioned the importance

of collaboration with other team members, colleagues, and supervisors. Participant 08 shared knowing what to look for when it came to possibly developing bias was a skillset that developed over time as a clinician. Participant 08 stated,

> I think you just approach things a little bit different, or you know that they, a client might be a little bit more difficult and so if you can plan ahead of time for that….. I think it's more me planning for myself mentally because it's really easy to get frustrated and so if I can kind of prep myself ahead of time like alright this might be a little bit more of a typical client interaction then I can go in a little bit more level headed as opposed to being caught off guard but it's almost like now you have that self-awareness where you know like you can check yourself, but you also have so much experience in it that you know what to look for at the same time.

Participant 01 also shared the importance of conducting self-checks to ensure they were not allowing judgement or bias to impact how they interacted with a client. Collaboration with colleagues and supervisors were also noted. Participant 01 shared,

> I do think that you know if I have a viewpoint of a client, I think that that can carry weight unless I'm really checking myself. What I mean by that is you know, my opinion, really you know, can change my outlook or trajectory of how I treat the client, so it's really important to ensure that you are objective and being honest with yourself and also you know collaborating with you know supervision or other clinical staff members so you can get through a bias or an opinion that you have with that one client.

Participant 05 and 11 noted the importance of collaboration with colleagues to overcome bias or judgement that had the possibility of impacting the client. Participant 05 stated,

> If I have some sort of sense I can't shake or feel like I am not going to be effective as a clinician for a client I seek out collaboration so I can figure out the best path forward for the client, so I do not run the risk of impacting their success. But I will say that even the angriest of clients have somehow always ended up coming around in group. I think that sometimes it just takes them time, especially if they are processing their own trauma from just being released from prison or something like that. So, it is also being realistic and meeting them where they are at as well.

Participant 11 reported,

> I think collaboration is huge and again not just only for your biases and your judgments but you may have one perspective and have someone else feel like hey you know I kind of saw it as this it kind of keeps you in check and it allows you to look at a client from different angles so I think collaboration is huge I think it it's very necessary to make sure that you're keeping yourself in check.

For many participants, not allowing bias to impact clients was how they could ensure they were doing the best as clinicians. Participant 07 shared,

> I wanna say no matter what, I was always respectful and did my best to keep my biases out of the treatment space. So, as a good clinician I believed I was able to do that and so yeah I did not let it impact how I treated them.

Participant 06 reported it being a rare occurrence if there was some internal conflict impacting them as a clinician and reported the importance of processing through. They shared,

> I feel like I do pretty well across the board. I'm not saying that there's not some clients that are difficult that I may really have some internal resistance to because I have and that's something important to work through, but that's pretty rare.

Participant 10 shared that not focusing on what is in the offender's file helps them from forming judgements. They mentioned the reality of also being human and having human reactions. Participant 10 stated,

> I don't know if anyone else is like this but I actually don't read the client's initial file outside of the needed contact information. I have found this to be effective because it keeps me from forming any misconceptions, I do recognize that I am still human, and I just try not to let anything cloud my mindset before I meet a client.

Participant 03 highlighted the role their own perceptions play and how they may impact their work as a clinician, with all clients, not just when working with sex offenders but also how being aware of that allows them the ability to tailor themselves to act a certain way with their clients. Participant 03 stated,

> I think our perceptions, or my perception as a clinician has an influence in how I interact with anybody not just in the sex offender group but even with my individual therapy clients, like with my kids, with the adults, my perception plays a big part in how I interact with all of them. And I think that's an important aspect

> of being a clinician because we understand what perception is and how it works… so I wouldn't interact with one of my kid's, individual clients the same way that I would with an adult individual client. So, I kind of have to tailor my interactions based on the environment and also based on the level that the client is at.

Participant 02 was the only participant who shared they hope their perceptions influence others outside of the profession. Participant 02 stated,

> In some ways I hope that my perceptions influence others too right, because I would like to hope that when people find out what I do for work or at least one aspect of what I do, that then that might change their initial perceptions too. I mean, I find it extremely beneficial especially with the good lives model because of the emphasis on the 10 basic needs. And everyone has needs so it's all about how we go about getting those needs met.

Having the ability to seek out colleagues for collaboration was mentioned to ensure clinician moral dilemmas do not impact the client by Participant 9, who also shared,

> I think it is really important for clinicians who do this work to have a lens of which they can view themselves and not allow their own moral dilemmas to influence how they view a client. But also, one that allows them insight to collaborate with or seek out referrals when needed so that a client is not harmed by their own bias or perceptions that could negatively affect the client.

Theme 4: Collaboration to Process Difficult Emotions if Present

Similarities in responses among participants highlighted a variety of emotions experienced when facilitating sex offender treatment. Collaboration was referenced as

being an important resource in processing difficult emotions if they manifest within the clinician. Participant 11 emphasized the importance of being self-ware of bias and potentially negative judgements and how seeking supervision and talking to others in the field is crucial in preventing a negative impact on client progress. Participant 11 stated,

> I think whether you're having counter transference or whether you have specific views that can negatively impact clients um and vice versa right if you have this view that your client is can't do any wrong your judgment will be clouded and your perspectives on that person can be clouded so I think it can go both ways I think it's really important to stay self-aware seek supervision when you need to and to talk to others who are in the field that have that specialized focus because it is easy to create your own judgments biases and that can really deter the progress or the treatment.

Doing what is best for the client was emphasized by Participant 02 who stated,

> I am sure that how I feel about a client has an impact on how I interact with them. I mean I do try and treat everyone the same right, but there is still a human element to it. I think collaboration is key in case there does need to be a change in the clinician. Because again it's all about what's best for the client right.

Some participants mentioned feelings of sadness when thinking of victims and the need to process those emotions. Participant 08 mentioned experiencing varying emotions based off the offense committed by the offender and becoming “numb” to it as well as experiencing dual sadness for the victim but the offender as well in some cases. Participant 08 stated,

> I think over the years I've become somewhat numb. I think you have to a little bit in order to do it otherwise I don't think you're a super effective clinician. If you let your own stuff, get in the way, but I think probably some sadness more based off of having to well I think there's two parts to it. so there's sadness for the victims, especially when we're doing sequencing around like what actually happens and we get really detailed with the sequencing part so there's sadness for the victims but then a lot of times there's also sadness for the offender um you know depending on um the need assessments we've done in terms of what needs haven't been met in their lives. You know the why the why behind this has happened, so I think it's kind of dual sadness.

Both Participant 06 and Participant 08 mentioned throughout the interview collaborating at multiple levels. They referenced the responsibility in collaboration as well especially related to probation so that other individuals working with the offender are on the same page. Participant 06 shared,

> 95% of the work I do is in collaboration with adult probation right. The clients that I treat are, they're in treatment as a mandated part of their probation and therefore I have a responsibility to be also communicating some of those concepts to individual probation teams so that they are also aware of some of those approach goals and how probation can challenge themselves to be in support of those to the extent that they can within their role.

Participant 06 further highlight how some clients are just difficult to work with and working through having reservations with keeping difficult clients in treatment. Participant 06 stated,

> Some of the clients that I've treated that are just really difficult. As an example, the other day I had to pull aside a client after group, and I said hey I really had some reservations about bringing you back in the group. He's someone that has not followed rules and there's been a lot of secrecy and deception. He's been discharged from other treatment agencies and so I had to tell him how it is and I said you know this probation and treatment it's a package deal, you have to be willing to do both and if you're not willing to follow your probation terms then, number one let's talk about what's making that difficult and how I might assist you in doing better beyond that. And if it's something you're not willing to do then treatment with me may not work out.

Participant 08 stated,

> I think that's really important to be able to process through that stuff and brainstorm I would say now in private practice um I would say colleagues and if I needed it um if I needed to kind of process through something I would just utilize a colleague that works with offenders as well. I think is really important to have, I mean the people that you can relate to who do this kind of work.

Theme 5: Overall Positive Emotions and Enjoyment of Work

Interview responses highlighted many positive emotions among clinicians such as feeling joyful, happiness, eagerness, fulfillment, pride, and similarities in overall positive

experiences facilitating sex offender treatment utilizing the GLM. Participants reported the positive emotions were related to different factors such as client progress or enjoying the work itself. Some participants reported being surprised with how much of a positive experience the work has been for them. Participant 04 mentioned participating in work as an intern reformed an initial negative view towards offenders, they also emphasized the importance of promoting positivity to reduce re-offending. Participant 04 further stated,

> Definitely positive emotions especially when I see a lot of progress. That makes me feel good especially when I see the guys feeling good, and that's what I want to promote. Because otherwise we're going to have reoffenders and the whole point is prevent them from re-offending.

Participant 03 and participant 02 both mentioned facilitating sex offender has been life changing and eye opening. Participant 02 stated, “I mean my experience has been kind of life changing to be honest as my views on offenders has changed. I never thought I would enjoy this work, but it is so rewarding.” Participant 03 stated,

> My experience has been joyful. I would say a bit of an eye opener. I've worked with many different groups of people, but my experience has been primarily with like substance abuse clients prior to sex offender treatment group. So, that group was a lot different from this type of group treatment, but I think my experience has been overall I would say joyful…. like I get a pleasure out of listening to the guys in my group not only talk about their growth, but also helping each other navigate through the obstacles and the hurdles, and things that they all have to go through. (phone rings)

Some participants mentioned finding a new passion they did not realize they had for the work. Participant 11 stated,

> So, I have found the experience to be really positive for me um since doing the good lives model I have found that this is one of my passions, so I have taken on a specific focus to work with individuals who have offended sexually.

Participant 08 reported something similar and highlighted how they have continued to develop in a positive way as a clinician. Participant 08 stated,

> I mean in terms of my experience I think it's been fantastic for me as a clinician. I've learned a lot and it's a really specific population that I would say most clinicians don't work with right, so I think the knowledge and experience that I have just gained in general has been just fantastic.

Participant 05 reported,

> I have grown so much as a person and a clinician since facilitating sex offender treatment. I know it may sound weird to those who do not do this kind of work but it is extremely rewarding and honestly I have found it so beneficial and rewarding when I see one of the clients I work start to really see what they are capable of and watch them continue to achieve goals and really change their behaviors and lives. It's just something I never thought I would be doing but I am so glad I said yes to the opportunity. My supervisor always taught me that they are going to be out in the community anyway at least we are working with them to make sure they are contributing members to the community.

Having a client "buy in" to treatment was mentioned by Participant 10 and Participant 01. Participant 10 stated,

> It has been an overall positive experience for me, and I do believe wholeheartedly that it is beneficial to clients or else I would not do it. It is not easy work but at the end of the day when you see a client finally have a buy in or win it changes everything and it is so encouraging to see and fulfilling.

Theme 6: Part of Training or Work Requirement

Most of the participants responded stating they did not learn about the GLM on their own. Most participants were either required to learn and implement the GLM as part of their training during field requirements while obtaining their degree or were required to become trained in the model as part of their employment requirements. Participant 07, who had never heard of the GLM prior to their field training stated, "The organization I work for, at the time that was a big focus for the owner and since I was being trained there and working there it was part of part of the opportunity of working in that space." Participant 05 mentioned it being the part of their opportunity while completed their practicum requirement for a doctoral program. Participant 05 stated,

> I actually was offered the opportunity to co-facilitate a sex offender treatment group at the site I was completing my practicum at. I was in a place where I was saying yes to every opportunity that came my way because I was still learning about who I was and had no real sense of what I wanted to accomplish overall.

Participant 04 stated they learned about the GLM through conferences before being trained in it at their agency. Participant 04 stated, “I went through a lot of conferences and trainings through ATSA and the good lives model sounded really positive.”

Some participants reported falling into the profession and that the GLM just happened to be the model being utilized at the agency they gained employment at. Participant 06 described his experience as almost accidental:

> People say there's no such thing as accidents, it sort of seems accidental, but maybe not. I'll give you a little bit of my trajectory. I did general mental health work in the 90s and then realized that I needed to go back to school if I wanted to have any reasonable income. So, when I went back to Graduate School, I was also looking for you know an upgrade in my job and there was a new, there was a civil commitment program that was new at the time at the Arizona State hospital and so I interviewed there in the mid 90s. And I took a position there. I don't know if you're familiar with civil commitment but there's I don't know maybe a dozen or so states in the country that have individuals that have committed sex offenses that meet certain criteria can go through a screening process and if they're determined to be a significant enough risk to the community then they can go from prison to civil commitment. So, that was my introduction to working with men that had sex offense histories. And then I did my internship at an outpatient agency in 99 and I just really enjoyed the work.

Participant 08 experience this as well. Participant 08 stated,

> They asked me, they're like hey do you want to do it and I was like sure. So, that's kind of how I got into at least into that kind of work and then when I moved over to a different agency they specifically used more of the good lives model with kids that sexually offend so it kind of like fell in my lap a little bit, and I just it's just such an interesting, it's an interesting population and so I've just kind of continued to work with that population and here in Arizona at least right now there's not a whole lot of people that are working with offenders. It's just very, very, small so I think the more people that are able to do so it's definitely helpful, I feel like it's even smaller with the people who utilize the good lives model for sure.

Theme 7: Make a Difference

Motivation to facilitate sex offender treatment utilizing the GLM was reported by some participants to be fueled by the desire to make some sort of a difference. Whether it be an actual difference that they could see or on less obvious level. Participant 01 highlighted how making a difference with true and honest rehabilitation was a motivator for them to pursue this line of work. Participant 01 stated,

> What motivated me to work with this population would be the hope of true and honest rehabilitation to make a true difference, knowing that they have served their time and it's our job to help them integrate into society in the most successful and collaborative way.

Making a difference was noted by Participant 02 as being an influencing factor as to why they chose to become a therapist. Participant 02 reported,

> I was motivated because I wanted to make a difference. I have always been one to push back against social norms and I wanted to be able to use my skill set for the better by making a real difference in sex offender rehabilitation. I went to school initially to become a therapist and continuing to pursue my education really led me to this path. I guess my main motivating factor is just to make the world a better place, right. I want to at least try to make a difference.

Some participants reported that wanting to give offenders a second chance was a motivating factor. Participant 03 stated, "I was motivated because I believe that everybody deserves a second chance, and that people are not their offense."

A few participants mentioned seeing a need in the community and becoming passionate about wanting to help the sex offender population complete treatment. Participant 09 reported,

> I actually started working with this population at the Arizona state hospital. I was really really against supporting the offender population at first and was surprised at how different the experience was versus what my initial thoughts were. Once I saw how much this population needed therapist and clinicians who were willing to work with them and see them as actual human beings, I became passionate about figuring out how to obtain state contracts to be able to facilitate sex offender treatment.

Participant 04 saw a need within their community for more positive alternatives:

> I think there was a need for treatment based off what I was hearing in the community. I was hearing in the community that the other programs weren't

> working for them or programs that they were involved in were not positive programs. And I think it's really important to give offenders a positive outlook on life instead of shame based.

Seeing the offender as a human being was mentioned as being a motivating factor as well as having the support of a supervisor and protecting the community. Participant 11 stated,

> I think there's a couple of reasons why I was motivated I think first and foremost I had a great supervisor with really good supervision um who I guess inspired me to take on this work. um I also think protecting the community and having a part in being able to protect my community was also another part in why I wanted to participate and to work with individuals who offend sexually. um and I also think just with my humanistic approach I'm able to do or to take on this work as well um with individuals who offend sexually.

Theme 8: Focus on Strengths Not Limitations

Similarities were found among participant responses regarding their influences and motivation behind utilizing the GLM for sex offender treatment. The strength-based approach was reported as being a contributing factor when determining to utilize the model. According to Barnao et al. (2016), the strength-based focus of the GLM focuses on building upon the strengths of the offender, not their limitations or past choices. Participant 04 stated,

> I come from a place where I don't think shame-based treatment can really help anyone. I don't think it is beneficial for anyone to just focus on just the offense. I think the good lives model can help anyone through treatment and I think it's

really important that we look at the whole person. We as clinicians, we've got to turn them down a positive path versus just shaming them right back into their negative path. We need to show them what they are capable of themselves by focusing on their strengths.

Participant 06 reported utilizing the GLM's strength-based approach in adjunct to other models. Participant 06 stated,

> I think what really appealed to me early on is the strengths-based approach. I think so much of treatment work historically was focused on risk reduction, relapse prevention and I understand that those are still some important elements, but I do think what was missing for a long period of time was healthy alternatives right. So, for telling these men and women that you need to avoid these certain behaviors or be shamed for those behaviors I think we were lacking in terms of well what do we replace that with number one and number two what goals were you trying to meet through your sex offending behaviors? And maybe other dysfunctional behaviors and therefore what tools and resources are we providing based on who you are as an individual, based on what's important to you and so therefore how can we use the good lives model from the beginning throughout treatment to present some healthy alternatives and then also a big part of what I do.

Some participants mentioned being introduced to the GLM via the agency they were working at. Participant 07 mentioned the same thing but highlighted the strengths-based approach was something she like about the model. Participant 07 stated,

> The agency where I worked at the owner and um she introduced the good lives model to me, and as I read it and learned more about it I really liked the positive and the strength based approaches. I like um not shaming people and not focusing on that history and that background of their offense. And I feel like the members in the group responded well to that. The members in group previously there was another therapist who did not use the good lives matter model and there and feedback from the members was it was not a positive response to that therapist.

Theme 9: Develop, Set, and Achieve Goals

Many participants mentioned that the GLM giving offenders the tools to develop, set and achieve goals was a contributing factor to deciding to utilize the model for sex offender treatment. Participant 03 reported,

> I like the good lives model because it doesn't, um excuse me, it doesn't harp on the offense. It doesn’t focus on the person’s criminal past. The good lives model, it concentrates and directs the client more to living a good life NOW and focusing on developing and achieving goals to live a good life. And the tools that is needed and fulfilling your dream and walking this walk and running this race, like everybody does benefit from this, not just offenders but normal people. Like this model it doesn't talk about you did this…or you did that, it's like what are you doing now, where are you now and what do you want to do in the future? Where does your future lie and how do you get there? And I think that's more important than other models that might focus on you know… you've committed a crime and focusing on shaming that crime and almost defining that person by their crime.

Some participants reported the GLM was a beneficial approach to sex offender treatment. Participant 11 stated,

> I think when using the good lives model it's really beneficial because it's not just focusing on the sexual offense right so there's also this component of looking at an individual's purpose and goal and there's different categories that an individual can kind of lean into and I think that's where the treatment is really helpful and beneficial and I think that's looking at their goals and their purpose and not taking as shameful perspective really helps to decrease that risk if and when they become reintegrated into the community because that is my ultimate goal at the end of the day if and when they do integrate back into the community I want them to have the tools to be successful so I really like the approach of not being shame based.

Theme 10: Generate Ability to Change Offending Behaviors

Participant responses highlighted the importance of the role the 10 basic needs play in the utilization of the GLM. The 10 basic needs according to Ward and Fortune (2013) is the foundation of the model as it helps illustrate the cognitive schemas, distortions, and needs not met that contributed to the offense chain and the behavior behind the offense being committed. The GLM addresses these 10 basics needs to generate the ability to change offending behaviors at the source (Barnao et al., 2016). Participant 05 shared,

> I would have to say the 10 basic needs is the aspect I feel is the most effective because it really allows for the client to explore what they really want out of their lives and how to go about getting those basic needs met so they can live a good

> life. One client is really set on implementing small goals so build on his strengths which I have seen really transform his entire being. It has actually been really cool to watch as a clinician because he went from someone who was angry at the entire world to someone who now feels like he can accomplish anything he sets his mind to.

Participant 02 shared the offense chain is fundamental in understanding how those 10 basic needs were being met by behaviors that lead to offending. Participant 02 shared,

> The aspects of the good lives model I find most effective is the emphasis on exploring what needs the individuals were not having met that lead them to offending. It's a foundational piece of the puzzle and then taking that information right and applying it in a real-life way then we can help build on the strengths the individual has in order to find new healthy ways to have those same needs met. The aspect then is actually changing those thought patterns which lead to the offense chain so then actually changing the behaviors that lead to the offense.

Some participants felt the GLM does such a great job at this that it can be used for other treatment programs not just sex offender treatment. Participant 05 stated,

> I actually think it's a brilliant model and can be utilized for other programs or even combined with other therapy models. I am motivated now to utilize strength-based models because I have seen how it helps clients and the positive effect it has on their treatment outcomes with the development of goals and needs being met in healthy ways versus the maladaptive alternatives, they were initially utilizing to fulfill those needs. It is actually quite a fascinating idea.

Participant 10 emphasized that all aspects of the GLM plays a role and are equally beneficial. Participant 10 stated, “I think all aspects are important. The exploration of the individual, the offense chain, cognitive schemas, and distortions, the 10 primary needs the whole thing. All of it is useful and part of the larger model focus.” Participant 03 stated they highly regard multiple aspects of the GLM but emphasized the importance of the 10 basic needs and how it creates the ability for the offender to truly change their behaviors. Participant 03 stated,

> I also like the hierarchy of needs like that was my, that's my favorite topic. It’s about trying to get them to see where their what hierarchy is within their own needs so for instance like health and welfare is that higher than interpersonal relationship or peace and happiness and like where do those needs fall within their list of from least important to most important? I think that that's for me the best part of the good lives model.

Theme 11: Take and Maintain Accountability

Similarities in participant responses highlighted they found the GLM being effective in motivating offenders to not only take accountability for their behaviors but to maintain it by acknowledging their behaviors. Participant 03 stated,

> I think getting the offender to number one: acknowledge the issue not necessarily acknowledge the offense but acknowledge the issue behind the offense… so acknowledge their whatever let them to the first step of the offense chain to that. So, it’s determining you know if it's a distortion, if it's a preference or if it's pedophilia with you know children like whatever that initial, that underlying issue

> that they might have is. Like helping them to realize that and work on that thing so that they're able to deter themselves from reoffending.

Participant 01 stated,

> The good lives model does a good job of not shaming clients with their offense and kind of gives them something to look forward, to what they have and their need areas. So, keeping them accountable, but also focusing on the future and how to do that and how to be productive.

Not using the offender's past choices as a way to shame them was mentioned among some participants as being an important factor in wanting to utilize the GLM for sex offender treatemnt. Participant 11 reported,

> I think the lack of using shame is really effective um building that rapport and that therapeutic alliance you know I see clients coming in who are very um guarded and reserved treatment is pretty off putting and a lot of it is seen in the beginning as punitive so using that good lives model and saying hey look I'm not here to shame you I'm not here to really pounding your head that you've done something bad um is really effective you know it it comes down to hey you have goals that you were trying to meet and you didn't necessarily meet them in a healthy manner so how can we go about that I think that is just really effective with these clients in my opinion.

Theme 12: Dependent on Rapport Between Clinician and Offender

Similarities were noted among participant responses regarding the important role rapport between the clinician and offender played in treatment outcomes. To many

participants, this was a main contributing factor regarding successful treatment outcomes. Participant 06 reported,

> It's really about building that rapport and the nature of the therapeutic relationship. I really think that's first and foremost in my mind. I think also clearly identified treatment goals and objectives and understanding and treatment pathway. I think giving clients hope so that they can understand the purpose and value of what they're doing and why they're doing it and what the outcome could be.

Participant 07 reported,

> I feel like rapport is an important aspect for the client to feel comfortable and to go to those more difficult places with the clinician. And then also that they will feel comfortable and trust that the clinician is going to help them through that, through whatever they're working on and then they will be more responsive to the interventions or to the directions given by the clinician if there is rapport.

Some participants mentioned the importance of rapport being built among all members of an offender's treatment team. Participant 07 stated,

> That also needs to include rapport with his team or their team. For example, that's the probation officer and any other people involved. The offender, the client they have to feel supported and build trust within that system and also their own support system. I feel like a combination of all of those things bring about more positive change and then also promote the offender's engagement and a desire to want to be better.

Participant 08 was the only one to mention including the support system the offender has access to outside of treatment. Participant 08 stated,

> I would say two things. I think #1 the rapport that I've built with the client. So, like our relationship I think is huge yes 100% and then two I would say um you know the clients support system in their life. I mean or even if we look at all the systems you know you have the individual systems for them themselves, you know the family system and taking a look and asking what does that look like? What about their peer system, housing, if they have employment or they're in school what does that system look like, and then also community. So, kind of looking at a combination of I think the five different systems. And making sure that um yeah there aren't any kind of negative drivers within those systems. I think those are all really important factors that contribute to successful treatment outcomes.

Participant 04 was the only participant who mentioned offender's not wanting to let down their therapist, and they reported they believed that resistance to wanting to disappoint their therapist plays a large role in reducing the risk for re-offending and successful treatment outcomes. Participant 04 stated,

> I think as a clinician you learn how important rapport is. I think though that building that strong rapport influences them because they don't want to let me down. They don't want to let other members of the group down. They don't want to let down on the other therapists who work with them. I think they really commit themselves to the program and I think they commit themselves to the

> facilitators of the program and I think that's the first and foremost just like with any kind of therapy it's all about what would my therapist say and do. I want my therapist to hear I did something positive and to them I think it keeps them motivated to stay on that positive path. So, I think that makes a big difference, right? If you go in as a therapist that's non-judgmental versus one that is judgmental, I mean they're being judged already by the probation officer, by the public, etc so to have somebody that's not judging them, that accepts them for who they are and all of their faults which you know, a therapist will have faults too, so I think they sense the genuineness. I think they can feel the genuineness and they honestly, I believe they do not want to let the therapist down.

The phrase "buy in" was mentioned by several participants referencing the offender becoming engaged in treatment and actively participating and how important rapport was to achieve that buy in. Participant 01 stated,

> I feel when there's a better rapport with a client the more buy in that you have and the more willing the client feels that there can be substantial change. When there's some barriers to the therapeutic relationship, I feel that it can be a little bit challenging to get buy in and cooperation because they might be skeptical of the relationship or your perception of them as a clinician.

Some participants stated they believe it is a combination of factors that influence successful treatment outcomes, but the clinician still plays a role. Participant 02 shared,

> I think it is a combination of the type of treatment, right and maybe the clinician as well. I mean I am partial to the good lives model but for good reason right. I

> also think it has to do with the willingness of the participant to actually buy into the treatment and want to make lasting changes. I guess it is a combination of the model being used, if the client buys into the model or treatment right and then the clinician probably plays a role in that too, again with the therapeutic alliance and rapport. So, yea, definitely a combination of factors.

Participant 11 also reported a combination of factors along with highlighting the importance of establishing rapport by stating,

> I think um I think being aligned with your client having good rapport but I also think boundaries right and I don't think we talked about that yet but maintaining boundaries and assertiveness in a respectful manner I think you can you can keep the client from leading you in different directions and what I'm what I think I mean by that is calling things out when you know that there's some some lies being happening or if something just is it what it necessarily is so if a client tells me something and I know that's not particularly true OK I need to address that so I think having those boundaries and having that assertiveness and and challenging our clients in a therapeutic manner is really vital to to the treatment and the progress as well.

Theme 13: Dependent on Willingness of Offender to Participate

Similarities among responses from participates highlighted the importance of the offender’s own willingness to participate in treatment for there to be successful treatment outcomes. While many participants focused on rapport being a large contributing factor, willingness of the offender to participate was often mentioned as co-contributing factor.

Some participants however, did not mention rapport as being as important to treatment outcomes than the willingness of the offender to participate. Participant 02 shared,

> The offender’s willingness to look at themselves and take accountability for why they did what they did. I guess a part of that is their ability to trust the clinician right? But again it comes down to their willingness to want to engage and be active in the treatment program.

Participant 10 stated,

> I would say it is the client themselves and their willingness to participate and make the changes right because it does not really matter at the end of the day if they aren’t willing to do the work. I am sure there is more to it but that to me is numero uno.

Participant 04 stated they have had successful treatment outcomes with offenders based off their willingness to participate in treatment, but they emphasized this was due to the positive unjudgmental nature of the GLM. Participant 04 stated,

> Definitely being non-judgmental and tapping into the real humanity of individuals. Which would be focused on treating them like a human being. And that's what I hear from some of my clients that don't feel like they're hearing it from therapists in the past which is why I think the good lives model has such a positive impact.

Participant 05 mentioned that the GLM does a good job of setting the foundation for a potentially positive treatment outcome along with the willingness of the offender to participate by stating,

> To be honest I think the goods lives model itself is such a great foundation for success for clients because it helps them see what they can achieve and highlights their strengths, but I also believe that it has a lot to do with the rapport established and the ability for the client to trust the clinician. I think that it is a combination of a great clinician, great rapport, great treatment model but also there is an element to it that requires the client to be willing to put in the work and hold up their end of the deal too. I mean we can only do so much as clinicians they also have to be willing to put in the work to complete treatment regardless of the model used, but I do believe the good lives model is the most effective model to have the best chance for client's to fully engage in treatment.

Figure 1 shows perceptions of clinicians towards offenders who utilize the GLM for sex offender treatment, clinician opinions the influences of those perceptions on treatment toward the offender, and clinician opinions of what impacts overall treatment outcomes.

Figure 1

Proposed Framework

Summary

Results from the data collected were presented in this chapter. The results obtained from the interview participants were aimed to examine the perceptions of clinicians who utilize the GLM for sex offender treatment. The following questions were answered:

RQ1: What are the perceptions of clinicians towards offenders who utilize the GLM for sex offender treatment?

RQ2: What influences the clinician to utilize the GLM to provide treatment to sex offenders?

RQ3: How do much of an influence do clinicians think their own perceptions towards offenders have on treatment outcomes?

Perceptions of clinicians towards offenders were found to be overall positive in nature. Participants reported experiencing a variety of emotions and highlighted the importance of collaborating with colleagues, supervisors and performing self-checks to ensure any difficulties if present did not impact the client. Participants acknowledged that if bias or judgement toward an offender were to occur it was usually based on their offense. However, participants emphasized the importance of collaboration to process through bias to ensure it did not impact client outcomes. Participants emphasized they treat offenders like human beings indicating that many offenders are often stigmatized and only viewed as their offense. Participants reported the importance of treating offender's just like any other client and not allowing any judgement or emotion to impact that. Some noted they had the ability to see everyone as equals while others stated it took time to develop the ability to compartmentalize those emotions but once the ability formed, they look forward to working with offenders. Some participants reported that focusing on building rapport and the therapeutic alliance allowed them to focus less on the offense committed by the offender. Some participants acknowledged that after a while they only see the offender as a person and often forget their offense all together.

Participants overwhelmingly reported being exposed to the GLM through training or work-related requirements. Participants reported enjoying utilizing the GLM and reported they found the model to be a beneficial tool in sex offender treatment as either a stand along program or in adjunct to other programs. Responses regarding the motivation to continue to utilize the GLM for sex offender treatment emphasized the strengths-based approach as being one of many important factors. Participants reported the ability for the GLM to hold offenders accountable while empowering them with the tools necessary to have their 10 basic needs met in a positive way. Participants reported the importance of focusing on the strength's offenders possess instead of shaming them or calling out their limitations. Participants reported the importance for offenders to be able to see what behaviors and choices lead to their offense by means of their offense chain in order to be able to prevent re-offending behaviors in the future. Some participants reported enjoying their work with offenders while utilizing the GLM, especially when progress was seen.

Treatment outcome influences were also noted as overall positive experiences and the perception of the clinician toward the client was noted as being an important factor in the ability to build rapport and the therapeutic alliance. Some participants stated that rapport between the clinician and offender was even more important than the model utilized during treatment. Some participants stated that building rapport and a strong therapeutic alliance is the key to successful treatment outcomes, and that in order for that to happen, the offender must trust the clinician. Some participants stated the willingness of the offender to buy into treatment by fully engaging and actively participating in the program was an influential factor in treatment outcomes and that was another factor

dependent on clinician perceptions. Other participants stated they believe treatment outcomes were dependent on a combination between the rapport built between the offender and clinician and the willingness of the offender to fully engage and actively participate in treatment. One participant stated they believed the offender was influenced by the pressure of not wanting to disappoint or let their therapist down, again emphasizing the importance of the rapport built. Collaboration with all members of a treatment team was also noted as being an important factor in treatment outcomes.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Clinician attitudes and perceptions have been evidenced in the literature to have an influence on overall treatment outcomes for individuals participating in sex offender treatment (Mivsheck & Shriver, 2022). The goal of sex offender treatment is to reduce the risk for recidivism among offenders who complete treatment (Gualco et al., 2021). The GLM is a strength-based alternative to mainstream treatment models such as RNR, which focuses on building up the esteem of the offender and not focusing on their offense committed or past choices (Barnoa et al., 2016). The purpose of this study was to examine the perceptions of clinicians towards offenders who utilize the GLM in sex offender treatment. By examining in depth the perceptions, emotions, and influence of clinicians who utilize the GLM, I attempted to understand the impact on sex offender treatment outcomes. The following RQs were utilized to explore this phenomenon:

RQ1: What are the perceptions of clinicians towards offenders who utilize the GLM for sex offender treatment?

RQ2: What influences the clinician to utilize the GLM to provide treatment to sex offenders?

RQ3: How much of an influence do clinicians think their own perceptions towards offenders have on treatment outcomes?

Semistructured interviews of a total of 11 mental health clinicians who either currently utilize or have utilized within the past 5 years the GLM for facilitation of sex offender treatment were conducted. The aim of these interviews was to answer the RQs

in an in depth, thorough way. As a framework, grounded theory was utilized. Data collected from the interviews were open and axial coded to organize the information obtained into categories. The data were further analyzed, and 13 themes emerged from the four categories. The categories and themes developed from the data collected formed a framework that illustrates the perceptions, emotions, and influences of clinicians towards offenders who utilize the GLM for sex offender treatment.

Treatment towards the offender was the first category in the framework that highlights how clinicians view and treat the offender prior, during, and after sex offender treatment. The findings indicated the clinicians viewed the offender the same way they did any other client with a focus on treating them like a human being. The second category focused on the difference of emotions that each clinician noted they experienced along with methods utilized to process through difficult emotions if present, such as collaboration. The findings revealed many of the emotions experienced were positive ones and the work was noted as being rewarding. The third category highlighted the motivation and influences of the clinicians to utilize the GLM for sex offender treatment versus mainstream models. Findings indicated the strengths-based focus and ability to make a difference were largely motivating factors. The fourth category highlighted the influence that clinicians believe their perceptions of offenders can have on treatment outcomes. The findings revealed clinicians feel that their perceptions of clients could impact rapport. Findings further revealed rapport was a main contributing factor along with the willingness of the offender to actively participate in treatment, which could also be influenced by the rapport built with the clinician. Themes derived from these

categories will be discussed in detail highlighting evidence found in existing literature in the following section. The next sections will discuss limitations of the study, recommendations for future research, and implications of the current study. A summary will conclude the chapter.

Interpretation of the Findings

The themes that emerged from analyzation of the data collected will be included in this section. The themes will be discussed in detail and will include findings from current literature to highlight the current knowledge evidence in the current literature, regarding the findings. Clinician views, bias, and treatment towards offenders will be discussed in the first three themes.

Theme 1: Treat the Offender Like a Human Being

The attitudes of clinicians towards sex offenders have been noted as having an impact on how the clinician interacts, views, and treats the offender (Hancock, 2019). Participants in the current study reported treating the offenders they work with "like a human being." The participants noted that treating offenders just like any other client was important due to the stigma surrounding sex offenders. One participant reported offenders are often not treated like human beings and only defined by their title of sex offender. Treating all offenders just like other clients was prevalent among participant responses. One participant stated, "I treat all of the clients the same regardless of how long they've been there if they're new to treatment, or if it's their first day or their last day I still treat them the same." According to Harper and Hicks (2022), the views of clinicians towards offenders can impact treatment outcomes in several ways, including risk management

judgement and the development of the therapeutic alliance. Participants in the current study supported these findings indicating that being able to view the offenders as human beings allowed them to move past their offense and focus on who they can become by participating in treatment.

Theme 2: Focus on Therapeutic Alliance Not Offense Committed

Responses from participants focused on the importance of building rapport and a strong therapeutic alliance and not focusing on the offense committed. Current literature has suggested that the therapeutic alliance is the main factor contributing to overall successful treatment outcomes (Sandell et al., 2007). Current literature has further supported participant responses regarding not focusing on the offense committed. It was further noted in the research that focusing on an offense committed can influence clinician attitudes, especially when more heinous offenses have been committed (Harper et al., 2017). These negative attitudes can impact treatment outcomes for sex offenders, as clinicians may be less motivated to provide effective interventions or support for their clients (Harper et al., 2017). Many participants reported viewing the offender like a human being helped with the ability to focus on building the therapeutic alliance and not the offense committed. It is evidence in the literature the importance of the therapeutic alliance and the correlation with successful treatment outcomes. According to Sandell et al. (2007), relationship between the therapist and the patient is impacted more by the attitude of the therapist towards the patient, not the other way around. Some participants in the current study mentioned offenders can identify if a clinician is negatively judging them and that this can impact the therapeutic alliance. Safran et al. (2012) found a

correlation between the mindfulness of the therapist and the effect on treatment outcomes for the client, again highlighting the importance of the views of the therapist towards the client in treatment outcomes. One participant reported difficulties they noticed if rapport was not established and how that contributed to a lack of a strong therapeutic alliance and willingness of participation by offenders: “If you don't have that therapeutic alliance it's gonna be hard to move forward.”

Theme 3: Recognize Bias Without Impacting Client

Participants in the current study mentioned the important role self-awareness played in the ability to perform self-checks as a way to ensure bias and judgement did not impact clients in sex offender treatment in a negative way. Current research has suggested that coping skills and overall attitudes towards therapeutic work does have an influence over the effectiveness of treatment outcomes by impacting how the clinician perceives themselves within the therapeutic relationship (Heinonen et al., 2020). Bias and judgement were found in the current literature to have an impact on treatment outcomes among clinicians who work with sex offenders.

According to Diciro et al. (2023), working with the sex offender population can impact clinicians in negative ways due to the nature of the offenses committed, which can impact the attitudes of the clinicians towards offenders. These negative attitudes can be influenced by the type of the offense (Holliday et al., 2013). Participants in the current study reported having the ability to change their initial perceptions of a client if negative and reported that remaining open and consistent with self-checks and awareness was crucial to preventing bias and judgement from negatively affecting clients. These

statements are support by research conducted by Harper et al. (2017), who indicated the attitudes and perceptions of clinicians are not permanent and are malleable and often change in a more positive direction after a client has been in treatment for a period of time.

Theme 4: Collaboration to Process Difficult Emotions If Present

Two themes emerged regarding emotions among participants. Participants in the current study noted the importance of their work environment and having access to other clinicians or colleagues to collaborate with, refer out, and process difficult emotions with if present. According to Blagden et al. (2016), the environment a therapist works in can play a role in perceptions of clinicians towards clients. Participants emphasized the importance of good supervision if the work was part of a training program. It was also noted among participants in the current study the importance of having the ability to discuss the difficulties of the job with others who understand exactly what the experience is like again without impacting the client's success. One participant stated, "I seek out collaboration so I can figure out the best path forward for the client, so I do not run the risk of impacting their success."

Theme 5: Overall Positive Emotions and Enjoyment of Work

Participants in the current study shared an overall enjoyment of the work describing it as fulfilling, rewarding and impactful which ultimately impacted how they treated clients in treatment. Positive emotions were reported by participants such as "happiness", "eagerness", and "honor." Participants in the current study further reported having a majority of positive and successful treatment outcomes for clients while

utilizing the GLM for sex offender treatment. The current literature noted that clinicians who hold more positive attitudes toward sex offenders are more likely to provide effective treatment interventions and support for these individuals (Fortune et al, 2015. According to Saxon et al. (2017), the mindset of the therapist can have an influence on treatment outcomes.

Theme 6: Part of Training or Work Requirement

Six themes emerged when exploring the motivation and influences among participant responses on what lead to them deciding to utilize the GLM in sex offender treatment facilitation. Each participant was either introduced as part of their training or work requirement. Participant responses indicated these experiences have been overall positive, which led to the openness and desire to continue work with sex offenders utilizing the GLM.

Current research is significantly lacking regarding influences and motivation concerning clinician utilization of the GLM for sex offender treatment. According to Springer et al. (2005), the training of the therapist is important but not as important as the openness of the therapist. The current literature has further suggested that the mindset of the therapist can influence how they facilitate treatment groups regardless of their training and that this can impact their leadership within that group setting (Springer et al., 2005).

Theme 7: Make a Difference

All participants in the current study referenced wanting to make a difference in some sort of way a factor in why they continue to facilitate sex offender treatment

utilizing the GLM. One participant reported wanting to make a true and real difference with last rehabilitation. While current research is lacking regarding the utilization of the GLM, Johnson et al. (2023) noted that positive reflections were found among clinicians/practitioners to form meaningful relationships and community support among offenders, which is a foundation associated with success within the GLM application.

Theme 8: Focus on Strengths Not Limitations

Among participant responses in the current study, it was noted the strength-based approach was a contributing factor when determining to utilize the GLM for sex offender treatment. According to Barnao et al. (2016), the strength-based focus of the GLM focuses on building upon the strengths of the offender, not their limitations or past choices. One participant shared they do not believe a shame-based treatment model can help anyone emphasizing they believe the GLM looks at the whole person and is beneficial for clients.

While research is currently lacking regarding utilization of the GLM, according to Tyler et al. (2021), a 5.4% reduction in recidivism was noted among the results in the study when compared to shame-based alternatives with a 19.6% recidivism rate, indicating a strengths-based approach may have a more positive impact on reducing recidivism risk. Participants in the current study noted experiencing a shift among clients in treatment who had moments of “buy in” into the treatment program, often for the first time having something positive about themselves to focus on.

Theme 9: Develop, Set, and Achieve Goals

Participant responses regarding the use of the GLM emphasized the importance of the model allowing the client to develop, set, and achieve goals during treatment. Participants in the current study noted this allowed for clients to build a high sense of self, which positively impacted their willingness to participate in treatment and contributed to their ability to achieve the goals they set for themselves.

In a sense, participants in the current study referenced this as being a positive cycle of change as the more goals the clients achieved, the higher their sense of self and more willingness to engage and further participate in treatment, ultimately leading to more positive treatment outcomes. Current literature has supported these findings, as according to Barnoa et al. (2016), participants in sex offender treatment utilizing the GLM had a positive shift in mindset. According to Barnoa et al. (2016), the longer the exposure the participants had to the GLM for treatment the more definite changes the participants experienced in their behaviors by means of not only developing and setting goals but being able to achieve those goals. Participants in the current study also noted the importance of giving the client time to find their own willingness to fully participate in treatment, as giving them the ability to truly buy in to the treatment philosophy and begin to shift their mindset to focusing on their strengths not their past choices that lead to the offense. Current research seems to support these findings. According to Jaimee (2021), the GLM "proposes the risk of offending lessens when an individual has sufficient level of capabilities and strengths to achieve their personal goals" (p. 3).

Theme 10: Generate Ability to Change Offending Behaviors

Another emerged from participants responses in the current study who referenced the ability for clients to not only develop, set, and achieve goals but to actually generate the ability to change offending behaviors was a key factor in continuing to utilize the GLM in sex offender treatment. Participant responses indicated that the GLM provided the foundation for clients to explore themselves before, during, and after their offense as well as explore who they are now and who they want to become.

Many participants indicated that giving clients the resources and tools to explore their cognitive schemas, distortions, and decisions that led to their offense allowed for self-awareness. Once self-awareness was determined, exploration of the 10 basic needs that all humans have of which the foundation of the GLM is built is then explored so clients can focus on finding ways to have their needs met in positive, prosocial ways instead of relying on offending to achieve those needs. Current research although limited seems to support these responses. According to Prescott and Willis (2022), the success of the GLM in treatment is due to allowing and supporting the client in understanding their 10 basic needs, supporting their strengths, exploring their old lives, and setting goals for who they want to be by implementing the components of the model.

Theme 11: Take and Maintain Accountability

Another theme emerged as participants of the current study reported utilizing the GLM for sex offender treatment allowed clients to not only take accountability for their past actions but to maintain the ability to take accountability for current behaviors. One participant reported they have found many of the clients they have worked with in sex

offender treatment do not want to disappoint other members of the group or their therapist. They reported that this model allows for a true relationship to form between not only the clinician and client but the client and other group members. Group members then also hold one another accountable. Another participant reported that the GLM does a good job of allowing the client to feel comfortable acknowledging the offense even took place as some offender's struggle with even admitting they did anything wrong. Another participant reported that it is useful that the GLM allows for clients to not only acknowledge their offense but also explore and acknowledge the issues that lead to their offense "not necessarily acknowledge just the offense but acknowledge the issue behind the offense."

Current literature has emphasized the ability for the GLM to serve a dual purpose. According to Harris et al. (2019), the GLM promotes risk reduction and true behavior change by both identifying behaviors but also modifying behavior. According to Harris et al., the GLM allows for this to occur due to the focus on prosocial attainment of the 10 basic needs instead of utilizing maladaptive behaviors to offend to have those needs met. Harris et al. further emphasized that the GLM indicates the actual human behavior of offending can be identified and then modified as a way to secure one of the 10 primary basic needs. This is consistent with responses from participants in the current study who have emphasized the importance of clients feeling empowered to make those behavior modifications after identifying where, why, and how they were getting their needs met by offending. Participants in the current study reported the ability for clients to then feel

empowered to have their needs met in healthy ways, ultimately changing their behaviors long term.

Theme 12: Dependent on Rapport Between Clinician and Offender

Two themes emerged from participant responses regarding how they perceive their influence on treatment outcomes for clients. Many participants reported there being an importance in building rapport with the client, so they felt safe to go to those places needed to truly process difficult factors that arise during treatment. One participant stated, "I feel like rapport is an important aspect for the client to feel comfortable and to go to those more difficult places with the clinician." One participant that stated clients need to feel safe and not judged in order for rapport and that therapeutic alliance to truly develop. Many participants reported the rapport between the clinician and offender being the most influential aspect in successful treatment outcomes. Current literature supports these findings. In a study conducted by Butt (2021), rapport was found to improve compliance with treatment, clinical outcomes, and client satisfaction. According to Sandell et al. (2007), the therapeutic alliance is noted as being a main contributing factor to successful treatment outcomes. Further research conducted by Safran et al. (2012) further supported these findings, suggesting that there is a correlation between the mindfulness of the clinician and relationship established between the client in treatment. Participants in the current study reported noticing differences in treatment outcomes with clients they did not have as strong rapport with. One participant stated they believe rapport is more important than the treatment model utilized.

Theme 13: Dependent on Willingness of Offender to Participate

The final theme that emerged among responses from participants in the current study was related to another influential factor on treatment outcomes. Participants reported that the willingness of the offender to participate was a contributing factor in whether treatment would be a success. Current research supports these findings. According to Holdsworth et al. (2014), the willingness of a participant is a contributing factor to treatment engagement and ultimately affects the outcome of treatment or whether treatment is completed. One participant shared the difficulties they faced when having to terminate a client due to unwillingness to participate. Another participant shared that due to their experience in the field, they could tell when a client was not putting forth all the effort due to something holding them back from either building that rapport or just being unwilling to participate.

According to Harrison et al. (2019), client expectations of treatment can also impact their willingness to engage. One participant in the current study shared that meeting a client where they are in treatment sometimes means their expectations for treatment based on previous experience does not allow them to be in an open space to be a willing participant in treatment and therefore negatively impacting treatment completion and outcomes. Some participants shared they believe it is a combination of rapport built between the clinician and client and the client's willingness to participate as to what influences successful treatment outcomes for sex offender treatment.

Limitations of the Study

Limitations of this study are also highlighted in Chapter 1. A limited number of clinicians utilize the GLM for sex offender treatment. Due to the limited number of clinicians who utilize the model, a small group of participants were recruited. Semistructured interviews were conducted to explore the perceptions of these clinicians in depth; however, the results obtained may only represent a small percentage of the population who utilize the GLM. This highlights the potential for the results to be generalized and not an accurate representation of other clinicians who work with sex offenders who utilize the GLM. The perceptions, emotions, and motivating factors represented in the findings of this study may not be representative of the general population of clinicians who utilize the GLM. Insight regarding future research due to the limited number of participants in highlighted in the next section.

Recommendations

The purpose of this study was to examine the perceptions of clinicians towards offender who utilize the GLM for sex offender treatment. A grounded theory framework was utilized to explore categories and themes derived from the data collected. The findings indicate overall positive perceptions among clinicians towards offenders who utilize the GLM for sex offender treatment. Each theme highlighted in this study could be further examined to determine if the same themes emerge among larger participant pools. According to Harper and Hicks (2022), research is lacking in how perceptions of clinicians towards offenders can influence treatment outcomes. As noted by Razali and Baker (2023), research is further limited exploring the utilization of the GLM for sex

offender treatment. The lack of current research exploring clinicians, sex offenders, and the utilization of the GLM suggests that more research needs to be done. One recommendation for future research concerns whether the number of years spent facilitating sex offender treatment can impact clinician perceptions towards offenders. Clinician burnout utilizing the GLM could also be explored to examine whether clinician burnout can affect treatment outcomes. Further research is also recommended to compare perceptions of clinicians who utilize the GLM with other treatment models. Lastly, perceptions of offenders who participate in treatment utilizing the GLM may also provide valuable insight into what influences successful treatment outcomes.

Implications

The responses provided by clinical mental health professionals in this study offer several social change implications. One social change implication noted among the findings shows that clinicians who utilize the GLM for sex offender treatment have overall positive perceptions towards offenders, even those with more heinous offenses, in sex offender treatment. In comparison to public perceptions of sex offenders, which is noted as being overall negative, often producing a visceral among individuals (Harper & Hicks, 2022). Participants in this study emphasized the importance of treating offenders like human beings and focusing on building rapport, not the offense. The findings showed that clinicians are often exposed to the GLM as part of their training or work requirement, but then often choose to continue the work as they find it fulfilling and rewarding. The findings showed there are some difficult emotions associated with working with sex offenders, but that with collaboration with colleagues, self-checks, and

awareness of bias and judgments, clinicians are able to move past those difficulties and focus on helping the client complete treatment. Even those clinicians who may have less experience facilitating sex offender treatment, the responses were similar and again focused on treating the offender just like a human being or any other client. One factor that arose time and time again was focusing on who the offender is now and not on their past choices, which led to their offense.

Grounded theory was utilized for this qualitative study. The social change implications concerning the use of this qualitative study allowed for exploration of how clinicians perceive offenders, the emotions they experience facilitating sex offender treatment, and their influences and motivations regarding utilization of the GLM for sex offender treatment. Codes were derived from the transcripts of the interviews conducted, which were then placed into categories. From the categories a total of 13 themes emerged. Each of these themes can be utilized as a basis for future research to determine if these same themes emerge among different populations of clinicians who utilize the GLM for sex offender treatment.

Conclusion

According to current research, perceptions of sexual offenders can influence professional judgements and attitudes and ultimately influence treatment outcomes (Harper & Hicks, 2022). Sex offenders are perceived in a negative light by the public and often stigmatized or defined by the term, which often creates a negative reaction among individuals (Harper & Hicks, 2022). Sex offender treatment has primarily focused on criminology and shame-based models such as RNR with the goal of reducing the risk of

recidivism (Barros et al., 2022). The GLM in sex offender treatment is a strengths-based model, which seeks to empower offenders to have their needs met in prosocial ways and changing behaviors that lead to offending by ultimately preventing recidivism (Dealey, 2018). The findings from this study highlighted a framework in which clinical mental health professionals who utilize the GLM for sex offender treatment hold overall positive perceptions towards offenders in sex offender treatment. The framework is distributed into four categories. The first category, treatment toward client, explored how clinicians view the offender/client as a human being and just like any other client for treatment not allowing any initial bias or judgement to impact their perceptions. The second category, emotions based off offense, explored the importance of collaboration to process difficult emotions if present and the overall positive and rewarding experience reported by participants while facilitating sex offender treatment. The third category, motivation to facilitate and utilize the GLM in sex offender treatment, revealed how professionals have similar reasons for continuing to utilize the GLM for treatment such as the strengths-based approach, accountability and wanting to make a difference. The fourth category explored influence on treatment outcomes, which highlighted that both the rapport built between the clinician and client and the client's willingness to participate in treatment have on overall treatment outcomes. These findings showed that clinical mental health professionals who facilitate sex offender treatment utilizing the GLM share an overall positive perception towards offenders and experience varying emotions and have multiple motivators and influences for utilizing the GLM in sex offender treatment.

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Appendix: Interview Questions

1. What motivated you to work directly with offenders by facilitating sex offender treatment?
2. What emotions do you experience during facilitation of sex offender treatment?
3. Do your emotions vary based off the type of offense the client has committed?
4. How do you perceive a new client for treatment?
5. Do your initial perceptions of the offender change your interactions with the offender?
6. What has your experience been facilitating sex offender treatment? Do you find it beneficial to the clients you work with?
7. What lead to you choosing the Good Lives Model in treatment versus standard treatment models?
8. What aspects if any, do you find effective within utilizing the Good Lives Model in sex offender treatment?
9. Have you experienced varying treatment outcomes for clients based off the level of rapport built with the client?
10. As a clinician do you feel your opinion of a client has an influence over how you interact? If so, what was your experience?
11. As a clinician do you believe your opinion of a client has an influence over overall treatment outcomes for the client?
12. In your opinion, based on your own experiences, what is the most influential aspect in successful outcomes of sex offender treatment?